CLINICAL PSYCHOLOGISTS' PERCEPTIONS OF THE PHENOMENON OF SCHIZOPHRENIA IN A PSYCHIATRIC SETTING IN THE EASTERN CAPE, SOUTH AFRICA

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COLETTE HAMMAN

Supervised by Alan Fourie

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ABSTRACT

Numerous international and South African scholars are critical of the dominant research on the phenomenon of schizophrenia. Rather than refuting dominant biomedical psychiatric conceptualisations of schizophrenia, there is a call for incorporating a focus on the psychology of the person diagnosed with schizophrenia. In South Africa, the integration of the psychosocial components of psychotic experiences into the understanding and treatment of psychosis are still neglected in biomedically-focused psychiatric settings. In relation to this call, the role of clinical psychologists working within these settings seems pertinent.

Against this background, this study aimed to explore and describe the perceptions of clinical psychologists, working in a psychiatric setting in South Africa, in relation to the phenomenon of schizophrenia. Informed by a social constructionist theoretical framework, this study utilised a qualitative research design and a semi-structured interview schedule. In-depth, individual interviews were conducted with three clinical psychologists and the transcribed interviews were analysed using thematic analysis.

From the data, perceptions were identified as largely polarised in relation to the phenomenon of schizophrenia. These polarised perceptions included: Physical impact of schizophrenia versus social impact of schizophrenia; rehabilitation of schizophrenia versus recovery within schizophrenia; diagnostic frameworks as useful versus diagnostic frameworks as limiting; and institutionally-defined identity versus self-defined identity. In terms of these polarised perceptions, an overarching theme of the medicalisation versus the demedicalisation of schizophrenia was identified. Therefore, the perceptions of clinical psychologists in this study were largely polarised towards either a medicalisation of the phenomenon of schizophrenia or a demedicalisation of it.

However, perceptions were also identified that evidenced an integration of the two sides of the polarities, and a holding of tension between seemingly incompatible or incongruent frameworks. The participants perceived psychologists as positioned in the middle ground between the medicalisation and demedicalisation of schizophrenia in a biomedical psychiatric setting. In response to the call for a focus on the psychology of the person diagnosed with schizophrenia, the findings support both the value and the need for an “integration of polarised perceptions”, “holding of the tension”, and “middle ground positioning” of clinicians between medicalised and demedicalised aspects of the phenomenon of schizophrenia.

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CHAPTER ONE: INTRODUCTION

The phenomenon of schizophrenia is generally considered to be one of the most severe mental illnesses (Mosotho, Louw, & Calitz, 2011). Schizophrenia is characterised by various factors, the most important being a chronic course and outcome (Mueser & McGurk, 2004), a combination of multiple aetiologies (Motlana, Sokudela, Moraka, Roos, & Snyman, 2004) and the large burden it imposes on affected individuals, their caregivers, and public health services (Chan, 2011). The burden of schizophrenia is said to be particularly substantial and on the increase in developing countries, including South Africa (Lund, Petersen, Kleintjes, & Bhana, 2012; Mayosi et al., 2009, 2012), with socioeconomic inequalities and poorly resourced public mental health care services (Motlana et al., 2004). It is argued that a poor understanding of the phenomenon of schizophrenia in the South African context adds to the burden thereof (Motlana et al., 2004).

The *American Psychiatric Association* (APA)'s *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; APA, 2013) states that there is no single symptom that is pathognomonic of schizophrenia, as it is a heterogeneous clinical syndrome. According to the DSM-5 (APA, 2013), people are diagnosed with schizophrenia if they manifest certain signs and symptoms of the illness for at least six months, with one month of "active phase symptoms" (i.e., two or more of the following: delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour, or negative symptoms such as diminished emotional expression, avolition, anhedonia, alogia and asociality).

Currently, the biomedical model is the dominant paradigm in modern health care used in most Western countries to diagnose disorders according to psychiatric diagnostic frameworks (Kirmayer, Lemelson, & Cummings, 2015). Although clearly contributing to the understanding and treatment of those diagnosed with schizophrenia, important questions have arisen as to whether the diagnosis provides a sufficient explanation or a meaningful understanding of the phenomenon of schizophrenia (Baumann, 2010). Reminiscent of the anti-psychiatry movement of the 1960s and the medicalisation critique of the 1970s and 1980s, recent critiques of the biomedical model of mental illness state that "the voice of the sufferer is silenced by virtue of being translated into the language of mental pathology, and the context of the suffering, is written out of the story" (Speed, Moncrieff, & Rapley, 2014, p. xv). A South African psychiatrist, Baumann (2010), claims that this is the reason why "an adequate understanding of the phenomena of the psychoses remains elusive", explaining that "the disease basis for schizophrenia, for example, is unknown, and the illness, as if outside a personal and cultural context, cannot define the person" (p. 279).

As such, rather than refuting dominant biomedical psychiatric conceptualisations of schizophrenia, there is a call for incorporating a focus on the psychology of the person diagnosed with schizophrenia (Cromby, Harper, & Reavey, 2013; Kirmayer et al., 2015). As such, a recent international proliferation in qualitative studies (refer to Boydell, Stasiulis, Volpe, & Gladstone, 2010; Geekie, Randal, Lampshire, & Read, 2012; Geekie & Read, 2009; Wood, 2013) focuses on incorporating psychological and subjective perspectives on the pathogenesis of schizophrenia, without disregarding the existing biological theories. An argument is made that the experience of schizophrenia can be viewed from different perspectives, each of which contributes to the understanding of the phenomenon in different ways (Geekie & Read, 2009).

The role of psychologists in relation to this call seems pertinent. Authors such as Barrett (1988, 1996) state that clinicians often filter the stories of mental health service users through diagnostic and therapeutic lenses that are tailored to fit pre-existing identities - for instance, that of a "schizophrenic". Psychologists have been urged to examine this practice critically, especially in biomedically-focused settings, in order to reflect on alternative ways of conceptualising schizophrenia without losing sight of the psychology of the person (Miller & Swartz, 1991). However, in South Africa, the integration of psychosocial components of psychotic experiences into the understanding and treatment of psychosis are still largely neglected in biomedically-focused psychiatric settings (Barnwell, 2015).

The current researcher explored in a previous study how individuals in the Western Cape province of South Africa experience and understand their diagnosis of schizophrenia and its associated symptoms (Hamman, 2017). The current study is a further effort to explore and describe the phenomenon of schizophrenia through a qualitative exploration of how clinical psychologists perceive schizophrenia in the Eastern Cape province of South Africa. It is hoped that this study can serve as a construction of useful knowledge that "constitutes an essential bridge between sufferer and helper - a platform for mutual understanding and for organising meaningful interventions" (Kirmayer et al., 2015, p. 648).

Terminology

In this study, the term “schizophrenia” will be used to refer to the psychiatric diagnosis of schizophrenia in the DSM-5 (refer to APA, 2013). This term is used to aid general comprehension and identify individuals who have met the symptoms in the DSM-5. While the term is used descriptively, it is acknowledged that the use of professionally clinical terms such as “schizophrenia” and “psychosis” are usually associated with the biomedical model and seen by some as labelling the experiences that these terms represent as “symptoms” of a “mental disorder” (Wood, 2013). As such, the current DSM terminology is used in this study where it has become the norm for discussing a particular phenomenon, while still trying to raise the critical awareness of the reader about the diagnoses that represent people’s distress (McWilliams, 2011). The use of the term “patient” is largely omitted in this study and substituted by “client”, “mental health service user” or “person diagnosed with schizophrenia”.

Research Aim

Against this background, this study aims to explore and describe the perceptions of clinical psychologists, working in a psychiatric setting in South Africa, in relation to the phenomenon of schizophrenia. In order to achieve this goal, the following research question was pursued:

- How do clinical psychologists working in a psychiatric setting in the Eastern Cape, South Africa, subjectively experience, describe and make sense of the phenomenon of schizophrenia? In other words, how do they construct schizophrenia?

Outline of Subsequent Chapters

Following from the introduction and description of the research aim in Chapter One, Chapter Two includes a literature review that considers three bodies of literature concerned with the phenomenon of schizophrenia as follows: The diagnosis of schizophrenia, the medicalisation of schizophrenia, and the psychology of the person diagnosed with schizophrenia. The research is also situated within a South African context. Chapter Three details the methods employed towards achieving the aim of this study, which includes a qualitative research design, social constructionist theoretical framework, a semi-structured interview schedule and thematic analysis. The results of the study and the subsequent discussion thereof in terms of relevant literature follow in Chapter Four. Lastly, in order to round off this exploration of the perceptions of psychologists in relation to the phenomenon of schizophrenia in South Africa, Chapter Five includes a summary of the findings, the limitations of the study, and implications of the study.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Schizophrenia is considered to be one of the most severe mental illnesses, imposing a large burden on developing countries, including South Africa (Lund et al., 2012; Mosotho et al., 2011). With this in mind, the current chapter consists of a literature review of the phenomenon of schizophrenia, which will focus on four broad areas, namely: (1) The diagnosis of schizophrenia, (2) the medicalisation of schizophrenia, (3) the psychology of the person diagnosed with schizophrenia, and (4) schizophrenia in the South African context. Firstly, in order to grasp something about the complexity of the phenomenon of schizophrenia, it is essential to understand how the concept of schizophrenia has developed over time. The discussion includes a critical view of one the current diagnostic frameworks of schizophrenia, by considering the anti-psychiatry movement. This is followed by situating the psychiatric diagnosis of schizophrenia within a critical discussion of the medicalisation of schizophrenia, with specific reference to the biomedical model of schizophrenia and the medicalisation critique. Next, an argument is made for focusing on the psychology of the person diagnosed with schizophrenia by looking at psychological processes, subjective experience, psychiatric transformations/constructions and the service user/survivor movement. Lastly, the phenomenon of schizophrenia is discussed in relation to South African research.

The Diagnosis of Schizophrenia

The Psychiatric Model

In contemporary psychiatric diagnostic systems, the diagnosis of schizophrenia is typically used to refer to a collection of illnesses in which there is partial or complete disconnection from reality; a syndrome that manifests in diverse symptomatology depending on a combination of external and organic factors (Berzoff, Flanagan, & Hertz, 2011). In the DSM-5 (APA, 2013), the psychiatric diagnosis of schizophrenia is listed in the chapter termed “schizophrenia spectrum and other psychotic disorders” which is organised according to a gradient of psychopathology. This chapter also includes schizotypal personality disorder and other psychotic disorders, such as brief psychotic disorder, delusional disorder, schizophreniform disorder and psychotic disorders induced by another condition. As mentioned in the introduction to this study, psychotic disorders are defined by abnormalities in one or more of the following domains: delusions, hallucinations, disorganised thinking, grossly disorganised motor behaviour and negative symptoms. Delusions are seen as fixed and rigid beliefs that are not amenable to change (APA, 2013). Hallucinations are seen as perception-like experiences that occur without an external stimulus (APA, 2013). This chapter in the DSM-5 emphasises that psychotic disorders are heterogeneous and that the time period and severity of symptoms are important predicting and distinguishing factors amongst the different disorders (APA, 2013).

The current nosological system of the diagnosis of schizophrenia can be traced back to the work of German psychiatrist Emil Kraepelin, who initiated the shift towards a more medical approach to mental health care by breaking down the notion of “insanity ”into disorders of mood (“manic depression”) and disorders of psychosis (“dementia praecox”) (Geekie & Read, 2009). Swiss psychiatrist Eugene Bleuler rejected Kraeplin’s pessimistic view of the prognosis of dementia praecox, developing this term into his own neologism “schizophrenia” in 1908 (derived from the Greek “skhizo” meaning split and “phren” meaning mind) (Geekie & Read, 2009). He distinguished between the “core symptoms” that were seen as pathognomonic and the “ancillary symptoms” that presented similarly in other disorders (Andreasen, 1997). Currently, the former is referred to as negative symptoms and the latter is referred to as positive symptoms (Andreasen, 1997). He argued that psychotherapy has the potential to affect variable outcomes in schizophrenia by working on repairing the “breaking of associative threads” between thoughts, behaviour and emotions (Birchwood, Hallett, & Preston, 1988, p. 16). This recognition of variability in outcome led to the development of various psychological theories, which claimed a psychological origin of schizophrenia (Wood, 2013). Amongst these theorists were Sigmund Freud, who preferred the term “paraphrenic” which disregarded the idea of a split in the psyche and rather argued that clients display the two fundamental characteristics of megalomania and withdrawn interest from the external world (Wood, 2013).

The plethora of signs and symptoms that were identified early on led to an over-diagnosis of schizophrenia during the 1960s and 1970s (Andreasen, 2007). In search of greater reliability in diagnosis, Kurt Schneider shifted the focus to what he called “first rank symptoms”, which is currently referred to as hallucinations and delusions (De Wet, 2013). Since then, what are currently classified as positive symptoms stand out as the symptoms in modern diagnostic frameworks that largely define the diagnosis of schizophrenia (De Wet, 2013). Schneider’s broad categorical approach to schizophrenia, together with the arrival of the DSM-III (APA, 1980), resulted in increased clarity about the symptoms associated with psychotic diagnostic categories as well as diagnostic agreement amongst clinicians and researchers (Flanagan et al., 2012). This also signalled an official shift to what is currently known as the dominant biomedical model of severe mental illnesses. This model classifies severe mental illnesses as brain diseases which can be diagnosed according to certain psychiatric diagnostic criteria (Karp & Birk, 2013).

The Anti-Psychiatry Movement

The anti-psychiatry movement of the 1960s refers to the works of psychiatrists and others who were critical of the dominant psychiatric claims and understandings around severe mental illness (Cromby et al., 2013). For example, Laing (1960) critically argued that traditional psychiatry tended to individualise and pathologise problems of living - problems which are actually rooted in relationships and existential questions about the meaning of life. As such, he perceived psychiatry as an agent of social control, with an unequal power relationship between the doctor and mental health service user. He rather attempted, with the use of clinical case studies, to understand the life world of people diagnosed with schizophrenia. Instead of perceiving schizophrenia merely as an illness in need of curing, he saw it as a journey, which can be distressing, yet also filled with meaning. While critics accused Laing of blaming families and relatives for what was seen as a biologically-caused illness, his theories continue to influence contemporary psychological theories that understand psychotic experience as having some inherent meaning and as related in some way to people's life experiences (Cromby et al., 2013).

Similarly, Szasz (1961) argued that, in psychiatry, the diagnostic process is highly subjective and therefore subject to social influence. He stated that someone suffering from a mental illness can fall victim to coercive and oppressive treatment by the discipline of psychiatry. His work remains influential in highlighting the importance of patient rights and consensual treatment practices (Cromby et al., 2013).

In Northern Africa, Fanon's (1963) *The Wretched Earth* explored the psychological effects of colonisation on a person. Fanon was inspired by the revolutionary struggles for independence when he established a form of socio-therapy, in stark contrast to an individualised psychiatry, which connects people's distress to their cultural backgrounds. His work emphasises the importance of culture in how people experience themselves and how power exerts an influence on how people define their identities (Cromby et al., 2013).

These above mentioned authors formed a part of a heterogeneous group (for other seminal writings, see Cooper, 1967; Foucault, 1963; Kleinman, 1988a; Rosenhan, 1973). Although they often did not identify themselves as anti-psychiatrists, their ideas were seen as part of the anti-psychiatry movement. Currently, these writings are seen by some people as out-dated and overturned by biological theories of mental illness. However, together with more recent challenges to the field of psychiatry (as mentioned below), the writings have continued to be valid and relevant (Jacobs, 2012).

The Medicalisation of Schizophrenia

The Biomedical Model

There exists a wide range of academic theories pertaining to the etiology of symptoms associated with the diagnosis of schizophrenia. Geekie and Read (2009) attempted to distinguish between the myriad of theories, namely: biological, evolutionary, neuropsychological, psychological, psychodynamic and psychoanalytic, communication and family, life event, sociological and anthropological, philosophical and existential, as well as spiritual theories of the etiology of schizophrenia. However, it seems that researchers are unable to agree upon the exact cause of schizophrenic symptoms (Berzoff et al., 2011).

