THE PSYCHOSOCIAL EXPERIENCES OF LOOKING AFTER A CHILD WITH PSYCHIATRIC ILLNESS AND THE IMPACT IT HAS ON THE FUNCTIONING OF BLACK EXTENDED FAMILIES

BY
Itumeleng Mpolokeng

In Partial Fulfillment of the Requirements for the Degree of
Masters in Clinical Psychology
In the Faculty of Human and Social Sciences
At the University of North West

Supervisor: L.P. Direko
External Examiner: S.D Sedumedi
2004

Abstract

This study is a qualitative study investigating the psychosocial experiences of Black extended families in caring for a child with psychiatric illness. The focus was on how the child's illness had an impact on family functioning. The researcher used a case study method, to investigate this phenomenon. Four case studies, which consisted of four Black extended families, were selected using purposive sampling. In investigating the phenomenon, semi-structured interviews and an assessment tool called Family Assessment Device (FAD) were used to collect data on family functioning. There were pre-selected themes and specific dimensions (based on the McMaster's model of family functioning) that the researcher investigated. The researcher also used systems theory and cultural factors of Black family systems (as a background theory) and the findings were analyzed using the pattern matching strategy suggested by Campbell (1975).

Firstly, the researcher found that in all cases, the children had similar behavioural problems, which was mostly aggression and disruptive behaviour, which resulted in families seeking help. The findings show that the child's psychiatric problem does, to a certain extent, impact on the family functioning, as the child's behavioural problem elicited increased/heightened emotional response by different family members. Looking after a child with psychiatric problem was found to be time consuming and was a laborious activity. However the findings show that the structure of Black extended families which is based (among other things) on the principle of shared responsibility and complex interpersonal relationships that exists among family members makes it easier to care and cope for a child with psychiatric illness. Though the findings show that there were differences in the level of interest and involvement that family members showed towards the child's problem.

The findings further show that the biological mother was the one who experienced the most burden and emotional stress as she was expected to take the ultimate responsibility in controlling the child's behaviour. This reflected the change of the Black extended families (in the current study) from being purely based on communal support system to incorporating aspects of individualism in the family system, therefore changing the functioning and structure of Black extended families as they were previously known.

Acknowledgements

- Firstly I would like to thank the God Almighty for sustaining me till this time. For providing me with the will, wisdom and strength so that I could finish this project.
- Secondly I would like to thank my family for their encouragement and support from the beginning to the end of this project.
- In the same breath I would also like to thank my supervisor, L.P Direko, for the effort and time he took in making sure that this project gets finished. I would also like to thank him for his advises in contributing to making this project what it is.
- Thirdly I would also like to thank Michael Temane, who co-supervised this project. I would like to thank him for his contribution, encouragement and availing himself so speedily
- Last but not least I would like to thank all those individuals who have also made contributions to this project at varying degrees. I particularly want to thank the participants whose contribution is invaluable.

DECLERATION

I, Itumeleng Mpolokeng, declare that the dissertation for the degree of Masters of Clinical Psychology at the University of North West hereby submitted, has not previously been submitted by me or any other individual for a degree at this or any other university. This is my own work in design and execution and all material contained herein has been duly acknowledged.

....

Signature Date

TABLE OF CONTENTS

CONTENTS OF TABLES AND FIGURES

List of Tables

List of Figures

CHAPTER ONE

1.1 Introduction and background to the study

Approximately about 16 children are seen for first evaluation at a Child and Family Unit of a Psychiatric Hospital, on a monthly basis. This number only includes outpatient children between the ages of 4-12 years. In the past years, a growing number of Black families have brought their children at a Psychiatric Hospital for some psychiatric or psychological problem.

Most of the families seen at the hospital have expressed feelings of distress and helplessness on the condition of the child and the way it has affected the family. Parents and family members in most instances are desperately seeking answer to the child's problem\difficulty, and most hope for a 'miraculous cure' to the condition of the child, as most have previously consulted with other health professionals, often with very little relief.

As Ingersoll and Goldstein (1995,p143) said " parenting is a supremely challenging experience, even the most delightful children can sometimes be demanding...and beyond all tolerance. As much as it is to be a parent how much more difficult it is to be a parent to a child who suffers from psychiatric illness". Parents and family members continuously battle to get their child right, while at the same time fight to keep the family intact, most of the time with great difficulty. They say the impact the child's behaviour has on the family is enormous as it affects relations and communication channels in the family (Ingersol & Goldstein, 1995).

The above discussion reflects somehow the characteristics of a system where change in one part of the family affects the rest of the system. The discussion below gives a brief introduction on psychiatric illness, in black extended families, and how families, as systems, function and attempt to cope with a child with a psychiatric illness.

For many decades, black families lived in close knit, communal functioning, where the neighbours and the community were part of the extended family. It is said that the most important characteristics of Black extended families is a sense of strong kinship bonds. As Boyd-Franklin (1989) in her studies found that most Black individuals, have at some point in their lives lived in an extended family, and that most Black families function as extended families.

The extended family is often composed of uncles, aunts, boyfriends, sisters, brothers, and friends. White (1980) in Boyd-Franklin (1989) said these individuals participate in the rearing of any Black child, where they interchange roles, jobs and family functioning. Loyalty and responsibility to others are expected from family members, and a strong sense of belonging is what maintains the strong kinship bonds.

Cheetam and Griffiths (1982) in their study found that any mishap or illness that befalls the family was the responsibility of the family and the community. A social network was therefore readily available to help with the crises and challenges a family experienced.

Furthermore, Asuni, Scoenberg and Switt (1994) found that such a support base had implications for recognition and toleration of mental illness, treatment and rehabilitation. It was only in extreme cases that the family would consult a traditional healer, who would then inform the family to perform appropriate rituals and ceremonies for the ancestors. As it was believed that any misfortunes that happens to a family was a sign that the ancestors were unhappy.

Over a number of years, there has been a growing number of Black families who brought their children to psychiatric hospitals. This increase is also reported by Asuni el at. (1994) where they conducted a study on African communities and found that children up to 9 years, 3-4% had psychiatric problems and 10-19 year olds the % increased by 5-10 %(Asuni et al., 1994).

This being the case, it appears that not much literature has been written on the subjective experiences of the family attempting to cope with a child with psychiatric illness.

The present study thus wants to find out/investigate what the psychosocial experiences of black extended families are, when faced with a child who has a psychiatric problem.

1.2 Problem Statement

More and more black families consult with western doctors, and more Black families are bringing their children in psychiatric hospitals. It therefore became apparent to the researcher (through working with these families) that families who had children with psychiatric illness were finding it difficult to cope with and handle the child's illness in the home environment.

It is through seeing these families in distress that the researcher was motivated to look at the psychosocial experiences and the impact the child's illness had on the functioning of the family, in Black extended families.

1.3 Aims/Objectives of the study

- The researcher hopes to explore the psychosocial experiences of members of the family caring for a child with psychiatric illness, in black extended families
  In particular, the researcher wants to investigate the influence/impact it has on the functioning of the family. Therefore it is important to look at the structure of the Black extended family, holistically. This includes:
  -who the family members are
  -family relationships/ and basic family functioning
  -communication systems
  -family rules and boundaries
  - problem solving methods
  -support structures
  - emotional experiences of family members

- As part of the investigation, the researcher hopes to also explore perceptions/understanding of the illness of the child

1.4 Research Question

The main research question that the researchers seeks to answer is:

- What impact does caring for a child diagnosed with psychiatric illness has on the functioning of the family, which includes (among other things) problem solving, communication roles, affective involvement, affective response, behaviour control and general functioning, among other things. These dimensions are from the McMaster model of family functioning.
- What is the family's general family functioning like?
- What are the subjective experiences of family members?
- What impact does the child's problem have on the relationships among family members?
- How do they perceive the child's problem and what do they think about it?

The questions were to be open-ended, which allows participants to explore the issue fully, without giving yes/no responds, and in turn allows the researcher to gain insight and deeper understanding of the interviewee's accounts. Even though the researcher did not prepare probing questions in advance, she used them whenever clarification or further elaboration on certain issues was needed. See questions in Appendix A.

1.5 Operational Definition of concepts

The following are the key concepts that will be used in this research, and are being defined specifically for the purpose of this study.

Family: it includes any close knit, co-living group, whether or not based upon ties of blood or marriage, interacting together and think of themselves as a family.

Extended family: this is an arrangement that consists of a number of kin spread across several households or living in the same household. It includes mother, aunt,

brother, in-laws etc, who share and exchange goods, services and emotional support (Baca- Zinn &Eitzen, 1993). For the purposes of this study the extended family must be living in the same household.

Psychiatric Disorder: The category 'psychiatric disorder' or 'mental illness' is an exceedingly broad and heterogeneous one that includes both behavioural (Conduct, ADHD and other behavioural problems) and emotional problems (mood disorders). These behaviours at least need to be handicapping and persistent, degree to which the illness affects different aspects of the life of the child and others.

In the current study, the disorder must in some way or another have an impact on those around him\her, and also include behaviours that are include bullying, threatening or intimidating others or staying out at night despite parental prohibitions (Kaplan, H.I & Sadock, B.J, 1998).

For the purposes of this study psychiatric disorder and mental illness are used interchangeably.

Affected child: It refers to all the children in the study that had being diagnosed with a psychiatric illness

Family Functioning: Family functioning is quite a complex phenomenon that can be used in a variety of ways. Amongst other things the researcher uses the six dimensions of the McMaster model of family functioning, which are: problem solving, communication, roles, affective responses, affective involvement and behavioural controls.

Unhealthy Functioning: is used in this study to reflect the family's difficulty in dealing with certain issues that arise within the family. It can reflect too much involvement on the one hand, and too little involvement on the other, concerning the lives of other family members.

Structure of the Family: Is defined in terms of the family's subsystems, supra-systems, roles, norms and values. Each subsystem has its own boundaries, needs and expectations. It basically looks at the interactional patterns that exist within a family.

ADHD (Attention-Deficit-Hyperactivity Disorder) according to the DSM-IV means a "persistent pattern of inattention/or hyperactivity" more frequent and severe than is typical of children at a similar level of development. Impairment must be present in at least two settings, and interfere with the developmentally appropriate functioning must occur in social, academic or work setting (Kaplan, H.I & Sadock, B.J, 1998).

Problem solving: which refers to the family's ability to solve problems effectively. These include practical problems like financial and housing problems, and also emotional (affective) problems at a level that maintains effective family functioning

Communication refers to the family's ability to exchange information, and how the information is received.

Roles are the repetitive patterns of behaviour that individual members of the family fulfil family functions (basically, the responsibilities of each member).

Affective involvement: to what extent do family members show involvement with one another, measured on a continuum of too little to too much involvement. In this study it also reflects emotional involvement and emotional expression.

Affective responsiveness refers to the ways family members respond emotionally to their various relationships within the family, and appropriateness of the response. These include love, fear, happiness, joy shown to one member or another.

Behaviour controls involve how the family sets limits on the behaviour that is physically dangerous, it looks at how the rules of behaviour are developed and maintained.

The above six dimensions of family functioning are from the McMaster model of family functioning in Epstein, Bishop and Levin (1978). They are used not as definite categories that define family functioning, but as guidelines on how to view family

functioning, and to organise it in more systematic way. Especially in the black extended family, which consists of the complex interrelationships.

Mental Health Settings is used interchangeably with psychiatric hospitals, and basically is taken to mean the same thing.

1.6 Significance of the study

There is a lack of information that focuses on psychiatric illness in black families, how families attempt to handle and cope with a child with psychiatric problem and how this has influence on the Black extended family.

Through studying black extended families the researcher hopes to give more insight on the lifestyle, structure and functioning on black families and how they as a multi-system attempt to cope with a child with psychiatric problems. Because of the explorative, nature of the study, it taps on aspects of family systems that has not been extensively researched, and thus hopes to close the gap in the existing literature.

1.7 Scope of the study

The study is conducted on black families, more specifically black extended families living in the township areas of Pretoria. The study is limited to those families that have brought their children at a Psychiatric Hospital in Pretoria for evaluation, diagnosed of a psychiatric disorder.

CHAPTER TWO

2.1 LITERATURE REVIEW

2.1.2 Psychiatric illness and family functioning, in general

Chapter two focuses on the research that has been conducted on the impact of family functioning in an attempt to cope with a child with a psychiatric disorder. The literature review is divided into three parts of discussion. The first part focuses on how families, reflective of nuclear white families, have been impacted by looking after a child/patient with psychiatric illness. It looks at the general view of how families, with children with different mental illnesses, have experienced caring for the child and what impact that had on the family functioning. The second part of the literature review focuses on the history of psychiatric illness in black families. Because literature shows that there are differences in how mental illness is perceived by different cultures, the researcher looks at how black families defined mental illness and what services were available for the mentally ill.

The last part of the review focuses on the theoretical framework of this study.

Almost all research on families of mentally ill patients has been conducted on Western population, primarily on middle-class, Caucasian subjects with intact families. Although the majority of studies have been done in the U.S, few black Americans and other minority groups are represented. Similarly, when one looks at the literature and services available in South African Context, mental health services were discriminatory to non-white people, and this was explained away by the fact that, because of cultural differences, there had to be different services, to protect ethnic identities (Fernando, 2003).

Developing an understanding and ways of helping families in these predicaments has long been an essential part of social work, community psychology, community

psychiatric nursing, community occupational therapy and psychology (Orford, 1987). There also has been a rapid growth in research on family functioning and in developing theories of family life, in understanding the structure of the family and its constituencies. One way or another, professionals and others who have dealings with illness, handicap or disorder have become aware of the family as a part of social context in which human difficulties occur (Laosa & Sigel, 1982).

Originally, families were the sole source of care and the community took little responsibility. As time passed, there was a movement towards removing patients from home to institutions in the 19th and early 20th century. There was a sudden sharp reversal in the 1950s where home and the community once again were the favoured place, and patients were rapidly being deinstitutionalized (Hatfield & Lefley, 1987). The reason for this was the community's sudden realization that patients were more likely to suffer from the effects of hospitalisation as they did from the mental illness itself. It was realized that people were much better off being treated at the community where they had established familial ties\bonds.

As the process of deinstitutionalization took place, families and the community realized that they were ill equipped with resources that would have been readily available at the hospital. It was further realized that the structure of the nuclear family could not cope looking after the physically or mentally ill people since there was at most two adults to take roles of major responsibility in the home. This would cause disruption in the "precariously balanced, emotionally charged system of the modern urban family"(Hatfield & Lefley, 1987:p32).

Clausen and his colleagues are one of the earliest researchers to study and document the consequences of mental illness on the patient's family, in 1952.They realized that studies conducted prior to that focus on the patient, and the family focused on tracing the origin of the illness and not on the family's perception of behaviour that becomes more deviant and how family members respond to this and how morale and cohesiveness were maintained in the family (Hatfield & Lefley, 1987). This paved way and laid the groundwork as many researchers took interest in this the family and how they coped with child\patient with mental illness. For example Creer and Wing (1974) in Hatfield and Lefley (1987) realized that sources of difficulty reported by the

families were many and diverse. However many families reported disruption on the family's everyday life and interruption with the functional tasks of the household. Similarly Kreisman and Joy (1974), in Hatfield and Lefley (1987) found that families were highly stressed due to the episodic eruptions and confusing nature of the illness, which requires continuous adjustment and the need to shift roles and provide constant care without a break, placed great strain on the family (Hatfield & Lefley, 1987).

Lots of studies have gone into looking at the family and particularly the impact on the family members of chronic illness or other disabilities, either in adults and children, and in the ways families cope with these circumstances. Pless and Roughman (1984) in Thompson and Gustafson (2002) particularly focus on adjustment difficulties that members of the family may experience, especially if it involves the child's functional limitation. He goes on to say there is a direct link between the psychological distress of family members and the functional limitation of a child. He says there are three types of processes that are likely to influence adaptation to stress, and these are: cognitive process (which involves the way the family perceives and understands the child's disorder), social support the family's coping strategies.

Orford (1987) in his work talks about different kinds of burdens that the family experiences, from emotional burden, to a burden as practical as financial hardships. He says it is the financial and practical burdens that families have not bargained for which often takes the whole system out of kilter, especial if the financial burden only affects one member of the family. These members he purports, end up being resentful, especially if they have spouses who aren't contributing or giving support in other forms.

Sleep, time and energy are said to be the number one burden that certain family members rate as highly stressful. He says that family members sleep may be disrupted because of the nature of the disorder, for example a child who cant sleep at night. He says sleep disturbance is probably of major importance in creating feelings of exhaustion, lack of energy and hopelessness in family members, particularly if there are other children who should be attended to. Further 'hidden' burdens include treatment that needs to be administered at home. Certain individual, especially the mother is responsible for ensuring compliance with treatment, and this may be

consuming of her energy and time. This usually becomes an extended stress or burden when medication needs to be fetched at the hospital, and when constant contact needs to be kept (Orford, 1987).

Research shows that those that are mostly affected by the child's illness, are those who are intimately involved with the child, which happens to be mothers. It shows that mothers carry the burden for caring for the child, they worry about the child's needs and how to console the child when these needs cannot be met. She examines her own conduct and that of others; friends, teachers and others involved with the child in an attempt to understand he origin of the child's problems. This results in increased level of intrusion into her daily life routine, than it would be for other family members or relatives (Hatfield & Lefley, 1987).

Other members might avoid/dissociate from the child as behaviour may cause immediate irritation, terror or despair. They may, as they avoid involvement with the child, avoid the mother (who is the primary caregiver) who tries to involve them or seek advice. Others may find conversations about the child's illness just as disruptive as direct confrontation with the child's behaviour. As a result they may come to dread the illness and the child, and work, friends and other interests outside the home might take first priority. Differences in response to illness of the child often threaten the family's pre-existing cohesiveness and peace. Husband and wife become estranged, brothers grow remote from sisters and the child ceases contact with a parent (Hatfield & Lefley, 1987).

Orford (1987) and his fellow researchers further reported about the different affective responses and involvement that family members go through. He specifically referred to the uncertainties, guilt and social restriction that members and relatives experience, especially if and when they don't fully understand what is wrong with the child. Diagnosis of the child can at times bring relief to family members, but diagnosis can also be potential area of suffering for the family.

Furthermore Hatfield and Lefley (1987) says this is because terms like schizophrenia, mania, depression have no universally accepted meaning and don't bring up specific

images of the problems or symptoms that the patient may experience. Instead, they bring images of dreaded outcomes, such as back-ward lunatic in a strait jacket, a criminal, skid, a bum, or funeral images of suicide and murder (Hatfield & Lefley, 1987).

They say family members react differently to the patient's illness. Some members go along with the psychotic delusions of a psychotic child, or will at times condone unacceptable behaviour because of the illness, or the disorder. This type of reaction he calls collusion. He says that the family members aren't merely victims of the stress caused by living with a child or relative with a particular disorder, instead many wonder/ or make up the etiology of the problem. They can either believe in the biological roots of the illness, or believe that it is due to interpersonal relations among family members (Hatfield & Lefley, 1987).

Furthermore they found that those who believe that the child's illness has biological roots, may conjure up images of a mentally deficient idiot, causing them to ignore areas of preserved functioning. They are likely to experience helplessness and overvalue professional attention. This may cause them to worry about the genetic vulnerability of other family members to developing the illness, and may experience despair for the child's future. These family members are more likely to see the behaviour as mere misconduct, or explain the behaviour as being lazy, silly or a fake, and they are most likely to distance themselves from the child (Hatfield & Lefley, 1987).

On the other hand, family members who attribute the child's illness to interpersonal and intrafamilial interaction are at risk for blaming family members, including themselves. They are often heard of saying " mother was too careful; father was too critical; brother didn't help enough in school work or sister dint include him enough in her life"(Hatfield & Lefley, 1987: p134). They say as a result, members of the family are set against each other as the accuser or the accused. Often, to avoid conflict, family members avoid blameful discussions, and what develops is corrosive form of silence, with explosive confrontations at times of crisis.

Orford (1987) says that what is most affected is usually relationships in the family, which often includes affection, communication, problem-solving and family cohesion. In communication breakdown family members might find it difficult to express heir feelings, or discuss openly anxiety-laden topics. Because of constant tension and breakdown in communication channels, family members find it difficult to make joint decision making, generating creative solutions to the problem and even relying on one another for problem solution. This affects the normal pattern of affection and cohesion, where there lack of consideration and compromises made, and this often results in constant and long-standing disagreements and frequent arguments. This results in accumulation of hurt and angry feelings, which in turn affects the family's rituals, like having dinner together. This eventually creates distance between family members (Orford, 1987).

Ingersoll, and Goldstein (1994) further on expantiate on the emotional roller-coster that family members experience. Parents may go through shame and embarrassment when a child with separation anxiety results in wild shrieks, tearfulness or throws tantrums. Confusion and bewilderment follows after they have consulted with different professionals and received advice, but still don't know what is going on or even how to handle the child. They say it is painful for parents to listen to a depressed child who, on a rare occasion opens up and pours his feelings of despair. Parents usually don't know how to respond when a child verbalizes 'I whish I were dead'. Because of this parents feel an overwhelming sense of guilt and failure and often blame themselves for the unhappiness or anger of their child (Ingersoll & Goldstein, 1994).

Ingersoll (1994) and his associate Goldstein further on say that depressed children go through mood swings and they are at their worst in the morning when they wake up with a bad temper, and this often throws the whole precariously balanced system out of kilter. They say it can be worse at the end of the day when a child refuses to do their homework, is irritable, complains about food at dinner and spends the rest of the day fighting with the siblings. Other emotions that parents and family members may experience are fear, fright, feelings of being trapped, anxiety, and preoccupation with family problems. Because of such problems some family members will resort to alcoholism, or report some psychiatric, psychosomatic and physical symptoms.

Wachtel (1995) says the mistake that parents make is not focusing on the day-to-day experiences and the family as a whole. He says most of the parents of the children that he has worked with describe life as being miserable, and often feel angry and resentful at the child for ruining their family life. Parents are said to go through the process of learned helplessness, and this is influenced by the chronicity of the child's problems, experiences in attempting to discipline the child, and futility of the search to understand the cause of the problem, and parents make the conclusion that the problem is unalterable.

