

The strengths of families in supporting mentally ill family members

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DECLARATION

I, Masego Cynthia Mokgothu, declare that the research concerning “The strengths of families in supporting mentally ill family members” is my own work that was never submitted for examination at any institution of higher learning and that all sources used or quoted have been acknowledged by complete references.

Signed on the _____ this day of _____ 2012, at North-West University,
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Regards,

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“I will lead the blind on roads they have never known, I will guide them on paths they have never travelled. Their road is dark and rough, but I will give light to keep them from stumbling. This is my solemn promise”.

Isaiah 42:16

I would like to thank my heavenly Father for being my fortress and guide when I needed His help.

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ABSTRACT

Since the introduction of the deinstitutionalisation policy in 1997 in South Africa, many families have agreed or have felt forced to take full responsibility of the care of their mentally ill family members. This impacted the lives of families because they were not well prepared for caring for their mentally ill family members. As a result of this, families were burdened, mentally ill family members defaulted treatment and ultimately revolving door admissions occurred. In spite of these concerns, some families do seem to cope with supporting their mentally ill family members. This makes it vital to explore and describe the strengths of families who take care of mentally ill family members in Potchefstroom, in the North West Province in order to formulate guidelines to support these families.

A qualitative, explorative, descriptive and contextual design was employed to understand what strengths families have to support their mentally ill family members. Purposive sampling was used to select potential participants. Unstructured individual interviews with an open-ended question were conducted with nine participants after ethical approval was granted under the RISE study (Strengthening the Resilience of Health Caregivers and Risk Groups), and the permission of the North-West Provincial Department of Health, the psychiatric hospital where the data was collected and the family members of the mentally ill family members were obtained. Data were audio-recorded and transcribed verbatim. A consensus meeting was held between the researcher and the co-coder after they had analysed data independently to identify themes that emerged from the data.

Twelve themes emerged from the data namely the strengths of getting the necessary treatment for the mentally ill family member, utilizing external resources, spirituality or faith, social support, supervising the mentally ill family member, finding ways to calm the mentally ill family member, explaining the importance of treatment to the mentally ill family member, finding ways to keep the mentally ill family member busy, trying to keep the mentally ill family member away from negative outside influences, trying creative ways to communicate with or understand the mentally ill family member, giving the mentally ill family member praise for doing something good or right and accepting the situation.

From the findings, it is clear that the families do have strengths to support their mentally ill family members, although they seem to rely more on external than on internal strengths. From the findings, literature and conclusions of this study, recommendations were made for nursing practice, nursing research and nursing education, including guidelines to support families in their support of a mentally ill family member.

[Key words: family, mentally ill family members, support, strengths, mental illness]

OPSOMMING

Sedert die implementering van die deinstitutionaliseringbeleid in 1997 in Suid-Afrika, het baie gesinne ingestem of geforseer gevoel om volle verantwoordelikheid te neem vir die versorging van geestesongestelde gesinslede. Dit het die lewens van hierdie gesinne sterk beïnvloed aangesien hulle nie goed voorbereid was daarop om 'n geestesongestelde gesinslid te versorg nie. As gevolg hiervan is gesinne oorlaai, geestesongestelde gesinslede het versuim om hulle behandeling te neem en uiteindelik het gereelde heropnames begin plaasvind. Ten spyte van hierdie kommerwekkende faktore, is daar gesinne wat wel daarin slag om 'n geestesongestelde gesinslid te ondersteun. Dit maak dit krities om ondersoek in te stel na die sterktes van gesinne in Potchefstroom in die Noordwes Provinsie wat suksesvol na 'n geestesongestelde gesinslid om sien en hulle goed ondersteun. Die studie het ten doel gehad om riglyne te formuleer om sodanige gesinne te ondersteun.

'n Kwalitatiewe, ondersoekende, beskrywende en kontekstuele ontwerp is gebruik om te verstaan watter sterktes gesinne het wat hulle in staats tel om geestesongestelde gesinslede te ondersteun. 'n Doelgerigte steekproefmetode is gebruik om potensiële deelnemers te identifiseer. Ongestruktureerde individuele onderhoude is gedoen met nege deelnemers aan die hand van 'n ope vraag nadat etiese goedkeuring verkry is binne die RISE studie (Strengthening the Resilience of Health Caregivers and Risk Groups (*Uitbouing van die Veerkrachtigheid van Gesondheidswerkers en Risikogroepe*), en toestemming verkry is van die Noordwes Provinsiale Departement van Gesondheid, die psigiatriese hospital waar die data ingesamel is en die gesinslede van die geestesongestelde pasiënte. Data is opgeneem en verbatim getranskribeer. 'n Konsensus vergadering is gehou tussen die navorser en die mede-kodeerder nadat al die data onafhanklik geanaliseer is om temas daaruit te identifiseer.

Twaalf temas het uit die data navore gekom wat die volgende as sterktes by gesinne identifiseer: verkryging van die nodige behandeling vir die geestesongestelde gesinslid, gebruik van eksterne hulpbronne, geestelikheid of geloof, sosiale ondersteuning, toesig oor die geestesongestelde gesinslid, die ontwikkeling van maniere om die geestesongestelde gesinslid te kalmeer, die verduideliking van die belangrikheid van behandeling aan die geestesongestelde gesinslid, ontwikkeling van maniere om die geestesongestelde gesinslid besigte hou, pogings om die geestesongestelde gesinslid weg te hou van negatiewe invloede van buite, ontwikkeling van maniere om te kommunikeer of om die geestesongestelde gesinslid te verstaan, uitdeel van mooi woorde wat die persoon prys as hulle iets goed of reg gedoen het, en aanvaarding van die situasie.

Hierdie bevindinge maak dit duidelik dat gesinne wel oor sterktes beskik om hulle geestesongestelde gesinslede te ondersteun, alhoewel hulle meer blyk te steun op interne sterktes. Aanbevelings is gemaak vir die verpleegpraktyk, verpleegnavorsing en verpleegopleiding gebaseer op die bevindinge, literatuur en gevolgtrekkings van die studie. Dit sluit riglyne in vir die ondersteuning van gesinne wat 'n geestesongestelde gesinslid moet ondersteun.

[Kernkonsepte: gesinne, geestesongestelde gesinslede, ondersteuning, sterktes, geestesongestelde persoon]

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CHAPTER 1: OVERVIEW OF RESEARCH

1.1 INTRODUCTION

In this chapter the background, the problem statement, research questions and objectives, paradigmatic perspective and research methodology will be discussed.

1.2 BACKGROUND

Only recently has our awareness started to grow so that we are able to comprehend the immense difficulties that families who take care of a mentally ill family member have (Hughes, 2005:1). These families are in desperate need of support and understanding, more so than in the past (Hughes, 2005:1). Lately, the tendency of caring for a mentally ill family member at home is common due to high costs of institutional care, poor institutional care and patients not suitable for admission due to their condition (Sreeja *et al.*, 2009:1).

The main goal of this deinstitutionalization is to enable people with mental health problems to integrate into society and lead normal lives (Hsiao & Van Riper, 2010:69). As a consequence of this unexpected shift, the families of mentally ill family members were given an unexpected a care-giving role for which they were untrained and unprepared for (Corsentino *et al.*, 2008:467). As a result of this, families and health care providers had to form a new partnership in care. Families and communities are currently recognized as the main health care resource and support in home care (Seloilwe, 2006:263).

From the above, it is clear that caring for an individual with mental illness in the community poses a heavy burden for caregivers (Zauszniewski *et al.*, 2009:413). Caring for a mentally ill family member takes time, is expensive and it is energy consuming (Jiji, 2007:43). De-Abreu Ramos-Cerqueira *et al.* (2008:1020) report that families of mentally ill family members usually have to face the duty of informal caring alone, without any training, orientation, support from health professionals, a situation that considerably enhances their objective and subjective burdens and may lead to psychological problems, such as depressive and anxiety symptoms and impairment in their quality of life.

Ndetei *et al.* (2009:293) also report that families of mentally ill family members experience both subjective and objective types of burdens. Subjective burden refers to the extent to which the caregiver perceives care responsibilities to be extremely demanding and stressful (Liu *et al.*, 2007:87). It includes guilt if the relative feels responsible for contributing to the illness, rejection of the mentally ill family member, anger that the illness has spoilt the relative's life, grief and sense of loss contrasting the present. Objective burden refers to outwardly measureable demands placed on family members, which include disruption of routines in careers, leisure time and households of families, financial difficulties, strain on interpersonal relationships, a reduction in social support and physical violence (Ndetei *et al.*, 2009:293). The person with the mental illness can dominate the

entire family through control and this can result in fear or helplessness and incapacity (Gravitz, 2001:72). Incapacity, separation, divorce, abandonment, financial difficulties, occupation restriction, frustration, anxiety, low self-esteem, reduction in leisure activities, negative effects on social relationships, experiences of discrimination and refusal and worry about the future are frequent family outcomes of mental illness (Marshall *et al.*, 2010:197-198).

Furthermore, family members typically experience six phases in the journey of living with someone with mental illness (Muhlbauer, 2003:1076), namely (1) development of awareness, which includes the initial recognition of a problem, feelings of concern and unsuccessful efforts to seek assistance, (2) crisis, which features a worsening of the problem beyond the family's ability to cope, an abrupt confrontation with the mental health care system, enormous emotional distress, difficulties communicating with health care providers and financial concerns, (3) cycle of instability and recurrent crisis, which presents with instability and recurrent crises, anger, grief, and loss, searching for explanations, treatment, and more knowledge, intensified financial concerns, some benefit from newer treatments, dissatisfaction with the health care system and feeling of stigma, (4) movements towards stability, which describes major changes in the family's thoughts, values and behaviours, including finding ways to regain control, managing guilt, helplessness, changing perceptions, dealing with ethical dilemmas related to control and developing symptom management techniques, (5) continuum of stability, which is a feeling of improved symptom management and decision making developed through the support of professionals, friends, relatives and support groups, and lastly, (6) growth and advocacy, which describes the family's awareness of their personal growth and concern for their relative.

However, Wynaden (2007:381) has identified four main reasons why families are committed to caring for their mentally ill family members. Families are obliged to care, they are owners of their difficulties, they must protect vulnerable members and they are self-reliant. They are a reliable resource in the sense that they provide food, support, and rehabilitation of a sick family member along with their own needs, care for physical needs, and financial support (Wynaden, 2007:383). They also monitor symptoms, help with medication management and intervene on the patient's behalf to get treatment (Rose *et al.*, 2002:517). These reasons cause families to continue to care for their mentally ill family members even when caring is costly and difficult.

Despite the challenges faced by these families, they seem to have resources, knowledge and skills to call upon in difficult times, such as traditions and rituals (Anuradha, 2004:385). They also share and derive strength from other embedded systems such as extended family and social systems (Njue *et al.*, 2007:49). Extended families might include the relatives, kin and other members connected to the family, while social systems include economic, educational and other resources available to families within a given culture (Njue *et al.*, 2007:49). Families also seem to have knowledge to define their situations and are able to link and offer potential and actual solutions to handle their difficult situation (Anuradha, 2004:383).

Even though these families have strengths and are acknowledged for taking care of their mentally ill family members, few are initially fully prepared emotionally, physically and financially to face this situation (O'Grady *et al.*, 2004:10). By recognizing and building on family strengths, families can be empowered. This, according to O'Connell (2006:42) can be done by helping families to define their situations, give meaning to their situations and by adopting a strength-based approach.

Such a family needs understanding of what they are experiencing so that adequate and appropriate support can be offered (Hughes, 2005:1). This, according to Anuradha (2004:389), can be accomplished by understanding family dynamics such as cohesion, flexibility and communication in the family as a system. Family cohesion is defined as the emotional bond that family members feel toward other family members. This is expressed through commitment and spending time together, especially during family events such as weddings, births, deaths and illnesses (Njue *et al.*, 2007:49).

Family flexibility is the ability to change and adapt to both normative family processes such as growth and development of members and aging of family members. It is also expressed by coping with non-normative events such as the illness or death of a family member that cause stress to the family. Family communication allows sharing of information and the feelings, both negative and positive, that family members have towards each other (Njue *et al.*, 2007:49). Through communication family members are able to express their mutual caring and interdependence (Njue *et al.*, 2007:49).

In conclusion, it is clear that the movement of mentally ill persons into the community without any training, orientation, or support systems from health professionals has created a problem for the families. Families use whatever information that comes their way to solve their problem. In this regard, it is important that the community, health professionals and the government join hands in caring for mentally ill people.

1.3 PROBLEM STATEMENT

From the above discussion it is clear that the lives of the families of mentally ill persons are severely affected by deinstitutionalisation and the implications this has for the family. Prior research findings on family care-giving of mentally ill family members have indicated that some of these family caregivers lack an understanding and the skills related to effective management of mental illness (Seloilwe, 2006:263). Families seem to lack professional support, resources and community support. They need education about mental illness, training in effective care giving and effective strategies, as well as the formation of self-help groups in the community (Jiji, 2007:43).