Currently, the biomedical model is the dominant paradigm that is used in modern Western healthcare to diagnose disorders. The biomedical movement, or the "decade of the brain", gave rise to the dominance of biological theories of schizophrenia from within fields such as biological psychiatry and neurology. According to the biomedical model, health constitutes the freedom from disease, pain, or defect (Fernandez-Ballesteros, 2003). This implies that the "normal" human condition is "healthy" (Fernandez-Ballesteros, 2003). Geekie and Read (2009) state that biological theories assert that severe mental disorders, such as schizophrenia, are "abnormal" and "unhealthy" conditions mainly caused by biologically-based brain diseases which can categorically be separated from "normal" human processes. The essence of this biomedical position was articulated by former APA president Paul Applebaum, who noted that "our brains are biological organs by their very nature. Any [mental] disorder is in its essence a biological process" (as cited in Deacon, 2013, p. 848). Abnormal neurodevelopment (see Fish & Kendler, 2005; O'Donnell, 2007) and neurodegenerative processes (see Theberge, Williamson, & Aoyama, 2007) have for instance been widely studied as central to the prolonged dysfunction observed in the diagnosis of schizophrenia.

In line with biological theories of schizophrenia, a number of medications have been developed to minimise the symptoms associated with the diagnosis (Taylor & Ng, 2012). These medications include "typical" antipsychotics that are mainly found to reduce the positive symptoms of schizophrenia, but are also shown to result in a range of extrapyramidal side-effects such as restlessness, muscle stiffness and changes in breathing and heart rate (Berzoff et al., 2011). Thereafter, the “atypical” antipsychotics were developed to target both the positive and negative symptoms, with fewer side effects (Berzoff et al., 2011). However, metabolic side effects have been documented and the rates of noncompliance to these medications are very high (Berzoff et al., 2011). Medical treatments have also been shown to be effective in that it helps clients to manage many of the intense emotions of the illness experience (Taylor & Ng, 2012).

Various authors, including Andreasen (2007), Deacon (2013) as well as Kirmayer, Lemelson and Cummings (2015), recognise that biological theories of severe mental illnesses, such as schizophrenia, play a crucial role in informing both theory and practice and greatly broadening contemporary understandings of the phenomenon of schizophrenia. Biological theories have benefitted areas such as improving problem recognition, mobilising an effective response and also reducing the stigma associated with mental illness (Kirmayer et al., 2015). Standardised measures and operational criteria for disorders have also contributed to increasing the reliability of diagnostic concepts and improving communication among researchers and clinicians (Deacon, 2013). However, these authors also critique the extent of the usefulness of the biomedical model of mental illness and maintain that the concepts of illness and health have greater complexity (White, 2002).White (2002) argues that the model’s focus on physical processes (for example the pathology, biochemistry and physiology of a disorder) often does not take into account the role of social and environmental factors or individual subjectivity. Closely related to these critiques of the biomedical model, are debates around the medicalisation critique.

The Medicalisation Critique

The medicalisation critique was one of the most dominant perspectives in the medical sociology of illness and health during the 1970s and 1980s, reflecting concerns similar to the anti-psychiatry movement mentioned above. One of the main advocates for the medicalisation critique, Ivan Illich, emphasised a holistic approach to health that includes a focus on the spiritual, personal and social dimensions that are needed to cope with illness (Gillespie & Gerhardt, 1995). Other advocates of this critique disseminated strategies for demedicalising and diminishing medical power, arguing that it would improve the autonomy and control that people have over their own health (Lupton, 1997). More recently, authors from outside as well as inside the field of psychiatry, such as Speed, Moncrieff, and Rapley

(2014), again claim that “the neurochemical society that we currently inhabit acts to banish suffering by representing it as a condition arising from bodily dysfunction that needs fixing, rather than a social problem that needs redressing” (p. xv).

Most critiques against the medicalisation of severe mental illnesses revolve around (1) the slow progress in understanding and treating mental illnesses from a biomedical perspective, (2) the possible overdependence on medications and other biomedical treatments, as well as (3) the neglect of a focus on clients’ life worlds (Geekie & Read, 2009). Of the first of these critiques, Kleinman (2015) writes in the foreword to the current influential text *Re-envisioning Psychiatry*:

> After a half century of serious biological research, it seems that all but the true believers are beginning to lose confidence and are feeling ashamed of the simple fact that we do not understand the pathophysiology of depression, anxiety disorders, bipolar disorder, or schizophrenia. Nor do we possess a single biological test that can be routinely applied in the clinic to diagnose these or other mental disorders – which, given the large investments in biological research, is nothing short of scandalous (p. xvii).

Of the last of these critiques, Patel (2014), a psychiatrist and global mental health expert, problematises what he calls “the deliberate tilt in the balance between the personal narrative and the biomedical concept, toward the latter” (p. 17). Patel (2014) contends that mental health experts seemed to have set aside the complexity of the interaction between the social, cultural, political and historical contexts of suffering and as such, have lost touch with the lived emotional suffering of people in the world, especially in the developing world. Andreasen (2007), a prominent American neuropsychiatrist and neuroscientist as well as influential early advocate of the biomedical model of mental illness, describes in hindsight (see her earlier work, Andreasen, 1984) that the unfortunate results of current diagnostic frameworks of mental illness are that it can discourage clinicians to get to know their clients as individual people with interesting signs and symptoms. According to her, this can result in diagnoses that lack validity and have a dehumanising impact on the field of psychiatry. Related to this, are numerous studies (such as Lorem, Frafjord, Steffensen, & Wang, 2014) that have shown that medical treatments are sometimes presented as the only solution to emotional distress in psychiatric settings, with inpatients frequently being told to calm down, be silent or alternatively, get sedated.

Other authors, including Hornstein (2013), accept the usefulness of having criteria that distinguish one type of suffering from another, but argue that in order to be meaningful, diagnostic categories must stem from lived experience. She contends that the biggest problem with the DSM-5 is that it “continues unchallenged the tradition of adding to a profusion of diagnoses that are already so far away from lived experience as to have little clinical use” (Hornstein, 2013, p. 30).

Evidently, a review of the above mentioned literature highlights various critiques of the dominant biomedical psychiatric construction of schizophrenia. Traditions in fields such as critical psychiatry, medical anthropology, medical humanities, medical sociology, psychology, as well as theoretical frameworks such as social constructionism, have begun to address these arguments. Based on this, the current study argues that an understanding of the phenomenon of schizophrenia requires a depth of understanding that extends beyond the biomedically-focused diagnostic frameworks (Baumann, 2010); it requires incorporating a focus on the psychology of the person diagnosed with schizophrenia.

The Psychology of the Person Diagnosed with Schizophrenia

Psychological Processes

Continuing on from the anti-psychiatry movement and the medicalisation critique, the field of psychiatry has also more recently been challenged. Rather than refuting psychiatric and biomedical models of mental illness, there are also calls for incorporating a focus on the psychological understandings of people’s distress, or psychological understandings of the pathogenesis of mental illness. For instance, authors have increasingly argued for the use of narrative (Chase, 2005; Cohen, 2008; Holmes, 2000; Thomas & Longden, 2013) and other qualitative approaches (such phenomenology) to the study of mental illness in psychiatry (Baumann, 2010; Brown & Lloyd, 2001; Kirmayer et al., 2015; Whitely & Crawford, 2005). Research by psychologists in the field of psychosis - such as cognitive-behavioural therapy for psychosis and the stress-vulnerability model of psychosis - led to an interest in the psychological processes involved in schizophrenia. These psychologists emphasised emotional rather than cognitive factors and acknowledged that environmental factors, specifically social adversity, play a role in psychotic experiences (Read, 2010). Recent research also increasingly highlights the relationship between culture and distress in schizophrenia (Cromby et al., 2013).

Garrett and Turkington (2011) propose an integrated model that combines cognitive-behavioural approaches to psychosis with psychodynamic psychotherapy. Psychodynamic skills are seen by them as essential in long-term processes where the sense of self of someone diagnosed with schizophrenia, can be nurtured over time by “bearing empathic witness to the patient’s existence as a person” (Lysaker & Lysaker, 2010, p. 11). Psychoanalytic object relations theory is also argued to be useful in understanding the unconscious meaning of delusions and hallucinations, stressors and trauma, and the ways in which self-esteem is regulated (Klein, 1935). They argue that this provides a frame which lends depth of emotional understanding to the treatment process of psychosis. This is combined with a cognitive-behavioural technique that initiates treatment by working with returning so-called “thing representations” of mental life to the boundary of the self. In other words, the conscious experience of psychotic symptoms that are seen as an event in the outside world, is returned to the inner world of thoughts and feelings (Garrett & Turkington, 2011).

The stress-vulnerability model maintains that schizophrenia results from a biological, psychological or social stressor interacting with a biological, psychological or social vulnerability (Zubin & Spring, 1977). According to this model, a person with a possible biological vulnerability to developing psychosis might become ill in response to the stressors of ordinary life (Zubin & Spring, 1977). Similarly, other studies related to this model argue that illness precipitants can include genetic factors (where a family history of mental illness is known) combined with psychosocial stressors. Psychosocial stressors have been shown to include trauma, neglect and abuse, bullying or victimisation, discrimination, school-related stress, as well as family difficulties and adverse life events such as illness and poverty (Cadario et al., 2012).

In terms of culture, certain studies illustrate similarities amongst psychotic processes across different cultures (Read, Doku, & Aikins, 2015). However, numerous arguments have been posited for an attention to culture and context in psychological and psychiatric research, theory and practice - not only in response to human diversity, but also in response to recent advances in the understanding of the brain’s plasticity, attunement to social interaction and adaptability (Kirmayer et al., 2015). For instance, Kleinman (1988b) used constructionist ideas to define illness as a person’s experience of changes to the body, and advocated for a focus on the suffering of the person. He elaborated this idea into the concept of “explanatory models” of illness, meaning “the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process” (Kleinman, 1988b, p. 121). He argued that these explanatory models are derived from a cultural context and are constructed by individuals to give coherence and meaning to their suffering (Geekie & Read, 2009). Research (such as Davidson, 2003; Geekie & Read, 2009) has been consistent in demonstrating that people with psychotic experiences attempt to make sense of and construct explanatory models of their experiences. This links to cross-cultural studies that show, for example, how cultures such as the Maori in New Zealand regard voice-hearing not as an ilness in need of interverntion, but rather as a natural, everyday experience or a gift (Cromby et al., 2013).

Subjective Experience

It has been asserted that little is still known about the personal experience of schizophrenia, with few qualitative studies exploring how people diagnosed with schizophrenia experience and understand their psychological distress and their subsequent diagnosis (Walsh, Hochbrueckner, Corcoran, & Spence, 2016). As a result, together with the increased focus on the psychological processes involved in the phenomenon of schizophrenia, there has been a recent international proliferation in qualitative studies focusing on the subjective experience of individuals diagnosed with schizophrenia (Read et al., 2015). Additionally, over the last few decades, some first-person accounts of people diagnosed with schizophrenia have highlighted the subjective experience of “recovery”. This term does not indicate the traditional meaning of full clinical remission, but implies a subjective experience of being relieved of symptoms and severe impairments in social, occupational, and relational areas (Lingiardi & McWilliams, 2017).

Examples of research in terms of subjective experience, include Davidson (1992) and Hirschfeld, Smith, Tower and Griffen (2005) who used phenomenological and person-centred approaches to study schizophrenia. Within these conceptual frameworks, “people are viewed as purposefully engaged in meaningful life projects that extend over time” (Davidson, 1992, p. 4). Their findings suggest that factors such as hope, courage, a sense of self and being an active agent in the process of recovery, are crucial for improvement. Geekie and Read (2009), while conducting first-episode psychosis research at an outpatient community mental health care centre in New Zealand, identified the following themes in people’s descriptions of their lived experiences: Storytelling and authoring, causes of psychosis, describing the experience, impact of the experience, responses to and coping with the experience as well as spiritual and cultural issues. In a similar study, Larsen (2004) investigated the experience of clients of a Danish first-episode psychosis mental health service. Like Geekie and Read, the findings emphasised meaning-making as an active process, with individuals capable of demonstrating flexibility in their recovery process by relying on personal resources, such as spirituality. As such, Boydell et al. (2010), in their review of studies of first-episode psychosis, found that the majority of recent qualitative research presents findings on complex individual and social processes such as achieving identity, acquiring meaning, doing activities and developing relationships. Kirmayer et al. (2015) agree that it is crucial to include agency, meaning-making and regaining a sense of control into understandings and treatment of the phenomenon of schizophrenia.

Psychiatric Transformation/Construction

Barrett (1988), in writing about the "construction of schizophrenia" in psychiatric settings, referred to the following:

> In the telling and the response, the story became a living thing - a joint possession of the group and was to a certain extent already alienated from its hero…expropriated from its owner and taken over by a group which viewed it somewhat in the fight of a property or trust (MacCarthy, 1951, p. 77).

With the use of this quote, Barrett (1988) makes reference to how someone's story (or experience of schizophrenia) can become constructed by others (or the psychiatric team) into something removed from the subjective experience or the psychology of the individual with the diagnosis of schizophrenia. The notion of the construction of an illness has developed over several decades (Fried, Harris, Eyles, & Moshabela, 2015) and is a part of the social constructionist theoretical framework of this study (that will be discussed in Chapter Three). Apart from individuals' own notions about their illness, their illness experiences are often significantly influenced by the perspectives of clinicians, including psychologists. Barrett (1988, 1996) conducted a historical ethnographic study of a hospital unit in Australia specialising in the treatment of schizophrenia. He wrote about how the interpretative clinical processes of reading, writing and interviewing in a psychiatric setting tend to define, construct and transform clients, their identities, and their experiences of schizophrenia. In his observations, he traces the transformation of lay constructions of schizophrenia to professional constructions of schizophrenia (Barrett, 1988). According to him, these "psychiatric transformations" socialise individuals into new identities – with them being redefined as "schizophrenic patients" (Barrett, 1988). These and other studies (such as Bannister, 1985; Fried et al., 2015; Thorne & Robinson, 1989) point to the important influence of the perspective of clinicians in the psychiatric team, including psychologists, on the course and outcome of schizophrenia.

The Service User/Survivor Movement

So far, this literature review has highlighted, amongst other things, that certain assumptions underlying the phenomenon of schizophrenia and dominant models of making sense of this phenomenon, are problematic.It has been argued that there is a need for a new paradigm that incorporates a focus on the psychology of the person diagnosed with schizophrenia. Similarly, works (such as Bracken & Thomas, 2010) in support of the service user/survivor movement called for opening up a space "in which other perspectives can assume a validity that was previously denied [to] them" (p. 727).

The mental health service user/survivor movement is seen by some as the "new social movement" by people who have not only experienced mental distress and made use of mental health services, but have pursued positive change in mental health services and by extension a more positive perception of people diagnosed with mental illness (Cromby et al., 2013). This movement advocates for a more sensitive and sophisticated approach to mental distress and "madness", as well as a more nuanced perception of what "madness" is (Cromby et al., 2013). Supporters of the movement are also actively resisting the view that they are an incompetent group with a lack of insight into their difficulties. They rather assert their ability to make a positive contribution and display competency in self-help and self-organisations (Cromby et al., 2013). Therefore, a focus on individuals' own expertise and on the value of people offering mutual support, comfort and understanding beyond that which mental health professionals can provide (Cromby et al., 2013). In the words of Baker (1989)

> Fundamental to this approach…has been its emphasis on partnership between voice hearers themselves and professionals…this was a refreshing change from most of the approaches that I had come across before which rarely, if ever, gave such importance to the views of those who had actually experienced the mental health difficulties under consideration (p. 11).

An example of a self-organisation is the Hearing Voices Network (HVN). While the HVN recognises that hearing voices can be a debilitating and tormenting experience for some people, it disputes that the experience is a "meaningless" symptom of psychosis (Cromby et al., 2013). Rather, it promotes positive explanations for voice-hearing and supports individuals in finding frameworks for developing their own ways of coping (Cromby et al., 2013). In other words, voice-hearing is seen as a socially significant and psychologically interpretable event that is related to subjective experiences in a person's life.

Correspondingly, the HVN argues that understanding and accepting the subjective emotional experience and meaning of hearing voices is an important part of recovery.