Though this made be the case, Orford (1987) says that those working with these types of families must be careful in assuming that all families with one or another disorder will automatically experience certain level of stressful events and negative experiences. He states that families have different experiences and different ways of coping. Several talk about the remarkable resilience of some families, or high levels of burden by many. They say the successful adjustment to illness/disorder may enhance the quality of relationships in the family, and may deepen feelings of empathy and understanding among family members.

Factors that may contribute to different patterns of adjustment are the following: the exact nature of the family's difficulty, this includes disturbances of behaviour, or change in personality, unpredictability of behaviour and mood, are most disturbing and difficulty to handle. Another factor includes the family's and relatives interpretation of the behaviour and attitude, for example if members assume that the behaviour is under deliberate control of the individual, or taking the behaviour to be intentionally provocation, and most common blaming certain individuals of the family, the mother for the past treatment of the patient (Orford, 1987).

As Boyd-Franklin (1989) said that its important to stress the effects of coping with family difficulties and problems may be positive rather than negative. For example in families that she worked with she found that there had been benefits for other siblings-they were, as a result- less selfish, kinder, more tolerant and understanding, while other families thought that there had been disadvantages including disturbances of their activities and inhibitions about asking friends over, or even visiting other

families. Other authors show that healthy siblings, children, or even grandchildren, may show emotional disturbance, behavioural problems at home or at school and have learning problems and poor school performance.

The first part of the literature focused on how families are affected when there's a child diagnosed with a disorder of some kind, and highlighting both personal experiences that individual members of the family might experience, and also looked at the ripple effects this has on the entire family. The second part of the literature focuses on the history of psychiatric illness and the availability of these services to black communities, and the literature on black families and how they have dealt with children with a psychiatric illness.

2.1.2 Psychiatric illness and family functioning in Black families

Firstly it is important to note that treatment of black families has really being an interest to the discipline of social anthropology, particularly in focusing on different types of families from different cultures of psychology. Other disciplines that have conducted studies on families are psychologist, more specifically family psychologies as they also have developed theories on the functioning, and structure of the family.

Boyd-Franklin (1989) in Orford, (1987:p227) said that the "literature on treatment of black families in therapy has not been extensive and has further been diluted by the fact that there has been no central forum of the literature for debate on crucial issues such as intervention issues". So a lot of black families have been seen through and understood in light of white, middle class family lifestyle.

The main reason for this was that as the anthropologists worked with different types of families, they came to realize that culture was important in shaping the perception and belief systems of people on mental illness. An ideology that most professionals in the mental health services did not take note of, and thus continued to study non-western white families through the 'eyes' of white middle class family living.

When looking at the history of mental health services, black people who were admitted at psychiatric hospitals were more likely to receive least desirable and least

optimistic diagnoses. They were more likely to be diagnosed as schizophrenic, while recent research suggests that many of these patients had an affective disorder that was misdiagnosed .It was also realized that mental health professionals, particularly psychiatrists and psychologists were mostly European, and thus did not have the background nor were they trained on non-European cultures. As Fernando (2003:p3) said "mental health services were frequently held to be insensitive to culture, and psychiatric and psychological therapies appeared to be inappropriate for many people from non-western cultural backgrounds"

For them behaviour that seemed bizarre and didn't fit other diagnoses was often diagnosed schizophrenia. As Asuni et al. (1994) said that a person's or a group's general health can be meaningfully understood from the knowledge of their race and social class. Understanding of the amount, pattern, type and level of impact of stresses on individuals could be greatly enhanced by including factors of race, social class, in analysis. Further more, they say the relative impact and meaning of any stresses, as well as the pattern of responses are influenced by the person's social class, ethnicity and culture, in addition to the effects of the individual's biological and psychological makeup (Asuni et al., 1994).

This becomes clearer as we take a closer look at the history of the concept of mental illness in African black families. When we talk about mental illness and how it was understood by black African communities, we talk about the belief system that governed societal ways of appropriate behaviour. At the same time this cannot be separated from people's way of living, how children were socialized and the kind of family systems that operated. It is generally understood by social anthropologists that black people preferred communal support systems, with emphasis upon the extended family system, social integration and group identification.

Asuni (n.d) in Mabetwa, P.J. and Direko, L.P (1992) said a child is usually reared in an extended family situation, where in addition to biological parents, there are always other surrogate parents. The mother-child relationship is less intense as it shared among the mothers and not limited exclusively for the biological mother. Therefore the bonding process of the child and others was different from what would be the case in white families. Crises, which include happy, neutral or unhappy events- including

illness, were primarily the responsibility of the family and the neighbours who were readily available and willing to help. Asuni(n.d) further said that all of these factors have implication for prevention of mental illness, recognition and tolerance of mental illness, treatment and rehabilitation. This reflected the trends that were dominant in the early 1980s.

When Cheetam and Griffiths (1982) made their studies on the Nguni people, they found that patterns of behaviour that constituted a threat to social cohesion and balance, disturbed behaviour or extreme disturbances of expression and reason, were regarded as madness. Mental illness therefore was looked upon with suspicion. They believed that mental illness related to:

- Failure to propitiate the ancestors with the necessary sacrifices or rituals
- Non observance of taboos and consequent ancestral displeasure
- Bewitchment in which the mind has been removed through a sorcerer who obtained a portion or evil influence from an 'xhwela'
- Object intrusion, in which removal of the mind has occurred through the action of one of the familiars such as the Thikoloshe, making incisions under the hair line
- Or bad blood and foam reaching the brain and excessive worry over matters that have been kept to himself (Cheetham & Griffiths, 1982: p955-p956).

Often when people were befallen by this misfortune, they were taken to traditional healers for help. However, over the years, there has been a growing population from the black communities that enter the mental health hospitals. More and more black people have sort relief to stress through mental health systems, and this in a lot of ways reflects the gradual decrease in communal support practices and more towards independent living and leading more and more individualized lives.

This is not to say that black people have abandoned their belief systems, instead as they got exposed to a western way of life, they started to adopt western ways of living, including alternative ways of looking and understanding those who became 'ill'. Most people nowadays still believe in the traditional healers, and at the same time acknowledge western medicine. This being the case, there remains little studies

that have been conducted and documented on this transition, and particularly on psychiatric illness in black people and how they cope with a child/or any family member with psychiatric illness.

Asuni et al. (1994) say that books on mental health and psychiatry have all been written in Europe, and as valuable as these books have been, and to a large extent continue to be, they are based on the western experience. There are numerous books that have been written on personality development, child-rearing practices, family structure, social and cultural surroundings.

In their study Asuni et al. (1994) admit that in African communities that they worked with, there were children's problems, but these problems they found were infrequently brought to attention (though this trend is rapidly fading away nowadays as we see many black families bringing their children to psychiatric hospitals). In the survey that they conducted in their study, they found that only children up to 9 years, 3-4% had psychiatric problems and 10-19 year olds the % increased by 5-10

They found that problem children more commonly lived in extended or multi-disciplinary families, and this they found, was due to the frequent inconsistent discipline. Children from homes that have been broken up because of divorce, desertion of one parent, were reported to be significantly more likely to be disturbed. In their study with Ugandan children, they found that the children had symptoms comparable to those exhibited in developed countries, although in Africa the symptoms were seen as mere forms of nuisance, which required punishment by the adults %(Asuni et al., 1994).

Furthermore, they realized that most children that were brought in to child psychiatrists presented with symptoms of mental retardation and epilepsy, figures ranging from 3-60 %, due to central nervous system infection. A low number of children were brought to the clinic because of general behaviour or acting-out disorders. Children with general behaviour disorders, learning difficulties and anti-social activities were not brought to the hospital, but were taken to the indigenous healers (Asuni et al., 1994).

However, they found that in general, there were still fewer behavioural problems in the black population than had been reported from other developing countries. This was due to the favourable aspects of community life still operating, and this included extended family relations, durable marital commitments and mutually supporting communal interdependence and traditions of social control (Asuni et al., 1994).

Research focusing on black families in therapy, exploration of black family systems and how families handle and cope with psychiatric illness in the family is even scantier. In the past, coping with problems and other challenges that the family experienced was dealt with by the social networks, appropriate rituals and ceremonies. Only in extreme cases did families refer their children to traditional healers. However over the years, society and communities transformed due to industrialization and globalisation, and this resulted in a growing number of black people consulting professionals for help.

Boyd-Franklin (1989) said, " if family therapy as a distinct approach is still in its infancy, family therapy with black families is still in its incubator stage" (in Orford, 1987: p227). She says that for many professionals working with black families today, their primary exposure to black people and black culture came through the literature of the 1960s.This literature described black families as disadvantaged, disorganized, chaotic, depressed and deprived. Literature on black families failed to look at the most important factors that shape and help to understand their family lifestyle better, which include cultural background, socio-economic and political factors.

For most therapists, the more at odd a black family was with the white, middle-class family model, the more pathological the family was considered. The researcher is not referring to just family systems that operate in black communities, because studies on that are plenty, with social anthropologists having taken the lead. What is referred to are theories in understanding black families in therapy, their functionality and how they deal with disorder in the family. As Boyd-Franklin (1989) in Orford, (1987) said that though there has been growing interest in black families, there aren't studies that integrate current research on cultural patterns into treatment.

Spencer, Brookings and Allen (1986) said that the lesson to be learned from research on black families and children prior 1970s is that black families cannot be accurately described without simultaneous and systematic consideration of their cultural context, history, economic and political realities.

From the discussion above, it is clear that mental illness has a huge impact on the functioning of the family, both negatively and positively. The ability of the family to handle and cope better, depends amongst other things on the pre-morbid functioning of the family and the support structure the family has. Research shows that looking after a child with psychiatric problems often has a ripple effect on the family functioning, affecting communications, ability to work together and respond to one another positively.

At the same time, as we read from the discussion that mental illness is functionally and conceptually related to culture, as it defines criteria for appropriate behaviour. This establishes the trends that people follow. And when we look specifically to African people, their belief system of mental illness was based on the social, religious, ancestral and magical factors. The ill were taken to traditional healers, as the elders believed they had the powers to communicate with the ancestors. However, as more and more people got exposed to western life, there was a shift in the way they perceived mental illness, and this influenced their practices concerning treatment of those who became ill.

2.3 THEORETICAL FRAMEWORK

2.3.1 Systems and Structural theory concepts

Different family theorists have used different theories to better understand the family, but one of the most commonly used theory is the systems theory. In order to study and understand the functioning of the family, it is important to look at it holistically, with its responsibilities, structure and units of its constituencies. Goldenberg and Goldenberg (1990) described the family as a group of interrelated parts that could only be understood when seen in their totality and not as individuals.

Structural family theorists similarly focus on the structure of the family and the functional demands that organize the ways in which family members interact. They tend to focus on the functioning or dysfunction of the family structure. These are the points that are of interest to the researcher, to look at how family members organize themselves in terms of their transactional patterns.

When we study the family, we are studying its pattern of behaviour, consisting of rules, boundaries, values and patterns of interaction that govern people within the family unit. To understand how certain disorder/disturbances or external forces impact the functioning of the family, it is important to study it holistically, to understand what constitutes a system. As most theorists, particularly family therapists, postulate that an illness or disturbance in an individual originates within the family, and change will only come about if one studies the family, as a whole, and not individuals. As Steinglass (1984) in Okun and Rappaport (1984:p98) said " a member's behaviour is a product of various interactive relationships"

This is a point that begins the focus of the study, but from a different angle. In most cases, the family therapist, to understand the individual with a mental illness, studies the environment (family) that the child comes from. Though the researcher acknowledges this fact, the discussion focuses on what happens to the family system, when there is an identified person (in this study, a child) with a particular mental illness. What happens to the family functioning, or rather how is the family functioning affected by the child's illness?

The study therefore is based on the systems notion that change in behaviour in one part of the social system (for example individual family member) will affect all other parts of that system (this is the entire family). Focus therefore is on relationships within the entire family system rather than the individual in the family. The researcher is particularly interested in investigating how the family functioning of extended families is affected by caring for a child with psychiatric illness.

The notion of a family as a system has its roots in the general systems theory that was pioneered by Ludwig von Bertalanfy in the 1950s.He defined a system as " a dynamic order of people (along with their intellectual, emotional and behavioural processes)

standing in mutual interaction"(von Bertalanfy, 1975) in Okun and Rappaport (1984:p110). French (1977) in Okun and Rappaport (1984: p99) further explained a system as "a family being composed of a set of elements and a set of rules that determine the relationships among the elements and functioning in a way that makes the whole a greater than the sum of its parts". Looking at this definition it seems that it can be applied to all kinds of families, including Black extended family system.

Wolman and Stricker (1983) further explain the system as consisting of special set of people with relationships among them, and these relationships are established, maintained and reflected in their communication patterns. They say a system therefore is not a mere list of family members, but a description of relationships between and among them. These relationships in turn make the system whole, and not summative. By this is meant that the family as a whole cannot be further reduced. Family members, or subparts are seen in context of the whole rather than individuals that are added up to make a whole.

The structural approach, similarly studies the family as a whole. It however puts emphasis on the structure of the family, and the functional demands that organize the ways in which family members interact. Minuchin (1974) says it is based on the concept that a family is more than the individual bio psychodynamics of its members. Family members relate according to certain arrangements, which govern their transaction. Each family unit either functions along normal developmental lines or encounters difficulty in negotiating the expected life cycle crises. So when a family runs into difficulty it can be assumed that it's operating within a dysfunctional structure.

Structural theorist therefore, tend to prescribe healthy functioning or dysfunction of the family, to look at the rules and regulations that control and maintain the family system. Families are therefore rated according to a continuum scale where on the one end is enmeshment and on the other end is disengagement in the ways they related to one another (Wolman & Stricker, 1983).

They focus on the actual structure within which elements of communication take place. One of the well-known structural theorists is Talkon Parsons, who proposed

that the family, like all other social systems, if it were to survive, it had to develop the mechanisms to meet certain functions of the family, which include the physical and psychological needs of family members. In carrying these functions, families have to deal with three sets of tasks.

The first is basic instrumental and affective tasks such as provision for food and shelter. And the affective tasks include provision of nurturance, affection and support when family members experience disappointments or frustration. The second is developmental tasks, which happen during the process of growth. This process includes individual developmental stages, which are the developmental milestones-from infancy to mi-life crisis, family stages, which involve structural changes in family development, such as marriage, first pregnancy and birth of first child. The third and last is hazardous events which include crises that occur –illness, accidents and unemployment (Epstein et al., 1978).

Epstein et al. (1978) say families vary in the ways they accomplish these tasks. They say in some families, meeting basic instrumental tasks may be difficult, while other families may accomplish instrumental tasks without any difficulties, but may experience problems in accomplishing developmental tasks. Others may have accomplished basic and developmental tasks with ease, but may experience difficulties when faced with hazardous events like unemployment, illness, and so forth. They further say that the family's ability or inability to solve problems associated with accomplishment of tasks is primarily determined by the pre-existing vulnerabilities within the family.

The following are basic tenets found in the systems and structural model of family functioning.

Closed/Open systems: Closed systems are those that exist as isolated units, and for a family to be an interpersonally closed system would mean that it had no outside communication and no relationships with other possible components. The family members would be the only persons communicating with each other, so their system boundary would be drawn easily and it would be a boundary over which nothing

passed. An open system, on the other hand operates in hierarchical relationships where the environment subsumes a system, which in turn contains several subsystems. Their boundaries are open to many interactions with other people; individual members may form strong relationships with non-members, and a particular family exists in the context of a larger, extended family (Wolman & Stricker, 1983).

Complex systems are composed of subsystems: Subsystems refer to a functional group involving two or more family members, and any one individual family member belongs to several different subsystems. A subsystem may be a piece of a larger structure and at the same time also a complete structure in itself. Within the boundary of a particular subsystem, members may be engaged in collaborative, interactive pattern, and not necessarily in coalition against other sub-systems within the family. Munichin (1974) says what takes place within various subsystems is often of a less importance than how well the boundaries between these sub-systems are maintained. The reason for this is because differentiation of family members is considered to be important as it enhances personal growth and autonomy (Wolman & Stricker, 1983).

The subsystems within a larger system are separated by boundaries: A boundary is defined by structural theorists as rules and regulations that separate the system from its environment. The characteristics of a boundary determine how exchanges are carried out. A boundary can be highly permeable, where feelings and thoughts are easily exchanged, or it can be fairly permeable, where thoughts and feelings are either not exchanged at all, or are exchanged with difficulty. They say permeability of a boundary is neither good nor bad in itself, what is important is to look at the actual circumstances (Wolman & Stricker, 1983). Family boundaries, though, must be semi-permeable so that there is balance of the family system with the outside community.

Any system is an organized whole, and elements within the system are necessarily interdependent: The concept of organization means that the elements within the system have some type of consistent and predictable relationship

with each other. The system is an integrated, coherent entity that is more than the mere composite of independent elements. Despite this wholeness, change in one part of the system may cause change in many parts of the larger system. The whole family system may be changed in a way that is greater than the sum of its individual changes.

The patterns in a system are circular rather than linear: Most theoretical approaches view behaviour as the end product of one or more forces, where behaviour is caused by some internal or external force. Circular notions of causality emphasize how the behaviour 'fits' into sequences of other interactions. Wolman & Stricker (1983: p68) "noted that behaviours are viewed as interdependent components of a recursive feedback loops". The behaviour of person A influences the behaviour of person B, which in turn influences the behaviour of person A. Such a view argues against blaming problems on any one individual in the system. So to understand behaviour, therapists need to look at the cycle/spiral within which they occur.

One can therefore ask what circles are operating/happening in this family? One therefore sees the individual with his/her family in context of current relationships. Communication and behaviours are seen from everybody that is present, composing of many circular loops that play back and forth, with the behaviour of the one person (the index person) being only part of a larger, "recursive dance".

Systems have homeostatic features that maintain the stability of their patterns: The interactions in any given family system are maintained within a range of functioning that is balanced or held in equilibrium. When there is behaviour that deviates, corrective feedback is given to restore behaviour to acceptable behaviour (this is, central tendency). As the system grows, and as there is a need to adapt to external events, the range of expected behaviour also changes. The behavioural equilibrium in a family system is therefore dynamic and not static (Wolman & Stricker, 1983).

Tendency for family systems to seek balance serves to maintain stability and sometimes prevent change. For example structural therapists believe that the

behaviour of any family member, in particular that of a symptomatic family member, or the painful distress he causes to the family is viewed as homeostatic. That is, returning the family to its mode whenever it is faced with some external or internal stress. Therefore the family's attempt to deal with the difficult behaviour of a family member may be directed at preserving the status quo.

Evolution and change are inherent in open systems: With development of living systems comes change. Throughout a lifespan, individuals go through change physically and in relation to with their environment. As things in the immediate environment change, individuals too are required to change their behavioral strategies. Likewise, for successful functioning, there should be changes in the environment as well. Family systems are also required to function in the same manner. Families are said to have a dual nature, where they attempt to maintain constancy with the changing environment. While on the other hand, they are growing and changing their rules and structure in response to the changing environmental circumstances. These changes result in more complex and differentiated relationship patterns (Wolman & Stricker, 1983).

Communication: Most of our relations with each other are based on and regulated by our communication with them. The family as an emotional system survives by the family's pattern of communication, which defines, maintains or changes the nature of the relationship among family members (Wolman & Stricker, 1983:p66). All communication therefore is seen to convey not only the content, but also the information about the relationship between family members. Various family members are chosen to interpret communication from extra-familial sources and relay it to the family, non-verbal communication, subtle styles of speaking and choices of phrases establish and strengthen family identity and isolate the family from the influence of others (Wolman & Stricker, 1983).

Wen-Shing Tseng and Jing Hsu (1991) said the extent to which open communication among family members is encouraged varies greatly among families in different

cultural groups. Cultural tradition greatly affects the extent to which families feel comfortable about revealing their private lives to outsiders

Feedback system: According to the systems theory, living systems exchange information with the environment and use the energy or feedback from the environment to grow, differentiate, modify or correct its course of action. Feedback system enables the family members to interact with each other and with the environment in an attempt to maintain balance between internal needs and external demands. This, in turn maintains the system's functioning. The feedback system operates by correcting errors, encoding environmental stimuli and limiting input to what is helpful and useful to the system. A process called feedback loop-system .For the feedback loops to be effective, the system needs to have structures of communication, regulation of critical parameters and change of reference points from which the feedback loops operate. Negative feedback would therefore be a result of the system maintaining stability and resisting/preventing change, while positive feedback will increase change over time. This is if one member of the family leaves, there is allowance for the system to be reconstituted (Wolman & Stricker, 1983: p68-69).

Enmeshment-disengagement continuum

The structural theorist or family therapist places importance on the quality of affective involvement between family members, which occurs along a continuum that lies between enmeshment at one extreme, and disengagement at the other continuum. At the enmeshed end of the continuum, the boundaries between family members or between one sub-system and another are diffuse. Such diffusion is explained according to the McMaster model as over-involvement or symbiotic. At the disengaged end of the continuum, boundaries are inappropriately rigid and reflect lack of involvement in the McMaster's affective involvement. Families that show lack of affective involvement to its family member are said to reflect a chaotic and under-organized pattern of interacting (Epstein et al., 1978).

Having said this, Wen-Shing Tseng and Jing Hsu (1991) warns that families of different ethnic groups tend to manifest specific patterns of affection. There is therefore a need among professionals working with families to create a baseline in

evaluating the emotional responsiveness of families. The way that families express behaviour in public or privately is greatly influenced by the family's cultural background.

Furthermore, Carter and McGoldrick (1999) found that though there is capacity among African Americans to openly express their feelings, such expression might be held in check in an effort to minimize intergenerational conflict. Such conflict may threaten unity and destroy the energy needed to deal with everyday life. Tension is likely to occur when individuals are perceived to concentrate in their sorrows, engaging in self- destructive behaviours or pursuing individual interests without concern for others.

Other theorists further warn that those working with families should be careful of not oversimplifying the complex structure and transactional patterns that exists among family members. The therapist needs to be aware of the behavioural patterns of interactions between members, but at the same time also be aware of the private experience of family members, and meaning they attach to these transactional patterns.