Families who do not cope present with physical problems such as headache, backache, arthritis, gastric ulcers and high blood pressure (Chang *et al.*, 2010:268). The burden of caring for a mentally ill family member also lead to social isolation because of fear of being stigmatised, shame, guilt, frustration, anger, grief, low self-esteem, depression, financial difficulty, their private life is affected and they rarely go out (Zauszniewski, 2009: 413). When they go out they continue talking about the

mentally ill family member, finding it difficult to focus on anything else (Gravitz, 2001:71). At times they wish that the problem could go away or wish that their mentally ill family member would disappear. Other families end up divorcing due to blaming one another for the behaviour of the mentally ill family member. On the other hand other children complain about being neglected because they are normal and not problematic (Jiji, 2007:50). Because of this family conflict, children's academic life becomes affected and they also become ashamed to bring their friends home because of the unpredictable home environment (Jiji, 2007:50).

Although most families experience challenges, some are still able to demonstrate individuality, purpose and strength of character (Wynaden, 2007:386). They share the characteristic of overcoming the hardship, not only to survive the day-to-day burden associated with caring for a mentally ill family member, but also to grow into stronger, more flexible and healthy family (Zauszniewski *et al.*, 2009:413). During the researcher's practice as a psychiatric nurse in Potchefstroom, it became evident that some of the families of mentally ill family members are able to cope with taking care of such a patient, while others are unable to cope. In cases where the families are unable to cope, the mentally ill family member tends to relapse due to defaulting treatment and this in turn leads to revolving door admissions (Du Plessis *et al.*, 2004:4).

Limited research is available that explores the strengths of families that cope with caring for mentally ill family members. The families of mentally ill family members live with and have to assume total responsibility for their ill relatives, and yet little is known about their strengths in these circumstances (Seloilwe, 2006:263).

In this research, the focus is to explore the strengths of families who take care of mentally ill family members in order to formulate guidelines to support these families. This research is a sub-study under the umbrella of the RISE study, which is a study on "Exploring the Strengthening of the Resilience of Health Care Givers and Risk Groups" (Koen & Du Plessis, 2011).

It is applicable to this study in the sense that families of mentally ill patients' health is at risk since taking care of the mentally ill is expensive, it is energy consuming and brings disruption of routine. At the same time, families might possess strengths or resilience to support their mentally ill family members. Little research has been conducted on "The strengths of families in supporting mentally ill family members". There is a subsequent need to explore and describe their strengths in order to formulate guidelines to strengthen their resilience and well-being.

1.4 RESEARCH QUESTIONS

In light of the above, the following research questions will be explored:

- What are the strengths of families in supporting mentally ill family members?
- How can families of mentally ill family members be supported to support their mentally ill family members?

1.5 RESEARCH OBJECTIVES

A research objective is a real, measurable end towards which effort or ambition is directed (Brink, 2006:79). In the context of this study the research objectives were as follows:

- To explore and describe the strengths of families in supporting mentally ill family members.
- To formulate guidelines to support families in supporting mentally ill family members.

1.6 PARADIGMATIC PERSPECTIVE

A paradigmatic perspective contains a basic set of beliefs and assumptions that guide an investigation (Klopper, 2008:67). Paradigmatic perspectives include meta-theoretical, theoretical and methodological assumptions and these are defined below.

1.6.1 Meta-theoretical assumptions

Meta-theoretical statements are axiomatic statements and are not meant to be tested (Klopper, 2008:67). The meta-theoretical assumptions are based on researcher's view, namely a holistic view on person, environment, health and nursing. These assumptions regarding the person, environment, health and nursing are described below.

1.6.1.1 Person

For the purpose of this study, a person is a physical-psychological-social entity with each component interacting with others. If there is something wrong with the physical body, it will influence the emotional and psychological well-being of a person. Similarly, if a person has an emotional problem, it will affect physical aspects such as sleeping, eating and social interaction. In this study, persons refer specifically to the family members and mentally ill family members. The family members and the mentally ill family members interact together as a whole in an external environment within which the mentally ill family member is supported.

1.6.1.2 Environment

Environment includes an external and internal environment. The external environment consists of physical, social and spiritual dimensions. The internal environment comprises physical, social, psychological and spiritual aspects. This research focuses on both the internal environment of the family who is supporting the mentally ill family

member, which will include the strengths, as well as the external environment, such as support systems and health care services which may also enable such a family to cope.

1.6.1.3 Health and illness

Health is seen as a state of general physical, psychological and social well-being, and not only the absence of disease. It is a state that involves whole person, based on normal functioning of the tissues, a practical understanding of the principles of healthy living and a harmonious adjustment to the environment. Wholeness is therefore maintained when an individual interacts positively with his/her environment and when health cannot be maintained, professional help is the solution. In this study, the emotions and social life of families is affected during the process of supporting mentally ill family members, so they need to be strengthened.

1.6.1.4 Nursing

Nursing is defined as the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through diagnosis and treatment of human responses, and advocacy in health for individuals, families, communities, and populations (Stoelting-Gettelfinger, 2009:88). In this study, nursing refers to providing support to families while focusing on their strengths to care for the mentally ill family members.

1.6.2 Theoretical assumptions

The theoretical assumptions include the reflections of the researcher's view of valid knowledge in existing theoretical or conceptual frameworks (Klopper, 2008:67). Theoretical perspectives are important because they direct attention and provide a framework for interpreting observations (Bowling, 2009:129). The theoretical assumptions include the central theoretical argument as well as conceptual definitions of core concepts applicable to this research.

1.6.2.1 Central theoretical argument

The exploration and description of the strengths of families who support mentally ill family members will lead to the formulation of guidelines to support the families of mentally ill persons in Potchefstroom in the North West Province.

1.6.2.2 Conceptual definitions

The following definitions are key to this research:

- **Family**

Family is a group of individuals who live together during important stages of their life-time and who are bound to each other by biological, social and psychological relationships (Avasthi, 2010:114). It is a societal agency that meets the social, educational, health, psychological and several other needs of its members (Anuradha, 2004:383).

Families in the process of maintaining themselves encounter many challenges, such as mental illness (Anuradha, 2004:383). The family is required to make more basic changes in the family system when confronted with a crisis situation such as changes in goals, rules, boundaries and pattern of functioning (Greeff *et al.*, 2006:286). In this study, nuclear families comprising of parents, children and spouses, as well as extended families will be included.

- **Mentally ill family member**

A mentally ill family member is a person who is diagnosed with mental illness and who receives care, treatment and rehabilitation services or who is using a mental health care service (Uys & Middleton, 2010:89) and who is supported by his/her family. In this study, mentally ill family members refer to the mentally ill persons who are supported by family members.

- **Strength**

Strength is the capacity for feeling, thinking and behaving in a way that allows for optimal functioning in the pursuit of valued outcomes (Snyder *et al.*, 2011:67). Potential strengths in families who experience mental illness are factors such as learning to overcome negative emotions, fears and attitudes, balancing many family needs and maintaining supportive relationships and family stability (Saunders, 2003:183).

Strengths help families to manage relapses and increase their ability to resolve future issues (Zeman & Buila, 2006:53). This can be done by emotional and spiritual support. Emotional support is the total number of statements that illustrate family caregiver demonstrations of reassurance, concern, and affection (for example, "I told her that I love her"). Spiritual or religious support measures the degree to which faith communities and local congregations provide help, support and comfort (Campbell *et al.*, 2010:7).

- **Mental illness**

Mental illness is an upstream determinant of many health outcomes which includes cardiovascular disease, diabetes mellitus, reproductive illness, substance misuse, tobacco use, unsafe sex, HIV infection, accidental injuries, and violent behaviour (Lund *et al.*, 2008:444). Mental illness includes conditions such as schizophrenia, bipolar mood disorder, major depression, personality disorders, post-traumatic stress disorder and anxiety disorders (Cook, 2000:196).

In the context of this study mental illness refers to a condition that interferes with the person's ability to function, to fulfill roles, the person's independence, ability to maintain employment, ability to complete or advance in education and the ability to initiate and maintain social contact (Cook, 2000:196).

- **Support**

Support refers to helping people to deal with difficult life situations (Feitsma, 2005:11) such as mental illness. Support can be divided into physical, social, spiritual and financial support. Social support is described as a nexus of interpersonal ties consisting of family, friends, or other people who provide some type of support that leads one to believe that he or she is cared for, loved, valued, and belongs to a network with mutual obligations.

Perceived social support refers to the individual's networks based on his/her subjective appraisal (Wen-Jiuan & Lundeen, 2006: 1380). Social support can be measured in terms of its size (e.g. number of distinct people identified), its function (e.g. type of support such as instrumental, informational or emotional), or by the quality of support (Pernice-Duca, 2010:13). According to Ramirez Gacia *et al.* (2006:624), instrumental support is the total number of statements that illustrate family caregiver task orientated assistance such as completion of errands, (for example "I helped him fill out an employment form"). While financial support means to give money to a person voluntarily in times of crises. Support increases a person's sense of belonging, intimacy, competency and self-worth, which can promote positive mental health (Lam *et al.*, 2007:21). In this study family members, community and health care workers support mentally ill family members.

1.6.3 Methodological assumptions

The methodological assumptions of this research are based on the Botes model (2009:8) of research. According to the Botes model, nursing takes place on three levels, namely nursing practice, research and the paradigmatic perspective. On the first level, which is nursing

practice, nurses identify problems in nursing practice and aims at improving nursing practice by doing research (Botes, 2009:8).

For the purpose of this research, the problem identified is that, little is known about the strengths of families who support mentally ill family members. On the second level, the researcher conducts research in accordance with the research process. Such a researcher is guided by the research problem identified on the first level (Botes, 2002:8). The third level is the paradigmatic perspective as described under Section 1.6 and its purpose is to determine research decisions (Botes, 2002:8).

1.7 RESEARCH METHODOLOGY

1.7.1 Research design

A qualitative, explorative, descriptive and contextual design was used to explore and describe the strengths of families who support mentally ill family members. The design is appropriate to this study as its purpose is to explore the depth, richness and complexity inherent in the phenomenon under study (Burns & Grove, 2009:51). In this study, families' strengths in supporting mentally ill family members were explored and described. The research was conducted in a psychiatric unit in Potchefstroom in the North-West Province.

1.7.2 Research method

The research method includes sampling, data collection, and data analysis.

1.7.2.1 Sampling

According to Brink (2006:124), sampling refers to the process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest. Sampling is divided into population, sampling method, and sample size as discussed below.

- **Population**

The population that was studied as part of this research project was the families of mentally ill patients in Potchefstroom in the North West Province.

- **Sampling method**

Purposive sampling was employed to select potential participants as the researcher intended to use specific participants who she believed would provide rich data in order to gain an understanding and discover new meaning (Burns & Grove, 2009:355), in this case the families who support mentally ill family members. The sampling method and selection criteria for inclusion of participants are discussed in detail in chapter 2.

- **Sample size**

As this was a qualitative study, the sample size was established when meaning became clear, and data were fully examined at the point of data saturation. Data saturation refers to the point at which the sampling provides information that repeats itself and no new themes come forth (Burns & Grove, 2009:357).

1.7.2.2 Data collection

Unstructured individual interviews with an initial open-ended question were conducted with one family member of each of the mentally ill family members who voluntarily took part in the study. These are interviews that are free-flowing in its structure, limited only by the focus of the research (Brink *et al.*, 2006:154). They are conducted more like a normal conversation, but with a purpose (Brink *et al.*, 2006:152). They are particularly appropriate for exploratory and qualitative research studies, where there is not enough knowledge about the topic to structure questions in advance of data collection (Brink *et al.*, 2006:152).

The interview question was: “What are your family’s strengths in supporting your mentally ill family member?” Interviews were conducted at a psychiatric unit, since it is a place that is convenient for the participants and that lends itself to privacy and confidentiality. Participants were asked to give permission for an audio-recorder. They were aware that the information they gave was recorded for the purpose of data analysis and that it will be kept confidential. The audio-recorder interviews were transcribed for the purpose of data analysis. Communication techniques such as clarifying, summarizing and reflection were used to facilitate the discussion.

1.7.2.3 Data analysis

Data captured on the audio-recorder were transcribed and translated from languages such as Setswana, Southern Sotho, Northern Sotho to English and analysed using codes and coding as well as reflective remarks (Burns & Grove, 2009:523). This was done by categorizing themes using symbols or abbreviations to classify words in the data (Burns & Grove, 2009:523). An independent co-coder analysed the data and a consensus meeting was held between the researcher and the co-coder.

1.8 ETHICAL CONSIDERATIONS AND TRUSTWORTHINESS

Ethical principles and guidelines for trustworthiness were followed in conducting the research as discussed in Brink *et al.* (2006:38). These aspects are discussed in detail in chapter 2.