Schizophrenia in the South African Context

It is possible that these above mentioned international studies do not adequately capture and incorporate the complexities of schizophrenia in the developing world (Baumann, 2010; De Wet, 2013). As such, the use of relevant local literature situates the phenomenon of schizophrenia in a South African context. The literature is arranged chronologically to illustrate the development of the phenomenon of schizophrenia in South Africa. There appears to be limited existing studies that research the phenomenon of schizophrenia from the perceptions of psychologists in the South African context. As such, local research will be discussed that relates to the constructions of mental illness and schizophrenia, culture, discourses in psychiatric settings, subjective experience of schizophrenia and psychologists working within the public mental health care system.

Over more than a decade, numerous articles from South African authors have paid attention to psychosocial, socio-historical and political factors (or the neglect thereof) of severe mental illnesses in public psychiatric settings. More than 20 years ago, Miller and Swartz (1991) informed psychologists working in hospital settings in South Africa to be aware of the subtle and powerful strategies employed to minimise and devalue the importance of psychosocial and cultural issues related to mental illness. They urged clinical psychologists to examine the biomedical model and its assumptions critically, in order to achieve new ways of constructing mental illness. Swartz (1991) argued from a social constructionist perspective, that the use of biomedicine in colonial Africa assisted in decontextualising the social and political influences of society on the development of pathology, by mostly highlighting the “natural” causes of pathology. It was further argued that biomedicine utilised scientific reasoning to colonise the “native” by emphasising the difference between different ethnic groups (Swartz, 1991). Research during this time also investigated concepts related to schizophrenia that was unique to the South African context, such as the concept of “ukuthwasa” - commonly used to describe the emotional turmoil of a person on a path to becoming a traditional healer and who is deserving of support, special treatment and sympathy (Swartz, 1998). The themes of jealousy, bewitchment, guilt and ancestral calling were also found to be common explanatory models for schizophrenia in Africa. As such, clients and families often support treatment and hospital admission for symptomatic control, together with further traditional interventions (Mbana et al., 2002).

More than 15 years ago, Cloete (2002) wrote about the underlying discourses observed in the practices of psychology and psychiatry, from the perspective of a clinical psychology intern working in a public psychiatric setting in the Western Cape. She stated that dominant discourses should be de-constructed and multiple “realities” incorporated in attempting to make sense of and work with mental illness. For instance, psychologists should acknowledge the usefulness of diagnostic categories, but at the same time remember that the categories are not all there is to psychological evaluation and therapy. Also, the perspectives of both the clinical psychologist and client should be perceived as two accounts of similar issues, with one not being “better” and the other not being “worse” (Cloete, 2002).

Yen and Wilbraham (2003) expanded on this research by noting, with the use of a social constructionist lens, that the diagnoses of clients’ illnesses, or “psychiatric formulations”, play a role in constructing the identities of the clients as well as practitioners. For instance, they observed that psychiatric conceptualisations (compared to psychological and traditional conceptualisations) carried the most value in a public psychiatric hospital setting in the Eastern Cape, due to the incorporation of the biomedical discourse. This acted to distribute power between a psychiatrist, clinical psychologist and indigenous healer in their study. They also examined how the power of the Western psychiatric discourse was specifically demonstrated by the use of the diagnosis of schizophrenia. By highlighting the empirical reality of schizophrenia, the extreme nature of the illness and the negative consequences of psychosis, it seemed to reinforce that the phenomenon was the expression of an underlying psychiatric disorder, instead of a “cultural illness”.

Thereafter, Elphick (2008) studied the constructions of borderline personality disorder by mental health professionals in a South African context. She again highlighted the problematic consequences of the biomedical model’s approach to situating the cause of mental illness within the individual. Thereby, the focus is on the individual as the site of pathology, rather than taking into account broader socio-cultural influences. She concluded that the universal biomedical understanding does not seem to provide a discursive space for alternative illness understandings within the South African mental health system.

Currently, the South African mental health care system still largely operates from within the biomedical framework, with biological theories of severe mental illness, such as schizophrenia, taking president (Barnwell, 2015). Barnwell’s (2015) research focused on the difficulties that clinical psychologists face in providing psychological services within this framework to people diagnosed with schizophrenia in the Eastern Cape. Clinical psychologists in his study felt like they have to assert and defend themselves and the identity of their profession in over-biomedicalised public mental health care settings. He stated that, if this is not done, clinical psychologists risk either being marginalised within multidisciplinary teams or “consumed” by the biomedical approach. Barnwell (2015) cautions that, by neglecting the integration of psychological interventions (that has been empirically shown to be valuable) into the treatment and management of schizophrenia in South Africa, psychologists may neglect the subjective experiences of their clients. He posits that this could have negative implications on the client’s healing process.

Building on this (and other) previous studies within the South African context, the current researcher recently conducted a social constructionist study on the subjective experiences of individuals diagnosed with schizophrenia in the Western Cape (refer to Hamman, 2017). Interviews with people carrying this diagnosis highlighted traumatic histories of abuse and submission. This highlighted the need to take individual histories seriously, even in people with a diagnosis of schizophrenia. The data further suggested that while all of the participants clearly had psychotic experiences, they also experienced rich and diverse emotional worlds. However, despite their traumatic experiences and in contrast to their complex experiences of emotional distress, participants, when discussing their diagnosis, both explicitly and implicitly adhered to a medical discourse of schizophrenia. Informed by this medical model, they constructed themselves as abnormal and as having a dysfunctional brain, which needs to be medically treated. Lastly, caring for others and being cared for by others seemed to be very important for restoring a sense of humanity. However, this care was mainly provided by families, rather than in the context of the psychiatric setting. It was argued by the current researcher that, despite the fact that the diagnosis is helpful and facilitates the medical treatment of the client, it can also obscure some of the very complex emotional experiences of individuals who carry the diagnosis - often meaning that mental health service users are not dealt with as complex human beings who have been hurt and also not defining themselves as such. The current study is designed to further explore and describe the phenomenon of schizophrenia in the South African context.

Conclusion

As has become evident, various authors have been critical of the psychiatric model as well as the biomedical model, both internationally and in South Africa. This specifically pertains to the psychiatric diagnosis of schizophrenia and the medicalisation of the phenomenon of schizophrenia. While the value of biomedical knowledge and psychiatric diagnoses within classification systems such as the DSM, are acknowledged, this research also calls for a focus on the psychology of the person diagnosed with schizophrenia. This call is supported theoretically, empirically and by mental health service users. The role of psychologists in relation to this call also seems pertinent. As such, drawing on social constructionist theory and its critique of psychiatric and biomedical constructions of psychopathology, this study will "…allow for, even encourage, multiple stories, and a multiplicity of 'truths'…" in researching the phenomenon of schizophrenia (Geekie & Read, 2009, p. 11).

CHAPTER THREE: METHODOLOGY

Introduction

In Chapter Two, a literature review concerned with the phenomenon of schizophrenia was discussed. A detailed description of the methods employed in the current study follows. This chapter includes a description of the qualitative research design of this study and a discussion of the theoretical underpinnings of the social constructionist framework. This is followed by issues pertaining to collecting data from the participants of this study. Thereafter, the implemented data analysis method is discussed. This chapter ends with an exploration of issues pertaining to validity, reflexivity and ethical considerations.

Methodology

Research Aim

The previous chapter argued for a focus on the psychology of the person diagnosed with schizophrenia as well as the role of psychologists in relation to this call, also in South Africa. This study therefore set out to explore how clinical psychologists, working in a psychiatric setting, perceive the phenomenon of schizophrenia. The underpinning question of the research is: How do clinical psychologists working in a psychiatric setting in the Eastern Cape, South Africa, subjectively experience, describe and make sense of the phenomenon of schizophrenia? This aim was engendered by a social constructionist theoretical perspective and qualitative research methodology, which included a semi-structured interview schedule and thematic analysis.

Research Design

The research design of this study, informed by social constructionism, is qualitative in nature. According to Willig (2013), qualitative research methodologies are concerned with how individuals experience and make sense of phenomena in their world. It therefore focuses on exploring subjective aspects of human experience and reflecting upon it in a way that leads to a deeper and more complex view of personal subjectivity that is often overlooked in quantitative research methodologies (De Vos, Strydom, Fouche, & Delport, 2005; Terre Blanche, Durrheim, & Painter, 2006). Qualitative research also highlights the nature of phenomena in different contexts (Mason, 2002). Denzin and Lincoln (as cited in Mertens, 1998) effectively capture the definition of qualitative research as follows:

> Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them (p. 160).

A qualitative research design is therefore concerned with (1) exploring the subjective understandings and experiences of participants in relation to other people and their contexts; (2) the way in which social processes and discourses work; and (3) the significance of the meanings that are generated (Mason, 2002). This made it the clear methodology of choice for studying the perceptions of psychologists, working in a South African psychiatric setting, of schizophrenia.

Theoretical Framework

This study is located within a social constructionist theoretical framework. This framework determined which aspects of the phenomenon under investigation are attended to or not attended to, the method utilised to investigate the phenomenon, and the ways of understanding and presenting the findings. Social constructionism - a postmodern and poststructuralist way of understanding the world (Andrews, 2012) - encourages a critical and sceptical stance towards what is typically seen as general, objective knowledge in the positivist tradition in science (Burr, 2003). Social constructionism challenges essentialist or realist theories by theorising that reality is socially constructed. As such, rather than searching for the “true” meaning of psychosocial phenomena, social constructionism highlights the ways in which the meaning of phenomena is negotiated, the ways in which those in power often determine the meaning of phenomena, and the ways in which meaning of phenomena is represented in language (Hare-Mustin & Marecek, 1990). In other words, in challenging the scientific notion of positivism, social constructionist researchers engage in an active and subjective approach of becoming involved in trying to understand the ways in which different people make sense of phenomena in different contexts (Burr, 2003).

From a social constructionist point of view, there is a strong focus on the social and relational issues that influence the construction of a person’s reality (Owen, 1990). This perspective suggests that people, as social beings, are complex constructions influenced by their cultures and histories (Owen, 1990). Knowledge is therefore not seen as universal and eternal, but rather influenced by the values of individuals in specific social- and political contexts (Stoppard, 2000). Also, as language is seen as constructive in this framework

(Macleod, 2002), studying a phenomenon from a social constructionist perspective often includes examining the underlying dominant discourses (or systems of reasoning) that pre-exist in a certain context (Willig, 2013). Therefore, this framework suggests that there exist "knowledges", "meanings" and "realities" instead of a single "knowledge", "meaning" or "reality" (Willig, 2013).

Social constructionism is particularly relevant in the study of illness, health and diagnosis (Parker, 2006). In medical sociology, the social construction of illness and diagnosis is explored by examining how social forces shape the understandings of and actions taken towards health, illness and healing (Brown, 1995). In accordance with the approach of Brown (1995), this study included the understanding that people make sense of their own and others' illnesses largely in accordance with the dominant social elements of medical knowledge. This study also includes a critical view of the phenomenon of schizophrenia in a psychiatric context dominated by the biomedical model. As such, while biomedical components were seen as useful, there was also a focus on how schizophrenia is socially constructed by different individuals in a particular context (Gwyn, 2002). This study therefore focuses on how the phenomenon of schizophrenia is constructed in a specific context based on people's experiences, understandings and descriptions of it. There is also an acknowledgement of the discursive nature of a construction, as the use of language in specific cultural, social and historical contexts can influence the meaning of an illness (Willig & Stainton-Rogers, 2008). It is argued that, if schizophrenia research increasingly focuses on how mental health service users and mental health professionals experience and make sense of the phenomenon of schizophrenia in different social, cultural and institutional contexts, it can lead to new and alternative meanings of schizophrenia. Brown (1995) explains this further as follows:

> We may consider the social construction of a phenomenon to involve a multiplicity of social forces that combine to create and modify the phenomenon. Rather than a given biomedical fact, we have a set of understandings, relationships, and actions that are shaped by diverse kinds of knowledge, experience, and power relations, and that are constantly in flux (p. 34).

Participants

Sampling. The current study made use of purposive, non-probability sampling, as three participants from the target population, who met the inclusion criteria and with direct reference to the research question, were included in the study (Bless, Higson-Smith, & Sithole, 2001). As mentioned before, in qualitative, social constructionist research, the focus is on rich, detailed understandings of phenomena from the experiences of specific participants (Reid, Flowers, & Larkin, 2005). As such, a smaller sample size is acceptable so that allowance can be made for sufficient in-depth engagement with each individual participant (Bless et al., 2001). The aim of this study was not to make generalisations (Bless et al., 2001) of the phenomenon of schizophrenia as it applies to the wider population of psychologists in South Africa, but rather to investigate the subjective experiences, descriptions and understandings of the phenomenon of schizophrenia for these particular participants. In order to guide the sampling of participants, inclusion criteria were as follows: (1) Clinical psychologists registered with the Health Professions Council of South Africa; (2) currently employed in a psychiatric hospital setting in the Eastern Cape, South Africa; and (3) who have had experience of working in this context with people diagnosed with schizophrenia.

Recruitment. Once ethical approval was obtained from the Psychology Department at Rhodes University, the head of clinical psychology at the chosen psychiatric institution was contacted over email to request permission to recruit participants through the institutional population of psychologists (Appendix 1). Once the proposal was reviewed by the research committee of the institution and permission was granted in writing by the head of clinical psychology, psychologists were contacted with the use of a list of contact details provided by the institutional clinical psychology head. The 10 psychologists on this list, who all met the inclusion criteria, were emailed and provided with information detailing the study (Appendix 2). This initial email specifically mentioned that care will be taken as to not interfere with health service delivery during participation and that confidentiality and anonymity of the study will be prioritised. This included omitting the socio-demographic details of the participants, their institutional affiliation and any specific information about patient-clinician relationships. Protecting the anonymity of the participants was seen as of specific importance in this study due to the limited amount of staff in the hospital and small size of the community where the hospital is located. For the three psychologists who, in the end, were able to participate, meetings were scheduled in order to obtain informed consent and conduct the interview at the particular institution.

Data Collection

Data for the current study was collected by means of conducting individual, in-depth, open-ended, and semi-structured interviews (Appendix 4) with the sample of three clinical psychologists, at a psychiatric setting. According to Willig (2013), semi-structured interviews are the most widely used data collection method in qualitative research and is in congruence with thematic data analysis (as discussed below). The semi-structured interview schedule indicates the areas of interest that were covered by means of the interview and provides an outline of the general style of interviewing. The aim of this semi-structured design was to provide a degree of structure to the interviews while maintaining flexibility within this structure that would allow for participants to share their subjective perceptions.

Following Willig and Stainton-Rogers's (2008) guidelines for conducting open-ended interviews, as well as the skills suggested by Kirmayer et al. (2015), the interviews were conducted in an open and informal manner in order to build rapport and encourage spontaneity of interaction from the participants. The researcher attempted to ask as few questions as possible, while implementing active listening techniques such as positive attending, paraphrasing, summarising, clarifying and reflecting (Fisher & Embree, 2000). In this way, participants often led the interviews into novel and unexpected areas, which elicited rich, detailed data and thick descriptions regarding their perceptions. As mentioned, issues of confidentiality, privacy and anonymity were discussed and implemented, contributing to an open and trusting relationship between the researcher and participant.

The interviews were conducted in the private offices of the psychologists at the relevant psychiatric institution, at a time and date most suitable for them. The three participants were each interviewed once, with the interviews lasting between 60-90 minutes. The interviews were conducted by the researcher in English, as all the participants were proficient in this language. After discussing with the participants that the interviews will be recorded and in which manner these recordings will be used, the interviews were audiotaped and transcribed verbatim following the suggestions of Kvale (1996).

Data Management

Certain data management techniques were implemented to respect the anonymity and preserve the confidentiality of what participants shared with the researcher. The interview data, audio recordings and transcriptions were stored electronically on a private computer in files that were protected by passwords which were securely stored. Hard copies of transcripts were destroyed after use. Only the researcher and research supervisor had access to the data. Upon completion of the study, the audio-recordings will be erased. In addition, the names and surnames of participants were not used in any of the data collected and transcribed. Participants were given a pseudonym that was linked to their data, and these pseudonyms were used in the current document and will also be used in any future academic outputs, such as presentations and published articles.