Family functioning is a very complex phenomenon that can be assessed in a variety of ways. There are a lot of dimensions that theorists have used. For the purposes of this study, the researcher used (among other things) the McMaster model of family functioning to describe family functioning of the families under study. The McMaster Model of Family Functioning describes the structural properties, the way the family is organized, and the patterns of transactions among family members, which have been found to distinguish between healthy and unhealthy families. It is based on six dimensions, which are: problem solving, communication, roles, affective responsiveness, affective involvement and behavioural controls. This model is described in [(Epstein et al., 1978) in Will and Wrate (1985: pp15-23)].

Problem solving refers to the family's ability to solve problems (these include practical problems of everyday, financial, and affective problems). Dysfunctional family is thought to have difficulties with affective problem solving, while other

families have difficulty with both practical and affective problem solving. The ability of a family to solve a problem involves identification of a problem, and consensus that the problem is a problem; adequate communication about the problem between family members; developing alternative ways of dealing with the problem and deciding on one course of action. Families who are markedly dysfunctional may not be able to come to any consensus about identification of the problem.

Communication refers to the family's exchange of information and how this information is received, and the ability of the family to communicate about instrumental and affective issues. The information can be clear and direct, instead of masked and indirect, received by the person that its intended for. Communication can be verbal or non-verbal, and there needs to be congruency in the way the message is communicated. Communication can either be validate, ignored or disqualified, and the more functional the family, the more validated the communication and the more dysfunctional the family, the more often communications are ignored or disqualified.

Roles are the repetitive patterns of behavior by which individuals fulfil family functions, and may be concerned with instrumental or affective areas. For maintenance and stability of roles, there needs to be role allocation and role accountability, and the family needs to be clear who assigns these roles. Within the family, one needs to ask if there clarity of family members that provide for food, clothing and money? and also who provides nurturance and support and for who? The most effective functioning is when all necessary family functions have clear allocation to the relevant individuals, and the least effective is when family functions are not allocated to any particular individuals.

Affective responsiveness refers to the how the family responds emotionally in their relationships. Are affective responses broad or restricted, and are they appropriate to the situation or not. There are two types of feelings that can be expressed-welfare feelings and emergency feelings. Welfare feelings include feelings of love, happiness, tenderness and joy, which are supportive and positive. Emergency feelings include feelings of fear, panic, anger and disappointment. For effective family functioning, the family should be able to respond to both kinds. Though

cultural differences in expression and responding to certain feelings should be considered.

Affective involvement refers to the family's interest and involvement with each other, and can be applied to the family as a whole, and to sub-systems. To what extent do family members show involvement to one another, and what are its qualities? Epstein et al. (1978) describe a spectrum of six types of affective involvement based on a continuum of too little involvement at one end, and too much involvement at the other. The six types are: lack of involvement, involvement without feelings, inconsistent involvement, narcissistic involvement, empathetic involvement, over-involvement and symbolic involvement.

Lack of involvement is when families appear to function as if they were strangers who happen to be living together. They show no interest or emotional investment to one another. Involvement without feelings is when families show interest to one another, but without emotional investment between family members. Inconsistent involvement happens when there is constant fluctuation (which is the main characteristic that defines the family's interactions) of involvement among family members. Narcissistic involvement is when some family members invest in others for gratifying their self-esteem, and this may happen within sub-systems relationship.

Empathic involvement with other is based on accurate assessment and emotional state and needs of others. Over-involvement when family members are over-close and over-intensive (this excludes families where there is a tendency to be over-protective and excessively warm). Over-involvement may be present in families who appear to be in a state of constant conflict, where constant expression of anger may be masked by the member's inability to separate from each other. Symbolic involvement is usually seen in severely disturbed families and refers to the most extreme type of over-involvement where individuals have extreme difficulties in differentiating from one another. None often sees this kind of involvement in dyadic relationships-like one between some psychotic children and their mother.

Behavioural controls refer to how the family sets limits on behaviour that is physically dangerous. It also involves the expression of sexuality and aggression and how these are developed and maintained through the process of socialization. Behaviour controls and the rules developed by the family can either be rigid, flexible, laissez-faire or chaotic. In the rigid behaviour controls, rules are inflexible and are not open to negotiation; in flexible behaviour control, there's reasonable amount of flexibility in establishing rules, where new situations and context of the behaviour is taken into account. In laissez-faire behaviour control, anything goes, and in chaotic behaviour controls, there are random shifts in rules for behaviour where the entire spectrum from laissez-faire to rigid is included. In this case, the rules of behaviour may be followed and used by both parents or may function independently.

Wen-shing Tseng and Jing Hsu (1991) say definitions of functioning, dysfunctional, healthy and pathological vary among families of different cultural backgrounds. Professionals tend to think individualism is healthier than enmeshment, and that mutuality is more mature than isolation, and flexibility is more adaptive than rigidity.

Most therapists also working with families tend to believe that certain attributes of the family, such as open in expression of affect, having respect for subjective views and encouragement of personal autonomy are desirable for psychological health in the family. They say these views may not be applicable to other families of other cultures where collectiveness and sharing, and concealing of private affection may be emphasized. Therefore what is healthy, desirable functional family behaviour may be subject to cultural variation and require careful definition (Wen-Shing Tseng & Jing Hsu, 1991).

Furthermore, they noted that in most kinship cultures male adults are addressed as 'father', 'uncles', and female adults as 'mothers', whether the adult is related by blood or not. This, they say doesn't reflect an enmeshed relationship, rather it reflects the cultures emphasis on cohesiveness and belonging of members to a larger clan. Under such kinship terms, the family boundary is greatly expanded (Wen-Shing Tseng & Jing Hsu, 1991).

Ingoldsby and Smith (1995) say the theorists tendency to concentrate and focus on white, Western two-parent families has limited our understanding of other families and has resulted in tendency to compare all families, regardless of cultural, ethnic, racial or class difference. This resulted in diverse family patterns being overlooked, misunderstood, and judged as deviant, dysfunctional or to be in the same path to the nuclear family. On the same note, some theorists believe that family systems has important concepts to offer to multicultural family studies, as it could be adapted to describe the interactional and communication processes among family members (Ingoldsby & Smith, 1995).

For the purposes of this study, the researcher used systems theory as a basis and guidance of assessment of family functioning. Most concepts that are discussed above can be applied to families of other cultures.

McGoldrick, Giordano and Pearce (1982: p.84) said "It has become a cliché that family therapy involves a systemic approach', 'a system' referring specifically to the nuclear family. Given the reality that most Black families are embedded in a complex kinship network of blood and non-related persons, therapists must therefore be willing to expand the definition of a 'system' to kinship network". The following discussion therefore, looks at the family system model of black extended family, values and important concepts in family functioning.

2.3.2 Black Family Systems

Boyd-Franklin (1989) found that through working with black families, and having been raised in a black family, many black families function as extended families in which relatives with a variety of blood ties have been absorbed into a coherent network of mutual emotional and economic support. Boyd-Franklin (1989) says though there is diversity among Black families and communities, the sense of strong kinship bonds seems to transcend through most Black families, a prominent characteristic seen in the extended family system.

The extended family system tends to be large and constantly expands as new individuals are incorporated through marriage, informal adoption of children, older

parents returning after a divorce or finding difficulty finding work. Three or four generations usually live close by or reside in the same household. In the extended family system strong value is placed on loyalty and responsibility to others. Family members are expected to stay connected and reach out (Carter & McGoldrick, 1999).

It is however important to mention that black extended families exist in many different forms and structures. These family systems are not rigid or static and many undergo considerable change over time. Assumption is that any one black person may have participated in various family forms at different times in his or her lifetime. Living arrangements are extremely variable and changeable, manifesting what Minuchin (1974) described as permeable boundaries.

Boyd-Franklin (1989) say there are various types of extended families, which they explored in their study, and these were divided into four major types: subfamilies, families with secondary members; augmented families and non-blood relatives (Boyd-Franklin, 1989).

2.3.2.1 Various Types of Black Extended Families

Subfamilies

These are composed of at least two or more related individuals. This is an 'incipient' extended family that includes a husband-wife subfamily with no children of their own, living with their relatives; or simple nuclear extended family, which has a husband-wife subfamily with one or more children living in the household of a relative's family. It also includes an "attenuated" extended family that consists of a parent and child subfamily living in the house of a relative. Many poor black families often find economic circumstances force them to live in these types of families, a situation where they have to double up, where over crowding and lack of privacy is created. This in turn, makes definition of boundaries around subfamilies difficult (Boyd-Franklin, 1989).

Secondary Members

This is a group of extended families who take in different relatives or secondary members, which includes minor relatives- nieces, nephews, cousins, grandchildren, peers of the primary parents, including cousins, siblings close to age with primary parents, elders of the primary parents, including aunts, uncles, and parents of the primary family.

Augmented Families

This type of extended family is composed of children who are raised in households where they are not even related to the heads of these families. This group also includes adults who are boarders, lodgers or long-term visitors. These individuals are therefore not related by marriage, ancestry or adoption.

Non-blood Relatives

This type of black extended family has individuals who are not related by blood ties but make up part of the family in terms of involvement and function, and are referred to as " fictive kin". These family members might include play " mamas", "aunts" or "uncles", grandmothers and grandfathers, neighbours, babysitters and close friends.

Boyd-Franklin (1989) further pointed out to the numbers of uncles, aunties, older brother and sisters and boyfriends that operate in the black home. She said that a variety of adults and older children participate in the rearing of any one black child, and these adults at some point or another interchange roles, jobs and family functions in such a way that children don't learn on extremely rigid distinction of male and female roles.

2.3.2.2 Cultural factors on Black Family Systems

For many black extended families reciprocity or the process of helping each other and exchanging and sharing support, goods and services is a very central part of their lives. It is considered to be one of the most important survival mechanisms. The level

at which family members interact include kinship, affectional and emotional factors. Reciprocity might take many forms, from lending money to taking out 'kin insurance' where a family member takes care of a relative's child, with the understanding that the same help will be returned when needed. It also takes the form of emotional support where it is known that a relative can be counted on to share the burden in times of trouble, and that one will offer such support in return (Boyd-Franklin, 1989).

Boyd-Franklin (1989) though, noted that the problem with this reciprocity system in some black families is that it can cause some imbalance where there can be overburdening of one or more individuals.

At times an individual in the family comes to occupy an overly central and depended upon position in the family network. This member functions as a switchboard through which all messages are conveyed. In these kinds of families Boyd-Franklin (1989) noted that the extended family system exists in structure, but the exchange of support is imbalanced to the extent that one member may become burnt out. Boyd-Franklin (1989) said when working with extended families its not just adequate to ask whether the extended family support system exists, but also if it functions in a supportive and reciprocal way.

Tied to the concept of reciprocity is role flexibility, which has been seen as a definite strength in Black family. Because of the economic hardships faced by many black families, role flexibility was developed as a survival mechanism. Within the nuclear family, they say in order for both parents to work, black women had to act as the 'father' and men as the 'mother' while the other is off to work (Boyd-Franklin, 1989).

Similarly, in the extended family, aunts, uncles and cousins could also assume parental roles as the others went to work. And when all adults are working, children also are required to assume parental roles necessary for survival of the family. While this is seen as strength, it can also result in boundary and role confusion or situation in which one individual becomes overburdened (Boyd-Franklin, 1989).

There is a proverb that goes " it takes a village to raise a child", and it works well if roles are clearly defined, rules are consistent and the ultimate authority is established.

Carter and McGoldrick (1999) however, say when there is lack of distinction among the functions that different caretakers have and the process of decision-making is not clearly defined, confusion is likely to result.

Roles that are particularly considered important in Black families are the mothering role, and the grandmother's role.

Mothering role in Black families

Boyd-Franklin (1989) in her study with black families found that the mothering role was a particularly important role in the family, and across generations. For many black women, she found that a family is extremely important, and a lot of black women grew in extended families where there were good models of mothers, grandmothers, and aunts who played the mothering role for many, across generations. Motherhood was a role that was taken seriously, and found that mothers felt strongly about raising children no matter what hardships they experienced.

Motherhood was therefore seen as an important part of the role image of many Black women, despite the complexity and compounded nature of this image. Many black women grow up, as mentioned above, with multigenerational models of "mother". Therefore mothering was not an isolated activity but was shared with many (Boyd-Franklin, 1989).

The Grandmother role in black families

The role of a grandmother is one of the most central ones in Black families, yet can be one of the most problematic and complex roles. Grandmothers are frequently very central to the economic support, and play important roles in child-care in Black families as many black children are raised by grandparents. Grandmothers are seen to represent a major source of strength and security for many Black children (Boyd-Franklin, 1989).

One of the major sources of problems and complexity about this role is that in many black families it has never evolved and takes even an extra generation to evolve. What happens is that a child, while the biological mother is in her teenage hood, sees the

grandmother as "mother", as she is the one who assumes the mothering role. Often it causes role and boundary confusion as she (the teenage mother) at a later stage becomes an adult and wants to take on a role as a mother. The transition is difficult as she must "1) displace her own mother; 2) change her family's perception of her as a sibling; 3) change her child's and perception of her mothering" (Boyd-Franklin, 1989:p72).

Black men as fathers and their role

There is considerable variability in the response of Black men to fatherhood. Some live in the home and take an active role in rearing their children; some live in the home but are peripheral to the lives of their children and some are involved but live outside the home. Some acknowledge their children, some do not; some provide support and others do not. Boyd-Franklin (1989) found that despite this, social science literature shows that the Black man is peripheral to the lives of their children. An assumption that is misguided. Boyd-Franklin (1989) pointed out that though there is variability in the role of the Black man as a father and husband, the fact that his identity is tied to his ability to provide in adverse economic circumstances could easily give rise to perceptions of non-family-oriented or uncaring Black man.

In his review of the social science literature, John McAdoo (1981) in Boyd-Franklin (1989: p225) found that "exploration of the Black father's role in the socialization of his children is almost non-existent in social science literature", It appears that there is clear evidence that Black men are equally involved in rearing their children, particularly in decision-making matters. Though literature shows that socio-economic status plays a role in engagement patterns in as far as fathers help with childrearing. It was found that many of the Black, middle-income fathers were equally involved in childrearing and decision making in their children's lives (Boyd-Franklin, 1989).

In black extended families it was found that because there were numerous people who were involved in childrearing, it increased the number of potential role models. It was found that men who were involved with the mothers (and not married) of these children may become like husbands, boyfriends, or friend "play daddies" to the child/children and were seen as people who raised them. At times, such a man may

bring his own extended family, who may become part of the child's kinship network (Boyd-Franklin, 1989).

Role Confusion

Boyd-Franklin (1989) found in her study found that there are three common forms of roles in the extended family that could cause role confusion. These were where: the non-evolved granny, three generational family and parental child.

Non-evolved granny: where the granny is a major power, and a central person in the family. Her role as the centre person remains so for many generations, even if the mother to a child presents herself as the primary caretaker. It is the granny who makes important decisions in the child's life. Some professionals say this causes problems particularly during the developmental life cycle where, roles evolve and change, as people grow and mature. For example a child who grows in the family as a teenager, has a baby. As she grows, she may want to take more responsibility for her child, but may find that neither her child nor her mother is willing to accept the redefinition of roles (Boyd-Franklin, 1989).

The granny, may therefore become overly central, and at risk of system overload and burnout. This may have quite an effect on the lives of the entire extended family from exacerbating the harsh realities of poverty to causing conflict of role related issues (Boyd-Franklin, 1989).

In the three generational family, familial roles become blurred where the mother of the adolescent with a baby never fully becomes a granny while her daughter is never allowed to fully function as a mother to her own child. Minuchin (1974) developed a structural approach to working with these families whose goal was to help for instance the grandmother, to support her daughter in learning to be an effective parent, and where they were able to negotiate a new alliance where they were able to share parental responsibilities. This results in a restructured family where the child is given clear signals and messages by both the mother and the grandmother, and thus be able to make a distinction between the responsibilities of both parents.

In families that are functioning well, boundaries are clear no matter how many adults are involved. Boyd-Franklin (1989) found that in most families, functional structure has never being fully developed and it needed to be built for the first time.

Parental child involves a role that is played by a child when all adults have gone to work. Because of economic hardships that most black families face, it was and still is important for all members of the family to contribute in some way to the income of the family. The child takes over the responsibility of caring for younger children. For this system to work, the parents had to delegate some responsibilities of childcare while the elders were at work. The elders still remain in charge where the parental child reports to the parents on arrival. Here the boundaries are often clear and well defined (Boyd-Franklin, 1989).

The parental child family structure becomes dysfunctional when the parents give up some responsibilities and place unreasonable responsibility on the child.

2.3.2.3 The Question of Functional or Dysfunctional Black Extended families

It has been illustrated in the literature that most theorists that worked with black extended families found the family functioning model to be deficient and pathological, while ignoring its strengths and positive aspects. The strengths of black extended families resulted in being lost in the shadow of normal nuclear family model. There has, however, being growing evidence that extended families are indeed functional family models (Boyd-Franklin, 1989).

Just as there is diversity among black families, there are many different types of extended family structures. It is important for those working with families to have a clear understanding of how structures and roles developed by the family interplay, to realise when are functional and how they become problematic and dysfunctional when they are confused or unclear (Boyd-Franklin, 1989).

Aponte and Van Deusen (1981) in Boyd-Franklin (1989) found three factors that relate to the structure and functioning of the family, and they have been found to be the building blocks of social relationships. These three dimensions are only meaningful when one takes a closer look at the purposes through which people relate to one another. These are boundary, alignment and power. To distinguish whether the family is functional or dysfunctional, these three factors need to be discussed in relation to the extended family.

As we have discussed above, boundaries of a system are the rules defining who participates and how, and the roles of those who are in. Related to the boundary issues is the concept of enmeshment-disengagement continuum concerning how involved families become with one another. Stack (1974) in (Boyd-Franklin, 1989) found that black families often have very close relationships, with a great deal of interaction and reciprocity, and this closeness often results in the roles, boundaries and rules of participation becoming very blurred. Thus black extended families have been found to fall more on the enmeshment range (Boyd-Franklin, 1989).

Minuchin (1974) found that in complex extended families where Black children were raised, it was not unusual for enmeshment or blurring of boundaries to occur. However in its extreme, it can cause fusion or lack of self-differentiation, which can be exaggerated in some families. This lack of differentiation particularly becomes a problem/or toxic for many young adults who go beyond their families in terms of education and profession. The level of differentiation necessary is often frightening for them and can cause problems as they enter and start their own families (Minuchin, 1974).

Furthermore black extended families have also being found to fall on the disengaged range where a child growing in the extended family may be generally ignored, and grow up by him\herself. This child is sent to school, therapy and so on by himself (Boyd-Franklin, 1989).

Similarly, Wen-Shing Tseng and Jing Hsu (1991) say the degree to which boundaries are emphasized between family members differs greatly among different cultures, whether or not boundaries are clearly established, open or closed, receptive to others

or prone to outside invasion. In a family that culturally values individualization and autonomy, emphasis is placed on each member having his or her own boundary, speaks up for his or herself and protecting his/her territory. However within a family that culturally values group-togetherness, the boundary between family members is not an essential one. One family member may speak up for another, and anyone concerned with his/her individual rights or territory would be seen as acting disrespectfully.

Furthermore, Aponte and Van Deusen (1981) in Boyd-Franklin (1989: p108) say the concept of alignment includes two concepts: alliance and coalition. They say "alliance refers to family members working together on something of shared interest, and coalition is defined as a process of joint action against a third person" .In black extended families, they found that alliances and coalitions are cross-generational and may include other key individuals who are outside of the family, but who are very involved and are consulted on key issues. And this may cause major problems for the other family members.

Similarly, Aponte (1976) in (Boyd-Franklin 1989: p434) equates this to power or force, which is defined as " the relative influence of each family member on the outcome of an activity". He says this issue is a complicated one in black extended families because it usually is the case that another relative or non-blood relative has considerable decision-making power in the family. Since these structural dimensions are inherent in every transaction, Aponte and Van Deusen (1981) say one cannot fully understand social transactions until these three dimensions are considered in relation to the action's goal.

Families are said to develop their own unique structure. Aponte and Van Deusen (1981) in Boyd-Franklin (1989) say to understand structure in action, it is important to take a closer look at how family members carry out their different tasks with one another. Different tasks may require different structural patterns in family relationships. Most families, it appears, have a pattern that dominates and characterizes most of its interactions.

Aponte and Van Deusen (1981) in Boyd-Franklin (1989) purport that unorganised families seem to have difficulty when it comes to identifying their structure. They appear chaotic, roles are neither clearly defined nor are they consistently assigned, and family members do not seem to easily team up to solve problems. Furthermore, they use the same few approaches to solving problems, even when they don't appear to work. Relationships lack a constant, coherent and flexible structure. Constancy, coherency and elaborateness, they say, are the fundamental mechanics of an organized family structure.

With constancy, family members trust what to expect from one another. With coherency, they have patterns of relating that have an internal compatibility, patterns that reinforce one another and enable family members to work together successfully. With elaborateness, a family has a flexible repertoire in the ways it copes with life's expected and unexpected tasks (Aponte & Van Deusen, 1981) in Boyd-Franklin (1989).

Furthermore, they warn that one cannot say a family is well functioning just because it has a workable structure. The spirit of the family is what 'breathes' meaning into the structure. In an unorganized family, alignment, power and boundaries may be unreliable, poorly defined, limited or rigid to varying degrees. The spirit that motivates a family's transaction may be more demoralizing than inspiring (Aponte & Van Deusen, 1981).

In conclusion, when we look at family functioning, as we have seen from the above discussion, it is important to consider the family's cultural background as it shapes the way family members function and interact with one another. Particularly, when looking at black extended families, one is confronted with a complex system, consisting of multiple relationships, which give a family system a different structure, as compared to nuclear family systems.

CHAPTER THREE

3.1 Research methodology

3.1.2 Research Design

It is not possible or meaningful to give an account of any detailed subjective experience without relating stories about the context they are lived. For this reason, this study uses a qualitative method as it is said to be able to bring to 'live' the meanings and values that people bring in their experiences. Through this method, the researcher is able to focus on the interactive processes and events of everyday life of the families under study (Denzin & Lincoln, 1994).