1.9 LITERATURE CONTROL

To confirm the findings obtained in this research, the research results were compared with relevant literature and existing research findings as discussed in chapter 3.

1.10 CLOSING REMARKS

This chapter provided an elaborated discussion of the background, the problem statement, research questions and objectives, paradigmatic perspective, and brief reference to the research methodology. The next chapter will provide a detailed description of the research design and method.

1.11 CHAPTER OUTLINE

Chapter 2: Research methodology

Chapter 3: Discussion of research findings and literature control

Chapter 4: Conclusions, shortcomings and recommendations

CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

This chapter provides a detailed discussion of the methodology that was followed in this research including the research design, research method, ethical issues and trustworthiness.

2.2 RESEARCH DESIGN

An explorative, descriptive and contextual qualitative research design was used to explore and describe the strengths of families who support mentally ill family members. Qualitative research is more concerned with the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world (Merriam, 2009:13).

Qualitative researchers are interested in understanding how people interpret their experiences, how they construct their world and what meaning they attribute to their experiences (Ulin *et al.*, 2005:5). This design is appropriate in the sense that the researcher wanted to explore and describe the strengths of families who support mentally ill family members. This design is discussed in more detail below.

2.2.1 Explorative

An explorative study explores the dimensions of a phenomenon or develops or refines a hypothesis about relationships between phenomena (Polit & Beck, 2008). In this study, the phenomenon that was studied was “The strengths of families in supporting mentally ill family members”.

2.2.2 Descriptive

A descriptive study is a study that has as its main objective the accurate portrayal of the characteristics of persons, situations, or groups and/or frequency with which certain phenomenon occur (Polit & Beck, 2008). In this study, there was a need to describe the phenomenon of strengths of families in supporting mentally ill family members. A descriptive design was thus applicable.

2.2.3 Contextual

This research was conducted in a specific context, hence a contextual design. According to Holloway (2005:275) the research context is the cultural, temporal and physical/geographical setting in which the research takes place. In this study, the context was families of mentally ill persons admitted at a psychiatric unit in Potchefstroom in the North-West Province.

These families attended family conferences in the psychiatric unit, which are meetings held between a family, mentally ill family member and multi-professional team (a psychiatrist, a nurse, a social worker, a psychologist, occupational therapist, dietician, physiotherapist and speech therapist) with the intention of making the family aware of the condition of the mentally ill family member and how he/she should be cared for. Families attending conferences typically include parents, sisters, brothers, aunt and uncles of the mentally ill family member. Most families were not highly educated and attended school up to grade ten or twelve.

These families' mentally ill family members are mostly diagnosed with schizophrenia, psychosis due to substance abuse, psychosis due to general medical conditions such as epilepsy, HIV, temporal brain injury, dementia, uncontrolled diabetes, or cerebro-vascular incident, bipolar mood disorder and major depressive disorder.

Most of these mentally ill family members were re-admitted more than five times and in most cases families are involved in their treatment and rehabilitation. The population included in the research was Southern Sotho, Northern Sotho, Setswana and English speaking.

2.3 RESEARCH METHOD

A short discussion of the research method was given in chapter one. A detailed description of the population, sample, the method of data collection, data analysis and literature control follows.

2.3.1 Sampling

Sampling is divided into population, sampling method and sample size, as discussed below.

2.3.1.1 Population

The population studied in this research was family members of mentally ill patients admitted to a psychiatric hospital in Potchefstroom in the North-West Province.

2.3.1.2 Sampling method

Purposive sampling was employed to select potential participants. This means a researcher selects specific participants who would provide rich data in order to gain insight and discover new meaning (Burns & Grove, 2009:353), in this case the strengths of families in supporting a mentally ill family member. Selection criteria for inclusion of participants were formulated and were used to identify potential participants. These selection criteria were as follows:

- a) Participants should have been family members between the ages 18 and 49 from both genders. This age group was included as they were old enough to convey their opinion;
- b) Participants should have been family members of mentally ill patients;
- c) Participants should have been family members who cared for mentally ill persons;
- d) Participants should have been willing to participate and sign a consent form; and
- e) Participants should have been willing to give permission to be recorded during the interview.

Families were recruited via operational managers and at family conferences in a psychiatric unit of a psychiatric hospital rendering services to mentally ill persons.

2.3.1.3 Sample size

The sample size was established when meaning became clear and data was fully examined and when sampling provided information that was repeating itself and no new themes came forth, that is, when data saturation was reached (Burns & Grove, 2009:357). In this study, the researcher intended to collect data from at least ten families to answer the research questions.

2.3.2 Data collection

The discussion of data collection is divided into the role of the researcher, the physical environment and the method of data collection.

2.3.2.1 The role of the researcher

Before conducting the research, the researcher ensured that ethical approval was granted. This research was a sub-study of a larger study that had already been granted ethical approval, entitled “Exploring the Strengthening of Resilience of Health Caregivers and Risk groups (The RISE study)” (Koen & Du Plessis, 2011). The ethical clearance reference number is NWU-00036-11-S1 (see Appendix A).

Furthermore permission to conduct the research was obtained from the North-West Provincial Department of Health (see appendix C) and the management of the psychiatric hospital (see Appendix E). Upon receiving consent for conducting the research, the researcher approached operational managers to act as intermediaries (see Appendix F). After confirmation from operational managers, the researcher met families of mentally ill patients who were willing to participate and explained the purpose of the research project.

Families who were willing to participate were given consent forms to complete prior to collection of data. Participants were interviewed at a place convenient for them. As the researcher is also trained as an advanced psychiatric nurse, she was seen as a skilled interviewer and conducted the interviews herself.

2.3.2.2 Physical environment

Interviews were conducted at a place of the participants' choice to ensure comfort, privacy and confidentiality. Participants were interviewed at the premises of the hospital where it was quiet and where no disturbances occurred.

2.3.2.3 Method of data collection

The families of mentally ill family members' strengths were explored by using unstructured individual interviews with an initial open-ended question. These are interviews that are free-flowing, with its structure only limited by the focus of the research (Brink *et al.*, 2006:152). These interviews are conducted as purposeful conversations (Brink *et al.*, 2006:152). This is particularly appropriate for exploratory and qualitative research studies, where there is limited knowledge about the topic (Brink *et al.*, 2006:152). The interview question was: "What are your family's strengths in supporting your mentally ill family member?" The language used for interviewing participants was English, Southern Sotho, Northern Sotho, or Setswana, as preferred by the participants.

Participants were asked to give permission for an audio-recorder so that they could be aware that the information they gave was recorded for the purpose of data analysis. They were assured that data will be kept confidential. Interviews were audio-recorded and transcribed verbatim for the purpose of data analysis. The interviews were then translated into English. The following communication techniques were used during the interviews as described by Okun (2008: 76-78):

- a. *Probing*: "An open-ended attempt to obtain more information about something, which is most effective when using statements such as": "Tell me more about...," "Let us talk about that....,"
- b. *Clarifying*: "An attempt to focus on or understand the basic nature of a participant' statement". For example "I'm confused about...could you go over that again, please?" and "Sounds to me like you are saying..."
- c. *Summarizing*: "The interviewer synthesizes what has been communicated during the interview and highlights the major affective and cognitive themes".
- d. *Paraphrasing*: "This is a verbal statement that is interchangeable with the participant's statement and contains words that are similar to those of participant".

- e. *Interpreting*: “This occurs when the interviewer adds something to the participant’s statement or tries to help the participant to understand his/her underlying feelings, their relation to the verbal message and the relation of both to the current situation”.
- f. *Reflection*: “This refers to communicating to the participant your understanding of his/her concerns and perspective”. For example “You are feeling uncomfortable about seeing him” and “Sounds like you are really angry at your mother”.
- g. *Minimal verbal response*: “The verbal response of occasional head nodding that is usually accompanied by “yes” and “mm-mm” which indicates that the interviewer is listening and following what the participant is saying”.

2.3.3 Data analysis

Data analysis refers to the process of sifting the raw data to find patterns, themes, properties, relationships and to interpret the findings (Gorman & Clayton, 2005: 206). Data captured on the audio-recorder was transcribed and translated from languages such as Setswana, Southern Sotho, and Northern Sotho to English and analysed manually, using codes and coding, as well as reflective remarks (Burns & Grove, 2005:523). This was done by using Tesch’s eight steps of thematic content analysis (1990:142-145) which is found in Creswell (2009:186) and follows below.

- a. The researcher reads through all the transcripts carefully to get a sense of the whole.
- b. The researcher then selects the interview that was most interesting, or the shortest, goes through it and thinks about the underlying meaning.
- c. After the researcher has completed this task with several participants, a list of all the topics is made and similar topics are clustered together, formed into columns, arranged into major topics, unique topics and leftovers.
- d. The topics are then abbreviated as codes and the codes are written next to the appropriate segments of the text.
- e. The researcher checks for the most descriptive wording for the topics and converts them into categories, groups together topics that related to each other and lines are drawn between the categories to show interrelationship.
- f. The researcher then makes a final decision on the abbreviation for each category and arranges codes alphabetically.
- g. The data material belonging to each category is gathered in one place and a preliminary analysis is performed.
- h. The researcher re-codes the existing data he/she deems necessary.

The raw data as well as a work protocol (see Appendix H) were sent to an independent co-coder for analysis and afterwards a consensus meeting was held to identify themes that emerged from the data.

2.3.4 Literature control

To confirm the findings obtained in this research, the research results were compared with relevant literature and existing research findings (Brink, 2006:52). The library of the North-West University, different databases, journals, the World Wide Web and inter-library loan services were used. New information obtained from this research was highlighted as unique findings (see chapter 3).

2.4 TRUSTWORTHINESS

Trustworthiness refers to the credibility of the findings in qualitative research and the extent to which readers can trust the research and its findings (Holloway, 2005:296). To ensure trustworthiness of this study, the researcher applied Guba's (1981) model. The four aspects of trustworthiness include truth-value, applicability, consistency and neutrality and are discussed below.

2.4.1 Truth-value

Truth value asks whether the researcher has established confidence in the truth of the findings for the participants and the context in which the research was conducted (Krefting, 1991:215). In qualitative research, truth-value is obtained from the discovery of human experiences as lived and perceived by informants and this is called credibility (Krefting, 1991:215). This means that in this study the researcher explored the lived experiences of families and tested their findings by comparing it with research that had already been done. In order to ensure truth value, credibility must be established by implementing several strategies namely:

2.4.1.1 Prolonged engagement within the field

This means that credibility requires adequate submersion in the research setting to enable recurrent patterns to be identified and verified (Krefting, 1991:217). The researcher spent enough time with participants so that they felt comfortable to disclose information that they considered confidential. Communication techniques were used to ensure exploration.

2.4.1.2 Reflexivity

This refers to the researcher's critical self-awareness which means that the researcher questions and observes herself at the same time listening to the participants (Ulin *et al.*, 2005:23). Here the researcher partners with participants to explore themes and find answers, interpret what is heard, responds to and not only absorbs information, but also influences how it is elicited (Ulin *et al.*, 2005:23). This also means the

researcher continuously reflects on his or her own characteristics and examines how he or she influences data gathering (Krefting, 1991:218).

Reflexivity also includes describing and taking account of the unpredictability in the research, unexpected disclosure, and expression of deep feelings of participants and of their own emotions during the research (Holloway, 2005:279). The other approach is the researcher's thoughts, feelings, ideas and hypotheses that are generated by contact with participants. This allows the researcher to realize biases and preconceived assumptions and helps the researcher to change the manner in which he or she collects data or approaches analysis (Krefting, 1991:218).

2.4.2 Applicability

Applicability refers to the degree to which the findings can be applied to different contexts and settings or groups and also the ability to generalise from findings to larger populations (Krefting, 1991:216). In qualitative research, applicability is not relevant as it is conducted in a natural setting with few controlling variables and more importantly because its purpose is to describe a particular phenomenon or experience, not to generalise to others (Krefting, 1991:216).

2.4.3 Consistency

Consistency considers whether the findings will be consistent if the investigation was replicated with the same participants or in a similar context (Krefting, 1991:221). Qualitative research emphasises the uniqueness of human situations rather than identical repetition of results (Krefting, 1999:221). Variability is more important in qualitative research. In this study the researcher explored the different lived experiences of families supporting mentally ill family members, which lead to the formulation of guidelines to support mentally ill family members.

2.4.4 Neutrality

Neutrality entails freedom from bias during the research procedure and results in description (Krefting, 1999:222). It also refers to the degree to which the findings are a function only of the informants and conditions of the research and not of other influences, motivations and perspectives (Krefting, 1999:222). Audit strategy is a major technique to ensure confirmability. In this case a co-coder who is experienced in qualitative research was involved by availing raw data and audio-recordings to her and requesting her to independently analyse the data, after which a consensus meeting took place.