Data Analysis

When considering a data analysis approach most suitable for the research question of this study, thematic analysis was deemed most appropriate. Braun and Clarke (2006) argue for the use of thematic analysis as a useful and flexible qualitative analytic method within psychology. They argue that it provides a guide for identifying, analysing and reporting patterns or themes within the data (Braun & Clarke, 2006). The researcher is said to play an active role in identifying, selecting and reporting themes to readers (Braun & Clarke, 2006). Specifically relevant for this study, is that thematic analysis provides a rich and detailed, yet complex, account of the data and is compatible with constructionist paradigms within psychology (Braun & Clarke, 2006). In this study, thematic analysis, informed by a social constructionist theoretical framework, examines the ways in which perceptions, descriptions, experiences and meanings are influenced by a range of discourses operating within society. It acknowledges the ways in which people make meaning of, or construct, their experiences and, in turn, how the broader context influences these meanings (Burr, 2003). This type of thematic analysis tends to focus more on identifying latent themes within the data (Braun & Clarke, 2006). This implies that the analysis goes beyond the semantic content of the data, and attempts to examine underlying ideas, assumptions and conceptualisations that shape the semantic content of the data (Burr, 2003).

The process of thematic analysis, informed by social constructionism, as described by Braun and Clarke (2006), consisted of six phases. Firstly, the researcher familiarised herself with the data by transcribing the data herself. The first interview was transcribed verbatim within a week of conducting the interview, before proceeding to conduct subsequent interviews. This gave the researcher a thorough understanding of the transcription process in order to proceed with the following interviews with more insight and skill. Due to the constructive nature of transcripts, the research interviews were transcribed by the researcher herself as well as listened to for a second time after transcription. This provided the researcher with a good overview of the data and ensured that she engaged with the data even before beginning with the analysis process. It also enabled her to attempt to clarify unclear words or narratives and recall non-verbal communication such as silences, tone of voice, or laughter. This was followed by the reading and re-reading of these transcripts to structure initial ideas. Secondly, initial codes were generated by coding interesting features of the data according to the research aim across the entire data set and then collating data relevant to each code. The ATLAS.ti qualitative data analysis programme was used in order to assist in coding the transcripts and generating lists of initial codes. Next, codes were manually organised into potential themes and data relevant to potential themes, was gathered. Fourthly, themes were reviewed in relation to the coded quotes and also the entire data set. Themes were refined by generating clear definitions and names of each theme. All themes were also included into the overall narrative of the analysis. Finally, the written report of the analysis was produced (see Chapter Four) which included selecting compelling quotes in support of the themes and relating the analysis back to the research question and the literature (Braun & Clarke, 2006).

Throughout the study, the data was continuously revisited and read interpretatively and reflexively. Particular emphasis was placed on reflexivity throughout this study as the manner in which researchers interpret the participants' experiences, is directly influenced by their own experiences and understandings (Willig & Stainton-Rogers, 2008). The application of reflexivity in this study will be explored next.

Reflexivity

As mentioned earlier, social constructionism is understood as implying the impossibility of the existence of an absolute knowledge or "truth" in human psychology (Willig, 2013). Social constructionism goes further by acknowledging that knowledge is negotiated and created - or co-constructed - out of assumptions and ideas made available through interpersonal and social contexts (Willig & Stainton-Rogers, 2008), including influential psychological theories. Social constructionist psychological research then should be concerned with reflecting on the participants' as well as the researcher's ideas and assumptions rather than uncovering "truths" about people and the world around them (Willig & Stainton-Rogers, 2008).

As the personhood of the researcher is clearly involved in the current study, the researcher saw herself as a co-creator of the psychological knowledge that was constructed in the interaction between the researcher and participants. Instead of viewing the subjective influence of the researcher on the study as a methodological problem, as in conventional positivist research ideas, an awareness of what the researcher brings to the interaction is seen as useful and relevant (similar to psychoanalytic approaches in psychology):

> Subjectivity is viewed by psychoanalysis, as with much qualitative research, not as a problem, but as a resource (and topic). To draw upon one's own subjectivity in the research process does not mean that one is being "objective", but that one actually comes closer to a truer account. In psychoanalytic terms, the "investment" the researcher has in the material they are studying plays a major role in the interest that will eventually accrue from the research (Parker, 2005, p. 117).

In order to maintain this appreciation of the influence of subjectivity on the research, the researcher adopted an analytic stance which consisted of maintaining "free-floating attention". This, according to Kvale (1996), is a serious, non-intrusive, yet ruminative and reflective type of activity - used to facilitate a conversation in which the participants are encouraged to talk freely and thoughtfully, while an awareness is being held by the researcher of issues such as personal subjectivity, the discursive context, the relational characteristics of the interview, as well as personal reasons or motivations for the phenomenon under study. Therefore, the findings that will follow are, very importantly, the researcher's "making sense" or co-constructing of psychologists' perceptions.

The researcher kept an awareness of her positioning as a white woman who grew up in a middle-class and urban community in the Western Cape. She is currently a clinical psychology student and intern working in a state hospital in the Eastern Cape province of South Africa. In this context, the researcher is surrounded by people involved in and influenced by the "language" and "discourses" of modern Western practices of psychiatry and psychology, in a largely biomedicalised setting. As a "new" therapist and clinician in such a setting, the researcher is aware of experiencing a sense of wanting to be a "better" psychologist and provide a "better" service. This need might be due to a longing "to be of use" or "do more" in response to some personal insecurities. These securities are often tied to underlying emotions such as shame, guilt, disconnect, and anxiety of "not knowing what to do or how to be" in relation to a person suffering from and experiencing this mysterious illness diagnosed as schizophrenia. In a postmodern and post-structuralist era this might be understood as a need to deconstruct the dominant existing discourses and pay attention to the concepts of justice and care in the practice of psychology in order to assist in facilitating a more just and caring service to clients (Cloete, 2002). This informed for instance the way in which the interviews particularly focused on exploring the complexities of schizophrenia as a phenomenon, rather than only in the diagnostic sense. The aim of the study is in line with the writings of Estroff (2004) that suggest expanding schizophrenia paradigms to welcome, acknowledge and include new understandings, perspectives, contradictions, and complications.

Furthermore, in thinking about some of the assumptions and power hierarchies that are often taken for granted within psychological and psychiatric disciplines and settings (Cloete, 2002), the researcher maintained an awareness of the representation of the people who this study is centred on (Chase, 2005) - people suffering from and experiencing the distress and symptoms associated with schizophrenia. The researcher again referred to the writings of Estroff (2004) in terms of important concerns regarding the professional dominance of knowledge production and reproduction. Estroff (2004) raises the following questions: If researchers and clinicians do not know what living with schizophrenia is like, and therefore lack the knowledge to sufficiently understand the experience, does it challenge their authority to write about and dictate treatment for and the management of schizophrenia? On the other hand, as mental health service users often struggle to acknowledge, remember or gain insight into the experience and the associated diagnosis, does that give researchers a responsibility to indeed study this phenomenon to the best of their abilities?

The aim of this research was then not to search for the “truth” behind schizophrenia, but rather to reflect on how it would be possible to think differently in representing phenomena such as schizophrenia; to explore the experience of the psychologists working with schizophrenia, the experience of people suffering from schizophrenia and the experience of researchers who study schizophrenia. It is hoped that this research will be applicable outside of academia and affect social change in the lives of the people who have experienced psychosis or schizophrenia.

Processes of Validation

Validity and reliability are essential concepts in research to ensure the credibility and trustworthiness of work, specifically pertaining to qualitative research findings. This is because qualitative research has been criticised for its limitations of interpretations of data, allowing subjectivity to influence interpretations and its lack of transparency of theoretical paradigm and methodological steps. According to Golafshani (2003) as well as Hollway and Jefferson (2000), criteria traditionally applied to quantitative research, such as reliability, objectivity, and generalisability, should be considered for re-definition in order to render them applicable to qualitative studies.

Firstly, reliability in qualitative research can be understood in terms of the concept of credibility. Qualitative researchers can make their research credible by focusing on interpreting their research findings from different angles, acknowledging the possibility of various interpretations of data, and exploring the same issues in-depth or in different contexts (Willig, 2013). This study followed Davidson's (2003) suggestion to provide descriptive detail in quotes from participants to allow for contradictory and alternative meanings (such as the opposing perceptions referred to in Chapter Four) to emerge from the data. This includes looking for data that did not fit in with the identified themes and in this way ensuring that all the relevant data have been attended to (Yardley, 2008).

Secondly, validity in qualitative research can be understood in terms of the concepts of recognisability and trustworthiness. Janesick (2000) explains that this has to do with providing explanations or interpretations of the data that fit the description in a way that is trustworthy, or methodologically, rhetorically and clinically convincing. In an attempt to avoid decontextualizing data, thematic analysis in this study focused on taking extensive verbatim quotes from the raw transcribed data, to serve in support of selected themes. The resulting analysis were also revised regularly and checked during supervision with the research supervisor to ensure that the analysis did not stray from the raw data itself.

Thirdly, generalisability can be understood in qualitative research terms in terms of the concept of transferability. Bryman (2012) suggests that the researcher can ensure that research is transferable by providing adequate descriptions of methodology so that it can be reproduced and applied to different samples and in different contexts. This was attended to by aiming to follow a clear, visible, and systematic research process as far as possible (Patton, 2002), as evident in this chapter.

Ethical Considerations

Ethical clearance for the current study was obtained from the Humanities Higher Degrees Committee (HHDC) of Rhodes University through the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department (PSY2017/36) (Appendix 5). The following general and specific ethical considerations were implemented:

General ethical considerations. According to Ponterotto (2013), informed consent in constructionist paradigms can pose challenges, as neither the researcher nor the participants can be certain of where the interviews will lead or what will be uncovered. The researcher can therefore not be certain of what they should be preparing the participant for as part of obtaining an informed consent. Informed by this awareness and in an attempt to be transparent and minimise uncertainties, participants were fully informed prior to the interview about the nature of the study as per the informed consent form (Appendix 3). These consent forms highlighted the following: (1) the nature of the research, expected duration and procedures; (2) the contact details of the supervisor and researcher; (3) the participants' rights to decline to participate and to withdraw from the research at any point; (4) that the participants are free to voice concerns they might have or develop about their participation in the study; (5) that confidentiality and anonymity will be prioritised; (6) that the interviews will be audio-recorded; (7) the dissemination of findings; (8) the feedback of findings to participants; and (9) that the necessary ethical clearance has been granted. All the participants signed these forms that are meant to protect the participants' as well as the researcher's rights and contribute to the transparency of the research procedure (De Vos et al., 2005).

Specific ethical considerations. Kritzinger, Kritzinger, and Saunders (2015) are of the opinion that anonymity should be viewed on a continuum as it is idealistic to assume that a researcher can achieve complete anonymity of participants. The qualitative researcher is often engaged in a balancing act - on the one hand, trying to protect the identities of the participants and on the other hand, maintaining transparency and integrity of the data. However, specific ethical measures were taken in this study to attempt to preserve confidentiality and anonymity with respect to collecting and analysing data: (1) Participants' identities were protected by using pseudonyms and by excluding any identifying information. The informed consent form explained that the findings may contain information about their personal perceptions about the phenomenon of schizophrenia, but that the research report and any future academic outputs will be designed in such a way that it will not be possible to be identified by the general reader; (2) The institutional affiliation of the participants was redacted from the report and the interview transcripts, so as not to affect the reputation of the institution or affect the anonymity of the participants; (3) The patient-clinician relationship was respected and confidentiality ensured through there being no requirement of participants to divulge information about their clients. The researcher rather sought broader/general comments about the phenomenon than specific identifiable information.

Furthermore, risks of the study were minimised as far as possible by reminding participants that they are free to decline to talk about issues during the interviews and that they are free to withdraw at any point during the study as well as by providing them with the contact details of the researcher and supervisor. Also, as the researcher is a student psychologist and has previously conducted interviews as part of a previous study, she employed her experience in interviewing to minimise risks. It was made clear that participants would not receive remuneration for their participation in this study. However, the potential benefits of the study were discussed, such as helping clients in the future by helping healthcare providers gain a better understanding of how to best understand and treat schizophrenia-related illnesses, specifically in the South African context. Voluntary participation was also ensured in that institutional gatekeepers, such as the clinical psychology head, were not, apart from granting initial access permission, involved in the recruitment of participants. Furthermore, participants were asked at the end of the interview whether they would like to have feedback about this study. Those who agreed will be provided with a copy of the research project once it is completed. Permission was also requested from participants for academic dissemination of results, including in academic journals and at academic conferences. In all instances of dissemination of results, care will be taken to ensure that individual participants and institutions are not identifiable.

Conclusion

In this chapter, the qualitative research design of this study, informed by a social constructionist theoretical framework, was explained. The data for this study was obtained through individual, open-ended, semi-structured interviews with three clinical psychologists working in a psychiatric setting in South Africa. This data was analysed by implementing thematic analysis as set out by Braun and Clarke (2006), which will be presented and discussed in the following chapter. Finally, issues pertaining to validity, reflexivity and ethical considerations inherent to the study, were also discussed.

CHAPTER FOUR: RESULTS AND DISCUSSION

Introduction

The aim of this study was to explore and describe the phenomenon of schizophrenia from the perceptions of clinical psychologists working in a psychiatric setting in South Africa. This chapter details and discusses the themes identified through a thematic analysis of the data informed by social constructionism. After multiple readings of the transcripts, a prevailing sense of opposing or polarised perceptions was identified within and between transcripts. In terms of these polarised perceptions, an overarching theme of Medicalisation versus Demedicalisation of Schizophrenia was recognised. Therefore, the perceptions of clinical psychologists in this study were polarised towards either a medicalisation of the phenomenon of schizophrenia or a demedicalisation of it. At times, there were also perceptions that evidenced a combination or integration of the two sides of the polarities.

For the purposes of this study, the following definition of medicalisation was adopted: “Medicalisation consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to ‘treat’ it” (Conrad, 1992, p. 211). This often includes instances whereby non-medical and social problems or human conditions become defined and treated as illnesses or disorders (Conrad, 2007). Demedicalisation then is seen as the obverse of medicalisation; therefore, the process by which a problem ceases to be defined as an illness or a disorder (Conrad, 2007). The divide between the medicalisation and demedicalisation of phenomena is also reflected in the literature, particularly the medical sociology literature on health and illness (e.g. Halfman, 2011). Chapter Two reflected something of this divide in terms of reviewing the literature on the medical and psychiatric models of schizophrenia, compared to the psychology of the person diagnosed with schizophrenia.

The overarching theme of Medicalisation versus Demedicalisation of Schizophrenia informed the structuring of the write-up of the results. As such, each theme will be discussed in terms of sub-themes that are polarised towards either a medicalisation of schizophrenia or a demedicalisation of schizophrenia. This chapter is structured according to these polarised perceptions, as follows: (1) Physical Impact of Schizophrenia versus Social Impact of Schizophrenia; (2) Rehabilitation of Schizophrenia versus Recovery within Schizophrenia; (3) Diagnostic Frameworks as Useful versus Diagnostic Frameworks as Limiting; and (4) Institutionally-defined Identity versus Self-defined Identity. It is the tension between these polarised perceptions of the phenomenon of schizophrenia which becomes evident within this research. A fifth theme, Integrating Polarised Perceptions of Schizophrenia, evidences a combination or integration of medicalisation and demedicalisation and a holding of the tension between these seemingly incompatible or incongruent frameworks. Direct quotes from the data are included in order to both substantiate themes and evidence some of the complexity inherent in the phenomenon of schizophrenia, as discussed in the literature review.

Results and Discussion

Physical Impact of Schizophrenia versus Social Impact of Schizophrenia

On the one hand, the phenomenon of schizophrenia was perceived as a physical illness that is located in the brain. The participants spoke about it in terms of the physical impact on the body and the brain. Schizophrenia was also associated with marked and irreversible degeneration, specifically in terms of what are classified as negative symptoms. This perception can be seen as polarised towards a medicalised view of schizophrenia. On the other hand, the phenomenon of schizophrenia was depicted in terms of the social impact that it has on people's lives. This perception can be seen as polarised towards a demedicalised view of schizophrenia. Therefore, the phenomenon was perceived as physically, but also socially, erosive.

Physical impact of schizophrenia. Participant 2 **(**P2) stated that schizophrenia is a physical illness, caused by an abnormality in the brain. In the *APA Dictionary of Psychology*, "abnormal" refers to any deviation from what is considered typical, normal, usual, or healthy, particularly if the deviation is considered as maladaptive - an interruption to or restriction of daily life that is either distressing for others or distressing for the self (Van den Bos, 2015). For this participant, the abnormal physical nature of schizophrenia implies that it is a severe illness. Schizophrenia was contrasted to mental illnesses of a more "emotional" nature that might be socially constructed. Similarly, Participant 1 (P1) described schizophrenia in terms of physical loss as well as chronic and acute side-effects of medication.