Though the study is mainly qualitative, there is a quantitative element to it. In the quantitative part, the researcher uses an assessment tool to measure family functioning in black extended families. For the purposes of this study the quantitative part was used to complement the qualitative findings (this section is discussed later).

3.1.3 Sample and Sample size

The researcher used purposive sampling to select the sample, whose method is to purposively select cases that fit with what the researcher intends to do. Purposive sampling is used to select unique cases that are especially informative, and the researcher often has subjective information about getting such a population. The researcher can therefore hand pick the cases to be included in the sample that fits with the researcher's intension. Often when the researcher purposely selects a few cases, the intention is to do in-depth investigation. Therefore the purpose is less to generalise to a larger population than it is to gain deeper understanding of the cases selected.

Four cases were chosen from the existing list of the families who brought their children at the Psychiatric Hospital for evaluation. The families live in two of the urban townships in the Metropolitan area of Pretoria. Out of the four cases that were chosen, each consisted of different numbers of family members. In total 13

individuals were interviewed out of the four cases. For the purposes of this study, only key family members (those who intimately interacted with the child) were interviewed. The reason for this was that because of the usual big size of extended families, the researcher could experience difficulty in reducing the information gathered into meaningful material.

3.1.4 Phenomenological Study

Based on the nature of the study, a phenomenological approach was implemented, as phenomenology is concerned with the lived experiences of individuals being studied. A phenomenologic study, therefore, allows the researcher to explore and investigate the lived experiences of participant's through in-depth conversations. And this, in turn allows the researcher to gain entrance to the participants world, to have full access to their lived experiences (Mouton & Marais, 1990). Through direct conversations with participants, the researcher seeks to have a better understanding of what goes on at home, how the child's illness affect those around him and the functioning of the family.

The research is also explorative. It is explorative because the study being examined is relatively new (this is focusing on extended families and how they are affected by caring for a child with psychiatric illness) and not a lot of research has been undertaken on this particular topic.

3.1.5 *Case Study Method*

The researcher used a case study method, suggested by Donald Campbell (1975) in Yin (1983). His approach describes a "pattern matching" strategy where pieces of information from the case studies are related to some theoretical proposition. A multiple-case method, consisting of four cases is used in the study.

The researcher gives a narrative description of all four cases (in the form of the interviews conducted). It is through the narrative description of the researcher about the cases that gives a rich understanding of the case at study (Neuman, 1997). The researcher chose narrative, qualitative case studies because they consist of people's own spoken or written words or accounts of their observable activities, thus capturing

the interaction of a system. Usually narratives are not organised or recorded in any specific categories predetermined by the researcher (Miles & Huberman, 1984). However, for the purposes of this study, the researcher organised the narrative accounts of participants in a number of pre-selected themes.

3.1.6 Inclusion/Exclusion criteria

A criterion includes families who have brought their child for evaluation to the Hospital, with a child having been diagnosed with a psychiatric illness. The researcher is not focusing on a particular psychiatric disorder, but on a broad range that is inclusive of both behavioural and emotional problems. The reason for dealing with disorders across the board and not just one specific disorder was the realisation that there was similarity of experiences (emotional and other burdens that the families went through) that families complained about across all disorders.

Children whose cases were chosen were between the ages of 7-12, inclusive of both boys and girls. It however turned out that only boys made it to the chosen list. The children should be residing in a Black extended family.

3.2 Data Collection Technique/Instrument

3.2.1 Instrument

Data was also collected using an assessment devise called The McMaster Family Assessment Device or (FAD, which stands for Family Assessment Device. The FAD describes the structural and organisational properties of the family. It also describes the patterns of transactions among family members, and has been found to be able to distinguish between healthy and unhealthy families. The model identifies six dimensions of family functioning, with an extra scale that assesses the overall health/pathology of the family. These dimensions are: Problem solving, Communication, Roles, Affective responsiveness, Affective involvement and Behaviour control, which have been expensively discussed in the literature review (Epstein, Baldwin & Bishop, 1983)

FAD has got 53 items. The Device is useful in that it identifies problem areas within the family in the most simple and efficient way. The researcher therefore used this devise mainly to identify amongst other things problem areas within the family. The Device gives statistical representation.

It is a paper and pencil questionnaire, which can be easily filled in by family members. Each family member rates his or her agreement with how well an item describes their families by selecting among the four alternative responses: strongly agree, agree, disagree and strongly disagree. (Epstein et al., 1983). See Appendix B for the questionnaire.

Because the Device is in English, and the sample is Tswana speaking, the researcher translated (mostly verbal) the items for better understanding for the participants, as some of the psychological jargon could be confusing.

3.3 Reliability of FAD

The FAD has a reliability of 0.7 (Epstein et al., 1983: p175-177). The Table below summarises the descriptive aspects of the scale by Epstein et al. (1983).

3.3.1 Table 1

Reliabilities, Means, and Standard Deviations of the Seven Scales of the FAD (N = 503)

	Reliability (Chronbach's *alpha*)	Mean *	Standard Deviation	Number of Items
Problem solving	.74	2.3	.47	5
Communication	.75	2.3	.51	6
Roles	.72	2.4	.43	8
Affective Responsiveness	.83	2.4	.61	6
Affective Involvement	.78	2.2	.50	7
Behavioural Control	.72	2.0	.41	9
General Functioning	.92	2.2	.58	12

***Scores range from 1 to 4 with 1 reflecting healthy functioning and 4 reflecting unhealthy functioning.**

3.3.2 Validity of FAD

The FADs of individuals from families that were clinically presenting were compared with individual from families that did not present clinically. It was expected that families with individuals who were clinically presenting should reflect less healthy family functioning compared to families. 218 were from nonclinical families and 98 were from clinical families. The results showed that 67% of the nonclinical group and 64% of the clinical group were correctly predicted. Overall, the results were highly statistically significant ($p < .001$), (Epstein et al., 1983).

3.3.3 Semi-structured Interviews

The researcher also used semi-structured interviews. This approach is often used when the researcher wants to obtain specific information from participants. Therefore, there are a number of pre-selected topics/themes that shape the structure of the interview and the questions to be asked. These pre-selected themes direct participants to cover and discuss certain points about the topic, and avoid others (Denzin & Lincoln, 1994).

The researcher had pre-selected categories/themes, which reflect the notion of family functioning. These are: childcare, conflict resolution, finances, time spent together as a family, discipline and establishment of rules. What were also included are the six dimensions of McMater's model of family functioning, which include problem solving, communication, roles, affective responsiveness, affective involvement and behaviour control. The reason for pre-selected categories is that the researcher was particularly interested in investigating specific themes (relationship patterns, communication) among family members, and look at how these aspects of the family is affected by a child's illness.

Prior to the formal interviews a child was brought to the Psychiatric Hospital by some members of the family, usually the mother or grandmother, for first evaluation. During which information about the history, development and onset of the illness was taken. At a later stage, participants were interviewed as a family, and not individually (this is because of time constrains), at their respective homes. The reason for interviewing the family as a whole reinforces the concept of seeing the family as

whole system, and it also gives the researcher the opportunity to observe how the family interacts. Four families were interviewed, each consisting of different numbers of family members. Interviews were conducted in a quiet place, with very minimal interruption.

The length of the interviews depended on the number of family members, therefore interviews lasted between 1- to 3 hours. A tape recorder was used to record the information. The researcher verbally explained the study to the participants, and 10 minutes (and less) was given to allow for questions or clarifications prior to the actual interview. At the end of the interview, all participants were given the FAD questionnaire to fill, which took about 15-20 minutes. All the interviews were transcribed verbatim.

3.4 Data Analysis

Analysis of case study evidence is one of the least developed and most difficult aspects of doing case studies. Much depends on an investigator's own style of rigorous thinking, with sufficient presentation of evidence and careful consideration of alternative interpretation. One particular strategy is by Campbell (1975) in Yin (1983), who suggests, as mentioned earlier, "pattern matching" where pieces of information from a case study is [matched] to some theoretical proposition. Such a strategy compares an empirically based pattern with a predicted one. If, through the researcher's findings, the pattern coincides, then the results can help a case to strengthen its internal validity. The original objectives and design of the case study presumably were based on such proposition that in turn reflected a research question, reviews of literature and new insights (Anastas & MacDonald, 1994). Furthermore, the theoretical proposition would have shaped the data collection plan. The proposition helps to focus attention on certain data and ignore other data.

In analysing and interpreting the findings, the researcher used some concepts from systems theory to explain some phenomena. The reason for this was systems theory has been used by many theorists and therapists in explaining the functioning and dysfunction in the family. Most family therapists, when looking at a disorder located in a certain individual in the family, have used systems theory (amongst other family

theories) to better explaining the systems functioning, as a whole, and not just one individual. Systems theory is therefore best suited, since an extended family is a system in itself, the difference, amongst many, is the complex interrelations that exist among individuals in extended families.

The researcher, through the process of "immersing" herself in the raw data, was able to identify patterns that emerged from the data and "matched" them with the theoretical propositions of systems/structural theory. Through the process of data analysis, the researcher also used the cultural variables/factors that are said to be common in extended families. There were also new themes/concepts that emerged from the data, and were integrated into the theory. The method of analysis is in a lot of ways illustrative in that empirical evidence is used to illustrate or anchor a theory. Through the illustrative method, the researcher has a pre-existing theory, and the researcher sees whether evidence can be gathered to confirm or reject the theory (Neuman, 1997). And that is how analysis was conducted in the current study.

3.5 Ethical Considerations

A good qualitative study is one that has been conducted in an ethical manner. In qualitative research, ethical dilemmas are likely to emerge with regard to collection of data and dissemination of findings. The participant-researcher relationship and the focus of the study determines how much the researcher reveals about the purpose of the study, how informed the consent can really be. One of the most important things to consider when doing research is doing no harm to participants. The research should therefore benefit participants (Bromley, 1986).

The researcher gave a written consent (see Appendix C), which informed participants of the study, purpose of the study and permission to disseminate findings. Because research situations often evoke feelings of anxiety, 10 minutes was spent focusing on how they felt about participating and disclosing their most private lives to the researcher. Confidentiality and autonomy was guaranteed by using pseudonyms where appropriate. All the names of individual were changed to hide the identity of individuals, but the facts and the details of the cases are real (they are unaltered). The hospital names in Pretoria has also been concealed.

Chapter Four

This chapter consists of the narrative description of the four case studies, focusing on the following themes: childcare, financial impact on the family, discipline, conflict resolution, time spent together by the family and perception. First the researcher gives a brief background of the child's illness and the interview, which consists of the above-mentioned themes. The second part includes the descriptive results of the FAD. In reporting the FAD results, the researcher makes constant comparison with the six dimensions of the McMaster model of family functioning, which were discussed in the interview.

Case study One

4.1 BACKGROUND

Lebogang (Lebo in short) is a 10-year-old boy, who was in grade 3 at the time when he was brought to the hospital. In 2001, he was diagnosed with ADHD and Conduct Disorder at the Eesterus Clinic where he was given Ritalin for treatment.

Lebo's behaviour is reported by the mother (Dodo), aunt (Maki) and aunt's daughter (Magy) (later in the interview) to have started when he was still young. They reported his behaviour to have become worse as he grew older to a point where they could not 'manage' with him,

The main complaint/problem on first evaluation that was identified by both the family and at school is: hyperactivity, aggression (both physical and verbal; doesn't listen when spoken to; breaks and steals things (including money)

4.1.2 THE INTERVIEW

Lebo is the only child of his mother (Dodo) and lives in an extended family that is composed of his mother, aunt's daughter (who has a place of her own, but occasionally visits), 2 of aunt's children (teen and young) and 2 grandchildren.

4.1.3 Childcare

Looking after children seemed to depend on who was available at the time the children came back from school, which seemed to be Maki (since she was in the teaching profession,). Though all three of them did take part, particularly at night, and during the weekend. Maki and Magy seemed to better understand and tolerate Lebo's behaviour than what Dodo did, though they admitted that looking after Lebo is strenuous and time consuming.

It seemed, though, that emotionally, Dodo experienced stress the most, as she expressed feelings of helplessness, she seemed to have no patience with Lebo and reported to loose her temper easily with everything that he does. While the aunt on the other hand seems to channel his hyperactivity in being 'handy around the house, which he thoroughly enjoys.

4.1.4 Financial impact on the family

It appears that Maki takes care of the financial expenses, which includes buying groceries, paying rent and the bills, with occasional help from Magy and Dodo. Dodo explained that financially, Maki has helped her a lot, since she doesn't earn a lot of money. She complained that most of the money she earns, she spends on transport fetching medication and visiting Lebo at the hospital. She said, " I spend most of my money on transport, and nothing else. I don't see what I work for", she reported. She further expressed that she finds it tough as she has to constantly borrow money from her family, and finds that Lebo's illness has been 'costly' on the whole family.

4.1.5 Discipline and establishment of rules

Maki once again seems to be the one laying the rules of the house, and people seem to follow them. She says even though at times the rules are bent a little, everybody knows what is expected of them, even with discipline it's the same. "I try to give them what is due to them, and I think that is what motivates children and keeps them out of trouble. When a child deserves praise, give him praise and that good behaviour is reinforced" Maki continued to say that Dodo, on the other hand, " is always shouting at Lebo, forces him to listen to him, and at times hits her", and this seems to aggravates Lebo's behaviour. Maki further said that at times she get impatient with

her because she complains about the child's behaviour but doesn't treat him right. "I get really frustrated listening to her at times" she said. She further said that a child like Lebo, one has to focus on the good things he does, and give him praise for that.

Dodo, during the first evaluation had expressed her frustrations because at times she feels like she is being told how to treat her own child. She however admitted that she often doesn't say anything to Maki about how she feels. This at times causes tension, as she would avoid Maki instead of voicing her disagreement. Dodo further expressed that at times she doesn't agree in the ways that her child is disciplined, as she at times feels its too harsh, but doesn't confront Maki. It therefore appears that at times a lot of tension is caused, as Maki and Dodo do not agree on how to discipline Lebo.

4.1.6 Conflict and Conflict resolution Maki responded by saying that she believed the best way to resolve conflict is by confronting it at that time, to avoid holding grudges to a point where people live in the same house but don't speak to each other. They all agreed on this point, and that generally there aren't a lot of squabbles in the house, besides when it comes to Lebo and him fighting with other children in the house. Maki voiced her frustrations of the constant complaints about Lebo from the neighbours, and expressed that " At times I do feel like Dodo is not doing enough, and I tell her that".

4.1.7 Time spent together by the family

The family though seems to treasure the times they spend together, though those times aren't often. This happens during weekends when everybody is around, or some rare nights when they play cards, or when they invite other relatives for a braai, or lunch. They say occasionally, they go out for lunch, but don't do this very often. Dodo added by saying that " we enjoy each other's company, but most of the time we are all busy doing our own things".

She further explained that Lebo's behaviour has gotten to a point where it has restricted the family visiting other people or relatives. " It seems like people don't understand him, nor have patience with him, Maki said.

4.1.8 PERCEPTIONS

When it comes to how they understand/ and what they think of Lebo's illness, it seems like Maki and Magy understand it better than Dodo does, and this is reflected in the ways they treat the child. Maki started by saying in the beginning, she thought Lebo's behaviour was just childhood naughtiness, and he would outgrow it. But as he grew older, his behaviour became worse and they realised that there was a problem. Magy said that she could notice that the child was hyperactive and his behaviour was excessive and beyond childhood naughtiness. That is why she suggested they seek professional help.

Dodo added that she was confused by Lebo's behaviour and couldn't understand what was going on. She further said at times she felt the Lebo was just being spiteful and naughty. But says when Magy suggested they take him to a Psychiatric hospital, she realised that there could be something serious.

Maki added that regardless of this, Dodo still treated Lebo the same. It seemed as if Dodo did not understand what Lebo was diagnosed of, and what it meant in relation to his behaviour and the way she reacts to him. She expressed that even after the diagnosis she still didn't fully understand what is going on, and how she should treat him.

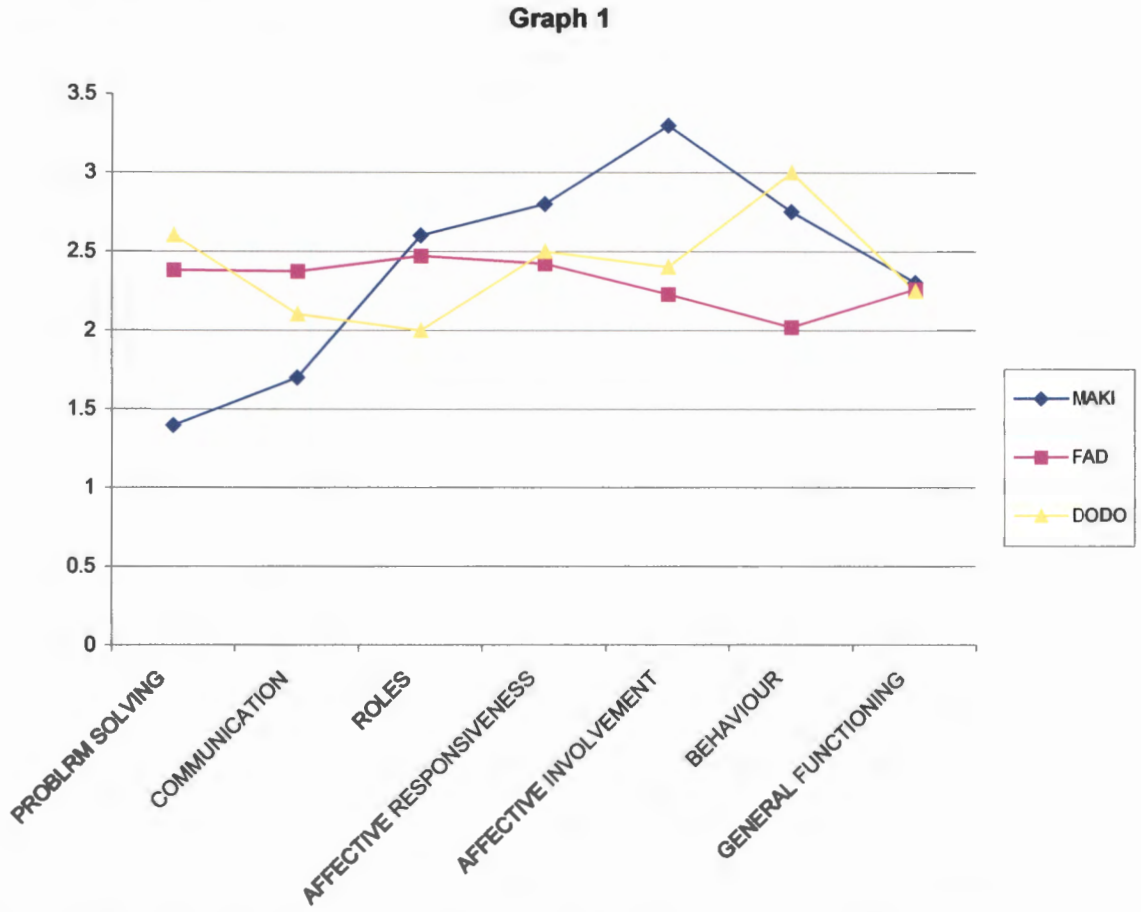
4.2 The FAD Results

The graphs below show the mean scores of the responses made by individual members to the various statements of the FAD questionnaire where each individual had to show their level of agreement (strongly agree, agree, disagree and strongly disagree) to a number of statements on these categories: problem solving, communication, roles, affective responsiveness, affective involvement, behaviour control and general functioning.

The individual mean scores were measured against the FAD mean score, 1 reflecting healthy functioning and 4 reflecting unhealthy functioning. In this current study, unhealthy functioning reflected the family's difficulty in dealing with certain issues that arise within the family. The mean scores that were above the FAD mean score, in

the current study, were found to reflect different individual's level of involvement across the continuum of too much to too little involvement or interest in the family. The scores also seem to reflect individual or personal characteristics that family members adopt in executing things in the family.

4.2.1 Figure One



The graph depicts the mean scores of family members on the seven dimensions of the Mc Master's FAD, against the FAD mean scores

Affective Involvement: The most significant category to first comment on is affective involvement, which shows Maki to have a high mean score of (3.3), much higher than the FAD mean score of (2.2). With Dodo's mean score at (2.4). This reflects a somewhat unhealthy functioning in as far as affective involvement is concerned for Maki. These findings are consistent with interview results where Maki appeared to be overly involved in what was going on in the mother-child relationship between Dodo-and-Lebo, concerning discipline.

Behaviour control: Maki's mean score is (2.75) and Dodo's at (3.0) and the FAD mean score at (2.0). Their mean scores show significant difference from the FAD mean score, indicating a somewhat unhealthy functioning concerning behaviour control is concerned. This, was found in the interview, to reflect the differences in the

way both attempt to control Lebo's behaviour, and the overall inability to control Lebo's behaviour.

Problem solving: The figure shows Maki's mean score concerning problem solving to be (1.4), and Dodo's to be (2.6), reflecting a healthier functioning for Maki. Dodo's higher mean score reflects difficulty she finds in dealing with "affective problems", where during the interview it was indicated that she at times "dissociates" from conflict, instead of expressing how she feels, on the aspect of conflict resolution

Communication: Maki's mean score is (1.7), Dodo's (2.1), indicating an overall healthy functioning. As was found in the interview, they are able to exchange and share information, with Maki being most open in what she disagrees with, and Dodo being less communicative in expressing what she does not agree with during conflict.

Roles: Maki's mean score is at (2.6), just above the FAD score of (2.5) and Dodo's at (2.0), reflecting a more healthier functioning. Makis's mean score somehow reflects the overall dominance she assumes in the household, in terms of her involvement and effort in doings things in the house, especially in the general running of the house and childcare. Similarly, Dodo's mean score also indicates her participation in as far as doing chores, and childcare are concerned. The scores also reflect the level of parental roles, in giving nurturance, discipline and childcare, with Maki having the ultimate authority.