2.5 ETHICAL ASPECTS

For this research to be ethically grounded, the researcher must have ethical responsibility to recognize and protect the rights of human research participants (Burns & Grove, 2009:189). Ethical approval and permission to conduct the study was thus obtained as discussed under “the role of the researcher” (see 2.3.2.1). Moreover, the human rights that require protection in research are the right to self-determination, the right to privacy and confidentiality, the right to anonymity, the right to fair treatment and the right to discomfort and harm.

2.5.1 The right to self-determination

The right to self-determination is based on the ethical principle of respect for persons (Burns & Grove, 2009:189). This principle holds that because humans are capable of self-determination, they should be treated as autonomous agents. In this research, the participants were informed about the purpose of this research, the objectives and the expected benefits.

Participants were also informed about the right to choose to participate or not. In addition, they were informed about the right to withdraw from the study at any given time without being penalized. They were also informed about the consent form that had to be signed at the beginning to give consent for participation and for the use of audio- recorder during data collection.

2.5.2 The right to privacy and confidentiality

Privacy is the right an individual has to determine the time, extent and general circumstances under which personal information will be shared with or withheld from others (Burns & Grove, 2009:195). Participants were informed prior to participation that the information that they gave won't be discussed with people outside the research team and that an audio-recorder will be used during the interview. They were also told that no information will be gathered without their knowledge and when interviewed, there won't be any disturbance.

2.5.3 The right to anonymity

Complete anonymity exists when the participants' identity cannot be linked (Burns & Grove, 2009:196). For complete anonymity to exist, the participants were assured that codes will be used during the interview and that their identity won't be linked to the data collected.

2.5.4 The right to fair treatment

The right to fair treatment is based on the ethical principle of justice. This principle states that each person must be treated fairly and should be given what he/she is due or owed (Burns & Grove, 2009:198). The researcher arrived at the agreed time and place. No activities were

changed along the way without the consent of the participants. Participants were families of mentally ill family members and were selected fairly.

2.5.5 The right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of beneficence which holds that one should do good and above all, do no harm (Burns & Grove, 2009:198). Participants were protected from any harm and humiliation (Brink *et al.*, 2006:38). When there were participants who were emotional due to what they have gone through, the researcher conducted debriefing.

2.6 CLOSING REMARKS

This chapter provides an elaborated discussion of the research design and method, trustworthiness and ethical related aspects. The next chapter will provide a detailed discussion of the research findings and literature control.

CHAPTER 3: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

This chapter offers a discussion of the data collection and analysis as it is realized, as well as the discussion of research findings and literature control.

3.2 REALIZATION OF DATA COLLECTION AND ANALYSIS

The researcher wanted to conduct ten unstructured individual interviews with family members of mentally ill patients, but data saturation was reached after nine interviews were conducted. Although the initial planning was to conduct interviews with families, only one member per family was available during data collection. These participants participated on behalf of their families. Initially the researcher wanted to identify participants via operational managers of a psychiatric unit but the researcher was assisted by social workers who were responsible for arranging family conferences.

The interviews were mostly conducted in Setswana, Southern Sotho, Northern Sotho and English. An audio-recorder was used to record the interviews for the purpose of data analysis and the recordings were translated into English and transcribed verbatim. Data analysis was done manually by using Tesch's eight steps of thematic content analysis as discussed in chapter 2.

A consensus meeting was held between the researcher and a co-coder after they had both analyzed the data independently, by using thematic content analysis (see Appendix H for the work protocol). An example of an interview is provided in Appendix I and field notes are available in Appendix J. Themes that were identified during data analysis follow in Table 1.

Table 1: Themes identified as family strengths in supporting mentally ill family members through thematic content analysis

Theme (arranged according to frequency of occurrence)	Description	Number of reports (frequency of occurrence)
Getting the necessary treatment for the mentally ill family member	Hospitals, clinics, rehabilitation and counseling	9 reports/100% of participants
Utilizing external resources	South African Police Services, churches and traditional healers	8 reports/89% of participants
Spirituality/Faith	Family members invited friends, the mentally ill family member was invited to the prayer meeting	7 reports/78% of participants
Social support	Support from other family members, support from neighbours	7 reports/78% of participants
Supervising the mentally ill family member	Keeping the person safe, making sure he/she takes his/her medication, making sure he/she eats enough	5 reports/56% of participants
Finding ways to calm the mentally ill family member	Talking to him/her politely	4 reports/44% of participants
Explaining the importance of treatment to the mentally ill family member	The family members explained the need to attend hospital appointment, dangers of smoking dagga explained	3 reports/33% of participants
Finding ways to keep the mentally ill family member busy	Clean the house or prepare food	2 reports/22% of participants

Trying to protect the mentally ill family member away from negative outside influences	For example: “Pimps”, friends who use drugs	2 reports/22% of participants
Trying creative ways to communicate with or trying to understand the mentally ill family member	Talk to the mentally ill family member, simple ways to solve problems	2 reports/22% of participants
Giving the mentally ill family member praise for doing something good/right	Praising the mentally ill family member	1 reports/11% of participants
Accepting the situation	Trusting in God	1 reports/11% of participants

3.3 RESEARCH FINDINGS AND LITERATURE CONTROL

Themes that were identified as family’s strengths are discussed by describing the theme, providing quotes from interviews as evidence and discussing relevant literature.

3.3.1 Getting the necessary treatment for the mentally ill family member

All the participants emphasized the need for their mentally ill members to be treated for mental illness. One of the most prominent strengths of families of mentally ill patients is that they make sure that whenever they encounter any problem with the mentally ill family, some means should be derived to take them to the necessary treatment facility. Below are some of their statements from the transcripts:

- Interview 6: “Re ne ra tshwanela ke go mo isa bookelong”
(We had to take her to the hospital)
- Interview 8: “Ke ne ka fetsa ka go mo isa tlilining mme ba mo romela kwa bookelong”
(I then decided to take him to the clinic and they referred him to the hospital)
- Interview 4: “Re ne ra mo isa bookelong”
(We then took him to the hospital)
- Interview 2: “Ke ne ka fetsa ka go mo isa bookelong”
(So I decided to take him to the hospital)

According to Carroll (2008:46), family members and close relatives often assume the role of the caretaker for the mentally ill family members and take them to treatment, ensuring their compliance to the therapy and their general well-being.

Avasthi (2010:124) also found that families play a role in increasing treatment compliance in patients with mental illness by supervising and monitoring the drug intake, taking the patient to doctor's consulting rooms at regular intervals and getting serum levels of the psycho-tropics medication checked.

3.3.2 Utilizing external resources

Most of the participants reported using external resources as strengths to support their mentally ill family members. This included the South African Police Service, mostly to help them apprehend their aggressive and violent mentally ill family members who at times are too difficult for them to handle.

Another external resource used by families was traditional healers as some families hold the belief that the mentally ill family member's behaviour was related to supernatural causes. Other family members reported that the church was helpful to them as it kept their family member away from the streets because they were reading the Bible a lot and preached at the congregations' homes. Below are quotations from the transcripts that support these findings:

- Interview 8: "Ke ne ka leletsa sephodisa mogala"
(I phoned the police)
- Interview 9: "Ka nako dingwe re ne re leletsa sephodisa mogala mme ba mo ise bookelong"
(At times we would phone the police and they used to take him to the hospital)
- Interview 4: "Go na le nako e ke neng ka mo isa kwa ngakeng ya Setswana"
(I once took him to one traditional healer)
- Interview 5: "E ne e le leloko la kereke nngwe e bidiwa dipaki tsa Jehofa"
(He was a member of Jehova' witness church)

Taljaard (2012:374) confirms that people who are severely affected by mental illness are often not in the right state of mind to recognize how they are and how dangerous their behavior is, so a concerned family member can by all means ask the intervention of the South African Police Service.

Adding to this, Jonsson *et al.* (2009:37) also mention that according to the Mental Health Care Act of South Africa (No.17 of 2002), members of the South African Police Service must apprehend the mentally ill person when they have reason to believe either by personal observation or information obtained from the health care professional that the person is mentally ill and is likely to inflict harm to himself/herself and the others.

Rose *et al.* (2004:46) confirm that families resort to calling the police as a way of getting a relative into treatment to avoid responding too intensely to the mentally ill family member's aggression.

In addition, Nonye and Oseloka (2009:21) indicate that, as this case, there is still a strong belief in the magico-spiritual origins of human ailments, especially mental disorders. Disorders are attributed to supernatural causes, so often visiting a church is the family's first choice when they seek external support. Furthermore, Greeff *et al.* (2006:288) confirm that participation in social groups such as a church is effective in decreasing the family's burden and promotes emotional well-being because churches promote positive healthy behaviour and discourages negative behaviours.

Concerning the issue of seeking help from traditional healers, Sordahl *et al.* (2010:601) confirm that the families of the mentally ill family members do take their mentally ill family members to traditional healers and prefer to be referred to physicians only when the mentally ill person does not respond to traditional medicine. Adding to this Sethabouppha and Kane (2005:45) found that families of the mentally ill preferred taking care of their mentally ill at home because they believed that spirits, ghosts or supernatural powers caused their mental illness and so traditional therapy was found to be their first choice.

3.3.3 Spirituality/Faith

Most of the families emphasized their faith in God as internal strength to support their mentally ill family member. Some families practiced their faith/spirituality in the form of prayer. Families invited relatives to their homes to come and help them with their situation by praying with them. One family stated that inviting their mentally ill family member to prayer meetings to teach the person about God helped a lot as they believed it would ameliorate their future. These are some of their statements from the transcripts:

- Interview 8: "Ke ne ka rapela gore a re reetse fa ke bua le ene ka go tlogela tiriso ya dritibatsi"
(Prayed that I wish he could listen to us and quit smoking drugs)
- Interview 7: "We teach them about God"
- Interview 6: "Until such time their cousin explained the situation to the uncle who came with his prayer team and prayed for them"
- Interview 4: "...absolutely nothing I can do rather than praying for him because it helps a lot"

Rabinowitz *et al.* (2010:499) found that an increase in religiosity and spiritual support are associated with lower incidences of depression, as well as increased self-esteem and self-care. Moreover, Scharf (2007:73) indicates that a sensible religion promotes a positive worldview, helps to make sense of difficult situations, gives purpose and meaning, discourages

maladaptive coping such as use of drugs and negative activities, enhances social support, promotes other-directedness, helps to release the need for control, as well as provides and encourages forgiveness, thankfulness and hope. Spirituality, according to Lukoff (2007:644), increases a sense of being whole.

3.3.4 Social support

Some participants reported assistance by their neighbours, for instance one case where neighbours bring the mentally ill family member home because they realized that she wasn't well in her mind. Another participant said that the family was helped by an uncle who advised them to approach their situation in a different way in order to help their mentally ill family member.

One participant reported being helped by neighbours who accommodated their mentally ill person for the night when the patient reported that he is scared of his family members. Another participant reported being helped by her mom, who paid for the traditional healers bills. Below are some of their statements from the transcripts:

- Interview 6: "Re ne ra thuswa ke baagisanyi ba ba neng ba mo tlisa gae fa ba lemoga gore ga a itekanela mo thaloganyong"
(We were helped by people from the neighbourhood who used to bring her whenever they realized that she wasn't well in her mind)
- Interview 1: "but now my uncle is my mentor". "Uh he said to me, approach it like this"
- Interview 3: "Mme wa me o ne a nthusa ka madi gore ke kgone go mo isa kwa ngakeng ya Setswana"
(My mom helped me financially to take him to the traditional healer)
- Interview 4: "O ne a simolola go robala kwa moagisanying"
(He started sleeping at the neighbor's house)

According to Zabow (2008:61), distressed family members and close relatives are not always fully aware or able to make decisions in crisis situations (acute psychosis, suicide and homicidal behaviours) and so they need guidance and advice in these instances.

Zeman & Buila (2006:55) found that social support or personal networks that come in a form of family, friends or other informal relationships are resources for persons with mental illness. Lawska *et al.* (2006:191) also mention that motivational processes such as internally-focused cognition and mental processes such as setting goals, attributions, self-efficacy, outcome expectations, self-esteem, social comparisons, values and self-evaluations are the key factors determining human behaviour.

Motivational talks help families to better take care of their mentally ill family members. Motivational processes relieve tension by fulfilling the needs and restoring the balance while

mental processes enable the orientation in the surroundings. Contact with peers, according to Castelein *et al.* (2008:71), can play an important role in the prevention of social and emotional isolation.

3.3.5 Supervising the mentally ill family member

Participants stated that they were doing everything in their power to keep an eye on their mentally ill family member in order to make sure that the mentally ill family members are safe, have eaten and that they took their medication as prescribed. Below are some of their statements from the transcripts:

- Interview 8: “Re tla tlhokomela gore o nwa ditlhare tsa gagwe sentle ka go mo sala morago”
(We are going to make sure that he takes his medication properly by keeping an eye on him)
- Interview 2: “Iterele dijo...fela o di dira ke le teng”
(Prepare food for yourself...but he would do that under my supervision)

According to Dangdomyouth *et al.* (2008:43), some participants in that study stated that taking care of the mentally ill family member during the day time wasn't enough as they were required to stay in the same room, sometimes the same bed with the patient in order to observe for psychotic symptoms.