> P2: *So at ***[1] [name of university][2] we did lots of social constructionism, like mental illness is a social construct – it's not...it's not real or it's something we've created or like some mental illnesses – like it's emotional, you need therapy, it's not a physical illness and then...schizophrenia for me is like the one that is 100% physical. Like it's a physical illness. Like it's something in the brain. So it's severe. Like the things*

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[1] ***: Text omitted to maintain confidentiality and anonymity

[2] []: Indicates additional words for clarification purposes

> *people – either the distorted beliefs they have or the hallucinations they have or the...like the level of the disorganisation of thought or behaviour is something in their brain that's gone very wrong and...*
>
> P1: *Uhm physically we can start with that. So, you know you got the acute side effects of anti-psychotics but then you've also got the chronic, so lots of people will have tardive dyskinesia so something kind of marring – you know you think about the stigma of mental illness – here's this person that looks...for lack of a better word...mad you know they look - there is something very obvious about the fact that their mouth is doing something that is not what you would normally associate – or that they did not have 14 years ago - that the community will notice. The stiffness, the weightgain, you know that's another problem, so...suddenly you're taking this mediction to take away your psychosis, but due to the fact that the medication has made you put on 20kg's, now you've developed type 2 diabetes. Now you're having problems with your feet, you know, so, uhm...so, there are so much loss physically.*

Similar to P2's description of schizophrenia as "severe", P1 associated the course of schizophrenia with irreversible and marked cognitive damage, fall-out and degeneration. Schizophrenia was also constructed as a long-term and cruel illness - resulting in a "hollow shell of a person".

> P1: *Seeing the lifespan of someone with schizophrenia, I find it a very cruel disease and lots of people have used this phrase – this is the phrase that doesn't sit comfortably with me, but "the hollow shell of the person" – you will hear people say that around someone who has had schizophrenia for 20 years. I think the level of degeneration that happens with an illness is so marked...*
>
> P1: *I think we sometimes focus on the positive symptoms so much because I think they – they're there. The deficits are easier to forget. But those are sometimes the long-term difficulties that patients really need help with, don't know if we always...focus on the long-term effects or the consequences of fall-out. Ja.*

Social impact of schizophrenia. Apart from the physical impact, P2 stated that the illness also has a particularly "eroding" impact on a person's life. P2 as well as P1 explored the impact on the family system and damage to relationships.

> P2: *Because over time it takes so much away from them. And for me in that way schizophrenia is different to depression or anxiety disorders or eating disorders – any of the other... axis I disorders...'cause it seems to really erode what you're able to do with your life and that's sad.*
>
> P2: *I've had – one was this year, like the wife of a patient who had first episode psychosis and obviously it impacted on her, because imagine that you got married and everything is fine and your husband has a (sigh)*[3] *– and what does that mean for the future.*

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[3] (): Refers to nuances in non-verbal behaviour

> P1: *Also family members who've perhaps invested in maybe this is their son and this is the first family member who's ever made it to university and now...and also you think about kind of when the illness expresses itself, sometimes it is when someone is in varsity, you know, it's that 19/20 year old, uhm. That loss is shared by that family system.*
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> P1: *And I also think families are quite...(sigh) there is a lot of wandering around you know perhaps a lot of families find it difficult to uhm really look after someone who is perhaps in a prodrome or starting to get unwell. How to manage this. There has been extreme cases where families have really been desparate and tied a sufferer up uhm...you know you can understand how that must have – how that will impact on relationships.*

Due to this social impact of schizophrenia, P1 highlighted the problematic lack of and need to establish so-called "scaffolding" after deinstitutionalisation. For this participant, this "scaffolding" included establishing community support in order to support the family and create a sense of community. This, according to her, can contribute toward repairing what is referred to in the literature as the "revolving door phenomenon" - the repeated re-admission of people to hospitals or other institutions, often because they were discharged before they had adequately recovered or relapsed after discharge (Van den Bos, 2015).

> P1: *'Cause we don't have halfway houses anymore, you know like psychiatry 15/20 years ago there was a lot of halfway houses that kind of – we talk about scaffolding. There were places where someone could kind of re-engage in their life but still sheltered in a way, uhm, those spaces don't exist and I've just had so many experiences where I've spoken with moms who are not coping, even after their son or their daughter have done *** [psychoeducational programmes] and I just feel like if there was money put into those types of systems that we would strengthen that so that people or sufferers wouldn't need to come back as much because their illness would be managed and they wouldn't be getting psychotic again which then wouldn't worsen their prognosis you know all of that stuff.*
>
> P1: *And also a sense of community. You go back home and you might look a little bit differently or people will constantly remind you of when you were sick you – you know. Uhm, so you might have a sense of community where your process is normalised: I was also sick and I also did things I can't remember or strange things but we're okay. How lovely. Almost kind of group therapy that's not group therapy. Like loss of alienation, that support, ja.*

Some of the perceptions in the Physical Impact sub-theme can be seen as in line with the medical model and the traditional Kraeplinian chronicity paradigm - both informed by and in support of a medicalised perception of schizophrenia. P2 constructed schizophrenia as consisting of disorganised thoughts and behaviours, hallucinations and distorted beliefs, physically manifesting as an abnormality in the brain. This is a biological perspective that emphasises physiologically-based causative factors (Van den Bos, 2015). In the medical model, psychosis is defined as the experience of an “abnormal” mental state that is characterised by serious impairments or disruptions in higher brain functions as manifested in behavioural phenomena, such as delusions, hallucinations, and disorganised speech (Van den Bos, 2015). Furthermore, P1 noted the marked long-term and irreversible degeneration, deficits and cognitive decline associated with schizophrenia. Similarly, the chronicity paradigm assumes that the course of schizophrenia consists of consistently poor and negative outcomes (Berzoff et al., 2011).

However, both the medical understanding and chronicity paradigm of schizophrenia have been challenged in the literature over the past decades. To reiterate the arguments that were made in Chapter Two, authors like Bannister (1985), Barrett (1996) and Fried (2015) have repeatedly warned clinicans, particularly psychologists, against narrowingly adopting a medicalised approach to treating schizophrenia. They argued that this may serve to obscure the complexity of emotional responses to psychotic experiences and neglect relevant psychosocial factors linked to individual histories (such as abuse, neglect, trauma or poverty) (Read, Os, Morrison, & Ross, 2005).

As an alternative to the medical model, Engel (1977) developed the biopsychosocial model, which highlights biological, psychological, and social factors through a systems approach. The quotes of participants about the social impact of schizophrenia may be understood as in keeping with the principles of the biopsychosocial model. Hamman (2017) reports that people diagnosed with schizophrenia describe experiences of intense loneliness and of being alone in their understandings of themselves. They also expressed a need to belong and relate to a community. This is in accordance with other international (Berzoff et al., 2011) and South African (Bradfield & Knight, 2008) qualitative studies, reporting that a common experience of people with schizophrenia is a sense of loss of interpersonal relationships, loneliness and social isolation. As mentioned by P1, the sense of belonging to a community is usually found outside of “normality”, with other “sick” and marginalised people that can provide camaraderie (Zubi & Connolly, 2013). The study of Kotze, Van Delft, and Roos (2010) draws attention to the needs of outpatients in Pretoria. All the outpatients in their study asked for improved support in managing the consequences of a diagnosis of schizophrenia. Similar to the statements made by P1, the outpatients in their study advocate for psychosocial and aftercare treatment programmes and psychoeducational groups to address loneliness and the loss of friends and family (Kotze et al., 2010). Despite the development of the biopsychosocial model and arguments against the medicalisation of schizophrenia (as discussed in Chapter Two), interventions in the South African public mental health care system still largely neglect psychosocial issues within a biomedical construction of schizophrenia (Yen, 2010).

Rehabilitation for Schizophrenia versus Recovery within Schizophrenia

In terms of the second theme, perceptions around interventions for schizophrenia were seen as having a rehabilitative focus. Rehabilitation mainly includes diagnosis and medical treatment, which is carried out in a predominantly medical or psychiatric setting. The participants perceived psychologists as having a limited role in these interventions which were seen as neglecting a psychological understanding. However, it was also identified from the transcripts that participants appeared to acknowledge the limitations of the medical model. They spoke about instances where the symptoms of schizophrenia do not respond to treatment and appear more linked to individuals' histories, psychosocial difficulties and emotional experiences. Psychologists were then seen as playing an important role in people's recovery processes. This perception is in line with the recovery model of schizophrenia.

Rehabilitation for schizophrenia. P2 and Participant 3 (P3) were clear that the setting within which they work is medically-focused. For them, this means mainly working from a medical understanding of schizophrenia, rather than a psychological understanding. For P3, a medical understanding is the "easiest" way to intervene when faced with the realities of the health care system which is characterised by high numbers and diversity of clients.

> P2: *And...so – ja our theories speak about dopamine – is that the thing with schizophrenia? I think it is. Let's just say neurotransmitters. There's no attention here paid to like psychological causes of schizophrenia. I mean if you said that in a ward round, they would just laugh at you. Ja (laughs) there's no space there's no space. No there's no space for that kind of thing, uhm it's medical.*

> P3: *I largely work with the psychiatric or medical understanding. Uhm, just because of the high volume of patients. Uhm, well the high volume of patients, the multiple like co-morbid or complicating factors such as substance abuse, but also the very impoverished context which most of our patients come from, the fact that they haven't uhm generally had uhm secondary education, let alone tertiary, sometimes not even primary uhm and if they have, then there still hasn't been – there isn't really an awareness of psychology or psychological ways of understanding. Uhm, ja so the easiest thing to do given all of those factors is to generally go with the medical or psychiatric explanation.*

Due to the perceived physical nature of schizophrenia (as mentioned in the previous theme), schizophrenia was seen as being treated the same as any severe physical disease like for example cancer would be. P1 described how rehabilitation with acutely psychotic people mainly consists of diagnosis and medication, with psychologists seen as playing a limited role. Despite the long-term consequences of the illness on the person, treatment was seen as mostly focused on short-term and ameliorative "patching up".

> P1: *Sometimes I feel that... (sigh) It feels like our interventions stop at diagnosis and medication – not psychologists I don't think that's our role – but I think sometimes... [...]*[4] *It just felt like we were just patching and sending back someone without actually really helping them engage in this massive shift in their life. Massive – it's a bit like saying to someone: sorry you've got cancer but you know, take some pills and good luck.*

> P1: *I think it must be one of the most...terrible diagnoses to get cause you're kind of saying to someone this is degenerative, things are gonna get worse, we don't have a cure, so we're gonna give you medication that might make it better or best case scenario take the psychosis away, but you're gonna probably take this for the rest of your life and sorry but now you're gonna develop metabolic syndrome – you're gonna get the metabolic syndrome, or you can have extrapyramidal side effects (sigh).*

The rehabilitation of schizophrenia was seen by P2 as falling more within the domain of psychiatry with its emphasis on prescribing medication.

> P2: *I think it's a place more for psychiatry than psychologists. Like they need medicine not therapy.*

Recovery within schizophrenia. The participants, working predominantly from medical or psychiatric understandings of schizophrenia within a biomedically-focused setting, described schizophrenia as a severe illness caused by an abnormality in the brain. However, the transcripts also revealed perceptions of this phenomenon that opposed this view. For P1, the dominant medical model is problematic in that it contributes towards a "narrowing of self" of someone diagnosed with schizophrenia. P2 described how the medical model falls short in addressing psychosocial difficulties.

> P1*: I'm gonna go back to what I was talking about with – if we think about schizophrenia being such a narrowing of self. Uhm I don't know whether the medical model uhm...is adequate enough – I think it just focuses on symptoms, medication and it feels for me not enough. If I'm being very articulate. I don't feel like in the way that we treat and individualise stuff like schizophrenia – I don't think it's enough.*

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[4] […]: Indicates that parts of the participants' original speech have been omitted from the quotation

> P2: *Uhm...but in terms of like the bigger picture – like the social situations – the social...like the psychosocial problems that the country faces and that we end up coming up against. Uhm...I can't do anything about that.*

In line with an awareness of the limitations of a medical approach to the rehabilitation of schizophrenia, the participants perceived psychologists as having important roles to play in the recovery process. Psychological interventions, such as therapy and psychoeducation, were aimed at developing identity, facilitating active engagement with the illness and containing emotional distress.

> P2: *I mean, having a mental illness is not the end of the world, like it's difficult and I think schizophrenia in particular robs you of things, uhm, especially over time if it's been untreated, but even people with schizophrenia who are very well treated often relapse and it can – it can rob you of relationships, of your sense of self, of who you are, of like stable employment, uhm and so I think there is a nice role for a psychologist to try and help someone...uhm...re-work their identity or - they are not schizophrenia, schizophrenia is just one part of who they are.*

> P2: *We have a clinic here – I am involved in that from this year and that's really cool – I enjoy that work. Uhm because there – so I'm a psychologist there and there's – there's psychiatrists who are seeing the patients and then they refer the patients to me if they feel they need intervention so a lot of them have schizophrenia and bipolar, uhm...and they just need – they need therapy for psychoeducation but also like for containment or coming to terms with the impact that schizophrenia has on their life.*

P1 described an inpatient programme that consists of a collaborative approach between the psychologist and person diagnosed with schizophrenia where people are encouraged to play an active role in their recovery process and express uncertainty and confusion. Conversations in this programme include the following:

> P1: W*e try to run a programme where we provide a lot of psychoeducation, so what are your exact symptoms, what exactly happened, do you remember what happened, what did your family say, uhm, let's try to make sense of this you know.* [...] *What is your medication and what does it do for you, do you feel like it's the right medication. Now you've also got side effects and how do you manage those uhm, providing actual psychoeducation about schizophrenia. Okay well – this might impact your ability to work or it's going to get worse.*

> P1: *And try to have a conversation around that and – look it's very didactic – it's very psychoeducational, but I'm hoping within those groups there is enough space for someone to say...I don't understand or I don't feel like this – you know so that there can be active - some active engagement in that.*

As stated in the previous theme and mentioned by the participants, current psychiatric practice is still largely dominated by a biomedical approach to intervening with serious mental illnesses (Jacobs, 2012) throughout the world and also in South Africa (Barnwell, 2015). Medical treatments have been shown to be effective in that it helps clients to manage many of the intense emotions and distressing symptoms associated with psychotic experiences (Taylor & Ng, 2012). As such, participants in this as well as in Barnwell's (2015) study agree that "…when it comes to psychotic disorders, psychiatrists seem to have the monopoly" (p. 126). While the advantages of anti-psychotic medications are undeniable, Swartz (1991) argues that an exclusive focus on pharmacological treatment can lead to the "containment" of people's distress through medication and the marginalisation of psychological issues in South African psychiatric care (Swartz, 1991) – and in the person diagnosed with schizophrenia. This is in line with P1 highlighting the problems with "patching up" symptoms without fostering an engagement with the impact of schizophrenia on people's lives.

Historically, studies of schizophrenia have to a large extent discounted the possibility of recovery in schizophrenia (Andreasen, 1997). However, recent research related to the recovery model suggests new reasons for optimism about the outcome in schizophrenia (Warner, 2009). The recovery model acknowledges possibilities for recovery, along with the re-emergence of the person from behind the diagnosis (Geekie & Read, 2009). Warner (2009), an American psychiatrist and expert on recovery from psychosis, describes "recovery" in this model as a diffuse concept that includes factors such as being productive, reducing stigma, and functioning independently. This model emphasises the need for a person diagnosed with schizophrenia to be supported in a recovery process that encourages self-determination, self-sufficiency and the potential for growth (Ahern & Fisher, 2001).

De Wet et al. (2015) implemented a phenomenological approach to analyse the subjective experiences of recovery in a sample of people diagnosed with first-episode psychosis in schizophrenia in Cape Town. Their findings highlight the importance of support, caring for another person, spirituality, and rediscovery of personal abilities in contributing towards a sense of agency. While participants in the current study did not explicitly focus on spirituality and caring for others, they encouraged active engagement, sharing of personal experiences as well as having agency as part of a recovery process. The recovery model would be seen as rejecting the perceptions in the Physical Impact sub-theme that people with psychotic experiences are suffering from an irreversible or chronic condition.