Affective Responsiveness: Dodo's mean score is the same as the FAD mean score of (2.5), Maki's mean score at (2.7), reflecting a somewhat poor functioning. On the one hand Maki is able to express her support and love for the whole family, and for Lebo and Dodo in as far as Lebo's behavioural problem goes. At the same time, she has expressed a lot of frustrations and 'intolerance' concerning how Dodo disciplines Lebo, and the frustrations on the constant fighting and complaints about Lebo's behaviour from neighbours. It also reflects the level of involvement concerning childcare and discipline for Lebo. Dodo's mean score also reflects her ability to respond with love and support, and frustration to Lebo's problem. However, the interview shows that Dodo experiences the most emotional stress concerning Lebo's behavioural problem. Her mean score somehow doesn't reflect this.

CASE STUDY TWO

4.3 BACKGROUND

Tshepo (the patient) is a 10-year-old boy who was in grade two at the time of admission and consequent interview. His referral came from a General hospital in Pretoria. Tshepo's mother's sister (Thandi) was the one who suggested that the child be taken to the clinic, who referred them to a Psychiatric Hospital in Pretoria.

The main reason for referral and admission was his disruptive, aggressive behaviour, which the family and the school could not handle or cope with. He stole money from the granny (MaMotse), he was reported by the teachers as impulsive and disliked going to school.

Initially, Tshepo was brought by the mother, Cynthia for first evaluation, but the consequent interview included MaMotse, Cynthia's brother (Thabo), older sister (Thandi), his grandfather (Papa Pitso) and as the interview continued, the other siblings came in.

4.3.1 THE INTERVIEW

4.3.2 Members/number of people in the family

MaMotse explained that there has been in total 30 people that have lived in their home at one point or another, but currently only 14 people were staying in the house.

4.3.3 Childcare

It seemed that during the week Cynthia was mostly responsible for looking after the home and the children, as she seems to be the one who is unemployed, or with not many responsibilities outside the home. Thandi added by saying that everybody helps out, especially during the weekends and when she comes from work. When its time for bathing, eating or doing something in the house, all the children did it together. "There is no child in the house that will sleep dirty, or sleep without eating, though. MaMotse continued. Everybody gets the same treatment, with or without a child's

parent or not. That is how we were taught when I was growing. We help each other out".

Childcare seemed to be quite a chore for certain members, but for others it seemed that they were not that concerned about Tshepo's behaviour; it only became a 'problem' when it affected them directly. For example when he doesn't listen, when he steals money. Others seemed to avoid Tshepo, and seemed to be irritated by his behaviour. They therefore had minimal contact with him.

4.3.4 Financial impact on the family

It seems like the grandparent's pension (MaMotse and Papa Pitso) money carries the family a long way, though Thandi and Thabo help out at times. Cynthia seems to depend entirely on her mother, and Thabo, as they seem to extensively help her with Tshepo's school fees, clothes and whatever is necessary. Though she said she receives child grant, she says most of the money she spends on transport to visit Tshepo at the Hospital. She says it's difficult (financially), as she has to rely on others for money, and at times has to wait until the end of the month to do certain things.

MaMotse also added that they feel the financial burden too as at times they have to sacrifice something so that Cynthia can reach her child, or take him a 'little something to the hospital' .As a result, only Cynthia has visited Tshepo at the hospital. Thabo and Thandi added that they also don't earn a lot of money, and they have to meet their own responsibilities, and also help Cynthia out at times (especially Thabo). Thabo further added that " we wont leave our own family member suffer, we try to make ends meet, though at times things don't turn out they way we want".

4.3.5 Discipline and establishment of rules

When it comes to discipline it appears that all the elders take part, but it seems there is an expectation for Cynthia, to take the ultimate control, especially when Tshepo's behaviour 'gets out of control'. Thandi started the conversation by saying that when a child grows in a big home, everybody has a look out "but the mother must take the lead. She must show the child right from wrong. "Tshepo can be really difficult to

handle, and we all get frustrated. It doesn't help if the mother sits back and does nothing", she reported.

Cynthia further continued the conversation by saying most of the time Tsepo gets a lot of hidings, and at time sit is difficult for her as a mother to watch. "Its difficult when everybody hits your child, and when I speak up for him it is as if I am condoning his behaviour At times people say things that are really hurting. So most of the time I need to talk to someone who is neutral to the whole thing, and that is my friend", she pointed. Those are the times I cannot stand; I feel at times I am blamed for what Tshepo has done, for the way he turned out". Thandi added by saying when a child is out of order, they need to be put back on track, and times the mother doesn't help out. "Now if the mother does not help, or say anything, who will", she added.

4.3.6 Conflict and Conflict Resolution

MaMotse started the conversation by saying that often when there is conflict, its about what Tshepo has done, and there is an expectation that Cynthia do something about that behaviour. She further added that the 'fighting' can get so bad that people start avoiding each other, and this creates a lot of tension at home. "So I call them so that they can iron out their differences, especially when people aren't talking to each other. That really "gets to me, I cannot stand that", she pointed.

Thandi further added that it's all about respect. " I am the eldest, and they must respect me". At times they say I am harsh, but I just say what I believe to be right", she said. Cynthia added by saying that in most situations when there's conflict, 'I get out of people's faces. She further expressed the difficulty she finds in approaching people, Thandi in particular, as one has to be mindful of what is said. "She is always reminding you who the eldest is, and I must "watch" what I say, she continued". When this conflict arises, she says she rather avoid the person and the situation. Most of the time, she says she shares her problems with a friend.

4.3.7 Time spent together by the family

Thabo started the conversation by saying that most of the time, he spends with his friends, at times to avoid conflict or squabbles in the house. And Lerato added that at times, she and Cynthia do spend some time together, talk about problems and try to give each other advice, while Thandi seems to be closer to MaMotse. It therefore appears that family members spend more time with each other, than together as a family.

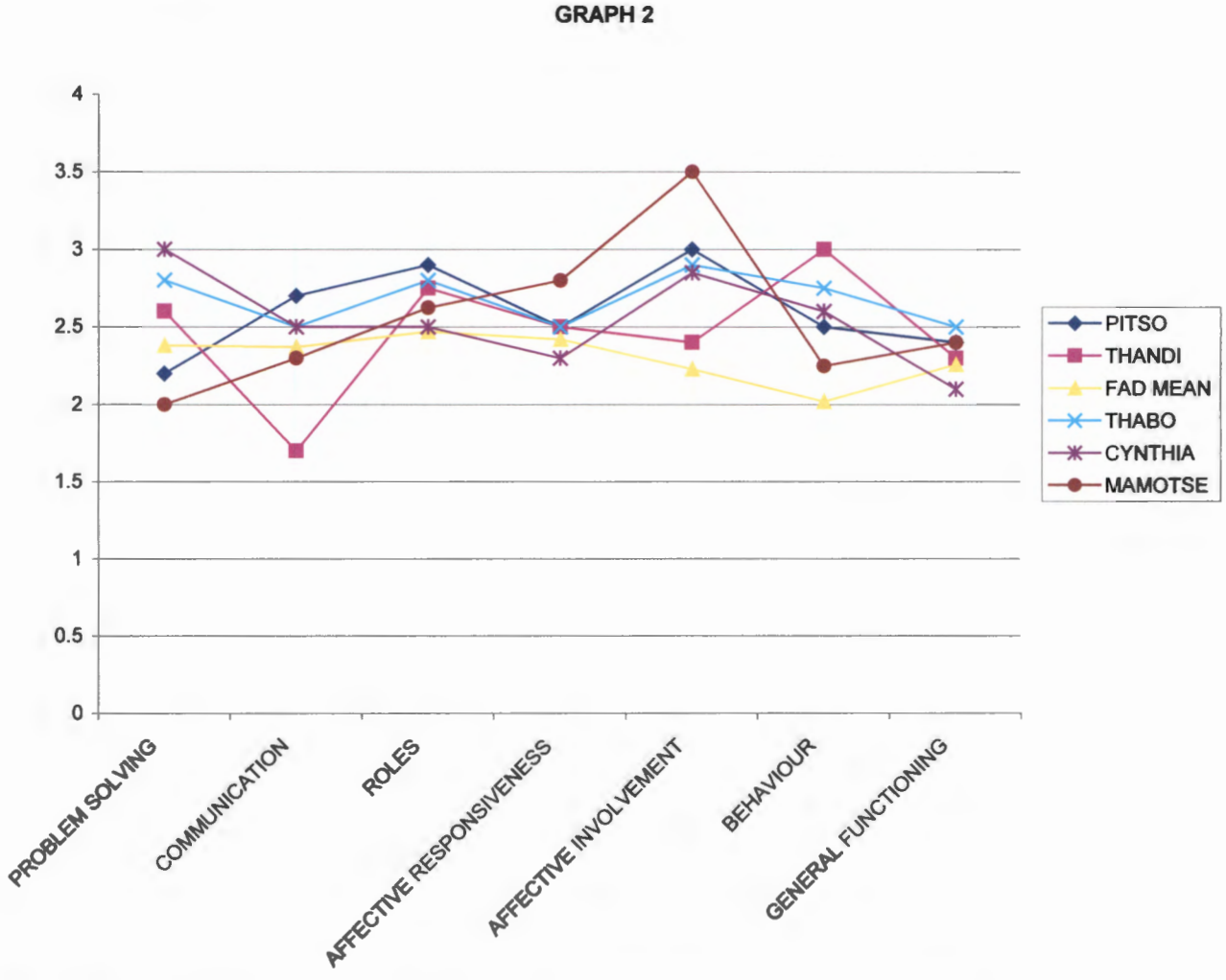
4.3.8 PERCEPTIONS

It appears that the family had different perceptions of the child's 'behavioural problem'. MaMotse started by saying Tshepo's behaviour shocked everybody. At first, she said they didn't think much of his behaviour, but later he started doing strange things. At some point she thought that the child was bewitched, especially when he burnt a shack. " We couldn't understand what would drive a child to do such a horrible thing. He was like a child possessed, she said". Cynthia added by saying that at some point they thought it was the company he kept, but his behaviour continued to get worse, even at school. Thabo further added that they could see that his naughtiness was different from those of the other children in the family.

It also appears that lack of education or adequate information about the child's 'problematic behaviour' contributed to the confusion, and the way they responded to him. As Thabo stated "we didn't know what to do, so the best way we dealt with him was to give him a hiding, but we saw no changes". Instead it seemed like beating him made him worse".

MaMotse said when she heard that Tshepo was to go to a Psychiatric hospital she got really worried. "I thought the child was not ok in the head. I prayed night and day for that child. I know how people can get when there is a crazy person. She continued to say, we had a cousin and she had a mental problem, and I saw how people treated her. It was very difficult, but what could one do".

4.3.9 Figure 2



The graph depicts the mean scores of family members on the seven dimensions of the Mc Master's FAD, against the FAD mean scores

In **Problem solving:** it shows PaPa Pitso's mean score to be (2.2), MaMotse's is (2.0), against the FAD mean of (2.2), showing a fairly healthy functioning, which reflects, to a large extent the effort and the trouble MaMotse takes in attempting to help resolve conflict, and giving support wherever her help is needed. While Thandi's, Cynthia's and Thabo's mean scores are above the FAD mean score of (2.2), with Thandi's mean score at (2.6), Cynthia's at (3.0) and Thabo's (2.8). Thandi's, Thabo's and Cynthia's mean scores reflecting unhealthy functioning are mostly reflected in their difficulty with resolving mostly affective problems than instrumental problems (which they reflected to be able to handle), with Cynthia being mostly

affected as most of the affective problems (which may include the blame she at times gets from some of the family embers) she experiences have a lot to do with Tshepo's behavioural problem.

Roles: The family's mean scores range from [(2.5) to (2.9)], with Papa Pitso with the highest mean score of (2.9), Thabo's at (2.8), Thandi's at (2.75), Cynthia's at (2.5) and MaMotse's at (2.625). These scores reflect the different roles that each member fulfils, and they show unhealthy or poor functioning within this family. It seems like though each play different roles (financial, domestic), there seems to be uneven 'distribution' in as far as childcare and the general maintenance of the house is concerned, with Papa Pitso and Thabo doing the least, domestically, thus their high mean scores of (2,9) and (2.8) respectively.

Communication: It shows different mean scores for individual members, with Thandi's mean score at (1.7) reflecting her ability to be able to give information when needed-like she did with Cynthia, as was indicated in the interview. MaMotse's at (2.3), Cynthia's (2.5) reflecting difficulty she experiences in expressing herself and communicating with other family members when conflict arises. Thabo's mean score at (2.5), and Papa Pitso's at (2.7). The family's mean scores reflect the general communication patterns that exist within the family where information exchange, thoughts, feelings are shared and exchanged more easily within the subsystems, than together as a family. Their mean scores reflect a somewhat unhealthy functioning.

Affective involvement: Shows the individual family mean scores to be significantly different from/higher than the FAD mean score of (2.2), with MaMotse's highest mean score at (3.5), PaPa Pitso's at (3.0). Looking at the affective involvement dimension in the interview, it appears that generally, MaMotse is most concerned about the well-being of the family, where she mostly provides both economic and emotional support to the family, and appears to take upon herself to create peace in the home when conflict arises. Similarly, she also appears to worry, particularly about the well-being of Tshepo as she said during the interview "I prayed night and day for that child". Similarly PaPa Pitso also shows concern and takes similar interest in the lives of the family, though he does not take as much active

participation as MaMotse does (he is almost like a silent member in the family). Thabo's mean score is at (2.9), Thandi's at (2.4) and Cynthia's at (2.85), reflecting an overall unhealthy functioning. With the findings of the interview reflecting the family's overall difficulty when it comes affective involvement, showing the differences in the level of involvement and interest expressed concerning Tshepo's behavioural problem.

Behaviour control: There are slight differences in the individual's mean scores as compared to the FAD mean score at (2.0). Thandi's mean score being the highest at (3.0), Thabo's at (2.75), Cynthia's and PaPa Pitso's at (2.6) and (2.5) respectively and MaMotse's at (2.25). This reflects the overall difficulty that the family has in managing Tshepo's behaviour and the difficulty they experience in disciplining him.

Case study three

4.4 BACKGROUND

Amos is a 10-year-old boy, who was referred to the hospital by a speech therapist from a General hospital. He was diagnosed with ADHD at the age of 7, and has since been on medication.

The main reason for referral was mainly complaint coming from school that Amos's behaviour was uncontrollable. The teacher complained about his inattentiveness, disruption of others and being involved in constant fighting. Lolo also reported that he was destructive at home, did not listen. It also appears that Amos was being teased (because of his squint eye) by children at school and at home. This resulted in him being isolated and had no friends, which bothered Lolo a lot. She says this has really caused a problem as he spends his time in the house destructing people's things.

4.4.1 THE INTERVIEW

Amos is part of an extended family, which is made up of Lolo's sisters and brothers, and there are 11 people in the house, including him. Five children, him being the youngest and five adults, four females (two sister, daughter and herself) and two males (brothers to Lolo). She says there is another brother, but lives in Mabopane with his family. They live in a seven-roomed house, with one outside room which one of the sisters (Kedibone occupies). The house they occupy is a family house, but since both parents have past on, it was left on Lolo's name.

The interview included Lolo, Lolo's daughter (Gadi), and the two brothers were present but hardly participated in the interview. Kedibone was around, but did not join the interview, and Lolo's other sister (Thembi was not around). The reason for Kedibone's absence in the interview was that there seemed to be animosity between the two (Lolo and Kedibone) because of a family problem that took place in the past

years. This resulted in rift and tension between the two sisters. As a result Kedibone excludes herself and does not take part or involve herself with the rest of the family.

4.4.2 Childcare

When it comes to child-care it appears that Gadi and Lolo both take the responsibility, with the two Brothers playing a more passive/non-involved role. Gadi appears to do most of the work during daytime, with Lolo helping after work and when she's not working. They both agreed that the one person who really needs constant supervision is Amos, as they always have to keep an eye on him because he is always dismantling things in the house. Lolo says this often puts her in trouble with the others, as they constantly complain to her. Lolo further said the one person who also helped out in looking after Amos is Thembi (the other sister).

It is clear that childcare responsibility is shared, but it appears that generally she's the one who makes sure that Amos gets his medication, fetches it where it needs to be fetched, make sure he goes to the right school, basically his well being. She says at times its time consuming and drains her emotionally. "A brother, who stays in Mabopane, is also very emotionally supportive, especially when there are major problems in the house", she said.

4.4.3 Financial Impact on the Family

Lolo is the breadwinner, and is therefore responsible for the expenses, which includes paying the bills, buying grocery, fixing things in the house and so forth. She says at times she does feel burdened; especially since Amos goes to a special school (which is more expensive than normal schools), consults with a specialist (speech therapist), which is more money. It thus seems like Lolo as a sole breadwinner also 'bares the brunt' financially as she not only support the whole family, but has to sort out the 'medical bills' for Amos.

4.4.4 Conflict and Conflict resolution

Concerning conflict and conflict resolution, both Lolo and Gadi said there is not much communication about things that happen in the house. "When I have problems, I solve

them myself", Lolo said. It appears that family members generally keep to themselves, with not much involvement with each other.

However, it appears the one big problem that causes conflict among family members is Amos's behaviour. Lolo said often Amos takes other people's 'stuff' and destroys them. This really makes people angry, and at times she says they get angry with her, which causes conflict and tension. At times, Gadi added that she stands up for Amos, especially when the older boys or the Brothers give him a hiding, and this also seems to cause tension as it appears Gadi is condoning Amos's behaviour. She adds, " at times people really make a noise about that, but we all get over it and life goes on".

Lolo continued by saying another 'real problem' that seems to cause conflict and tension is Kedibone, as it appears she is rude and disrespectful and people seem to not know how to handle her. As Gadi said " she isn't close to anybody in the family, as she shouts and screams when she talks to people, so everybody avoids her"

4.4.5 Time spent together by the family

Lolo started by saying that her work keeps her busy, and even when she comes homes, she has to see to this and that, so she doesn't really get rest. There are many times that we are all at home, but doing different things, like these two were now watching T.V., and I would be doing something, and Gadi would be feeding the baby, or cooking. People in the house just get on with their business", she continued

4.4.6 Discipline and establishment of Rules

Concerning rules, and rules for appropriate behaviour, both Lolo and Gadi agreed that there isn't much of a hustle since the older 'boys' know when its time to come home, wash and go to bed. The only person they really struggle with is Amos as he needs constant supervision, and it appears he does not really listen or respond when reprimanded because he repeats the same 'mistakes' over and over again. Lolo continued by saying he gets a lot of hidings, and scolding and complaints from the Brothers.

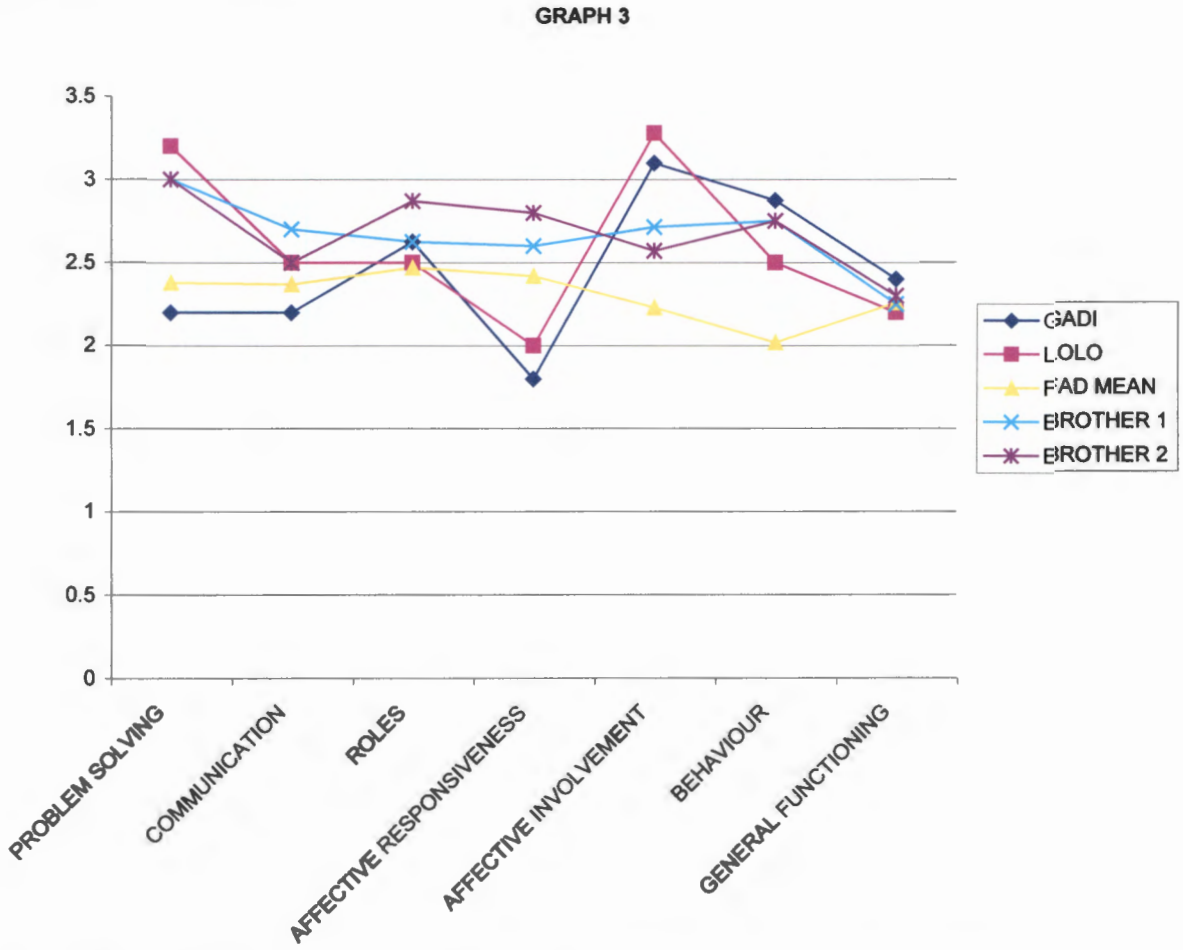
She further added she really gets stressed when Amos destroys something in the house, and she has to take the blame for it. As a result, she says she often looses her temper with him and doesn't know what else to do and how to handle him. It therefore appears that the family is having difficulty in disciplining Amos for his behaviour.