Adding to this, Quinn (2007:184) mentions that families stated that the need to supervise their mentally ill family members led them to withdraw from the community and relatives' celebrations because the behaviour of their mentally ill family member would embarrass them.

Again according to Rafiyah *et al.* (2011:160), families said they helped the mentally ill family members in performing daily living activities such as bathing, cooking, eating, dressing and taking medication. Dangdomyouth *et al.* (2008:47) mentions that one woman whose husband refused to take medication mixed it with his favorite food to make sure that he has taken his treatment.

3.3.6 Finding ways to calm the mentally ill family member

According to the statements below, families confirmed that talking to patients in an appropriate way helped a lot as they would become more violent and aggressive when they speak harshly with them. Others mentioned that calming them down when they were uncontrollable helped them to become manageable.

- Interview 4: “Re ne re bua le ene sentle”
(We were talking to him in a very appropriate way)

- Interview 8: “Ke ne ka leka go ritibatsa maikutlo a gagwe”
(I tried to calm him down)
- Interview 9: “Re ne re bua le ene ka boikokobetso”
(I would talk to him politely)

According to Dangdomyouth *et al.* (2008:46), other strategies employed by families to help mentally ill family members get better were to calm them down by using kind words and talking to them gently. Yap *et al.* (2012: 439) added that friends endorsed listening to problems of the mentally ill family member in an understanding way as a tactic to relieve their stress.

3.3.7 Explaining the importance of treatment to the mentally ill family member

The participants reported explaining the need for their mentally ill family member to go back to the hospital, as it was to the advantage of the whole family. Another family reported emphasizing the dangers of smoking drugs because they felt that the patient would become mentally ill again. Below are quotations from the transcripts that support these findings:

- Interview 3: “Re ne re bua le ene ka botlhokwa jwa go boela bookelong”
(We talked to him about the importance of going back to the hospital)
- Interview 8: “Ke ne ke leka go bua le ene ka kotsi ya go goga matekwane”
(I tried to talk to him about the dangers of smoking dagga)

According to Yap *et al.* (2012:433), friends endorsed seeking professional help and making a general practitioner appointment on behalf of a mentally ill family member.

3.3.8 Finding ways to keep the mentally ill family member busy

Families mentioned keeping their mentally ill family member busy by giving them something to do to keep their mind away from thinking about doing bad things. One family kept their mentally ill family member busy by asking him to clean the house. Below are some of their statements from the transcripts:

- Interview 7: “Re ne re dira gore a dire sengwe go mo dia”
(We looked into it that we give her something to do to keep her busy)
- Interview 2: “Ka nako dingwe ke mo raya ke re a phepafatse kakwa ga ntlo mme nna ke phepafatse felo gongwe “
(At times I would tell him to clean the other side of the house while I cleaned the other side)

According to Yap *et al.* (2012:440) friends endorsed increased physical activity as a way of keeping the mentally ill family member busy, as it also reflect their exposure to behavioural

motivation treatment. Rafiyah *et al.* (2011:160) confirms that relaxation, keeping busy or doing something was done as a routine activity with the mentally ill family members.

3.3.9 Trying to protect the mentally ill family member from negative outside influences

Participants mentioned that they protect the mentally ill family member from negative outside influences. They especially advised their mentally ill family member against befriending people who used drugs, as drugs had already affected his brain and school performance to such an extent that he left school to attend to his mental problem. The other family member discouraged the mentally ill family member from staying at the “pimp” as its owners use them to make money. See statements below:

- Interview 8: “Ditsala tsa gagwe le tsone di tlogetse sekolo ka ntlha ya diritibatsi. Re ne ra mo gakolola go se tlhole a tsalana le bone gape”
(His friend also left school because of drugs. I told him that I don’t want to see him with this friend of him any longer)
- Interview 7: “O ne a nagana gore oa ratiwa ntekwane o dirisiwa go bona madi)
(She thought somebody loves her only to find that somebody wants money from her)

Dangdomyouth *et al.* (2008:45) mentioned that families warned their mentally ill family members for using strong beverages and alcohol because it was affecting their emotional state and brought psychiatric symptoms.

3.3.10 Trying creative ways to communicate with or trying to understand the mentally ill family member

One participant reported an improvement in the mentally ill family member’s condition after talking to her about her condition. Another participant suggested that the mentally ill family member should use a compliment or complains book as a way of expressing her feeling as it seems as if it was difficult for her to talk about things that were troubling her. This would help the family in the sense that they would know the cause of her mental illness. See statements below:

- Interview 6: “Ever since we talked about it she is much better”
- Interview 1: “I said to her if you can’t speak to me about it, let’s find out what’s going on...compliments and complaints book...if you don’t feel comfortable in approaching me about it, ok, write it in the book...I’ll read it”

Tammentie *et al.* (2004:142) found that the positively worded statements of the dimensions such as clear and successful exchange of information between family members in order to clarify meaning and intention, describes the family’s health and

well-being and serve as resources in circumstances where a family has to adapt to new situations.

3.3.11 Giving the mentally ill family member praise for doing something good/right

One participant reported praising their mentally ill family member as a way of showing appreciation of the good things he did. This was done to show that he belonged to the family as his mother had passed on. See quotation of statements below:

- Interview 8: “I even praise him every time after bathing and he would feel happy”

There is no evidence of research concerning praising the mentally ill member for doing good things.

3.3.12 Accepting the situation

Only one participant reported accepting their mentally ill family members because of their religious belief as this helped a lot in being able to cope with the situation:

- Interview 6: “Ke amogetse maemo a me jaaka motho yo o pholositsweng”
(I have accepted the situation as a born-again Christian)

According to Lawska *et al.* (2006:191), mentally ill family member expects to be noticed, accepted, and sympathised with, and so a supportive and accepting environment is indispensable to optimize socio-professional therapy and rehabilitation of the ill. Huang *et al.* (2008:821) confirms that the families of mentally ill family members used positive thinking to solve their problem, which involved excluding the mentally ill from their lives in an attempt to keep their expectations grounded in normality, as well as focusing in knowledge acquisition on the illness and how best they can care for their mentally ill. Dangdomyouth *et al.* (2008:48) mentioned that families verbalized that they had to accept the role of the caregiver willingly because of compassionate, cultural and religious belief.

3.4 SUMMARY

The family members do everything in their power to help and protect the mentally ill family members. This was evidenced by making sure they get their treatment as prescribed, taking them to the necessary treatment facility, phoning the police in cases where the mentally ill family members were aggressive and violent, taking them to traditional healers, inviting relatives and friends to come and pray with them, supervising them, talking politely with them, discouraging

them to befriend bad friends or staying at the “pimps”, deriving some means to verbalize their complains, praising them for doing good things and accepting them the way they are. Families can thus be helped further by being advised on how to properly take care of mentally ill family members.

3.5 CLOSING REMARKS

In this chapter the discussion of data collection and analysis, as well as research findings and literature control concerning the strengths of families in supporting mentally ill family members was presented. In the next chapter conclusions, limitations and recommendations will be discussed.

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter presents the conclusions and the limitations of the study and offers some recommendations with reference to nursing research, nursing practice and nursing education.

4.2 CONCLUSIONS

The conclusions of this study are based on the research results, the confirmation from literature and the field notes.

4.2.1 The findings clearly show that families do have strengths to support their mentally ill family members. The most prominent strengths are more external in nature, namely the South African Police Services, traditional healers and churches. Although families rely more on external resources, they do utilize internal strengths as well, namely their faith/spirituality, prayer, praising the mentally ill, keeping the mentally ill busy and calming them down. These strengths help them to cope with caring for their mentally ill family member and to accept the person the way he or she is.

4.2.2 Families who cope with caring for a mentally ill family member are involved in several support activities. Firstly they recognize the mental illness and take the mentally ill family member to the hospital or clinic. Secondly they monitor compliance when it comes to medication and follow-up appointments. This is only possible when the families are sensitized with information on mental illness. If they are not, they may stigmatize the mentally ill family member or abuse the person.

4.2.3 The family's reaction towards their mentally ill family member is similar to Maslow's hierarchy of needs in the sense that it includes physiological needs (breathing, food, sex, sleep, homeostasis, excretion), need for safety and security (security of body, feeling secure with others, stability, financial security, morality, family, health and well-being, safety net

against accidents/illness and other impacts), need for love and a feeling for belonging (giving and receiving love, attainment of a place in a group with a feeling of belonging, sexual), esteem needs (self-esteem, confidence, achievement, respect for others, recognition and respect from others), need for self-actualization (achievement of one's potential, creativity, acceptance of facts).

It is similar in the sense that the family members try everything in their power to protect their mentally ill family member by making sure that they take them to the hospital/clinic when they realize that they are behaving strangely, they call the police when they are violent and aggressive or difficult, try to consult traditional healers, ask friends and relatives to come and pray with them, try to calm them down when aggressive by talking to them politely, try to keep them busy by giving them something to do so that they shouldn't roam around aimlessly, praise them when they have done something good to show them they love them and that they belong to the family, explain the importance of taking treatment and the dangers of smoking dagga, try creative ways to communicate with or understand them, supervise them by making sure that they have eaten and taken their medication, protect them from negative outside influences and that they accept them the way they to show that they love them.

- 4.2.4** Calming techniques can help families to be in control of their mentally ill family member since mentally ill person sometimes become more aggressive and violent when not addressed in a proper way. Praising the mentally ill family member when he or she does good or right things can improve the person's well-being because the person realizes that he or she is accepted and belong to the family. Lastly, when a mentally ill family member is kept busy all the time the person may stop roaming around the street and will not engage in substance abuse so easily.

4.3 LIMITATIONS OF THE STUDY

The major limitations to this study are as follows:

It was difficult for some participants to voluntarily take part in the study mainly because they were uncomfortable being audio-recorded during the interview, despite the fact that they agreed to participate after the researcher explained the interview procedure. They mentioned things like:

“Ask me one or two questions using an audio-recorder before we do an actual recording”

“Ask me a few questions first because my mother-in-law can be difficult sometimes”

The other limitation is that some participants were reluctant to participate. They were put at ease when the researcher mentioned the contact details of the supervisors and that the researcher also obtained permission to conduct research from the North West Provincial Department of Health, the

ethics committee of the institution where the researcher studied and the ethics committee of the psychiatric hospital. Thereafter they were more than willing to participate.

4.4 RECOMMENDATIONS FOR NURSING PRACTICE, NURSING RESEARCH AND NURSING EDUCATION

Based on the findings, literature and conclusions, recommendations for nursing practice, nursing research, and nursing education could be formulated as discussed below:

4.4.1 Recommendations for nursing practice

Based on the research findings, the recommendations for nursing practice include guidelines to support families in supporting mentally ill family members. The guidelines follow Maslow's framework, as the findings and conclusions illustrated similarities with this framework.

TABLE 2: Explanation for recommendations for nursing practice

Recommendations	Reference to supporting results	Reference to supporting conclusion
<p>1. Physiological needs: Psychiatric nurses should encourage families through educational programs to continue to maintain physiological needs to improve the quality of life of mentally ill family members.</p>	3.3.7	4.2.2, 4.2.3
<p>2. The need for safety and security: Psychiatric nurses should empower families in maintaining good health of a mentally ill family member by conducting psycho-education on the nature of the disease, treatment and management, side-effects of prescribed medication, signs and symptoms of relapse, coping skills and appropriate available community resources for dealing with a crisis situation.</p>	3.3.1, 3.3.2, 3.3.5, 3.3.7, 3.3.8, 3.3.9	4.2.4
<p>3. The need for love and a feeling for belonging: Psychiatric nurses should strengthen families by encouraging them to</p>	3.3.3, 3.3.4	4.2.2 & 4.2.4

<p>join support groups as this can help them to express their feelings, it can offer a role model for coping with problems, and families can help each other in a group. Listening to others can foster a sense of hope, enhance the emotional, physical, psychological well-being and talking to people with similar problems promote a sense of belonging.</p>		
<p>4. Esteem needs: Psychiatric nurses should empower families by strengthening their communication skills such as understanding and praise, conflict management skills such as a respectful attitude by means of psycho-education and case management.</p>	3.3.6, 3.3.10, 3.3.11	4.2.4
<p>5. Self-actualization: Psychiatric nurses should encourage prayer, faith, and acceptance by advising families to engage in prayer meetings and church activities as this will promote self-actualization and strengthen the family's ability to support their mentally ill family members.</p>	3.3.12	4.2.1

- **Additional recommendations**

In addition, psychiatric nurses should educate traditional healers about the basics of mental illness so that they can act as referral resources for mentally ill family members. Additionally, psychiatric nurses should educate police officers about the criteria used for involuntary hospitalization of a mentally ill family member to help families with aggressive and violent patients. Psychiatric nurses should also help families by means of training sessions that teach families about sharing task and household chores so that they should relieve one another in terms of caring for a mentally ill family member. Psychiatric nurses should reach out to families to meet their needs by providing them with training programs that will help them to generate income in order to help them improve their economic situation.