Diagnostic Frameworks as Useful versus Diagnostic Frameworks as Limiting

In the previous themes, perceptions polarised towards a medicalisation of schizophrenia were illustrated through a focus on the physical and degenerative nature of the illness that is mainly rehabilitated through diagnosis and medication. However, schizophrenia was also perceived from a demedicalised perception in that the social impact of the phenomenon as well as possibilities for recovery were considered.

As stated before, the DSM is one of the main psychiatric diagnostic frameworks used to diagnose disorders within biomedical psychiatric settings. In terms of the current theme, participants acknowledged the DSM-V diagnostic criteria of schizophrenia as a useful and adequate tool. The participants perceived clinicians as needing to portray confidence and certainty in this framework. Simultaneously, the transcripts also indicated an appreciation of the limitations of the DSM's representation of schizophrenia. In line with these limitations, the participants expressed uncertainty and confusion in relation to the diagnostic framework.

Diagnostic frameworks as useful. Despite describing it as a "black and white approach", P3 noted a predominant reliance on the objective diagnostic criteria of schizophrenia in the psychiatric setting. Also for this participant personally, the DSM provides a useful framework from which to work.

> P3: *Uhm, so there seems to be a greater reliance on DSM criteria uhm that way of understanding uhm symptoms or phenomenology uhm and less focus on the patient as a person and more focus on this is the disorder that we are treating. But of course that varies from person to person uhm and there are both psychiatrists and medical doctors who are uhm more able to hold differing opinions or theories, uhm. But ja I think that the most part it's a more black or white approach to understanding schizophrenia, uhm.*
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> P3: *It does provide a structure though from which to work, so uhm my very basic explanation generally entails that there's some behaviours that are added and some behaviours that are taken away to explain uhm positive and negative symptoms, so thoughts, behaviours, emotions that are added and thoughts, behaviours and emotions that are taken away, uhm. And these are the ones that you have – so in terms of providing a structure for me as a clinican uhm I found the DSM useful.*

Similar to P3, P2 perceives the DSM as a useful and good diagnostic tool. According to this participant, the DSM adequately represents the phenomenon of schizophrenia and people are either classified as "psychotic or not".

> P2: *So I know – so some of the other disorders they also changed to spectrum disorders, so like the autistic and asbergers and there I thought like really good. But with the psychosis...I think you're either psychotic or you're not. I don't think it's a spectrum-y thing and I think it is useful - like I said to have those paranoid, catatonic [diagnostic categories]. And also very useful – so they had psychosis due to general medical condition or due to substances or due to...what else. I think there may have been other things in the DSM-IV like – I can see that – that you can have a primary – like schizophrenia or psychotic disorder and then you can have it due to something else, but like a spectrum...I don't think so. I don't find that helpful.*

> P2: *There are some diagnoses that I'm very critical of. I think that they – you – they over...like you need too many ticks. To be able to give them that diagnosis. So I don't like the DSM in that regard. But with schizophrenia, I haven't seen – all I've seen is things to support what they've got outlined there. I think it's a very good tool, I think – ja what they've got there that is schizophrenia, uhm so those five symptom clusters.*

P3 described how portraying confidence and certainty in the diagnosis (despite possible personal uncertainties) aids in the acceptance of the diagnosis and adherence to treatment. However, this appeared to limit critical engagement with the diagnosis.

> P3: *Hmm. And then – I don't know how...it's probably an ethical grey area but it's almost like the more certain you seem about it despite - as a clinican – so despite how you might feel and any questions you have, the more certain you feel about it, uhm or the more certainty you project, then it aids them in accepting that diagnosis. Uhm, which isn't great if that's not their actual diagnosis and we've got it wrong. But it's sort of like if that's the best you have and that's all the information you're likely to have for now...and if that's going to help them adhere to treatment then ja. Cost versus benefit.*

> C: *Hmm. Ja. And how is it for you to try to display that certainty even though you yourself have some questions?*

> P3: *I try not to go there if I can help it. (laughs)*

P2 described similar professional qualities, but it was associated with the medical profession, rather than with psychologists:

> P2: *What I've seen from being in this field so long, is that doctors need to act like they know everything like 100%. They have to do that for us, for their patients. Uhm to instil confidence.*

Diagnostic frameworks as limiting. In contrast to the previous sub-theme, participants also engaged with the limitations of the DSM-5 diagnostic framework when it comes to schizophrenia. Uncertainty and confusion were expressed by them regarding the limitations of the framework. P3 commented on the difficulties with diagnosing schizophrenia and stated that it is confusing that internal processes and a variety of psychotic themes and disturbances are clustered under a single diagnosis.

> P3: *In terms of actually diagnosing, I think it's a lot more complicated. [...] What I've noticed recently uhm is that it's quite difficult actually to try to explain a diagnosis of schizophrenia to a person. Uhm...partly because I think a lot of the processes are internal - that psychotic experience is an internal one and patients very rarely have a memory of it after. But also because they quite rarely - and again whether it is related to the themes within their psychosis or uhm the actual presence of either perceptual disturbance or uhm disturbance in thought form or disturbance in thought content, uhm ja. I think that it's sometimes confusing for me as a clinician that all of these things get clustered under one diagnosis of schizophrenia, uhm.*

Furthermore, despite mostly working with the DSM, P3 stated that the existing theories of schizophrenia do not adequately capture the personal and diverse nature of delusions and hallucinations. This participant expressed an interest in the phenomenology of certain delusions and how it might be linked to a person's background and emotional experiences, such as helplessness, grandiosity or contentment.

> P3: *Hmm...I think that it's largely misunderstood. Uhm, by the general population. But also by health professions. I worry that uhm...we have these theories about uhm...what schizophrenia looks like, what perhaps contributes to it, uhm but I think since the time I was an intern and particularly in ward *** 'cause a lot of the men receive the diagnosis of schizophrenia, but the nature of their delusions and hallucinations are – it's so different, uhm and at the same time it's so like...uhm, symbolically related to what it is we know of their history.*

> P3: *Uhm...one of the people that I remember from my internship is a guy who uhm – his delusions were – had this quite religious theme to them and essentially what he was describing is that he was most uhm - 'cause he'd speak about the pharoh and about this girl that he was going to marry and about something to do with the sun. I remember thinking – okay he probably comes from a Christian family, but why that story in particular? Uhm, and why does he for example have this grandiosity about being essentially a prophet? Similar to people who say that they're Jesus or uhm that kind of thing. Uhm, and how is that different from people who then say they get messages from God uhm but they haven't identified with a particular character of theology. And then other people who feel as though uhm - they experience quite persecutory uhm delusions or hallucinations where there's either demons that are trying to kill them or people who are trying to kill them uhm or they feel as though there's somebody else in their body uhm which is essentially quite like – or it seems to me to be quite a helpless state to be experiencing passivity phenomenon – someone*

> *controlling your body or stealing your thoughts or broadcasting them uhm. That in – like juxtaposed with somebody who is grandiose and seems quite content in their uhm psychosis.*

Despite expressing certainty about the specific symptom patterns and need for medical intervention in schizophrenia, P2 also expressed uncertainty about what the inefficacy of medical treatments might imply for the phenomenon of schizophrenia.

> P2: *Like medicine is a science, yes, but it's not an exact science and so this thing called schizophrenia, yes there are certain symptom patterns and there is a phenomenon of schizophrenia, uhm...but the treatment doesn't always work. We've got people here for 16 years and they haven't got better so the treatment doesn't always work and then – what's that? We call it treatment resistant schizophrenia but maybe it's something different, uhm.*

Likewise, P1 stated that the rigidity of the criteria in the DSM means that people's actual presentations do not always fit neatly into the diagnosis. The use of substances, especially methamphetamine, further appeared to complicate the diagnostic picture.

> P1: *Maybe the chronology of it as well, so the six months and a month of active psychosis. I don't know if that's too rigid. Uhm, what I mean by that is that sometimes it feels like if you're a stikler which you should be and clinically rigorous, perhaps someone has been – through collateral – been psychotic for three weeks. Then what do you do diagnostically about that, you know? You don't have your month, so...do you kind of err on the side of saying that this is schizophreniform or psychosis not otherwise specified, so - but I know that that's part of the DSM is that it is it quite specific criteria so that doesn't always fit neatly because of someone's presentation.*

> P1: *...January to March of 2008 we had our first tik uhm patient. Now...you know it was kind of a Western Cape thing and now...what we are finding is that - you know with schizophrenia you need 6 months uhm almost a prodromal thing with the month of active psychosis you know to sort of...now we're finding that if someone takes tik, the effects of tik might take 6 months to resolve. So I wonder whether a lot of patients we see might be - we're misdiagnosing as schizophreniform, schizophrenia, rather than this actually being the effects of tik. So that's also complicating – also what happens if someone does have schizophrenia and they use tik...for example, so diagnostically and management-wise. I also think it's quite tricky.*

Further, all the participants expressed difficulties with negotiating cultural beliefs around what is perceived as a client suffering from schizophrenia within the current dominant diagnostic framework, such as bewitchment, "amafufunyana" or "ukuthwasa". For example, P2 mentioned that the cultural and medical models seem to "clash", and P1 stated that "it feels like negotiating two different kinds of explanations". Also, linking back to the confidence and certainty mentioned in the previous sub-theme, P2 reflected on the idea that clinicians might "shut down" cultural explanations in prioritising a medicalised view of schizophrenia.

> P1: *So I also think that in the context in which we work I suppose the majority of our patients are isiXhosa speaking and then you've got the cultural aspect you know someone- and so a lot of I suppose a patient's ability to make sense of what's going on is a lot of sense of bewitchment so how they make sense of - I suppose with our clinical lens we might think well this is obviously persecutory delusions. Uhm maybe for someone they feel like their neighbours are bewitching them and that feels quite tricky to negotiate two different kind of explanations of what's going on.*
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> P3: *Uhm and then that becomes particularly difficult when people have cultural understandings of their mental illness. So bewitchment or the calling to become a sangoma [...] Uhm and...uhm I am conscious of not wanting to shut down a cultural explanation...*
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> P2: *I know the two – the culture and the Western models - collide and they clash.*
>
> P2: *...we're not necessarily right. For all we know it is a phenomenon called amafufunyana or it is due to bewitchment or, uhm and who are we...we then come and impose on these people: take this medication this is what you have. [...] And I think sometimes we speak down to the patients...*

Various studies note the usefulness of diagnostic frameworks. For example, Deacon (2013) notes that the DSM plays a large part in the professional standardisation of a comprehension of psychopathology, has increased the reliability of diagnostic concepts and improved the communication among researchers and clinicians. Similar to what P2 and P3 in this study described, McWilliams (2011) argues that diagnostic frameworks can be useful in terms of providing a comforting structure to both the psychologist and client to guide understanding and treatment. Brown (1995) even suggests that "diagnosis is the language of psychiatry, the 'social representation' of psychiatric knowledge, as well as the psychiatric professions' presentation of self" (p. 389). Accordingly, Elphick (2008) states that professionals working within psychiatric settings are often placed in a position of power due to being in possession of knowledge in order to facilitate the treatment of a diagnosis that has been used to label a disorder.

While some authors and clinicians, like McWilliams (2011), note the usefulness of diagnostic frameworks, they also often acknowledge limits to the utility of diagnosis. Similarly, participants in this study acknowledged the usefulness and adequacy of the DSM, yet reflected on the limitations, uncertainties and complexities inherent in the seemingly "black and white" diagnostic framework. According to Cloete (2002), clinicians in the psychological profession, especially in a South African context, constantly have to work with "atypical presentations of pathology" that breaks the "ideal diagnostic mould" (p. 37). For participants in the current study, things that could "break the mould" included substances, chronology and treatment failures. According to Swartz (1996), an exclusive focus on diagnostic criteria, then, may transform or translate people's words into the language of psychiatry or psychology while "shrinking" the interesting and complex stories that they bring. Correspondingly, Estroff (2004) makes the argument that a person suffering from schizophrenia has a history, gender, kin, and social roles. Simply understanding the diagnostic label is seen as not enough (Estroff, 2004). For Farquharson (2014), then, a failure in the treatment of schizophrenia is often a failure of the understanding of the phenomenon. In this regard, McWilliams (2011) suggests that a diagnosis should not be applied beyond its usefulness. There should always be a willingness to reassess diagnosis, in line with the complexities of the person, as the treatment proceeds.

Cultural explanations of what is diagnosed as schizophrenia within the Eastern Cape were also specifically highlighted by the participants in the current study. For the participants, this limited the usefulness of diagnostic frameworks. Motlana et al.'s study (2004) illustrates the existing dichotomy between the traditional healing model and the medical model in South Africa. Similarly, Lund and Swartz (1998) researched Xhosa-speaking people's experiences of their condition in Cape Town by drawing on social constructionist theory. The participants in their study found both traditional African explanatory models (such as "amafufunyana") and Western psychiatric diagnostic categories (such as symptoms and treatment of schizophrenia) useful. In this regard, Kleinman (1988a) suggests that it should be kept in mind that a diagnosis is a complex social, contextual, cultural and psychiatric construction: "Observation is inseparable from interpretation...psychiatric diagnoses derive from categories. They underwrite the interpretation of phenomena which themselves are conjeries of psychological, social and biological processes. Categories are the outcomes of historical development, cultural influence and political negotiation (p.12)."

Institutionally-defined Identity versus Self-defined Identity

From the interviews with participants, it was identified that the identities of individuals diagnosed with schizophrenia in a psychiatric setting were defined by institutional features. An institutionalised identity was described as a medicalised body belonging to an institution and characterised by a narrow life, passivity and a lack of autonomy, agency and individuality. However, the participants also constructed the identity of a person diagnosed with schizophrenia as defined by individuals themselves. Creative projects within the institution, such as art and theatre projects, were identified as ways of fostering agency, autonomy as well as personal responsibility and choice within an institutional setting. Considering psycho-social issues such as power differentials within this perception is clearly polarised towards a demedicalised perception of schizophrenia.

Institutionally-defined identity. The participants described how the process of institutionalisation, dominated by a medicalised approach, can define the identity of someone diagnosed with schizophrenia in a psychiatric setting. As stated by P1:

> P1: *That's what I'm saying I find problematic with the medical model. It becomes this is who you are – it's quite narrow.*

P1 elaborated that this institutionalised identity is represented in a "stripping down of identity" when people are "put into" hospital attire. The aim of this appeared to be uniformity, at the expense of individuality.

> P1: *So if you think about it like I know when I've been in a hospital – if I put on a hospital gown there is something that takes away from me as the individual. Clothes express who we are in a way, but that hospital gown is quite institutional – suddenly I belong to this hospital You know then they're put into these pajamas with a big stamp *** [of the hospital's name]. So how interesting is that, there's a sense of stripping down of identity. You're definitely a patient. [...]*

For P1, features of an institutionalised identity include feeling physically different, but also losing the ability to show humanity through communication, expression and emotions. The result seemed to be someone with a passive, narrow and one-sided identity.

> P1: *Then you start seeing people with flattened affects, so their ability to communicate, their ability to show expression has been robbed, they don't have the inclination to do much, so now they're sitting and smoking or – so who they were beforehand is lost – they feel different, they feel physically different, uhm...and then their life becomes narrower.*

In P3 and P1's experiences of people diagnosed with schizophrenia, it is clear that these institutionalised features define the identity; people were described as lacking the agency to express themselves, wanting to please the clinician and defining themselves by their illness or diagnosis:

> P3: *Interestingly in the *** wards it's almost like uhm one of the features of institutionalisation that people don't really speak up for themselves. So it's almost*

> *when you ask a patient for their experience, they're almost at a loss for what – they say to you what should guide their answer – what do you want to hear.*
>
> P1: *So you will have patients walking around here – or mental health users - walking around here saying: I'm schizophrenic and my name is Harold, for example. So suddenly even someone's identity – the illness is first. And then their kind of name is second – they also kind of get known by their illness.*

According to P1, the institutionalised identity becomes particularly problematic when individuals are expected to show personal responsibility, choice, agency and autonomy regarding the management of their illness after deinstitutionalisation. Similarly, P2 explained how a lack of insight and personal responsibility often mean that people are dependent on family members for care and management.