4.4.7 PERCEPTIONS

Lolo started the conversation by saying that when people do not fully understand mental illness, or have a full understanding of what is wrong, there is tendency to treat that individual normal, like any other person. Therefore the ways he is disciplined will not be different from how other children are disciplined. She said she believes that her Brothers are not informed about Amos's illness, therefore they treat him like any other 'normal' child in the house. When Amos does something silly or breaks something, he gets a hiding or a scolding, and most of the time it makes him worse.

Gadi added that for most people in the community, when someone has got 'mental illness' his behaviour shows. Often the person is seen roaming the streets, is often looking dirty and is seen speaking to him or herself, and that is not the case with Amos. She believes that she (to a certain extent) and the Brothers don't really understand what mental illness is, and that a boy who is "naughty", always destroying people's things, and is at times aggressive could have "mental illness". Lolo added that she also did not bother discussing Amos's illness with the rest of the family. All they knew she said was that Amos was struggling at his previous school and he is currently going to a special school.

4.4.8 Figure Three



The graph depicts the mean scores of family members on the seven dimensions of the Mc Master's FAD, against the FAD mean scores

Problem solving: Lolo has a mean score of (3.2), Brother 1 and 2 with the same mean score of (3.0), and Gadi with a mean score of (2.2), almost the same as the FAD mean score of (2.3). This reflects (as was found during the interview) that the family experiences some difficulty in problem solving where they do not team up to solve problems, instead individuals have their own ways of solving problems. Lolo takes it upon herself to resolve whatever problems she experiences, particularly those concerning Amos without involving any of the family members. While the brothers play a passive role in what goes on at home. With Gadi's mean reflecting her attempt to help Lolo out in sorting out some problems at home (like looking after Amos).

It is interesting to see that both Lolo and the two brothers have very high mean scores, though their involvement and quality of interest in the family functioning is totally at opposite ends. This could be a good reflection of the disengaged-enmeshed continuum, where on the one end of the spectrum is too much involvement (in Lolo's case), and on the other is too little involvement (in the Brothers case)

Communication: It is also reflecting a somewhat unhealthy patterns of functioning, though the individual scores don't deviate from the FAD mean score (2.3) that much. Lolo's mean score is at (2.5), Brother 1 at (2.5) as well; Brother 2 at (2.7) and Gadi's at (2.2), just below the FAD mean score. This unhealthy pattern of communication was reflected during the interview where the two brothers hardly participated, with Lolo and Gadi doing most of the talking. Overall, what is indicated is the difficulty the family has in open communication and consultation concerning Amos's problem, and in general.

Affective responsiveness: Lolo's and Gadi's mean scores show a healthy functioning of (2.0) and (1.8) respectively, reflecting their ability to express a broad spectrum of feelings (particularly to Amos, and just in the care they show other members of the family). They are able to express love, support, and joy and at the same time express their irritation or dissatisfaction with what is going on. While the two Brothers mostly appear to express irritation, impatience and frustration specifically to Amos's behavior. Thus expressing a more restricted types of emotions, with their mean scores at (2.8) and (2.6).

Affective involvement: Lolo's mean score is the highest at (3.28), reflecting the quality of interest and involvement she has generally on the family, and more specifically with Amos's illness. Amongst the family she appears to be overly involved and overly sensitive to Amos's behaviour, and she appears to be mostly emotionally affected by Amos's behaviour. It also shows the excessive burden she carries, which appears to be unhealthy for her. Similarly, Gadi's mean score is at (3.1), also showing the concern and interest (to a lesser extent than Lolo) she takes concerning childcare, where she made it clear that at times she fights Amos's battles

when people seem to get on his case, which at times creates tension between her and those she was protecting Amos against.

While the brother's mean score are also at an unhealthy mean score of (2.75) for the both of them. For them this reflects the level at which they are disengaged, and they don't seem to show much interest and involvement in the general functioning of the house. This includes a range of things from helping out with childcare, chores to taking interest in Amos. Once again the mean scores reflect the different ends of the spectrum from too little to too much involvement.

Behaviour control: The mean scores of the two brothers is (2.75), reflecting on the one hand the high affective response Amos's behaviour elicits in them (irritation, impatience), which to an extent seems to affect their tolerance of his behaviour, thus the constant complaints to Lolo. Which at the end reflects their inability to handle and control Amos's behaviour. This to some extent applies to Lolo and Gadi as well, as they also still struggle in 'controlling Amos's behaviour in as far as discipline is concerned. Their mean scores are, (2.875) for Gadi and (2.5) for Lolo. While the FAD mean score is (2.0).

Case Four

4.5 Background

Karabo (patient) is a 7-year-old boy and was brought to the hospital by the mother (Sophy). He does not attend school (Sophy says mainly because of his behaviour. Karabo was diagnosed of ADHD, hyperactive type, and delayed developmental milestones, in September 2003, and has since been on medication

She says Karabo's behaviour started when he was still young, and was even expelled at crèche for his disruptive, in-attentive hyperactive behaviour. As he gets older, she reports his behaviour to have become more bizarre and puzzling that Sophy's mother (Tebogo) suggested they take her to mental hospital for check up.

On first evaluation Karabo was brought by Sophy alone, but the subsequent interview included the aunt (Letia) and Karabo's great grandmother (Lettie, who is deaf).

4.5.1 THE INTERVIEW

Karabo is Sophy's first born, and has a baby sister of three. They live in an extended family that consists of Letia, her child Kamogelo and Lettie.

4.5.2 Childcare

Childcare seems to be the responsibility of both as they are both unemployed, therefore they are always at home. They both agreed that Karabo keeps their hands "full" as they have to watch him 24-7. "You cannot turn your back around or do something when Karabo is around, otherwise you would find chaos", said Letia. When he plays with the children from the neighbours, there seems to always be complaints that Karabo has done this and that, or has hit so and so, to a point where parents don't want him playing with their children anymore. Sophy says as a result they have to be more watchful and give constant supervision.

It is clear that Karabo definitely keeps them busy to a point where they say they neglect doing other things, "especially when there is just one of us at home", Letia concluded.

4.5.3 Financial Impact on the family

Financially it appears that the family is struggling, as they are dependent on Lettie's pension money. They reported that with the money they buy only the necessary things needed in the house. The Letia adds that she has never worked before, while Sophy has recently found some casual work in town, so she helps with the little money that she gets. She says since Karabo has been going for consultation at the hospital, it has become really tough (financially), and at times has to walk for miles to get to the taxis because of not having enough money. What she also finds tough is the minimal fee that she has to pay every time for consultation at the hospital. "Its bad enough that I sometimes don't have money for transport, but what makes it more difficult is the fee they want every time I bring Karabo to the hospital", she says.

Sophy further explained that coming to the hospital means a day away from work, a day she doesn't get paid for, so she finds herself in a dilemma as on the one hand she wants Karabo to 'get better', and on the other she struggles financially. She further added that at times her father helps her with transport money when he can, however she has to "see to finish" when it comes to Karabo's well-being.

4.5.4 Discipline and establishment of rules

Concerning discipline and establishing rules in house Letia started by saying that its really difficult as Karabo doesn't seem to understand everything that he should or shouldn't do. "It never stops with Karabo. Today you tell him this; tomorrow he repeats the same thing. When you give him a hiding now, the next minute he's doing something else. You shout, you beat, nothing really helps, it gets tiring", Letia continues. Both Letia and Sophy agreed that they have tried everything, but his behaviour seems to get worse. Sophy also added that Kamogelo is also difficult to handle, and respects no one.

It appears that both Letia and Sophy are responsible for discipline, however they find it tough to establish and maintain strict rules as nobody really adheres to them. Letia concluded by saying though this may be the case; they try to show the kids right from wrong.

4.5.5 Conflict and Conflict resolution

Between the two of them, Sophy said they attempt to resolve all problems/conflict they experience. The times when there seems to be tension in the house is when they disagree on how Letia had, for instance punished Karabo in way that Sophy does not agree with. But Sophy added Letia has been very helpful and patient with her children. She continued by saying that when there is something that has been said that she didn't like, she cannot deal with it at the moment. " I tend to go away and cool of when I get angry, but the following day we sit down and I tell her what's bothering me", she said. "We are able to talk about everything and anything that goes on. At times I see how frustrated Letia gets with Karabo's behaviour, and she shouts or gives him a hiding, and there is nothing I can do because he has been naughty", Sophy continued.

Letia added that she is able to tell Sophy, at that moment what is bothering her, and things get sorted out. "We only have each other, so if we don't resolve our conflicts, it's not going to be nice in the house", she said.

At the beginning when Sophy and Karabo moved to the house, Letia adds that they used to fight a lot and there was a lot of tension about Karabo's behaviour "because I did not understand Karabo's behaviour. Sophy added that she used to get really upset and angry as Letia shouted or gave Karabo a hiding. "I used to be very short-tempered, and I would also take it out on Karabo. Because of this, we did not get along much". Letia added " I have since come to understand that is the way he is, and tolerate his behaviour more".

4.5.6 Time spent together by the family

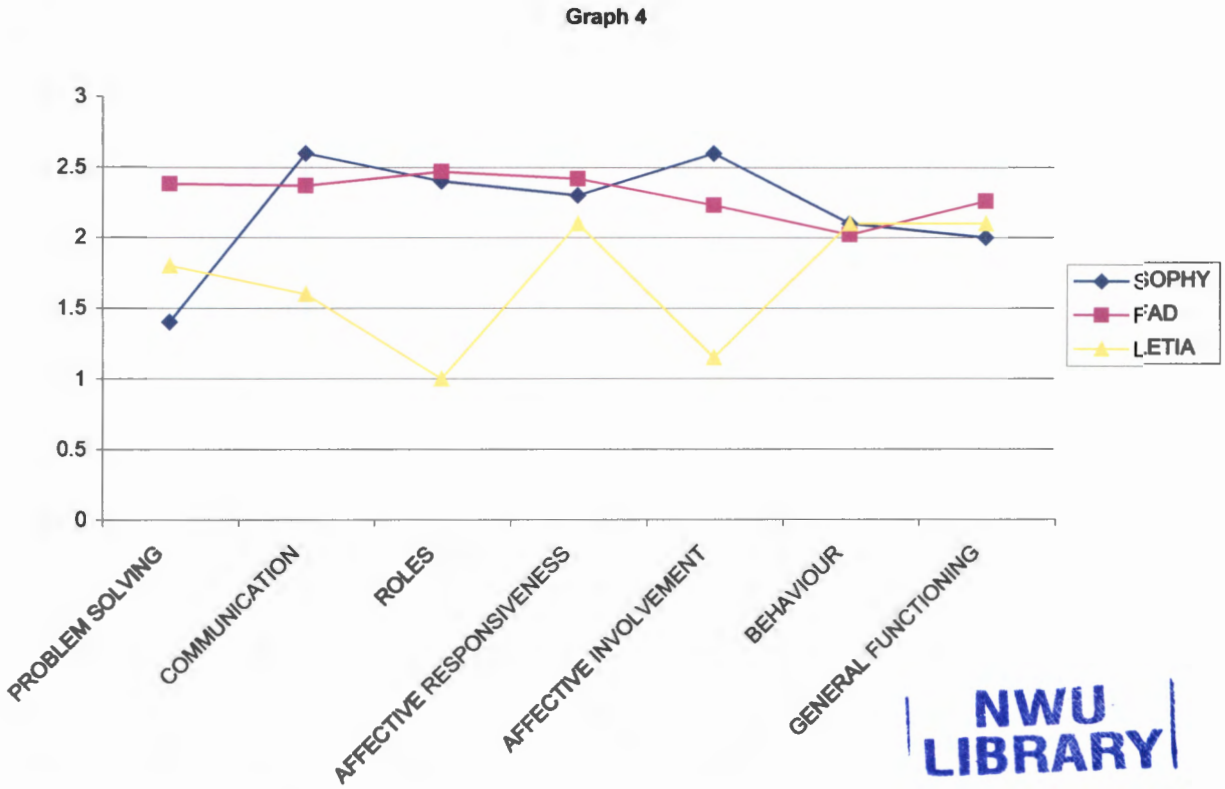
Concerning family time, Letia starts the conversation by pointing out that things were so much better when their father was still alive as they would have family gatherings with other relatives. However, a lot has changed. " People have their own homes, and they don't even come to visit mama anymore. Sophy adds that, "instead Letia is the one who visits them or takes them news about their mother"

4.5.7 Perception

It appears that both Letia and Sophy were confused and did not understand Karabo's behaviour. When I asked what they thought of Karabo's behaviour Letia started by saying she was personally baffled by the things that Karabo did at times. " You really don't know what goes on in that child's mind when he does certain things. At first, she says she thought Karabo was just being naughty like the times she has found him "mixing all sorts of things in the kitchen and smearing himself with a whole lot of Vaseline", she says. She explains that children at times do naughty things like that. However, when he started doing all these bazaar things, then its not child naughtiness anymore".

Sophy similarly added that Karabo's strange behaviour at times baffled her, and did not know what was going on, or what was causing him to behave the way that he did. She further explained that ever since Karabo started his consultations at the hospital, children have started calling him names. "They say he goes to a school for crazy people, and that hurts me a lot as a parent", she concluded

4.5.8 Figure Four



The graph depicts the mean scores of family members on the seven dimensions of the Mc Master's FAD, against the FAD mean scores.

Problem solving: The graph shows both Letia's and Sophy's mean scores of (1.8) and (1.4) respectively, reflecting their ability to solve problems or conflict. These findings are also consistent with the interview results as they reported to attempt to resolve problems, and come up with alternative ways of resolving a problem.

Communication: Sophy's mean score is (2.6), above the FAD norm, which indicates her inability to communicate about a problem at the moment (withdrawing from the conflict, as it happens), though she returns to Letia at a later stage to talk about it, which is reflected in conflict resolution in the interview. While Letia's mean score is a low (1.6), which reflects her ability to face a problem, and talk about it at that moment as it arises.

Roles: The graph shows Sophy's and Letia's mean scores to fall on the healthy range, with Letia's mean score at (1.0) and Sophy's falling exactly on the FAD norm (2.4).

Reflecting, once again their ability to share responsibility in doing things in the house, with Sophy's higher (though healthy) mean score reflecting her taking a more dominant role in as far as parenting is concerned. She takes the ultimate responsibility in making sure that, for example Karabo goes for his consultations, takes his medication, and so forth. While Letia's score falling exactly on a perfect score in the healthy functioning range. This reflects her ability to establish a level at which she involves herself, particularly in as far as (Karabo) problem/issues is concerned, in as far as her parenting role is concerned.

Affective responsiveness: Similarly, graph 4 shows Sophy's and Letia's mean scores of (2.3) and (2.1), to be below the FAD norm, reflecting a healthy functioning and the their ability to express a broad range of feelings to one another, and more particular to Karabo. As Sophy in the interview pointed that they are able to express their anger, disagreements with each other, though they may do it at different times, when conflict arises.

Affective Involvement: Letia's mean score is (1.15), this reflects the balance she is able to maintain in how much she gets involved, first in the general functioning of the family, and secondly in as far as Karabo's problem is concerned. In the interview in as far as childcare and parenting is concerned, Letia gives adequate support without being too intrusive in the mother-child relationship. Sophy's is at (2.6), which somehow reflects the level of involvement and the ultimate responsibility and control she assumes in handling Karabo's problem.

Behaviour Control: Both Letia's and Sophy's mean score is (2.1), against the FAD mean score of (2.0), almost on the FAD norm. Though they still struggle to get Karabo's behaviour under control, they attempt and are open to trying different ways of disciplining him, as they indicated during the interview.

4.6 Themes found in all four Cases

This section is made up of the findings of the themes that were investigated in this study, common to all four cases. It also contains what was reflected in the findings of the FAD results, and the new themes that emerged from the data, which are: the grandmother's role, Black men and their roles and Black extended families today.
Firstly, the researcher found that all the children presented with similar behavioural problems. This is:

- They were all diagnosed with ADHD
- Aggression (both physical and verbal)
- Impulsive, disruptive behaviour
- Stealing, and other additional problems like enuresis, delayed developmental milestones
- Onset of the problematic behaviour was early childhood
- Problematic behaviour was prominent both at home and school

The following is a list of findings on each theme, common to all four cases.

Childcare

- The researcher found that it was a shared responsibility among the family members, and the females played a more active role in day to day childcare than did the males
- Looking after a child with a psychiatric problem needed constant supervision, and was at times time consuming

Discipline

- All adults participated in disciplining the child
- The most popular form of discipline was hidings, and scolding (which proved not to work in most instances)
- The affected child's behaviour was regarded by some members as mere nuisance, which needed punishment by adults

- When the child's behaviour became unbearable, there was tendency to shift responsibility to the mother, where there was expectation to take control in disciplining the child (particularly in Cases 2 and 3)
- There were no standards or rules established by the family for bad or problematic behaviour

Conflict and conflict resolution

- Most of the conflict that arose within the families was about the child's behaviour
- Members had different ways of resolving conflict (some were more open than others), and in some cases this seemed to have an impact on open communication (particularly seen in Cases two and three)
- Resolving conflict on the child's behaviour was mostly avoided by family members
- In Case two, there was a sense of respect that was demanded by others (for example Thandi as an elder sisters demanded that her siblings treat her with respect), which created a gap and made it difficult to resolve conflict or disagreements

Financial Impact on the Families

- All families were from low socio-economic background, and this had an effect on the functioning of the family
- In most families, there was one source of income, which sustained the whole family. Those with economic status seemed to have power (mostly over how things were run in the house
- In all cases, the biological mothers experienced the most financial difficulty as they were unemployed, and therefore depended on others for transport money and other anemities
- The child's illness did somehow impact on the entire family, financially, as especially when the children were admitted at a hospital, as there were sacrifices that had to be made

Perceptions

- Family members had different understandings about the child's behaviour/illness, and this affected how each treated the child
- The child's behaviour was seen by others as mere nuisance, irritation and caused frustration and impatience for others
- It seemed like most members lacked information or knowledge about mental illness, and most did not believe that problematic behaviour could be considered/ and was a mental illness
- It appeared that mental illness was perceived as somebody who was "crazy, roamed the streets, was dirty, and someone that the community ridiculed"
- In some Cases, for example Case three, there was a lack of communication (by Lolo) about Amos's mental illness, and this affected how they responded to his behaviour
- In Case one, it was found that though Dodo (the mother) knew about Lebo's diagnosis, she still treated the child 'normal', and regarded his behaviour as at times being spiteful

Grandmother's role

- In all cases, it appears the grandmother plays an important role in the family in "holding" the family together. They seem to be regarded as the main support structure for the entire family
- The grandmothers appears to play a central role to the family's economic support
- They play head of the family as they take responsibility in important decisions in the family

Black men and their role as fathers

- In all Cases there seems to be no fathers as role models, with an exception of Case two
- The findings show that fathers are absent in rearing of their children, and do not make contribution towards the well-being of their children

Black extended families today

- It seems like the structure and shape of Black extended families have somehow changed, in this current study
- The concept of communal support system, social integration and group support appears to not be as intense as it was in the past. It appears the concept of individualism has also been integrated where the family gives support to a limited level

The themes discussed above reflect the family functioning and structure in the Black extended families studied. What follows is looking at how the child's illness affected specific aspects of the family. The following is a list of findings on the six dimensions that the researcher looked at.

Problem Solving (instrumental and affective problems)

- It appears all families were able to resolve instrumental problems, like money issues and childcare
- It appears that the families were able to identify the problem (the child's behaviour), and there seems to have been a fair amount of communication about the problem (amongst certain members of the family) and this resulted in the child being taken to a hospital
- However, it appears most members from the family had difficulty resolving affective problems. In Case one Dodo was unable to express her disagreement with Maki (in as far as discipline was concerned), instead she withdrew when conflict when it arose. Similarly, Cynthia withdrew whenever she felt "attacked" by some family members concerning Tshepo's behaviour
- Instead of coming with alternative ways to resolve the child's problematic behaviour, members tended to shift blame to the biological mother as seen particularly in Cases two and three

Communication

- From above, it may be concluded that there was lack of open communication about the child's problem and how it could be resolved (except in Cases one and four)
- In Case two, it seemed that the way members related to each other affected open communication. For example communication was more open among subsystems (individual members) than to each other, and this created boundaries that defined each subsystem. For example Cynthia-Lerato's and Thandi-MaMotse's subsystem, and this created distance among family members
- In Case three there was withholding of information by Lolo, from the rest of the family about Amos's illness, and this had consequences on how the rest of the family responded to Amos' behaviour.

Affective Responsiveness

(There are two types of feelings/emotions-love, support, happiness, tenderness; and fear, anger, panic, disappointment)

- It appears that in all cases, there was increased or heightened level of emotions in they ways members responded to the child's behaviour
- The range of emotions that some family members showed, especially when the child's behaviour seemed unbearable, were more negative
- The emotions elicited were irritation, frustration, impatience, and a sense of helplessness, expressed in particular by the biological mothers.
- Overall, it appeared the biological mothers experienced the most emotional stress from the constant worry on how to deal with the child's problem and how other family members responded to the child

Affective Involvement (the level and the quality of interest)

- Members from different families showed different levels of interest on the child's problem

- In Case one, it appears that Maki showed over involvement, as there was tendency to dictate to Dodo how to discipline Lebo. This in turn affected Dodo's ability to effectively and fully exercise her role as "mother" to Lebo, as Maki seemed to have ultimate authority in as far as things in the house went. This ultimately affected the mother child relationship between Lebo and Dodo as Lebo tended to give more respect and listen more to Maki than his mother
- In Case two it seemed that there was a limited level at which members got involved in each other's lives, generally. And there were varying degrees at which they showed interest to Tshepo's problem
- Similarly, in Case three it was found that the Brothers (Lolo's siblings) showed the least interest, and assumed a more passive, non-involvement, with Lolo carrying the most burden
- Case four showed the healthiest kind of involvement with Letia showing and giving the right amount of support without being intrusive

Behavioural Control

- In all Cases it seemed like there were no clearly stated rules or standards for bad behaviour, and ways of disciplining such behaviour, which resulted in inconsistencies
- This appeared to affect or contributes to the child's behaviour and the ability to control it

4.7 Comments and findings about the FAD

The findings on the FAD mostly reflect individual and personal characteristics that family members adopt in executing things in the family. For example some individuals would have a higher mean score, for example in problem solving, than would other members, and this reflected the differences in the ways they resolved problems. For instance, in Case One, Maki had a mean score of (1.4) and Dodo had a mean score of (2.6), which was above the FAD norm (2.2). Generally, it was reflected in the interview that the family is able to handle mostly instrumental problems. However, results show that Dodo experienced more difficulty in resolving affective

problems while Maki was more open and flexible. This therefore reflected the individual styles that each used when dealing with certain issues in the house.