4.4.2 Recommendations for nursing research

Based on the research findings of the study it is clear that there is a need for further research on the strengths of families who support mentally ill family members. The research should focus on the following:

- Research should be done on effective health education for families on the diagnosis of the mentally ill family member, the cause of mental illness and its impact on the daily functioning of a mentally ill family member. The educational program should also include side effects of prescribed medication, signs and symptoms of relapse and coping mechanism.
- Research should also be done on investigating available support groups in the community
- Research should be done on effective health education on acceptable communication skills between members of the family
- Research should be done on effective health education on proper care of the mentally ill family member.

There is a need for research in training police officers, which should include the management of aggressive or violent mentally ill family members and becoming familiar with criteria used for involuntary hospitalization.

Research should also be done aiming at educating families and their mentally ill family members on how to utilize their internal strengths to equip them with positive healthy behaviour to support the mentally ill family member.

4.4.3 Recommendations for nursing education

There is a need for nursing education for psychiatric nurses and other health professionals who provide care as part of mental health care service to the ill and their family members. They need to know what strengths family members have to support their mentally ill family members in order to improve the quality of care and to prevent recurrent re-admission.

This mini-dissertation will be available at North-West University (Potchefstroom campus) for health professionals as well as students. This mini-dissertation will also be sent to the North-West Province's Department of Health to inform them on the strengths of families to support their mentally ill family member and on the recommendations for nursing practice, research and education.

4.5 CONCLUDING REMARKS

The objectives of this research were achieved, namely to explore and describe the strengths of families in supporting mentally ill family members and to formulate guidelines in supporting mentally ill family members. Recommendations regarding the study were made for nursing practice, nursing research and nursing education. Implementation of these recommendations may help in reducing recurrent admissions of mentally ill family members and help families to improve their care of mentally ill family members.

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ANNEXURE A



Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: <http://www.nwu.ac.za>

To whom it may concern

School of Nursing Science
Tel: 018 2991884
Fax: 018 2991827
Email: emmerentia.duplessis@nwu.ac.za

1 March 2012

Dear Sir/Madam

Confirmation of ethical clearance

Regarding the project: (The strengths of families in supporting mentally ill family members (Student: Ms MC Mokgothu; Supervisor: Prof MP Koen, Co-supervisor: Dr E du Plessis)

This research is a sub-study in an overarching research project, entitled: *Strengthening the research of health caregivers and risk groups (The RISE study)*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00036-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

Ms Mokgothu's research will focus on exploring and describing the strengths of families to cope with supporting mental health care users and to formulate guidelines to support families to cope with supporting mental health care users.

Background information: Strengthening the resilience of health caregivers and risk groups (The RISE study)

The co-investigators identified the problem that the resilience of health caregivers as well as risk groups should be strengthened by means of a comprehensive, multi-faceted approach and that research should be conducted on how resilience of health caregivers and risk groups can be strengthened by means of such an approach. The purpose of the research is thus to develop a comprehensive, multi-faceted approach to strengthen the resilience of health caregivers as well as risk groups.

To achieve these objectives, it is necessary to explore and describe various health caregivers and risk groups. Within this overarching research project, Ms Mokgothu intends to focus on families of psychiatric patients, who are viewed as risk groups in terms of their well-being, and, in line with the objectives of the overarching research project, there is a need to explore and describe their strengths, in order to formulate recommendations to strengthen their resilience and overall well-being. The results of this sub-study will contribute to reaching the objectives of the overarching project by adding information on the strengths of

families to cope with supporting their mentally ill family member. We therefore confirm that the sub-study of Ms Mokgothu is covered by the above-mentioned ethical clearance.

Yours sincerely

Prof MP Koen
Co-investigator

Dr E du Plessis
Co-investigator



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOMKAMPUS

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Faculty of Health Sciences
Tel: (018) 299 4237
Fax: (018) 299 2464
E-mail: Este.Vorster@nwu.ac.za

Mrs. Marietjie Halgryn

13 May 2011

Dear Marietjie

ETHICS APPLICATION: NWU-00036-11-S1 (M.P. KOEN & E. DU PLESSIS)

The applicants responded in a satisfactory way to the comments made by the panel members.

Ethical approval is recommended.

Yours sincerely

A handwritten signature in cursive script that reads "Este (H.H.) Vorster".

Prof. H.H. Vorster

ANNEXURE B

ROOM 347

WITRAND NURSES' HOME

POTCHEFSTROOM

CELL NO.: 0731820226

15 MARCH 2012

THE DIRECTOR OF RESEARCH, POLICY & PLANNING

DEPARTMENT OF HEALTH

PRIVATE BAG 2068

MMABATHO

2735

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT WITRAND HOSPITAL IN POTCHEFSTROOM
IN THE NORTH-WEST PROVINCE

I am presently registered for the M.Cur (Psychiatric Nursing Science) degree at North-West University (Potchefstroom campus) and one of the requirements of this course is that I should conduct a research project. So for that reason, I would like to ask your permission to conduct research with the following title: **The strengths of families in supporting mentally ill family members**. The objectives of this research are:

- To explore and describe the strengths of families in supporting mental health care users.
- To formulate guidelines to support families in supporting mental health care users.

The reason for doing this research is that limited research focus on exploring the strengths of families to cope with caring for mental health care users. The families of mental health care users live with and have to assume total responsibility for their ill relatives yet little is still known about the strengths to cope with caring for a mentally ill family member.

A qualitative approach will be followed as its purpose is to explore the depth, richness and the complexity inherent in the phenomenon under study. Anon-probability purposive voluntary sampling method will be employed to select potential participants from different families. The criteria for inclusion for participants in this study are as follows:

- Participants should be family members between the ages 18 and 49 from both sexes.
- Participants should be families of mental health care user.
- Participants should be family members who care for mental health care user.
- Participants should be willing to participate and sign a consent form.

Privacy and confidentiality will be ensured, meaning that the identity of participants and the collected data will be kept confidential at all times. Participants will also be interviewed at a place comfortable for them. Their names won't be revealed when the research is published. This research has ethical clearance from the North-West University (Potchefstroom campus) as part of a larger study "exploring the strengthening of resilience of health caregivers and risk groups (The RISE study)" (Koen & Du Plessis, 2011). The ethical clearance reference number is NWU-00036-11-S1 (see attached document).

Enclosed please find a copy of the research proposal which entails information concerning the study.

I hope my request will receive your most favourable consideration

Yours faithfully

Masego Cynthia Mokgothu (Researcher)

Prof. M.P. Koen (Supervisor)

Dr. E. du Plessis (Co-Supervisor)

ANNEXURE C



health

Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

2ND Floor Tirelo Building
Dr. Albert Luthuli Drive
Mafikeng, 2745
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MMABATHO, 2735

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POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

To : Ms M.C Mokgothu

From : Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval Letter: Exploring the Strengths of Families in Supporting Mental Health Care Users

Purpose

To inform your good selves that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter to the districts or health facilities as proof that the Department has granted approval of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher. The department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

03/05/2012

Date



Healthy Living for All

ANNEXURE D

ROOM 347

WITRAND NURSES' HOME

POTCHEFSTROOM

CELL NO.: 0731820226

20 JUNE 2012

THE HOSPITAL MANAGEMENT

WITRAND HOSPITAL

POTCHEFSTROOM

2531

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT WITRAND HOSPITAL IN POTCHEFSTROOM
IN THE NORTH-WEST PROVINCE

I am presently registered for the M.Cur (Psychiatric Nursing Science) degree at North-West University (Potchefstroom campus) and one of the requirements of this course is that I should conduct a research project. I have already obtained permission from the North-West Department of Health to conduct research (see attached document) with the following title: **The strengths of families in supporting mentally ill family members.**

The objectives of this research are:

- To explore and describe the strengths of families in supporting mental health care users.
- To formulate guidelines to support families in supporting mental health care users.

The reason for doing this research is that, limited research focus on exploring the strengths of families to cope mental health care users. The families of mental health care users live with and have to assume total responsibility for their ill relatives yet little is still known about the strengths to cope with caring for a mentally ill family member.

A qualitative approach will be followed as its purpose is to explore the depth, richness and the complexity inherent in the phenomenon under study. Anon-probability purposive voluntary sampling method will be employed to select potential participants from different families. The criteria for inclusion for participants in this study are as follows:

- Participants should be family members between the ages 18 and 49 from both sexes.
- Participants should be families of mental health care user.
- Participants should be family members who care for mental health care user.
- Participants should be willing to participate and sign a consent form.

I will ask the operational managers of a psychiatric unit to act as intermediary and identify potential participants (see attached document). Privacy and confidentiality will be ensured, meaning that the identity of participants and the collected data will be kept confidential at all times. Participants will also be interviewed at a place comfortable for them. Their names won't be revealed when the research is published.

This research has ethical clearance from the North-West University (Potchefstroom campus) as part of a larger study "exploring the strengthening of resilience of health caregivers and risk groups (The RISE study)" (Koen& Du Plessis, 2011). The ethical clearance reference number is NWU-00036-11-S1 (see Appendix A).

Enclosed please find a copy of the research proposal which entails information concerning the study.

I hope my request will receive your most favourable consideration.

Yours faithfully

Masego Cynthia Mokgothu (Researcher)

Prof. M.P. Koen (Supervisor)

Dr. E. du Plessis (Co-Supervisor)

ANNEXURE E



health
Department of
Health
North West Province
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OFFICE OF THE SENIOR MANAGER MEDICAL SERVICES: WITRAND HOSPITAL

WITRAND NURSES
24/07/2012
POTCHEFSTROOM
CELL NO: 0731820236
20 JUNE 2012

ATTENTION: MASEGO CYNTHIA MOKGOTHU

Me Mokgothu
Nurses Home Witrand Hospital

Tel: 0731820226

RESEARCH REQUEST: THE STRENGTHS OF FAMILIES IN SUPPORTING MENTAL HEALTH CARE USERS

1. The above-mentioned research request refers
2. As you already obtained approval from the North West Department of Health in Mahikeng you are hereby informed that your request has been approved.
3. As it involves working with families and the Department of Social work mainly address these issues you need to make contact with Mrs D Grey at the social work department
4. The local PSG will be informed of the approval already granted by the Department at its next sitting

Kind regards

DR T G K OOSTHUIZEN
SENIOR MANAGER: MEDICAL SERVICES: WITRAND HOSPITAL
CHAIRPERSON PSG WITRAND HOSPITAL

WITRAND HOSPITAAL
2012 -07- 2 4
POTCHEFSTROOM
WITRAND HOSPITAL

N.L. Mocwaledi-Senyane
Mrs N.L. Mocwaledi-Senyane
2012 -07- 2 4
Chief Executive Officer

Cc: Mrs Grey

D. Grey

ANNEXURE F

ROOM 347

WITRAND NURSES' HOME

POTCHEFSTROOM

CELL NO.: 0731820226

20 JUNE 2012

THE OPERATIONAL MANAGERS

WITRAND HOPITAL

POTCHEFSTROOM

2531

Dear Sir/Madam

REQUEST TO ACT AS INTERMEDIARY IN RESEARCH AT WITRAND HOSPITAL IN POTCHEFSTROOM IN THE NORTH-WEST PROVINCE

I am presently registered for the M.Cur (Psychiatric Nursing Science) degree at North-West University (Potchefstroom campus) and one of the requirements of this course is that I should conduct a research project. I have obtained permission from North-West Department of Health and Witrand hospital management to conduct research with the following title: **The strengths of families in supporting mentally ill family members**. The objectives of this research are:

- To explore and describe the strengths of families in supporting mental health care users.
- To formulate guidelines to support families in supporting mental health care users.

In order to achieve these objectives individual interviews with an initial open-ended question will be conducted with one family member of mental health care users who is willing to take part. These family members of mental health care user should be residing in Potchefstroom in the North-west Province.

The role of the intermediary is to:

- To identify potential participants
- To explain the purpose, benefits and importance of the research project to the potential participants
- To explain to participants that debriefing will be done in case there will be any discomfort experienced during the process of data collection
- To introduce the researcher to the potential participants.

The selection criteria are as follows:

- Participants must be family members between the ages 18 and 49 from both sexes as they are old enough to convey their opinion
- Participants must be family members of mental health care users
- Participants must be family members who care of a mental health care users
- Participants must be willing to participate and sign a consent form
- Participants must be comfortable to be audio-recorded during the interview

Interviews will be conducted in June and July 2012 with those who agree to participate and the interviews will last for one hour and will be done at a place of their own choice. Their names and research proceedings will be kept confidential.