> P1: *I find it quite problematic because...particularly around the negative symptoms of schizophrenia – I don't think we're affording a lot of sufferers a chance to show a lot of agency. So you get told when to bath, you are not allowed to leave places and, uhm, you get told that you have to do this group. There's not a lot of choice. Uhm, that I find problematic because suddenly in the whole kind of hospitalisation we haven't fostered agency, choice, anything but now we expect someone to go home and stay away from dagga and show personal responsibility and agency of making sure they go to the clinic and taking the medication. For me...that doesn't fit. That's problematic.*
>
> P2: *Because often psychotic patients don't want to take the treatment because they don't think that they're ill, so their insight is very poor and they don't like taking it because of the side effects. So it's just helpful to have a family member that's willing to come in that will also be psychoeducated about what this illness is, uhm and how to manage it. And like to emphasise the need – as someone in the living environment please monitor that they're taking their treatment. Ja.*

Self-defined identity. The previous sub-theme focused on how the psychologists in this study perceive people diagnosed with schizophrenia in terms of an institutionally-defined identity. However, the participants also allowed space for the autonomy of the self in the construction of identity in schizophrenia, within institutional settings. P1described, for example, how theatre and art projects can function to counteract the institutionalisation of the hospital setting. In contrast to the above sub-theme, this provided people with opportunities to exert choice and agency in constructing their identities. For this participant personally, it provided an opportunity to address socio-political issues such as power differentials between "mental health professionals" and "patients", as well as allow clients and psychologists to "play with" what is usually expected within a hospital setting.

> P1: *An art project - we used to have a theater project, so suddenly I'm a performer, suddently I'm an artist, so I think those uhm those projects are just so valuable to try to counteract the illness as one way but also the institutionalisation of this place.*
>
> P1: *It was a non-therapeutic space where people could be who they wanted to be and, uhm, you know people could – elect to be – so it came for quite a socio-political stance, looking at power differentials a lot - and there a person could chose to be the king and try out what it would be like to have some power because they don't feel a lot of power here, uhm and, or well with this power I treat someone like this. Do I like that, do I not like that and I'm saying a bit like the externalisation like you get in narrative therapy. I think being able to put on the clothing – put on a king's hat – now I was talking about hospital clothing – here we got some props that just allows...a...play on the self. Different selves.*
>
> P1: *I think it was really lovely for me to relinquish perhaps - I mean that psychology role of what I thought was quite expected. So I would be able to be a role that uhm...so perhaps a patient could be the king and I'll be the servant. Looking at power differentials as well and suddenly in those spaces a person can play with selves that perhaps they can't in their real lives – it's suddenly like a playful space.*

Similarly, P3 also spoke about exploring self-defined identities so that people can regain a sense of meaningfulness in the society. Occupational therapists were seen by this participant as being more helpful in this regard than psychologists.

> P3: *The occupational therapists are really good at uhm holding multiple explanations, but also in exploring different roles for the person. So they're not just a patient with the diagnosis of schizophrenia, uhm and finding ways to uhm for patients with this diagnosis to – in aid of their rehabilitation and wellness, uhm to integrate uhm occupations that they can be a part of and that they will find meaningful and can contribute to a community or a society.*

As a psychologist, then, P3 attempts to maintain a curiosity, within an institutional setting, about the complexity of the identity and life of someone with schizophrenia.

> P3: *For me personally they stimulate this curiosity and then that translates into uhm me asking questions of patients that I sit down with that aren't really – it's not directly related to, okay this is I need to do an insight group, I need to do a substance abuse group with you, but questions that are just out of interest in who they were before they became a patient here, and what was going on for them and how in their understanding did they come to be here, what is it that they left behind by being here. Uhm ja.*

The quotes in the Institutionally-defined Identity sub-theme mostly construct people with schizophrenia as passive and lacking in emotional expression, autonomy, agency and individuality. Likewise, Lupton (1997) refers to the "medicalised bodies" of patients within institutional settings - people who are sitting around; seemingly being passive, slow, apathetic and lazy; and even losing a sense of humanity. Barrett's (1988, 1996) concept of psychiatric transformations/constructions discussed in Chapter Two is also relevant here. Similarly, Cloete (2002) states that the identity of a person with schizophrenia often becomes enmeshed with the identity of the illness, in medicalised settings (Cloete, 2002). Cromby et al. (2013) also note that people diagnosed with schizophrenia are frequently referred to as "psychotic" or "schizophrenic" in psychiatric settings - causing a loss of other aspects of their identity and individuality.

Similar to the problems with an institutionally-defined identity as noted by P1 and P2, the literature on the medical sociology of illness refers to the problematic implications of the "sick role". Studies suggest that the act of diagnosis or institutionalisation may invite clients into a perceived passive position (Cromby et al., 2013). It is stated that ill people might then be constructed as passive, helpless and disempowered and dependent on professional knowledge and intervention to "be cured" (Moncrieff, 2008). Similarly, for the participants in this study, this "sick role" seemed to be constructed as being ill and belonging to an institution, lacking autonomy and agency, losing individuality such as a personal name, being passive and lethargic, needing care and monitoring, and wanting to please the clinician. However,it has been argued that, if psychosocial difficulties form part of a psychiatric illness diagnosis, it might not always be helpful to encourage people to depend on professionals for their recovery, or rely solely on diagnosis and medication as interventions (Cromby et al., 2013). Erikson (1957) writes about the so-called double dilemma in the identities of people who are mentally ill. The struggle with this "double dilemma" may capture something of the tension between an institutionally-defined identity and a self-defined identity in this study, as follows:

> The patient has to seek definition as acutely sick and helpless in order to achieve a

> measure of public validation for his illness - and simultaneously has to use all his remaining strengths to struggle against that illness - a dilemma is posed which he may resolve by simply giving up the struggle altogether and submerging himself in the sick definition permanently (p. 271).

Just as Erikson notes a "submersion" in a "sick definition", Lysaker and Hermans (2007) agree that schizophrenia often involves a profound experience of one's self-defined identity as diminished. In reaction to this, studies, such as Farquharson (2014), explore the meaning of art making and exhibiting for people diagnosed with schizophrenia in the Eastern Cape. Similar to the statements made by all of the participants in this study, Farquharson (2014) empirically illustrates the importance of creating opportunities to "perform" or self-construct alternative identities as part of a person's recovery process. The exhibiting of artwork was seen as aiming to counter limiting "patient" identities by allowing those labelled as "psychiatric patients" to constuct an alternative and self-defined identity, such as that of an "artist" (Farquharson, 2014).

Integrating Polarised Perceptions of Schizophrenia

So far, throughout the analysis and discussion of the results, opposing or polarised perceptions were identified in terms of the phenomenon of schizophrenia. Medicalisation versus Demedicalisation of Schizophrenia was identified as the overarching theme that runs through the data. Participants therefore described, experienced and made sense of the phenomenon of schizophrenia with perceptions largely informed by and in support of either the medicalisation or demedicalisation of schizophrenia. However studies such as Halfman (2011) recommend not only identifying instances of medicalisation and demedicalisation of a phenomenon, but also identifying instances when the two processes occur simultaneously or interchangeably. As such, perceptions were also identified that evidenced a combination or integration, and holding, of these polarities. The participants saw psychologists as positioned in the middle ground between medicalisation and demedicalisation of schizophrenia. For instance, P1 advocated for clinical psychologists to have a different lens and identity, despite having to sometimes subscribe to the medical model in psychiatric settings.

> P1: *I don't think as psychologists we've kind of got...particularly clinical psychologists – we're very much part of that medical model which is useful, again not baby out with the bathwater, but I wish there were spaces that we could...slightly have more of an identity as clinical psychologists rather than being so much part of the medical model because isn't our function of being here is that we have a different*

> *lens, we offer a different lens. Sometimes it feels like...we need to subscribe to the status quo a little bit too much and I think it doesn't serve patients as well.*

Furthermore, P1depicted a balanced view of being open to "new things", such as the recovery model, while still acknowledging the usefulness of medication.

> P1: *Uhm, I voiced concerns around the systems but you know, people don't like change and, well, this hospital does that and I think that rehabilitation may be quite problematic and I think it's an old system and I think there are new things around recovery models. Uhm, ja I think there are a lot of buzzwords at the moment but this is just another way of trying to invite...mental health users, sufferers, patients uhm to be more active in their - in their recovery process. So ja I think as a pure medical lens I think there's lots of problems but I am not doing chuck the baby out with the bathwater – I absolutely believe in medication because I've seen someone come in here and medication has absolutely helped them regain their life again. So ja I want to get a balanced view of that.*

P2 places the role and identity of psychologists in working with schizophrenia "somewhere in between" occupational therapists and medical doctors – seeing the people diagnosed with schizophrenia as (demedicalised) human beings but also as (medicalised) schizophrenic patients.

> P2: *OT's do the most wonderful work with the patients and the majority of our patients are like psychotic spectrum disorders or bipolar that fits in – I mean they see the patients as human beings. [...] So I think their perceptions of schizophrenic patients are that these people are... (laughs) more people than schizophrenic patients. Does that make - whereas the doctors: like schizophrenic patient and for us somewhere in between. [...]And then – it sounds like I'm splitting – like idealising and devaluing. (laughs)*

Lastly, P3 referred to McWilliams's (2011) concept of "crazy versus not crazy" in the book *Psychoanalytic Diagnosis* when describing the construction of schizophrenia. In the following extracts, there were evidence of an integration and holding of the polarities between existing theories and subjective experience, between patient experience and clinician experience, between personhood and patienthood, as well as between crazy (or psychotic) and not crazy (or not psychotic). According to this participant, this perception can "reduce the otherness" or the "divorced position" apparent in psychiatric settings and normalise the experience of psychosis. In her words:

> P3: *So, my take on that book [Nancy McWilliams] – but a few other things that I've read as well, uhm and also where my particular interest lie is uhm in it's exploration of phenomenology, so uhm – but of course it incorporates uhm theories that have been established over the years, but it also makes room for experience. Both your*

> *experience as a clinican and uhm your patient's experience of their illness – of their illness in relation to their personhood, uhm...ja.*
>
> P3: *I think it's just in the introduction to psychoanalytic diagnosis and she starts off by saying uhm that her friend said: well to him it's pretty much crazy versus not crazy and she explained to him uhm that to us as psychologists it's sort of on a spectrum, like how crazy are you? Because we believe that everybody is crazy and then crazy in what way? Uhm, which I thought was quite a nice way of understanding that.*
>
> P3: *For me what that does is it reduces the otherness that can uhm occur in I suppose most settings, but in our context, in mental health contexts, uhm which then makes it so much easier to both empathise with the person and to help them to integrate this into their story or their identity because uhm in thinking about it all as on a spectrum - how crazy and crazy in what way - uhm it doesn't put you in this in this divorced position of uhm I am speaking to you about your craziness or your illness, it's normalising it to say that we all experience uhm perhaps stress, we all have different reactions to it uhm, some of our brains are more vulnerable than others uhm and so some of us have different reactions to others, some of our reactions manifest in different ways because these are the sort of factors that are influencing me, these are the factors that are influencing you, uhm ja.*

Jacobs (2015) writes about the difficulty of bridging what he calls the incommensurable worlds of value-laden structural dichotomies. He states that dichotomies of clinical phenomena in the psychiatric literature, including illness-disease, nature-nurture, healing-cure, and mind-body, often cause clients and their clinicians to be on opposite ends of many divides (Jacobs, 2012). According to him, this can complicate the task of comprehending complex issues. Miller and Swartz (1990) previously researched the place of clinical psychologists in general hospital settings, with regards to medical theory and practice. According to them, the involvement of the psychologist in the health care team is a complex matter, subject to a number of difficulties. This study specifically focuses on issues in interpersonal relationships, such as professional power relationships. Recently, Barnwell (2015) also focused on clinical psychology's identity in relation to the biomedical approach. The findings of his study illustrate how psychologists sometimes feel like they lose the identity of their profession in biomedically-focused public mental health care settings, specifically in terms of psychotic disorders.

The current theme also addresses, in line with the above studies, the middle ground positioning of psychologists, particularly in terms of the phenomenon of schizophrenia. The participants placed clinical psychologists "in between" medical doctors and occupational therapists in terms of having empathy for patients and advocated that they need to have a different lens, and more of an identity separate from the medical model. It is hoped that this middle ground positioning of psychologists in biomedical psychiatric settings might reduce instances of otherness and normalise the psychotic experience. It may also assist in bridging the divides between members of the multidisciplinary team who may have more one-sided perceptions in relation to the phenomenon of schizophrenia.

Conclusion

In this chapter, thematic analysis, informed by social constructionism, was used to identify themes within the data that was collected by means of semi-structured interviews with clinical psychologists working in a psychiatric setting in South Africa. The interviews focused on eliciting psychologists’ perceptions of the phenomenon of schizophrenia. Five themes were identified, presented and discussed in relation to the existing relevant literature.

The themes highlighted polarised perceptions, both between and within participants, with regard to the phenomenon of schizophrenia. These perceptions included Physical Impact of Schizophrenia versus Social Impact of Schizophrenia; Rehabilitation of Schizophrenia versus Recovery within Schizophrenia; Diagnostic Frameworks as Useful versus Diagnostic Frameworks as Limiting; and Institutionally-defined Identity versus Self-defined Identity. An overarching theme of Medicalisation versus Demedicalisation of Schizophrenia was identified as consistent throughout these opposing perceptions.

Throughout, the quotes from participants in support of these themes were noted as characterised by multiple uncertainties, complexities and ambivalences in describing their perceptions of schizophrenia. An unresolved binary thinking seems to operate to position the phenomenon of schizophrenia as mostly characterised by polarised perceptions. These opposing perceptions are perhaps suggestive of the challenges which psychologists face when dealing with the phenomenon of schizophrenia in current biomedical psychiatric settings (Barnwell, 2015; Cloete, 2002). Understanding the phenomenon of schizophrenia is said to often demand rapid shifts between perspectives in order to capture its complexity (Cloete, 2002).

Following from these polarised perceptions of schizophrenia, the discipline of clinical psychology was seen as needing to hold the tension between opposite perceptions. This includes acknowledging the uncertainties, complexities and ambivalences surrounding the phenomenon of schizophrenia in current psychiatric settings. The theme of Integration of Polarised Perceptions of Schizophrenia was therefore identified to evidence an integration and holding of the polarities within seemingly incompatible or incongruent frameworks.

The polarised perceptions in the sub-themes of this study might be better understood or “bridged” in terms of Fierz’s (1991) writings on *Jungian Psychiatry*. Fierz refers to a “dual standpoint" of the clinician. He stated that, while it might feel pertinent to take on a one-sided position or follow a clear line of treatment in certain cases, it should be equally important to not lose sight of the dual aspects of a case or a phenomenon. According to him, this "dual standpoint" is the only way to strike the right balance or middle ground with a client. Despite this, he acknowledges the difficulty of maintaining such a view (especially in demanding clinical settings) and suggests developing an awareness of one's own one-sided views on phenomena and then allowing for multiple possibilities and realities. Also in line with Fierz (1991) and the findings of the current study, Cloete (2002) writes that a space for therapeutic conversations is opened up by holding the tension between "normality" and "abnormality", rather than pathologising the stories that clients bring. Cloete's (2002) personal reflections act as a conclusion to this chapter:

> Being aware of undecidability and the ever-evasive nature of "truth", will help me as a therapist to be able to hold the tension between knowing and not knowing, between deciding and knowing that I actually cannot decide. It will prompt me into a more respectful stance towards Annie's and Adam's [pseudonyms for therapy clients] stories, it will keep my eyes open for possible injustice done in the shrinking of their stories in order to pen down "the truth". It will push me into the direction of a more just work ethics. It will turn my attention to evaluating and re-evaluating the law of the ward. Yet, paradoxically, the striving for justice might be the very starting point for my deconstruction, for my looking again (p. 33).

CHAPTER FIVE: CONCLUSION

Summary of the Findings

The main aim of this study was to explore and develop a deeper understanding of the phenomenon of schizophrenia from the perspectives of clinical psychologists working in a South African psychiatric setting. In order to achieve this aim, the following objective was pursued: To explore how clinical psychologists working in a psychiatric setting in the Eastern Cape, South Africa, subjectively experience, describe and make sense of the phenomenon of schizophrenia. This aim was attained with the use of a qualitative research design and in-depth, individual interviews utilising a semi-structured interview schedule. Data was analysed using thematic analysis, informed by a social constructionist theoretical framework.