The researcher therefore found the FAD results to highly correlate with the interview results, and the two methods complemented each other.

The researcher found that it was at times necessary to look at the interview context in interpreting certain mean scores. This was mostly in instances where at times family members got the same mean scores, but this did not always reflect the same kind of involvement and interest in the family. A case in point is Case 3, where Lolo and the two brothers had high mean scores (Lolo's at 3.2, and the brothers at 3) in problem solving, reflecting unhealthy functioning, yet the level of interest and involvement in the family were at total opposites. As it was indicated during the interview that the Brothers showed minimal interest and contribution in as far as problem solving was concerned, while Lolo on the other hand took sole responsibility in resolving things in the house. On the one hand, the mean scores reflected disengagement (in the Brothers' case) and on the other over-involvement (in Lolo's case).

CHAPTER 5

5.1 General discussion of all four cases

5.1.2 Introduction

This chapter is based on a discussion of the four cases discussed on the previous chapters. The discussion will be on the common patterns found in all cases on general functioning in Black extended families and the effects the illness had on the functioning of the family. For the purposes of this study, the researcher discussed certain themes together with the dimensions from the McMaster's model of family functioning, though they were investigated separately during the study. The reason for this was the high correlation between themes and the dimensions. The researcher used cross-case analysis- a strategy that enables the researcher to "look across individuals to identify what is typical about the phenomenon being studied" (Barker, Pistrang & Elliot, 1994: p224).

In the discussion the researcher will integrate existing theory with the cultural patters and social experiences of caring for a child with psychiatric illness in Black extended families and how the family functioning is affected. For the purposes of this study the researcher discussed some themes together as they are highly correlated (and also to avoid repetition). As Boyd-Franklin (1989) in Orford (1987: p228) said, " though there has been growing interest in black families, there aren't studies that integrate current research on cultural patterns into treatment milieu". This work will therefore be useful to all professionals working with children from Black extended families in better understanding about the structure and functioning of the Black extended system today.

5.2 General Functioning/Structure in Black Extended Families

5.2.1 Childcare and Affective involvement

Literature on Black families shows that shared responsibility or doing things together is an important characteristic of Black extended families. Boyd-Franklin (1989) in her study talks about reciprocity, which she says is a process of helping each other out and involves exchange and sharing of support, goods and services. Reciprocity or sharing the burden, she found, comes in different forms, which include financial and emotional support, among other things.

In the current study, the researcher found that family members helped each other out, or shared responsibility in as far as childcare was concerned. Not only was it a shared responsibility, but also Boyd-Franklin (1989) in her study found that a strong value was placed on loyalty and responsibility to others. This shared responsibility or reciprocity extended to helping each other financially and with emotional support, as was the case in this current study.

Looking after a child with a psychiatric problem seemed to be time consuming, as they needed constant supervision. This was evident in all of the Cases where in Case one both Maki and Dodo reported on the constant complaints they received from the neighbours about Lebo fighting others, or having done this or that. Maki said they therefore tried to keep him busy in the house to keep him out of trouble, and continuously look out for him. Similarly in Cases two, three and four they reported to have always being at a go and always keeping a look out for the child. This finding is consistent with what Orford (1987) in his studies found that time and energy were reported to be the number one burden that certain family members rated as highly stressful.

In Cases three and four, the findings show that both Amos and Kamogelo were 'isolated' by the neighbours, because of their problematic behaviour. Lolo and Sophy

said this therefore made childcare difficult and emotionally draining when caring for a child who was ostracized by the community.

Furthermore, the findings show that childcare depended on individuals' availability, and what role-in terms of giving emotional or financial support- could each member play. For example in Case one, it seemed like looking after children and doing chores in the house was the responsibility of both Dodo and Maki. The two interchanged roles of being mother or parent at some point and aunt or cousin at another time, therefore 'slipping' in and out of roles, depending on who was available. Boyd-Franklin (1989) refers to this as role flexibility, which she found to be a common pattern found in Black extended families. This pattern was similarly found in Cases, two, three and four.

Boyd-Franklin (1989), found that the concept of role flexibility was particularly useful because of the economic hardships that most Black families found themselves in. Therefore aunts, uncles, friends or neighbours interchanged the parenting role at some point. This was evident in Case two where Cynthia mostly cared for the children during the day, while some members went to work, and also later shared or participated in household work. Similarly, in case three Gadi cared for the children while Lolo went to work. And in case four both Sophy and Letia looked after and exchanged the role of parenting.

This pattern of functioning exhibited by the Black extended families in this study also reflects a systems concept of a system being an organized whole where elements within the system are necessarily interdependent. Wolman and Striker (1983) say a system is an integrated, coherent entity that is more than the mere composite of independent elements. Therefore each family member contribution is equally important to making a system whole and functional.

Though it appeared that interchanging roles was beneficial for most members in the family, the researcher found that different family members showed different quality and levels of interest, involvement and support with the child's behaviour. This is called affective involvement in the McMaster's model of family functioning.

In Case one, for example Maki and her level of interest and involvement in the family as a whole was very evident in the level of support and nurturance she gave to Lebo and Dodo (and the rest of the family). Both her and Dodo were generally involved and interested in the family lives. It however appears that there was blurring of boundaries as there was tendency for Maki to be overly involved in the mother-child relationship (between Dodo and Lebo) parenting (especially in terms of discipline), and giving nurturance to Lebo. This over-involvement is reflected in her high mean score of (3.3) of the FAD, and Dodo's mean score only at (2.4).

Munichin (1974) found in his studies that blurring of boundaries was not unusual in black extended families, [especially concerning childcare]. However, if it resulted in fusion or lack of self-differentiation, then it was dysfunctional, and this seems to have been the case in Case one. Boyd-Franklin (1989) found that such confusion or blurring of boundaries often occurs when transition needs to be made after the grandmother, has for many years assumed the role of mothering or parenting to her grandchildren, especially when the mother is a teenager during pregnancy. As the teenage mother becomes an adult, the transition to become mother to her own child often becomes difficult as she must 1) displace her own mother 2) change her family's perception of her as a sibling 3) change her child's perception (Boyd-Franklin, 1989: p72). In the current study, Maki reported to have played a mothering role to Dodo, and her mothering role was later extended to Lebo. As a result it appears Dodo to some extent, found it difficult to fully assume and exercise the role of mothering or parenting to Lebo. This in the long run seemed to have negative consequences on the relationship between Lebo and Dodo.

Furthermore, Boyd-Franklin (1989) found that in families that were functioning well, boundaries were made clear no matter how many adults are involved. She found that in most families, functional structure has never being fully developed and it needed to be built for the first time. This could possibly be the case for this family where both Dodo and Maki could establish a structure that worked for both of them.

In Cases two and three the findings show that the level of involvement and interest family members had in each other's lives was limited. The researcher found that family members related to each other more on a subsystem level, than they did

together as a family, and this seemed have had implications at which they took interest in as far as Tshepo's behavioural problem was concerned.

The findings show that different members showed different levels of interest, with MaMotse showing the most interest and concern for Tshepo's problematic behaviour. Some family members were at times, unable to give adequate emotional support when crisis arose, particularly at times when Tshepo's behaviour seemed to be unbearable. Their different mean scores of the FAD range from (2.4 to 3.5), which reflects the family's different levels of involvement, along the continuum of too little to too much involvement.

Interestingly, MaMotse's mean score was (3.5), which reflects unhealthy functioning (according to the McMasters's model of family functioning). The researcher however found that her high mean score was a reflection of the interest and level of involvement she has on the entire family, particularly her concern over Tshepo's illness. Epstein et al. (1978) said that over-involvement that reflects tendency to be over-protective and show excessive warmth towards family members excludes unhealthy functioning, as this is true in MaMotse's case.

Similarly, in Case three, it appears that Lolo, though received a lot of help from Gadi, took ultimate responsibility for sorting Amos out. This is reflected in their mean scores of (3.8) and (3.1) respectively, with the Brothers having shown the least interest in helping with Amos's problematic behaviour, with mean scores of (2.57) for both. Their mean scores reflect different ends of the continuum in affective involvement.

Case four shows the healthiest type of involvement with Letia showing and giving enough amount of support without being too intrusive in the mother-child relationship, with a mean score of (1.15). And Sophy seems to be the one with ultimate responsibility in as far as parenting is concerned, and having the overall concern about Karabo's behaviour problem, and her mean score of (2.6) reflects this.

5.2.2 Discipline and Behaviour control

Disciplining children is closely related to the Black system's concept of a shared responsibility, as most parents in the study participated in it. In as far as the child's behaviour goes, the researcher found that it was regarded by most adults in all cases as a mere nuisance or naughtiness that needed to be punished. Most adults gave the affected child a hiding whenever he was naughty or got involved in some kind of a fight. This appears to have been the main method that most adults used for discipline. These findings are consistent with what Asuni et al. (1994) in their study with African communities found that problem children's behaviour was seen as mere forms of nuisance, which required punishment by adults. This seems to have been the perception of most adults in this study.

This being the case, the researcher found that family members were unable to control the behaviour of the affected children. This is reflected in all their mean scores being above the FAD mean score of (2.0), in all the cases. One of the reasons seemed to be that there were no clearly stated rules/standards and ways of disciplining the child, which resulted in a lot of inconsistencies in as far as discipline was concerned. It appears that in most Cases, with the exception of Case one, they followed a more chaotic behaviour control approach where the rules for behaviour seems to be randomly shifted by different members of the family, as they saw fit. This approach covers the entire spectrum from laissez-faire to rigid (Epstein et al., 1978).

It appears that in Case one, though it became difficult to control Lebo's behaviour, (and this is reflected in their high mean scores of (2.75) for Maki and (3.0) for Dodo), there was an attempt to be flexible regarding discipline for bad behaviour as the rules for discipline were determined by the context and the situation for that particular behaviour.

Asuni et al. (1994) in their study found that a lot of problem children more commonly lived in extended or multi-disciplinary families, and they say this was because of the inconsistent discipline. From this discussion, the questions that come to the researcher's mind are does having multiple disciplinarians contribute to the lack of

change seen in the children's behaviours in the study, as there are no standards as to how and when should a child be disciplined? Does the method of discipline, which consists of hidings and scolding, work?

Furthermore, the researcher in the study found that when certain members' of the family could not handle the child's behaviour there was tendency to blame or shift the responsibility to the biological mother. This was particularly most evident in Cases two and three, where in Case two certain members could not handle Tshepo's constant fighting or always being in and causing trouble. They expected Cynthia to do something about the child's behaviour. During the interview, Thandi pointed out that it was Cynthia who should take the ultimate control in disciplining Tshepo. Similarly, in Case three, there was expectation by some family members for Lolo to control and take ultimate responsibility in sorting Amos out.

Hatfield and Lefley (1987) found that the blaming often resulted from members of the family attributing the child's illness to the interpersonal and interfamilial interactions, which often resulted in members being set against each other as the accuser or the accused, as it seems to be the case in this study.

5.2.3 Financial Impact on the family

In as far as the families finances or economic issues were concerned, the researcher found that family members often relied on one source of income for survival, and this seemed to have impacted on the family functioning as that money had to be distributed to certain aspects of family life, including the child's illness. For example in Case one, Maki was the main person who brought in a steady income, and therefore took care of rent, groceries and paying bills, while Dodo helped when she could. Similarly, in Case two it was found that MaMotse's and Papa Pitso pension money was what the family mainly survived and depended on. And in Case three, Lolo was the sole breadwinner and took care of all the financial expenses of the house. This was also found in Case four that Lettie (who played a passive, yet the most important role in the house) supported the family financially.

Interestingly, the researcher found that the biological mother in all four Cases were unemployed, therefore depended on the rest of the family members for financial assistance. They report to have experienced financial burden particularly when the child was admitted at a Psychiatric Hospital. Cynthia, in Case two reported that at times she found it very frustrating to wait for others to give her transport money, and Sophy in Case four reported that at times she worked very long distances as at times she did not have transport money. It therefore seems like the biological mothers experienced the most burden financially, though the rest of the family also felt the financial stress, as they also had to make financial sacrifices to help these children

What is reflected in the pattern of functioning in the discussion above is the systems concept of wholeness where Wolman and Stricker (1983) say change in one part of the system [causes] change in many parts of the larger system. They further talk about 'circular notions of causality' where they say, behaviour fits into sequences of other interactions. As we see above that what happens in the family affects the rest of members. If one individual in the family experiences financial burden, or has financial problems, the rest of the family members are somehow affected. This relates back to the Black extended family's concept of reciprocity and sharing the burden as a family. As was discussed earlier that members of the family were expected to stay loyal and were responsible to the others, and that is how the systems in these families seem work.

5.2.4 Conflict, conflict resolution and communication

The findings showed that amongst other things, the child's behavioural problem was one of the things that caused conflict or tension in the house, and family members had different ways of resolving the problem. The extent to which family members could resolve conflict seemed to depend on the communication patterns that existed among family members. Generally the findings show that there was lack a of communication in as far as trying to resolve the child's behaviour problem, together as family, in all cases, especially when it appeared to be unbearable.

For example in Case one, conflict often arose when there was disagreement about the way Lebo was disciplined, and Maki confronted the problem or the issue as it arose

while Dodo tended to at times withdraw from the conflict. This often resulted in tension between the two. Despite this, both Maki and Dodo attempt to have an open communication about Lebo's problematic behaviour as they (especially Maki) tried to come up with alternatives on how to best deal with Lebo's problematic behaviour. Their healthy mean scores of (2.1) and (1.7) indicated this.

In Case two, when conflict arose about Tshepo's behavioural problem there was no attempt to come up with alternatives of how to deal with and discipline the child, instead there was a tendency to shift the blame to Cynthia. The researcher further found that MaMotse was often used as a go-between to help resolve conflict

As Wolman and Stricker (1983:p66) in their study said "most of our relations with each other are based and regulated by our communication with them... and that all communication is seen to convey not only the content, but also information about the relationship between members" As was mentioned earlier that the family members (in this case) related more on subsystems level, than as a family, which created a gap among family members, thus making communication difficult when conflict arose.

Similarly in Case three the researcher found that generally, the family did not interact a lot, therefore exchange of information or communication was very minimal. And this became particularly evident in Amos's case as the family hardly communicated about Amos's behavioural problem; instead Lolo was the sole person that attempted to sort Amos out. As Wolman and Striker (1983: p70) said, " the family as an emotional system survives by the family's pattern of communication, which defines, maintains and/or changes the nature of the relationship among family members". Therefore, every individual's involvement or lack of involvement seemed to maintain a pattern of relating that existed in the family.

Their mean scores range from (1.7 to 2.7), with Thandi at (1.7) and MaMotse's mean score at (2.3), falling exactly on the FAD mean score of (2.3). This reflects her ability to easily communicate among all family members, and often being used as a go-between or a mediator when conflict arises. Cynthia's and Thabo's mean score at (2.5), indicating their tendency to withdraw from conflict (reflecting communication problems), especially Cynthia.

And in Case four it was found that though Sophy and Letia also had different approaches in resolving conflict, they always attempted to have some kind of common understanding, and this seemed to be fostered by their ability to have open communication with each other.

Having said this though, Wen-Shing Tseng & Jing Hsu (1991) in their study emphasized extent to which open communication among family members is encourage, varies greatly among families in different cultural groups. And it was found to be the case in the Black extended families in this study that open communication, where the entire family would attempt to resolve a problem together was not encouraged and this seemed to be part and parcel of the structure of these families. This could arise from the fact that in the past the elderly people in Black families were the ones that resolved family matters or any problem that affected the family system. Carter and McGoldrick (1999) found that older women were called to impart wisdom and provide functional support to younger family members. Now that there is a shift in strong communal support system (as indicated in these families), there seems to be nothing that replaces that structure, hence the biological mother is expected to take the ultimate control, as was seen in all the Cases.

Therefore according to the systems theory the feedback system is somehow dysfunctional. Wolman and Stricker (1983) say that there are feedback loops that operate within a system. For them to be effective, the system needs to have structures of communication where there is regulation of reference points (for example in the current study the elderly people would be regarded as reference points) from which the feedback loops operate. This would therefore enable family members to resolve conflict and family problems or crises more efficiently.

5.2.5 Problem solving

In problem solving, family members are required to identify the problem, agree on it and communicate about it, and should be able to come up with alternatives, according to the McMaters' model of family functioning. The researcher in all Cases found that family members were able to identify the problem, which was the child's behavioural

problem, and at a later stage professional help was sought. In Cases one and three it appears the problem was easily identified, as there were family members who were in the health profession. They therefore identified the excessiveness of the child's behaviour and knew resources that were available.

Unlike in Case two where it took longer for the family to seek help because they did not know where to seek help, though the family had identified the problem as it had some effect on family members.

Therefore, the findings show that at most the families could resolve instrumental problems, but had difficulty resolving affective problems as was discussed earlier.

5.2.6 Affective Responsiveness

The researcher found that in all the families, the child's behaviour elicited a lot of emotions. It appears that there were heightened or increased levels of emotions, especially when the child's behaviour became uncontrollable and unbearable. Epstein et al. (1978) pointed to the two kinds of emotions or feelings that families can express, that is: emergency feelings which include feelings of fear, anger, panic and disappointment, and emergency feelings which include feelings of support, love, tenderness, happiness and joy.

The researcher found that most family members expressed mostly emergency feelings, mostly frustration, irritation and impatience with the child's behaviour. This is particularly evident in Cases two and three, where certain family members would withdraw or avoid interaction with the child. For example in Case two, Thandi had a tendency to avoid interacting with Tshepo (especially when his behaviour appeared to be irritating and unbearable) though she did at times give support to Cynthia, and her mean score of (2.6) in the FAD shows this. Similarly in Case three, the Brothers in particular, responded more negatively and expressed more negative emotions, than Gadi or Lolo members did, and this is similarly reflected in their high mean scores of (2.6) and (2.8). While Gadi's mean score was (1.8) and Lolo's at (2.0), reflecting their ability to give support and love and express frustration and impatience as well.

Furthermore, researcher found, across all the cases, that the mothers and grandmothers could express and respond to the child's behaviour with both irritation and frustration and with love and support, than did the males in the study.

These findings concur with what Hatfield and Lefley (1987) in their study similarly found that different family members responded differently to the child's behaviour. Other members, they found, would also avoid or dissociate from the child as the behaviour may cause immediate irritation, terror or despair, as we saw is the case in the findings of the current study.

The researcher further found that the biological mothers experienced the most emotional stress as they constantly worried about the child's behaviour and the pressure they at times got from other members to do something about the child's behaviour. These findings correlate with what Hatfield and Lefley (1987) in their study found that mothers carry the burden for caring for the child, she worries about the child's needs, how to meet them and soforths. They found that this resulted in increased level of intrusion into her daily life routine, than it would be for other family members.

5.2.7 Perceptions

In terms of how family member understood and perceived the affected child's behaviour, family members had different views and perceptions. But the most prominent perception was the child's behaviour being seen as just a mere nuisance or naughtiness, as mentioned earlier. Therefore most adults treated the child and gave discipline like they would other children in the family when they became mischievous.

Orford (1987) in his study found that adjustment to a child's behaviour really dependent on the family's and the relative's interpretation of the child's behaviour and attitude. He found that behaviour which was interpreted as under the child's deliberate control or taking the behaviour to be intentionally provocative, it was common for family embers to blame certain individuals, especially the mother for the past treatment of the child.

Furthermore, the researcher found that in most cases, most family members did not have adequate understanding of mental illness, and this had consequences on how they responded to the child. The findings show that some members had preconceived ideas of what a person with mental illness looked and behaved like. Certain members had images of somebody who is crazy, roamed the streets, talked alone or was often ridiculed by the community. It therefore appears that they did not think that a child with behavioural problems could have mental illness. Cheetam and Griffiths (1982) found that only patterns of behaviour, which constituted a threat to social cohesion and balance, such as disturbed behaviour, extreme disturbances of expression and reason, were regarded as madness.

In Case two it appears that MaMotse at some point attributed Tshepo's behaviour to being "bewitched", especially when he did things that seemed to really puzzle the rest of the family. It therefore appears that some members (especially the older generation) still held cultural belief systems about behaviour that is unexplainable. As Cheetam and Griffiths (1982) in their study found that bewitchment was one of the factors that people attributed to somebody whose behaviour was puzzling.

5.2.8 Grandmother's role

Boyd-Franklin (1989) in her study found that grandmothers were often individuals who were found to be very central to the economic support in Black extended families. They were found to represent a major source of strength and security for many Black families, and this was a responsibility and a role they carried for many generations.

In the current study, the researcher found that grandmothers or those who assumed the role of grandmother (like in Maki's case) were found to occupy central positions in the family. In Case one Maki was regarded and acted as the head of the family and therefore had major influence on the decision making in terms of laying the rules, establishing discipline in the house. Similarly, MaMotse was regarded as the mainstay of the family, and was held at reverence by all family members. Her central position is mostly evident, among other things in being used as a go-between when conflict

arose. Furthermore, Lolo in Case one was depended upon by all members financially and in holding the family together.