You are more than welcome to contact me at the above-mentioned telephone numbers if you need any information regarding this research.

Thanking you in advance

Yours faithfully

Masego Cynthia Mokgothu (Researcher)

Prof. M.P. Koen (Supervisor)

Dr. E. du Plessis (Co-Supervisor)

ANNEXURE G

INFORMED CONSENT LETTER

TITLE: THE STRENGTHS OF FAMILIES IN SUPPORTING MENTAL HEALTH CARE USERS

RESEARCHER: MASEGO CYNTHIA MOKGOTHU

A. PURPOSE

I, Masego Cynthia Mokgothu, invite you to participate in a research study on “strengths of families in supporting mental health care users”. The purpose of this research is:

1. To explore and describe the strengths of families supporting mental health care users
2. To formulate guidelines to support families in supporting mental health care users

B. PROCEDURE

In case you agree, the following will happen:

1. You will meet me once for an audio-recorded interview that will last for about an hour.
2. The interview will be held at place of your choice.

C. ANONYMITY AND CONFIDENTIALITY

I will keep a confidential record of those who participated in the study as well as the interviews of the audio-recorder. Your names won't be on the audio-recorder and data won't be linked to your names. All the data will be kept at a safe place and no one except the researcher will have access to your interviews. Your names won't be exposed when the study is published or reported.

D. RISKS AND DISCOMFORT

There are no risks in sharing your information. In case there are questions that might affect your emotions please feel free to tell me so that you can be comforted in this regard.

E. BENEFITS

This study won't benefit you directly, but it will help in formulating guidelines to support families who take care of mental health care users as well as making it easier for mental health care service to give relevant information to families taking care of mental health care users.

F. VOLUNTARY CONSENT AND OPTION TO WITHDRAW

Your participation in this research project is voluntary and you are not obliged to participate. You have the right to withdraw from participating at any given time when you wish to do so without being penalized. You can do so even in the middle of the interviews.

G. PAYMENT

No participant will be rewarded for participating.

H. OFFER TO ANSWER QUESTIONS

If you have any questions concerning the study or participation in the study you are more than welcome to phone me (Masego Cynthia Mokgothu) at (cell phone number) or my supervisor Dr Emmerentia Du Plessis at (cell phone number).

I. COMMITTEE APPROVAL

This research study and its procedures have been approved by Ethics committee of North-West University (Potchefstroom campus) and the Department of Health in Mahikeng.

J. CONSENT

The above-mentioned aspects will be discussed with participants prior to participation to make sure that the participants understand the risks, benefits and obligations involved in participating in this research project.

Researcher.....Date.....

The above-mentioned aspects were discussed with me prior to participation and I understand the risks, benefits and obligations involved in participating in this research project. I understand that my participation is voluntary and that I may refuse or withdraw my consent and quit participating at any given time without being penalized.

I hereby consent to take part in this research project and that the interview will be audio-recorded.

Signature of participant.....Signature of witness.....Date.....

ANNEXURE H

REQUEST FOR PERMISSION TO ACT AS CO-CODER IN RESEARCH PROJECT

I am presently registered for the M.Cur (Psychiatric Nursing Science) degree at North West University (Potchefstroom campus) and one of the requirements of this course is that I should conduct a research project. I have obtained permission from North West Department of Health (see Appendix C) and Witrand hospital management (see Appendix E) to conduct research with the following title: **The strengths of families in supporting mentally ill family members.**

This research is also a sub-study as part of a larger study “Exploring the strengthening of resilience of health caregivers and risk groups “(The RISE study)” (Koen & Du Plessis, 2011) which was granted ethical approval. The ethical clearance reference number is NWU-00036-11-S1 (see Appendix A).

The objectives of this research are:

- To explore and describe the strengths of families supporting mentally ill family members.
- To formulate guidelines to support families in supporting mentally ill family members.

In order to achieve these objectives, I hereby request your assistance as a co-coder. Unstructured individual interviews with an initial open-ended question will be conducted with one family member of mentally ill patient who is willing to take part. The central question is as follows “What are your family’s strengths in supporting your mentally ill family members”. Included is my approved proposal as well as a work protocol for data analysis which was followed by using Tesch’s eight steps of thematic content analysis (1990: 142-145) which is found in Creswell (2009: 186) and follows below:

1. The researcher read carefully through all the transcripts to get a sense of the whole.
2. The researcher then selected one interview that was most interesting, or the shortest, went through it and thought about the underlying meaning.
3. After the researcher had completed this task with several participants, a list of all the topics was made and similar topics were clustered together, formed into columns, arranged into major topic, unique topic and leftovers.
4. The topics were then abbreviated as codes and the codes were written next to the appropriate segments of the text.
5. The researcher checked for the most descriptive wording for the topics and converted them into categories, group together topics that related to each other and lines were drawn between the categories to show interrelationship.

6. The researcher then made a final decision on the abbreviation for each category and arranged codes alphabetically.
7. The data material belonging to each category was gathered in one place and a preliminary analysis was performed.
8. The researcher re-coded the existing data she deemed necessary.

I hope my request will reach your most favourable consideration

Yours faithfully

Masego Cynthia Mokgothu (Researcher)

Prof. D. Koen (Supervisor)

Dr. E. Du Plessis (Co-supervisor)

ANNEXURE I

AN EXAMPLE OF AN INTERVIEW

The interviewer obtained informed consent and explained the focus of the research, namely exploring and describing the strengths of families in supporting their mentally ill family member to make sure that he/she understands what the interviewer wants to explore. The interview took place as follows:

Interviewer: Hallo

Interviewee: Hi

Interviewer: My name is Masego Cynthia Mokgothu

Interviewer: I'm doing eh..master in psychiatric nursing science

Interviewee : Yes

Interviewer: And at the moment I'm doing research on "The strengths of families in supporting mentally ill..mentally ill family members. So I just wanna know from you...firstly I just wanna know your ...just introduce yourself..

Interviewee: ok, my name is ...33years old..ja

Interviewer: ok..ok. I just wanna know from you..eh..when did your wife start becoming depressed

Interviewee: ok..if I can start from the beginning, she's always better ever since I met her. She was having something like "afwyking", like twitching like of the hand which I helped her to stop. But she does it every now and then when she gets nervous and the pulling of the thighs. Closing her eyes now and then. She used to sleep with her hand sucking her thumb. Eh..ja..It happened. It did not realized it that it was such a big problem...eh..because she did not really speak to me about it. Eh..ja.. She just ..I only realized it's a big problem when she started crying and she did not stop.

Interviewer: ok. I've just hear you saying that she started twitching the hand and she started crying, and by the time she started that, did you ask her what's troubling her?

Interviewee: I did..I did ask her and she didn't wanna speak with me. She didn't wanna tell me. She'll get depressed and you'll see that there's something wrong. I mean she's my wife. I..I feel that I know her better than anyone else. And you know it is vice versa.

And I know there's something wrong as soon as she starts twitching. Then I know and you'll ask her about it and she'll tell you that there's nothing wrong. But you can see..cause she'll get quiet. She'll get quiet and she's eh..temper short which I can notice when she works with my child..ja.

Interviewer: by the time she..by the time you ask her what's troubling her and she doesn't answer, what did you do to make it a point that you make her understand what's troubling her.

Interviewee: uhh.. At first I didn't realized it..which I did now after she got professional help. Eh that eh..I didn't know that she was suffering from depression. I thought that because I left my job and eh..basically before that we split up. We were trying for a second child for three years and nothing happened. And we actually started drifting apart..eh..she did her thing. And I did mine. I've got a hobby I rebuild my cycles I do it at home. She makes food and watch TV and doing her nails. Eh..ja. We started drifting apart and I went to the garage. We decided to split up and I sold everything and told her she can take whatever she wants eh...I sold everything and I moved to my dad. Then one week when I went to her to fetch James, and she came with because weren't upset with each other. And she told me that she thinks she's pregnant and I went and I bought a test and we decided that she isn't and I said to her we'll try again. Now I thought because of all of that I...you know the stress, financial stress and I thought its all because of that. Ok she started also crying everyday at work. She was very..how can I put it..very sensitive. Started crying about everything..then it did not make sense to me. Why does she cry about this. And now if I look back, it all makes sense. It not because of certain problem. She used that as an excuse. She's not suffering from depression.

Interviewer: so now that eh.. You realized that she kept on crying and all that. How did it come that she ends up being here?

Interviewee: ok let me tell you how I read that. Eh..I had some business to do because I had to start my own business. So I had to apply for money there some of my money to use. Ok! And I went and I picked her up for lunch. There was still lots of problems and I said to her put petrol in her car, don't chase to work, take James to work. Take it easy a lot of time.

Interviewer: Mmm

Interviewee: ok. And like I always I tell her put on a safety belt. And an hour after that one of a friend phoned her.....and I saidcause she's pregnant. She said ja they are shouldn't be upset. And then I said no I'm not upset. I'm not worried about the car so long as I arrive that's why. Then I phoned my dad. My dad came to pick her up and the car wasn't that bad than I thought it would be. Then when she came out she

started cryingthen I said to her don't worry I also banged one of our cars. It is not so bad. Luckily you areand I asked her why did she chased it to work. She said she stopped at one shop to buy herself nails cause I know its her hobby and I also get advantage of that because she ...so one day in the evening I asked her ok..eh..where's my cigarette? Did you take it. And she said why would she take it when she's doing her nails. And I said to her listen here, this doesn't make sense. Eh..she said to me she went to the shop.. mmm. After that she started crying. And I said to her I wanna speak to her I'm upset. Cause like my uncle spoke older brother...like my friend..he said to me my son, if you are upset don't try to solve anything because you making it worse.

Interviewer: Mmm

Interviewee: calm down and then speak to her. And then next day...ok.....the next day also and then I asked her tell me don't lie to me where were you.

Interviewer: Mmm

Interviewee: and automatically ja she doesn't she doesn't explain ...away and she went to see someone else..try and fix this. Because she lied to me. I was very disappointed. Actually heartbroken. And I said to her.. If we don't want speak to me just calm down and lets speak about this tomorrow.

Interviewer: Mmm

Interviewee: and me and my son left for my dad's house. And I went home to go fetch something else. I said to her ok listen here. We grown-ups. She was sitting in her room depressed. And I said to her listen, we grown-ups. Lets go visit my dad. Lets go and do our dirty washing in front of everyone. Lets speak about it tomorrow. OurI know my wife. She still b...about it. And I believe that I'd be kidnapped and make it a lot a little catch looking for me and she lied to me and disappears. And you start thinking what else did she lie to me about. Because I always believed her for everything I didn't even doubted that for one moment.

Interviewer: Mmm

Interviewee: and I did not say anything nasty to her. Which I felt she gonna argue with me because I'm upset. And I said to her we'll sit down tomorrow. Calm down and lets speak about this tomorrow. And she didn't want this. She just cried and cried. And I left for my dad and I started by bathing my son. I said at the lounge reading the news paper.....she said to me I want my phone. I want to phone. I want to phone my mother. I said to her..ja. I did nothing wrong.

Interviewer: Mmm

Interviewee: another thing is, when I speak to her. When I spoke to her, and another day I went to my dad's house as well when she approached me I said like very hard .and I said to her please I want to speak about this. I'm upset. I make it worse please ...the more I said to her leave me alone and the moment I said that she started screaming at me. Someone else was outside the room and they heard that she is screaming at me. They thought I was busy assaulting her.

Interviewer: Ja from what I have picked up from our conversation, I came to realized that the they are two strategies that you used whenever she's upset and crying. The first one was eh..whenever she's crying more especially when she'll be crying and sitting alone. You'll try to do good things for her like filling petrol in her car whenever you have money and try to do the good things. And try not to talk to her whenever you are angry. And try to take her out for a visit to your uncle

Interviewee: that was never my approach. I used to like when I'm angry say my sayings

Interviewer: Mmm

Interviewee: but now my uncle is my mentor. Uh he said to me, approach it like this.

Interviewer: Ja

Interviewee: and know what, she could handle it. That I'm so quiet she could handle it.

Interviewer: I also picked up now that except doing good things for her whenever she's upset and crying just to satisfy her so that you could realize what's troubling her. You'd do all those good things and then go out for a visit or maybe talk to your uncle about it. So I want know what else did you do to support her?

Interviewee: ok. Actually at first, cause like I said to you just now is time when she's upset and she cries and I'd tell her listen you not telling me everything. I'm not saying you lying to me but you not telling me everything. What do you know that I don't

Interviewer: Mmm

Interviewee: its upsetting me like this. I mean stuff that happened she would cry about it. And it doesn't make sense. And I know for the fact I know. I mean that's why I'm there for. I'm her partner. And so I' must know. Try and find out what the problem and into the root of the problem and I mean try now cause I know she did that for me. Ok and..uh..so I asked her what's going on. She could have told me. Then I think I ..made

my own assumptions maybe because we having a little bit of financial problems. I used to take home R32000 per month and now its gone. And I'll feel half guilty. Then maybe its because of the situation. Its my fault. Trouble at work. Maybe she wants to leave me. Maybe her mother doesn't like me so then I'll feel guilty. And I'll start helping her with the stuff. Ja just to make her feel better.