Within and between participants' data, a prevailing sense of polarised perceptions of the phenomenon of schizophrenia was identified. This included: (1) Physical Impact of Schizophrenia versus Social Impact of Schizophrenia; (2) Rehabilitation of Schizophrenia versus Recovery within Schizophrenia; (3) Diagnostic Frameworks as Useful versus Diagnostic Frameworks as Limiting; and (4) Institutionally-defined Identity versus Self-defined Identity. These perceptions were further identified as falling within an overarching theme of Medicalisation versus Demedicalisation of Schizophrenia. Therefore, the perceptions of clinical psychologists in this study were mostly polarised towards either a medicalisation of the phenomenon of schizophrenia or a demedicalisation of it. A fifth theme, Integrating Polarised Perceptions of Schizophrenia, was also identified and discussed.

In terms of medicalised perceptions, the phenomenon of schizophrenia was portrayed as a physical illness located in the brain. The participants spoke about it in terms of the physical impact on the body and the brain, such as marked and irreversible degeneration. In line with its physical nature, it was said that schizophrenia is currently mainly rehabilitated through diagnosis and medication. This rehabilitation is carried out in a predominantly medical or psychiatric setting. The participants saw psychologists as having a limited role in interventions, wherein a psychological understanding is often neglected. The participants also acknowledged the DSM-5 diagnostic framework of schizophrenia as a useful and adequate tool. Clinicians were perceived as needing to portray confidence and certainty in this diagnostic tool. From the interviews, it was further identified that the identity of individuals diagnosed with schizophrenia in a psychiatric setting were defined and dominated by institutional features. An institutionalised identity was described as a medicalised body belonging to an institution and characterised by a narrow life, passivity and a lack of autonomy, agency and individuality. The chronicity paradigm and biomedical model are inherent in the extracts under these sub-themes.

In terms of demedicalised perceptions, the phenomenon of schizophrenia was constructed in terms of the social impact that it has on people's lives. Participants also appeared to acknowledge the limitations of the medical model and the DSM's representation of schizophrenia. In line with these limitations, the participants expressed uncertainty and confusion with regard to the diagnostic framework. They spoke about instances where the symptoms of schizophrenia do not respond to treatment and might be linked to individuals' histories, psychosocial difficulties and emotional experiences. Psychologists were then seen as playing an important role in people's recovery processes. The participants also allowed space for the autonomy of the self in the construction of identity in schizophrenia within institutional settings. Creative projects were identified as ways of fostering agency, choice and personal responsibility. Considering psycho-social issues such as power differentials, as well as utilising principles in line with the modern recovery model, are polarised towards a demedicalisation of schizophrenia.

Following from these polarised perceptions, the last theme, named Integration of Polarised Perceptions, explored instances in the data that supported an integration and holding of the polarities. This research highlights, then, that the psychology of the person diagnosed with schizophrenia should perhaps be concerned with holding the tensions between seemingly contradictory, incompatible or incongruent conceptualisations. The findings support both the value and the need for an "integration of polarised perceptions", "holding of the tension", and "middle ground positioning" of clinicians between medicalised and demedicalised aspects of the phenomenon of schizophrenia.

Limitations of the Study

Methodology

Firstly in terms of the methodology, this study was conducted with a small sample of three psychologists in a specific psychiatric setting in a specific context at a specific point in time. While this is consistent with a qualitative research design, informed by social constructionism, this means that the range of perceptions that was represented is limited and is not generalisable to the greater population of clinical psychologists. While a bigger sample size in a larger variety of settings would have been preferable, the findings of this study might still be relevant in other contexts. The findings suggest that it is important for clinical psychologists to be aware of and hold possible tensions, contradictions and ambivalences when it comes to the phenomenon of schizophrenia and working psychologically with a person diagnosed with schizophrenia in biomedically-focused settings.

Another methodological limitation relates to the focus of the professional identity of the sample. Other members of the professional community in psychiatric settings who also engage with the diagnosis of schizophrenia and form part of the multi-disciplinary team, were not included in this study. These members, such as social workers, nurses and occupational therapists, often spend a large amount of time with people experiencing this type of distress and may provide different views in terms of how the phenomenon of schizophrenia is experienced and understood. Furthermore, the current sample only includes professionals working within a public psychiatric setting. As such, an adherence to a biomedical model and a medicalised perception of schizophrenia might be expected. Therefore, identifying the constructions of schizophrenia within different contexts (for example inpatient versus outpatient, public versus private sector, Eastern Cape versus Western Cape), with different socio-economic implications, would be another avenue of research.

Theoretical Paradigm

In terms of the theoretical paradigm, while the social constructionist theoretical framework of this study acknowledges the influence of subjectivity on the research and themes that were identified from the data (which was reflected on in Chapter Three as well as in the way Chapter Four was structured), it is possible that other researchers would have identified other themes from the data. It is a further limitation of this study that due to its scope, a more detailed investigation into the impact of the subjectivity of the researcher throughout the research process, could not be explored. Similarly, this framework suggests that the backgrounds of participants are important for the reader to understand where the participants are “coming from” and to indicate whether this could influence clinical psychologists’ perceptions of schizophrenia. However, the socio-demographic information was omitted in order to protect the anonymity of participants in a community and a hospital with a small demographic size.

Furthermore, while social constructionism and the research reviewed in this study is critical of the dominant biomedical discourse in modern health care, this discourse can be seen to operate within this research through the use of particular terminology and in the way that diagnostic categories like schizophrenia are understood. Despite this, the current research critically views certain types of language deployment and attempts to stimulate a renewed consideration of the psychological factors at play in the mental health disciplines (Elphick, 2008). However, social constructionism has been criticised for its tendency to reduce the tangible experiences of the people that it studies, to language (Terre Blanche et al., 2006). The implication of this is therefore that the distress or difficulty that the psychologists in this study may experience when dealing with the phenomenon of schizophrenia, may have been neglected or not adequately represented.

Also, a principle of social constructionism is to investigate how broader social structures, and those in power, influence the meaning of phenomena. However, by not situating the meaning of the phenomenon of schizophrenia within broader social contexts, such as acknowledging the status and hierarchy of those involved in the setting within which this research was conducted, the research may assist in the maintenance of certain power relations in broader social contexts (Burr, 2003). Conversely, by analysing these broader social structures it is possible that the subjective perspectives of the participants would have been neglected (Burr, 2003). Similarly, while the literature review outlined some of the problematic implications of applying traditional Western concepts to a South African context, the results were limited in the reflection on the need for a culturally relevant practice within the socio-historical and political background of mental illness within the South African context. Therefore, future research can further explore contextual issues, such as political, economic, and cultural factors, influencing the construction of schizophrenia.

Implications of the Study

By employing qualitative research methodologies, this research highlights polarised perceptions within clinical psychologists working with the phenomenon of schizophrenia in a psychiatric setting in South Africa. This study was, in the first instance, descriptive in that it provided a detailed description of the perceptions of three clinical psychologists regarding the phenomenon of schizophrenia in a psychiatric setting in South Africa. It was stated earlier that such descriptions are lacking in the local literature and follows on from previous research on schizophrenia in this context. Secondly, this study contributes towards providing documentation on the manifestation of schizophrenia in the specific context of the Eastern Cape. Thirdly, this study raises awareness and supports the call for a focus on the psychology of the person diagnosed with schizophrenia.

This research also holds particular value for the positioning of clinical psychologists in relation to this call – specifically in biomedical psychiatric settings. Studies have shown that, in these settings, medical treatments are sometimes presented as the only solution to emotional distress (Lorem et al., 2014). As mentioned previously in Chapter Two and Four, the consequences of this for the phenomenon of schizophrenia can include an exclusive reliance on medication as the only meaningful intervention, the minimisation of psychological dilemmas, and the neglect of clients’ complex inner and outer worlds (Berzoff et al., 2011). For Cloete (2002), this would mean a therapeutic under-utilisation of the richness of clients’ narratives, implying that “one avoids discussing the inevitable ambiguities of the individual patient” (Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995, p. 62).

The knowledge that was gained through this research can mostly be considered as useful if it can benefit people making use of mental health services by informing future research, policy and mental health practices. Kirmayer et al. (2015) ask: “Is there still a place for a reimagined psychiatry that aims to integrate biological, social, and cultural perspectives in a person-centred medicine that responds to the full range of mental health problems? (p.3)” It is argued in this study that clinical psychologists have a valuable role to play in the integration or “bridging” of “divided” medicalised and demedicalised aspects of the phenomenon of schizophrenia - within themselves, but also between members of the multidisciplinary team. In recognising the polarised perceptions within the phenomenon of schizophrenia, a caring, flexible, curious and collaborative approach can be facilitated in clinical settings. It is also hoped that this research can effect change outside of clinical settings. Psychologists are urged to advocate for a mental health policy that values an integration of both physical rehabilitation and social recovery, such as halfway houses and post-discharge support, for people diagnosed with schizophrenia. As such, this research supports calls for integrated and collaborative models that include a valued focus on the psychology of the person diagnosed with schizophrenia, while still acknowledging the existing biomedical and psychiatric “knowledges”.

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APPENDICES

Appendix 1: Gatekeeper Permission

For attention: [Head of Clinical Psychology]

REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH PSYCHOLOGISTS AT [NAME OF HOSPITAL]

Dear [Head of Clinical Psychology],

My name is Colette Hamman, and I am a student clinical psychologist (MA Clinical Psychology) at Rhodes University (RU) in Grahamstown. The research I wish to conduct for my Master's thesis involves exploring clinical psychologists' perceptions of the phenomenon of schizophrenia in a psychiatric setting in the Eastern Cape, South Africa. This project will be conducted under the supervision of Mr Alan Fourie, clinic coordinator and senior lecturer at the Department of Psychology, RU. I am hereby seeking your consent to approach clinical psychologists at [name of hospital] to serve as participants in my project.

The anonymity and confidentiality of participants as well as the patient-clinician relationship will be respected. The institutional affiliation of the participants will also be redacted from the interview transcripts and final report so as not to impact on the reputation of the institution or affect the anonymity of participants. Care will also be taken to not disrupt any health service delivery.

I have attached a copy of my research proposal that includes the method of data collection and consent forms to be used in the research process, as well as a copy of the ethics approval letter from the Psychology Department, RU. Upon completion of the study, I undertake to provide [name of hospital] with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me at colette.hamman@gmail.com or my supervisor at a.fourie@ru.ac.za.

Thank you for your time and consideration in this matter.

Yours sincerely,
Colette Hamman

Appendix 2: Participant Recruitment Material

For attention: [Participant's name]

INFORMATION LETTER TO PARTICIPANT

Dear [Participant's name]

I am one of the trainee clinical psychologists at the Rhodes Psychology Clinic this year. I wish to conduct research for my master's thesis that involves exploring clinical psychologists' perceptions of the phenomenon of schizophrenia in a psychiatric setting. This project will be conducted under the supervision of Mr Alan Fourie, clinic coordinator and senior lecturer at the Department of Psychology, RU.

I am contacting you to see whether you will be willing to be involved in my study. If you agree to participate, you will only be asked to participate in one individual interview of approximately 90 minutes at a place and time that suits you best. This interview will mainly focus on sharing your subjective experiences and understandings of schizophrenia. Everything you say will remain confidential and anonymous. Your identity, as well as your institutional affiliation, will be protected. The patient-clinician relationship will also be respected and confidentiality ensured through there being no requirement to divulge information about specific patients. Care will also be taken to not interfere with your health service delivery.

Upon completion of the study, I will provide you with feedback of the findings either telephonically or by email if you wish. If you require any further information, please do not hesitate to contact me at colette.hamman@gmail.com or my supervisor at a.fourie@ru.ac.za. I look forward to hearing from you.

Kind regards,
Colette Hamman

Appendix 3: Informed Consent Form

RHODES UNIVERSITY - DEPARTMENT OF PSYCHOLOGY

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I ____ (participant's name) agree to participate in the research project of Colette Hamman on clinical psychologists' perceptions of the phenomenon of schizophrenia in a psychiatric setting in the Eastern Cape, South Africa.

I understand that:

1. The researcher is a student conducting the research as part of the requirements for a master's degree at Rhodes University. The researcher may be contacted at colette.hamman@gmail.com. The research project has been approved by the relevant ethics committee, and is under the supervision of Mr Alan Fourie in the Psychology Department at Rhodes University, who may be contacted at a.fourie@ru.ac.za.

2. The researcher is interested in exploring the way in which clinical psychologists working in a psychiatric setting perceive the phenomenon of schizophrenia.

3. My participation will involve participating in one individual interview of approximately 90 minutes at a place and time that suits me best. Care will be taken to not interfere with health service delivery.

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 am not willing to disclose.

5. I understand that the interviews will be audio-recorded. Only the researcher and supervisor will have access to these recordings. Upon completion of the study, the audio-recordings will be erased.

6. My identity will be protected with the use of a pseudonym and by excluding any identifying information. The patient-clinician relationship will also be respected and confidentiality ensured through there being no requirement to divulge specific information of patients.

7. Any identifying information about my place of work will also be redacted from the report and the interview transcripts so as not to impact on the reputation of the institution or affect my anonymity.

8. The interview transcripts, without identifying details of participants and their institutional affiliation and patients, may be retained after the study and reused for further research purposes.

9. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience because of my participation, and to have these addressed to my satisfaction.

10. I am free to withdraw from the study at any time – however, I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation that I did not originally anticipate.

11. The report on the project may contain information about my personal experiences, attitudes and behaviours, but the report will be designed in such a way that confidentiality and anonymity will be ensured in the final report and future academic outputs.

12. Feedback of the findings of this study will be provided to me if I wish.

Signed on (Date):

Participant: ___________________________ Researcher: ______________________________

Appendix 4: Interview Schedule

1. Background

Thank you for your willingness to participate in this study. I would like to start with some background information about you.

- Please tell me about yourself.
- Please tell me about your career as a psychologist thus far.
    - Academic history
    - Training history
    - Occupational history
- Please share with me some general comments about your experience of working in mental health care settings.

2. Your perceptions of the phenomenon of schizophrenia

Now I want us to move to your perceptions of the phenomenon of schizophrenia.

- Firstly, what are your thoughts about the **phenomenon** of schizophrenia in general/what do you associate with the phenomenon of schizophrenia in general?

(Try to get the participant's own theory about schizophrenia. No leading questions, rather: tell me more, can you explain more?)

- What are your thoughts about the DSM-5 **classification** of the phenomenon of schizophrenia?
- I am interested in finding out what you think about the **role** of psychologists in terms of severe mental illnesses, such as schizophrenia, in a psychiatric hospital setting?
- Please tell me more about your **experience** of people diagnosed with schizophrenia in this particular institution.

(Try to elicit narratives, otherwise prompt with the following questions:)

- What work do you do with people diagnosed with schizophrenia in this setting?
- Please elaborate on this work (e.g. goals; what do you find helpful/unhelpful; feedback; what do you like/dislike; challenges; emotions).

3. Others' perceptions of the phenomenon of schizophrenia

Now I would like you to reflect on the perceptions of others or of this institution.

- What do you think might be others' thoughts about the **phenomenon** of schizophrenia?

- Please reflect on others’ perceptions of the DSM-5 **classification** of the phenomenon of schizophrenia?
- Please share some ideas around what others in this institution might be **experiencing** regarding people diagnosed with schizophrenia.

4. Closure

Thank you very much for taking the time to speak to me.

- Is there anything else that you like to share with me that we have not talked about?
- Would you like to receive communication about the findings of the study?
- Do you have any further questions before we end the interview?

Appendix 5: Ethical Approval Letter

RHODES UNIVERSITY
Grahamstown • 6140 • South Africa

RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

22 June 2017

Colette Hamman
Department of Psychology
RHODES UNIVERSITY
6140

Dear Colette,

ETHICAL CLEARANCE OF PROJECT PSY2017/36

This letter confirms your research proposal with tracking number PSY2017/36 and title, *'Clinical psychologists' perceptions of the phenomenon of schizophrenia in a psychiatric setting in the Eastern Cape'*, served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 14 June 2017. The RPERC notes that this project is supervised by Mr. Alan Fourie. Your project has been given ethics clearance.

Please note that should your project require consent from institutional gatekeepers, the RPERC requires that you submit written confirmation of this consent. Kindly also ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

Mr. Werner Bohmke
CHAIRPERSON: RPERC