Boyd-Franklin (1989) in her study found that such individuals who played a central role often functioned as a "switchboard" through which all messages were conveyed. As was seen in Case two where family members used MaMotse as a switchboard" for conflict resolution and offloading of their problems. Similarly, in Case three Lolo was depended upon by the entire family and was often used as the middleman to help resolve things. Boyd-Franklin (1989) said at times these families therefore may just exist in structure, and the exchange of support may be imbalanced to an extent that one member may become burnt out.

5.2.9 Black men as fathers and their role in Black extended families

In this current study, the researcher found that men or fathers to the children were not involved in the upbringing of their children. In all cases, there appeared to be no fathers or father figures (except in Case two where Thabo somehow played as a father figure to Tshepo, especially financially). This finding is contrasting to what Boyd-Franklin (1989) found that Black men were as equally involved in rearing their children, especially in decision-making matters. She further found that extended families increased the number of potential role models because of the number of people who were involved in childrearing. Therefore uncles, boyfriends would assume the role of "daddy". In this current study the researcher found that though there were uncles in the family-Case three- they assumed a passive role in helping with the rearing of the child.

5.3 Conclusion

This conclusion consists of the findings on the structure or functioning that was found to be most prominent in Black extended families, and the subjective experiences of having to care for a child with psychiatric illness, and how it was incorporated into the system, in this study.

The findings show that childcare/ looking after a child with psychiatric illness was a laborious and time-consuming activity, as they needed constant supervision. However, it was similarly found that it is an activity that was a shared responsibility by family members. Therefore adults interchanged the parenting role, depending on who was available. This role flexibility and reciprocity is said to be one of the important survival mechanisms in Black extended families, as it was found in the current study. Furthermore, the researcher found that though childcare is a shared responsibility, different family members showed different levels of interest and involvement to the child's psychiatric problem.

McGoldrick (1999) in his study said that there can be a number of individuals or parents that raise a child, for as long as roles are clearly defined and ultimate authority is defined. As research shows that there is tendency for very close relationships, which often results in blurring of boundaries in Black extended families. This characteristic seemed to work in most instances, but if this leads to 'fusion' of boundaries, it can be problematic, like it was the case in Case one. There was blurring of boundaries, which affected the roles that each parent played, which in the long run affected the mother-child relationship between Dodo and Lebo.

Asuni (n.d) says in Black extended families the mother-child relationship is less intense as it is shared and diffused among surrogate mothers, which makes the process of bonding different from the white families. This is beneficial in most instances, but with the findings in the current study showing that the mother is expected to take the ultimate responsibility for the child, maybe the mother-child relationship and the process of bonding should be re-emphasized in Black extended families. One of the reasons being that there are so many individuals that influence the child in some way or another which seems to make it difficult for the biological mother and the child to have a close bonding relationship.

Furthermore the researcher found that the child's illness had some financial impact on the family as in all families there was often one main source of income the family relied on. It was further found that in all cases the biological mothers were unemployed, therefore depended on other members for financial assistance. Therefore

there had to be financial sacrifices made by other family members. The concept of shared responsibility was again reflected.

It therefore appears that in extended families a parent/mother can rely on more than one person to work with, as it was evident in the findings of the study. It appears that it is the very structure of extended families where family members share the burden, either through financial, emotional support and sharing goods and services, that impacts on the family's ability to care for and cope with a child with psychiatric illness. The ability for family members to interchange and assume different roles seemed to impact on family functioning, and consequently on caring for a child with psychiatric illness.

The researcher found that generally, it was women (mother, grandmothers) who played important roles in the children lives and upbringing. While there were hardly any male and father figures who participated in the upbringing of these children.

Furthermore when looking at the McMaster's Model and the dimensions that were mentioned above it appears that the child's illness had an effect somehow. Concerning problem solving it appears all the families in the study were able to identify the child's problem and seek professional help. However, it appears there was difficulty in working together as a family to find alternative ways to sort the child's behavioural problem, in as far as discipline and behaviour control were concerned. It seems like generally, most families had difficulty in communicating about the child's behaviour problem, and that seemed to have implications in how they handled and responded to the child.

It also appears when the child's behaviour became uncontrollable/or unbearable there was tendency to shift the responsibility to the biological mother, as far as discipline was concerned. Therefore the biological mothers were found to have experienced the most emotional stress. However, the researcher found that generally the child's behaviour elicited a lot of emotions, where most family members expressed feelings of frustration, irritation and impatience, concerning the affective responsiveness dimension.

Furthermore, the researcher found that there were a number of contributing factors that contributed to the family's difficulty in controlling the behaviour of the child. The first one was lack of standards and rules established for bad or aggressive behaviour, which seemed to have implications on how and under which circumstances was the child disciplined, and what type of disciplined would then be applied. This in the long run resulted in inconsistencies in the way the child was disciplined.

Hatfield and Lefley (1987: p32) found that "As the process of de-institutionalization took place families and the community realized that they were ill equipped with recourses that would have been readily available at the hospital. It was further realized that the structure of the nuclear family could not cope looking after the physically or mentally ill people since there was at most two adults to take roles of major responsibility in the home. Therefore it appears communication channels, problem solving and decision making is easily affected and causes disruption in the "precariously balanced, emotionally charged system of the modern urban family".

When looking at Black families this appears to be less apparent as the sharing of responsibilities is divided among several adults, therefore there are number of individuals to rely on. Therefore though they may have experienced difficulty in resolving conflict, and openly communication about the how to better deal with the child's behaviour, it did not cause so much disruption, that families were completely thrown out of balance.

The researcher also found that perception or understanding of the child's illness affected, to a certain extent, the ways family members treated the child. And it appears that mental illness, for most of the participants did not (or could equal) disruptive, aggressive and hyperactive behaviour. Instead, family members regarded such behaviour a nuisance, and resulted in punishment by elders. Furthermore, the researcher found that it was mostly lack of adequate information about mental illness in general that affected some members' perception about the child's behaviour.

Overall the homeostatic features of systems theory are reflected where "interactions in any given family system are maintained within a range of functioning that is balanced or held in equilibrium"(Epstein et al., 1978:p29). So all the patterns of

interactions, and behaviours of individual members in the study work to maintain the status quo, regardless of the fact the maintenance of the status quo is functional or not. Furthermore what is also reflected is the systems theory concept of circular notions where Wolman and Stricker (1983: 68) "noted that behaviours are viewed as interdependent components of a recursive feedback loop...[where] behaviour of person A influences the behaviour of person B, which in turn influences the behaviour of person A".

The child's illness therefore does cause some disruption in the family, and inevitably affects issues of communication, problem solving and conflict resolution as the study showed that some family members still battled with coming together as a family and resolving the affected child's behavioural problem. However, it appears that the Black extended family principle and characteristics of reciprocity, role flexibility and sharing the burden to a certain extent contributes towards the families' ability to deal and cope with the child's illness, especially the biological mother. It is the complex interpersonal relationships that makes it easier to cope and does not throw the whole system out of kilter.

5.4 Black extended families today

The researcher found that the structure of Black extended families has somehow changed from being purely a collective unit, with emphasis on communal support system with social integration and group identity. The researcher found that though there were still kinship bonds, and the system still operated on concepts of reciprocity and role flexibility, which were found to be important characteristics in these families, there was movement towards individualism. This is reflected in the expectation of some family members for the biological mother to take ultimate control and responsibility for the child's behavioural problem. It is clear from the study that like it is found in Black extended families, a child is raised by everybody, and one can have several surrogate mothers. And this contributes a lot in "lifting the burden" of caring for a child with psychiatric illness. But the overall responsibility is placed on the biological mother, which contrasts to the olden days where everybody had equal responsibility.

As a result we see more and more families brining their children or sorting relief of stress through mental health system for their problems while in the past it was the community's responsibility and will to sort the problem. This shift is different from what is reflected in Asuni et al. (1994) study that though children were brought to psychiatric hospitals they were fewer than what was reported from other developing countries. This they found was due to aspects of community life still operating, where there was communal interdependence and traditions for social control.

Because of industrialization and globalisation, family lives have been changed forever, especially in Black urban settings like the ones used in this study.

Chapter 6

This chapter deals with further recommendation of the study, strength and limitations of the study and professional implications, if present.

6.1 Strengths of the study

- Focus on extended families and how caring for a child with psychiatric illness impacts on the functioning of the family. Where previous research had focused on nuclear families and how they attempt to cope with such experiences. This study therefore, is of pioneer work.

- Combining/integrating already existing theory/ or practical results on extended families and impact of psychiatric illness on the family. The researcher also highlighted and introduced some concepts or issues on extended families that are original.

- Combining quantitative and qualitative study, which gives the reader rich, information in as far as the study is concerned. Though both methods illustrated and focused on the same phenomena, the FAD showed the individual and personal characteristics of family members and their different styles of approaching things within the family. An element that was not as clear in the interviews.

- Using an instrument (FAD) that has mostly being applied to more conventional, nuclear families, on black extended families.

6.2 Limitations of the study

- Though the findings give more insight about the functioning of black extended families, the results are not generalizable to a bigger population.

Instead the findings are specific to each case. However, this study has laid excellent groundwork for research to be carried on a bigger scale.

- The researcher had pre-selected themes and categories, which limits the explorative study to just those themes. Similarly, the researcher was also working against a specified theory, which also limits the explorative nature of the study.

6.3 Recommendations for Further Research

- Developing a Model that is best suited for Black extended families, starting with the findings of this study and on new findings. This Model would then be used as a guideline for Black extended families in establishing the general structure for family functioning.
- Do a critical study on systems theory-in its totality, and not just selecting few concepts. This will illustrate how applicable systems theory is on working with black extended families. It will show the gaps and weaknesses of the theory.
- A study focusing on Psychiatric illness and attitudes and perceptions of black communities.
- A study on the mother-child relationship and the bonding process in Black extended families

- Carry the study on a much larger sample; therefore be able to make more generalisable findings about extended families.

- Exploring the role of culture and the impact it has on childcare and family functioning in Black extended families in South Africa

REFERENCES

Anastas, J.W & MacDonald, M.L (1994). *Research Design for Social work and Human services*. New York: Lexiton Books, An Imprint of Macmillan, Inc.

Aponte, H. J. (1994). *Bread and Spirit: Therapy with the new poor: Diversity of Race, Culture and values*. New York. London: WW Norton & Company.

Aponte, H. (1976). Under-organization in the poor family. In Boyd-Franklin (1989) *Black Families in Therapy: A Multisystems Approach*. New York. London: The Guilford Press.

Aponte, H & Van Deusen, J. (1981). Structural Family Therapy and the Treatment of Black Families. In Boyd-Franklin, N. (1989) *Black Families in Therapy: A Multisystems Approach*. New York. London: Guilford Press.

Asuni, T. (n.d). African and Western Psychiatry: A Comparison. In Mabetwa, P.J.& Direko, L.P.(1992), *African and Western Healing Methods/Clinical psychology*. Unpublished Compilation, Department of Psychology, University of North West, Mafikeng.

Asuni, T., Schoenberg, F. & Switt, C. (1994). *Mental Health and Disease in Africa*. Ibadan. Owerri. Kaduna. Lagos: Spectrum Books Limited.

Barker, C; Pistrang, N. & Elliot, R. (1994). *Research Methods in Clinical and Counselling Psychology*. Chichester. New York. Brisbane. Toronto. Singapore: John Wiley & Sons.

Baca-Zinn, M. & Eitzen, D.S. (1993). *Diversity in Families* (3rd Edi). Harper Collins College Publishers.

Bertalanffy, L. von (1975). Systems theory and the family. In Okun, B.F & Rappaport, L.J. (1984), *Working with families: an introduction to family therapy*. North Scituate, Massachusetts: Duxbury Press.

Boyd-Franklin, N. (1989a). *Black Families in Therapy: A Multisystems Approach* New York. London: Guilford Press.

Boyd-Franklin, N. (1989b). Family Therapy with Black Families: Minority Mental Health. In Orford, J (1987: pp227-231), *Coping With Disorder in the Family*. London. Sydney: Croom Helm.

Bromley, D.B. (1986). *The Case Study Method in Psychology and Related Disciplines*. Chichester New York. Brisbane. Toronto. Singapore: John Wiley & Sons.

Campbell, D. (1975). Linking data to propositions. In Yin, R. K. (1983), *Case study research: Design and Methods*. Beverly Hills. London. New Delhi: Applied Social Research Methods Series, Sage Publications.

Carter, B. & McGoldrick, M. (1999). *The Expanded Family Life Cycle: Individual, Family and Social Perspectives* (3rd Edi). Boston. London. Toronto. Sydney. Tokyo. Singapore: Allyn ABD Bacon.

Cheetam, R.W.S & Griffiths, J.A. (1982). *Sickness and Medicine: an African Paradigm*. S.A Medical Journal, Vol 62, pp954-956.

Clausen, M. (1952). Mental illness and family functioning. In Hatfield, A.B. & Lefley, H.P. (1987). *Families of the Mentally Ill: Coping and Adaptation*. The Guilford Press.

Creer, R.J. & Wing, B. (1974). Mental illness and family functioning. In Hatfield, A.B. & Lefley, H.P. (1987). *Families of the Mentally Ill: Coping and Adaptation.* The Guilford Press.

Denzin, N.K. & Lincoln, Y.S. (1994). *Handbook of Qualitative Research.* London, New Dedli: Sage Publications, Thousand Oaks

Epstein, B.N., Baldwin L.M. & Bishop, D.S. (1983). *The McMaster Family Assessment Device*. Journal of Marital and Family Therapy, 9(2), pp171-180.

Epstein, B.N., Bishop, D.S. & Levin, S. (1978). Central Concepts of the Model of Family Functioning. In Will, D & Wrate, R.M. (1985). *Integrated Family Therapy: A Problem-Centered Psychodynamic Approach. London*: Tavistock Publishers.

Fernando, S. (2003). *Cultural Diversity, Mental Health and Psychiatry: The Struggle against Racism*. Taylor & Francis Group Have & New York: Brunner-Routledge.

French, L. (1977). Systems theory and the family. In Okun, B.F. & Rappaport, L.J. (1984), *Working with families: an introduction to family therapy*. North Scituate, Massachusetts: Duxbury Press.

Goldenberg, I. & Goldenberg, H. (1990). *Family therapy: An overview*. Monterey, CA: Wadsworth.

Hatfield, A.B. & Lefley, H.P. (1987). *Families of the Mentally Ill: Coping and Adaptation*. The Guilford Press.

Ingersol, D.B. & Goldstein, S. (1994). *Lonely, Sad and Angry: A Parent's Guide to Depression in Children and Adolescents*. New York. London: Main Street Book Doubleday.

Ingoldsby, B.B. & Smith, S. (1995). *Families in Multicultural Perspectives*. New York. London: The Guilford Press.

Kaplan, H.I. & Sadock, B.J. (1998). *Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry* (8th Edi). Philadelphia: Lippincott Williams & Wilkins, A Wolters Kluwer Company.

Kreisman, M.P & Joy, I. (1974). Mental illness and family functioning. In Hatfield, A.B. & Lefley, H.P. (1987). *Families of the Mentally Ill: Coping and Adaptation*. The Guilford Press.

Laosa, L.M. & Sigel, I.E. (1982). *Families as Learning Environments for Children*. New York. London: Plenum Press.

McGoldrick, M., Giordano, J. & Pearce, J.K. (1982). *Ethnicity and Family Therapy*. New York. London: The Guilford Press.

McAdoo, J. (1981). Black men and their role as fathers. In Boyd-Franklin, N. (1989), *Black Families in Therapy: A Multisystems Approach*. New York. London: The Guilford Press.

Miles, M.B. & Huberman, A.M. (1984). *Qualitative data analysis*. Beverly Hills, CA: Sage.

Minuchin, S. (1974). *Families and Family Therapy*. Cambridge: Harvard University Press.

Mouton, J. & Marais, H.C. (1990). *Basic Concepts in the Methodology of Social Sciences:* Human Science Research Council.

Neuman, L.W. (1997). *Social Research Methods: Qualitative and Quantitative Approach* (3rd Edi). Boston: Allyn & Bacon.

Orford, J. (1987). *Coping With Disorder in the Family.* London. Sydney: Croom Helm.

Pless, L.M & Roghman, P. (1984). *Adaptation.* In Thompson, R.J., Jr & Gustafson, K.E. (2002), *Adaptation to Chronic Childhood Illness.* New York. London: The Guilford Press.

Spencer, M.B.; Brookings, G.K. & Allen, W. (1986). *Beginnings: The Social and Affective Development of Black Children.* New York: The Guilford Press.

Stack, C. (1974). Reciprocity and the Extended Family Network. In Boyd-Franklin, N. (1989), *Black families in therapy: A Multisystems approach.* New York. London: Guilford Press.

Steinglass, J. (1984). Systems Theory and the Family. In Okun, B.F. & Rappaport, L.J. (1984), *Working with families: an introduction to family therapy.* North Scituate, Massachusetts: Duxbury Press.

Wachtel, E. (1995). *Treating Troubled Children and their Families.* New York. London: The Guilford Press.

Wen-Shing T., & Jing Hsu (1991). *Culture and Family: Problems and Therapy.* New York. London. Sydney: The Haworth Press.

White, S.G (1980). Kinship Patterns in Black Families. In Orford, J. (1987). *Coping With Disorder in the Family.* London. Sydney: Croom Helm

Wolman, B.B. & Stricker, G. (1983). *Handbook of Family and Marital Therapy.* New York. London: The Plenum Press.

APPENDIX A

DISCUSSION GUIDE

I am going to discuss how the family, as a functioning unit has been impacted by caring to a child diagnosed with a psychiatric illness (emotional and behavioural). First, we need to look at the brief history of the child's diagnosis.

- What (tell me about the child's diagnosis) is the child's diagnosis, and when was s/he diagnosed?
- When was the child's change in behaviour identified, and by whom (school or at home or school and home)
- Briefly describe the child's problematic behaviour, what does he do, how does he behave?
- Who was responsible for taking the child for evaluation at the hospital?
- Is the child receiving any medication, and if so who gives him/her the medication

FAMILY FUNCTIONING AND STRUCTURE

- How many people live in the house, and how are you related?
- Tell me their names and ages
- What position is the patient in the family
- Who is responsible for looking after the children?
- What is your typical day like?, what time do you wake up, what do you do from then until evening?
- Do you get any help/support, and if so from whom?
- Are you all (both) employed, and how do you handle your finances? who is in charge of the finances
- If you have conflict/disagreements about something, how do you handle it? what do you do, talk about it, ignore it, talk to someone outside the family about if, ect
- Do you have time for each other? ,if so how do you spend time together?
- What activities do you together? and as a family?

- Do you have any rules set that the family must follow?, in terms of chores, curfew time, time of doing home work, going to sleep ect
- When trouble or crises come, what do you do? do you help each other, or or resolve it on your own
- Do u discuss problems, feelings, concerns with other members of the family?

- How do you, as a family and individually cope with stress/demands put on you? what do you do when faced with difficulties/problems inside and outside home
- What other demands do you have individually, and as a family? For e.g. economic/stress, religious, societal, environmental demands?

PERCEPTIONS

- How do you understand/perceive the child's behaviour? and what do you think of it?
- What kinds of feelings come up for you? And what do you do? talk about how the child's behaviour is affecting you to other family members, ect

APPENDIX B: FAMILY ASSESSMENT DEVICE (FAD)

	Strongly Agree	Agree	Disagree	Strongly Disagree
Problem solving				
After our family try to resolve a problem, we usually discuss whether it worked or not				
We resolve most emotional upsets that come up				
We confront problems involving feelings				
We try of different ways to solve problems				
Communication				
When someone is upset the others know why				
You cant tell how a person is feeling from what they are saying				
People come right out and say things instead of hinting at them				
We are frank with each other				
We don't talk to each other when we are angry				
When we don't like what someone has done, we tell them				
Roles				
When you ask someone to do something, you have to check that they did it				
We make sure members meet their family responsibilities				
Family tasks don't get spread around enough				
We have trouble meeting our bills				
There's little time to explore personal interests				
We discuss who is to do household jobs				
If people are asked to do something, they need reminding				
We are generally dissatisfied with the duties assigned to us				
Affective Responsiveness				
We are reluctant to show our affection towards each other				
Some of us just don't respond emotionally				
We do not show our love for each other				
Tenderness takes second place to other things in our family				
We express tenderness				
We cry openly				

	Strongly Agree	Agree	Disagree	Strongly Disagree
Affective Involvement				
If someone is in trouble, the others become too involved				
You only get the interest of others when something is important to them				
We are too self-centered				
We get involved with each other only when something interests us				
We show interest in each other when we can get something out of it personally				
Our family show interest in each only when they can get something out of it				
Even though we mean well, we intrude too much into each other's lives				
Behaviour Control				
We don't know what to do when an emergency come up				
You can easily get away with breaking the rules				
We know what to do in an emergency				
We have no clear expectation about toilet habits				
We have rules about hitting people				
We don't hold to any rule or standards				
Anything goes in our family				
There are rules about dangerous situations				
General Functioning				
Planning family activities is difficult because we misunderstand each other				
In time for crisis we can turn to each other for support				
We cannot talk to each other about the sadness that we feel				
Individuals are accepted for what they are				
We avoid discussing our fears and concerns				
We can express feelings to each other				
There are lots of bad feelings in the family				
We feel accepted for what we are				
Making decisions is a problem for our family				
We are able to make decisions about how to solve problems				
We don't get along well together				
We confide in each other				

APPENDIX C

CONSENT FORM

My name is Itumeleng (Tumi) Mpolokeng and I am working at the Child and Family Unit, at a Psychiatric Hospital as an Intern Clinical Psychologist. As part of our Masters programme we are required to do research on any topic of our interest. My research topic is: psychological impact on caring for child with psychiatric illness (emotional and behavioural problems), on the functioning of the family.

My interest is on looking at the emotional experiences of those caring for the child, what difficulties have they experienced and how they have coped, as a family.

This letter is therefore written to ask permission to interview you as a participant in my study. All information gathered will be treated confidentially, and all participants are guaranteed anonymity (hide identity). Participation is voluntary, and you can at any given time withdraw from the study. This letter is also written to ask permission to disseminate the results at the end of the study.

Your co-oporation will be appreciated.