Interviewer: ok, I out of all this conversation like I've said I 've ...there are four things that I've picked up from our conversation, that whenever you see her crying you'll confront her in a very proper way and try to find out what's the problem, that's the things you do for her whenever she's isolating herself from you. Secondly you would do good things for her like putting petrol in her car so that she should realize that you love her, and then thirdly you would take her out for a visit to your uncle and you would ask for your uncle's advice, so thank you very much for allowing me to ask you about your family's strengths in supporting your mentally ill family member. And I still promise you that whatever we've talked about, no one will know about it.

Interviewee: yes

Interviewer: and like I said to you prior to our conversation, that I can give you my lecturer's cell numbers so as anytime when you want to find out something you are welcomed.

Interviewee: ok. What I also do to win her trust is when not comfortable speaking to me, I said to her listen...cause I couldn't figure out what..look if you look back before we had this financial problem, I said to her if you can't speak to me about it, lets find out what's going on, compliments and complains book. When you having a problem, there's the book in the kitchen, if you don't like something I do to you, you don't feel comfortable in approaching me about it, ok write it in the book before you go to work. I'll read it. I promise you I won't approach you about it. And then lets sit about it and sort it out. Then whatever solution we need about it we write it down. Then in the future, when we get a problem like that, to avoid conflict, lets go and take the book. Ok this is what the solution was and we did agree whatever. You wouldn't agree to disagree. And we must not go to sleep in bed cause what happens is that out of my experience, you go to sleep and you angry, next morning when we wake up, you not angry anymore. Then the issue is unresolved. You go to work you come back just to avoid conflict. Ok now it built up, after a couple of years you look back and you won't remember all the issues. Yes but its in your mind. And then its too late. There's no turn around. So you have to solve it and even if you agree to disagree. Ja it must be solved.

Interviewer: I also understood what you are saying. You said uhh.. you once suggested that whenever there's a problem, you have to sit down, write it down on the book or whenever she's not comfortable to do to talk to you in person, then she must write her problems in the book. That I've understood. Ehh..this afternoon when we met I've

heard you talking about prayer, can you tell me more about it?

Interviewee: My wife is not that religious. I was told by my Mom that if I don't pray I'm breaking God's heart. My wife actually she's spoilt. I did not tell her the other night that I was reading the bible with my son explaining to him. So I said to her when you go visit your grandmother, does she read the bible for you? Then she said I don't think she got a bible. I told myself that I will visit her family more like her grandmother brought her up. But I didn't see a bible there in the entire big house. I told myself that I'm gonna be punished cause I'm the leader. They do whatever I do. So I really trust God. I've got a book that teaches about the bible. All the questions that you want to know. Why does God allow suffering. It explains everything. The other time after reading it I couldn't stop talking about it with my friends. Everyone wanted it and I didn't wanna give away the book. I said to her one day lets go and sit down even if its ten minutes, and read even if its three pages. Discuss it and this can bring a positive thing to our son. He gonna take that when he grows. She agreed and the next evening I went to her and she was busy doing her nails on the lounge. And I said to her listen can we do this. She said wait a minute. By then she was still busy doing her nails. She said she is tired. Another thing I was part of the church counselor. My Mom encouraged me to go to church. and the congregation was very small. My mom once asked me to go with. While I was sitting in church, in "babalas". I wasn't "lus" for that. And one day we went again and I asked her to join my mom. As I was part of the church counselor...I was a contract manager in Anglo Gold. When I go to work I was so nervous. I was asking myself. 'M I gonna be able to do this. Then I spoke to God the whole day. When I spoke to him in the morning, when I arrive at my people, it had disappeared. After a month this were going good. As in good. God only gives what you can trust you. If my wife was sincere supported me then I don't think I would have stopped. That what partnerships are for.

Interviewer: I've heard you saying that ehh..you suggested that a bible you be read every night and discuss afterwards. And the following day she wasn't interested. She was only interested in her nails. And that discouraged you. I just wanna know from you how many times did you try to encourage her.

Interviewee: a lot. I speak about it a lot. A while back we also had a fight when I wanted to help my cousin with a contract. He gave us one of his houses. Its big and we also had a fight. She went to her mother. I said to her lets pray about this. And for the first time we prayed loud. I prayed that night and the next day she didn't wanna pray. She even didn't want to read the bible for my son. She doesn't know how God speaks to you. She says she doesn't know how it works. I told her that when you drift away, he's gonna bring obstacles along your way. I told her that its not an excuse. I ended up watching TV but was in one of the discipleship. When they came to visit me they said "you've got a "lekker" house. And I and she had a fight I thought about it a lot. And I

said to my God help me to appreciate my wife and everything we've got. One day when I was sleeping in my bed at my uncle's house, I missed my wife and I thought that's what I asked for. Even when my son was born I asked God to give me the guidance to bring him up in his shadow. So ja this is the strength...how can I say it...the knowledge about the brains to guide him towards him. And my son is dedicated to me.

Interviewer: I've heard your family's strengths for supporting her. Then I just wanna thank you once more for prioritizing your time to come and speak to me.

Interviewee: pleasure.

Interviewer: thank you.

ANNEXURE J

FIELD NOTES

INTERVIEW 1

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on the 31 July 2012 at 19h30 and the room was warm. The interview was conducted in the board room and a notice of “no disturbance” was put on the door to avoid being disturbed. The board room was just next to the main door where security services were and they were made aware of the interview so that silence could be maintained.

Descriptive notes

This 33 year old male was the husband of the mentally ill family member who was admitted with major depressive disorder and pre-partum psychosis. This means she became psychotic during pregnancy and she was still pregnant at the time of hospitalization. They are a family of three, including their son. The participant went to school up to standard eight and was unemployed at the time of the interview. This was his wife’s first admission at a psychiatric hospital.

Reflective notes

He volunteered to participate after I explained the purpose of the research to him. He was suspicious in the beginning, but after a few questions he was relaxed. He was open and willing to give information concerning his wife. His voice was loud. He maintained good eye contact and used his hands to explain whatever he was asked about. He used both English and Afrikaans and the researcher understood everything.

INTERVIEW 2

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 3 August 2012 at 12h30 and the room was warm. The interview was conducted in one of the doctor’s consulting rooms and a notice of “no disturbance” was put on the door to avoid being disturbed. The doctor’s consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 41 year old male was interviewed and he was the brother of the mentally ill family member who was admitted with psychosis secondary to temporal brain injury. At home they are a family of four, including the parents. He went to school up to grade twelve and he runs a tavern as a source of income. His parents are pensioners and never went to school. The mentally ill family member also didn't finish school. The mentally ill family member was admitted for the very first time at a psychiatric hospital.

Reflective notes

The participation to the interview was voluntary and he signed a consent form only after understanding the purpose of the research. He was suspicious in the beginning of the interview and wanted me to explain the purpose of the interview time and again. The tone of his voice was normal and he maintained good eye contact. His mood was normal when explaining his experience of taking care of his mentally ill family member. He used both English and Setswana and was well understood by the researcher.

INTERVIEW 3

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 3 August 2012 at 13h30 and the room was warm. The interview was conducted in one of the doctor's consulting rooms and a notice of "no disturbance" was put on the door to avoid being disturbed. The doctor's consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 55 year old female was interviewed and she was the mother of the mentally ill family member, who was admitted with cannabis induced psychosis. Her husband divorced her during her son's illness and now they are a family of three together with her daughter and son who is now mentally ill. She is a domestic worker and went to school up to grade three. Her daughter is still at secondary school doing grade 11. The mentally ill family member was admitted for the very first time at a psychiatric hospital but has been admitted to a general hospital several times.

Reflective notes

She volunteered to participate after I had explained the purpose of the research to her and she was willing to give information concerning her son. Her voice was loud and she was talkative. She maintained good eye contact but she ended up crying when explaining her experience of taking

care of her mentally ill son. She was a Southern Sotho speaking participant and was well understood by the researcher. The researcher conducted psychotherapy afterwards and the participant went home smiling.

INTERVIEW 4

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 3 August 2012 at 14h30 and the room was warm. The interview was conducted in one of the doctor's consulting rooms and a notice of "no disturbance" was put on the door to avoid being disturbed. The doctor's consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 41 year old male was interviewed and he was the brother of the mentally ill family member, who was admitted with psychosis secondary to temporal brain injury. At home they are a family of five, including the parents. His other two brothers are married and they are not staying with them. The parents are pensioners and not one of them went to school up to grade twelve. It was the very first time that their family member was admitted to a psychiatric hospital.

Reflective notes

The participant volunteered to participate after the researcher had explained the purpose of the research to him and he was more than willing to give information concerning his brother. His voice was soft. He spoke Southern Sotho during interview and he was relaxed. The researcher did comprehend everything he was saying.

INTERVIEW 5

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 4 August 2012 at 15h45 and the room was warm. The interview was conducted in one of the doctor's consulting rooms and a notice of "no disturbance" was put on the door to avoid being disturbed. The doctor's consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 65 year old female was interviewed and she was the mother of the mentally ill family member, who was admitted with cannabis induced psychosis. Both her husband and she are pensioners and the husband runs a taxi business. They are a family of four including another son who helps the father with taxi business. No one at home went to school up to grade 12. Their mentally ill family member was admitted to a psychiatric hospital more than five times.

Reflective notes

The participant volunteered after the researcher had explained the purpose of research to her. She was relaxed and talked with a soft voice. She was speaking Setswana during interview and the researcher understood her very well.

INTERVIEW 6

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 6 August 2012 at 10h30 and the room was warm. The interview was conducted in one of the doctor's consulting rooms and a notice of "no disturbance" was put on the door to avoid being disturbed. The doctor's consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 65 year old female was interviewed and she was the mother of the mentally ill family member, who was admitted with psychosis due to HIV. They are a family of four including another daughter who has mental illness due to HIV. Her husband and she are pensioners and the two daughters never finish secondary school. The other mentally ill family member has been admitted more than three times and the one who was admitted during the time of the interview was admitted for the very first time.

Reflective notes

The participant volunteered after the researcher had explained the purpose of the research to her. She was more relaxed from the onset and end up being emotional as time goes on due to what she has experienced with the two mentally ill family members. Psychotherapy was conducted and the family member went home being relieved. She spoke Southern Sotho and she was well understood by the researcher.

INTERVIEW 7

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 14 August 2012 at 10h30 and the room was warm. The interview was conducted in the board room and a notice of “no disturbance” was put on the door to avoid being disturbed. The board room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 55 year old male was interviewed and he was the guardian of the mentally ill family member, who was admitted with psychosis due to substance abuse. He is a pastor who also runs multiple businesses. He went to school up to grade 12 and tertiary institution. It was the first time that his mentally ill family member was admitted to a psychiatric hospital.

Reflective notes

The participant signed a consent form after the researcher has explained the purpose of the research. He was relaxed and more than willing to share his information with the researcher. He spoke English and Afrikaans and was well understood by the researcher.

INTERVIEW 8

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 17 August 2012 at 12h30 and the room was warm. The interview was conducted in one of the doctor’s consulting rooms and a notice of “no disturbance” was put on the door to avoid being disturbed. The doctor’s consulting room was just next to the main door where security services were and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 57 year old female was interviewed and she was the aunt of the mentally ill family member, who was admitted with psychosis due to substance abuse. She was unemployed at the time of the interview. The mother to the mentally ill family member passed on while he was very young. The aunt went to school up to grade 10. The mentally ill family member went to school up to grade 10 and left school due substance abuse. It was the mentally ill family member’s second admission to a psychiatric hospital.

Reflective notes

The participant volunteered to participate and signed the consent form after the researcher has explained the purpose of the research. She was relaxed and willing to share her story with the researcher. She spoke Xhosa and Setswana and was well understood by the researcher.

INTERVIEW 9

Demographic notes

This unstructured interview with a family member of a mentally ill patient was conducted at a psychiatric hospital in Potchefstroom in the North West Province. This interview was conducted on 25 August 2012 at 16h00 and the room was warm. The interview was conducted in one of the doctor's consulting rooms and a notice of "no disturbance" was put on the door to avoid being disturbed. The doctor's consulting room was just next to the main door where security services was and they were also made aware of the interview so that silence could be maintained.

Descriptive notes

A 50 year old female was interviewed and she was the mother of the mentally ill family member, who was admitted with bipolar mood disorder and dementia. She was employed and went to school up to grade 10. The mentally ill family member was admitted for the first time to a psychiatric hospital but many times to different general hospitals.

Reflective notes

The participant volunteered after the researcher had explained the purpose of the research. She was relaxed and she was more than willing to share her story with the researcher. She spoke Southern Sotho and was well understood by the researcher.