LIFE-STORIES OF CHRONIC MENTALLY ILL PEOPLE IN THE COMMUNITY

by

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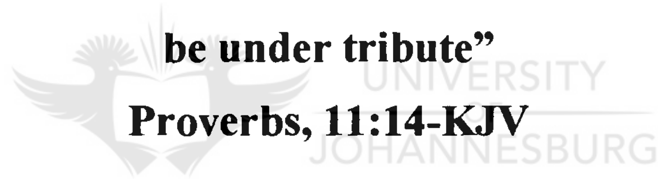
"The hand of the diligent shall bear rule: but the slothful shall be under tribute"

Proverbs, 11:14-KJV



Dedication

I dedicate this study to all nurses facing the new millennium. Special dedication goes to my family who has relentlessly supported me throughout.

To my husband, Sebofo who endured loneliness during my absence, my son Kabelo, who missed mum the most. For that I owe them my love and dedication.

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SUMMARY

In Botswana, the emphasis of mental health services is on the prevention of mental illness, the promotion of mental health, treatment and rehabilitation of the mentally ill.

However, guidelines for psychiatric nurse practitioners to follow when executing the above-mentioned services are non-existent, resulting in the difficulties in rendering the services.

The researcher has also observed that chronic mentally ill people in the community are dependent on their caretakers in meeting almost all their daily living activities. This results in frequent admissions to the psychiatric unit as the caretakers attempt to lessen the burden of having to take care of these people.

To explore this observation further, the researcher conducted a study on the life-stories of chronic mentally ill people in the community. The objectives of the study were to:

- Explore and describe the life-stories of chronic mentally ill people in the community.
- Describe guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

The researcher used the framework of the Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999), which has an approach that is Christian-based, strives towards excellence and views chronic mentally ill people holistically in an integrated bio-psychosocial manner (body, mind and spirit).

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A functional reasoning approach based on Botes' model (1994) was followed. A qualitative, explorative, descriptive and contextual research design was used to answer the research questions. In-depth, semi-structured phenomenological interviews were conducted with chronic mentally ill people who met the sample criteria.

To persuade my audience that the findings of this research are worth paying attention to, Guba's (Lincoln & Guba, 1985:290) model of trustworthiness was used.

Data analysis was done according to Tesch's (in Creswell, 1994:155) method. The results of this study show that chronic mentally ill people in the community who were identified as respondents in the study are depressed due to mental illness. Their depression was evidenced by hopelessness, social isolation, life-style changes and dependency syndromes. Based on these results, guidelines were developed for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

Conclusions were drawn and recommendations were made concerning psychiatric nursing practice, nursing education, research and the policy makers.

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TSHOBOKANYO

Mo Botswana, kgatelelo mo ditirong tsa boitekanelo jwa tlhaloganyo e mo go kganeleng bolwetsi jwa tlhaloganyo, go tokafatsa botsogo jwa tlhaloganyo, kalafi le go shafatsa balwetsi ba tlhaloganyo.

Le fa go ntse jalo, ditselana tseo baoki ba bolwetsi jwa tlhaloganyo ba ka di salang morago fa ba dira ditiro tse ke sa tswang go di bolela fa godimo, ga diyo, seo se bo se dira gore ba dire ka bothata.

Motlhotlhomisi gape o lemogile gore ba lwala tlhaloganyo ba lobaka lo lo leele ba ba okelwang mo motseng ba ikaegile segolo bogolo mo batlhokomeding ba bone go ba direla tse di tlhokafalang mo botshelong jwa letsatsi le letsatsi. Se, se tlhola go amogelwa kgapetsa-kgapetsa mo dikokelong tsa bolwetsi jwa tlhaloganyo, labaka e le gore batlhokomedi ba balwetsi ba leka go fokotsa mokgweleo wa go tlhokomela ba ba lwalang,

Go tlhotlhomisa temogo e ka botlalo, motlhotlhomisi o ne a tlhotlhomisa ka matshelo a ba ba lwalang bolwetsi jwa tlhaloganyo ka lobaka, mme ebile ba okelwa mo motseng.

Maikaelelo a tlhotlhomisa e, e ne e le go:

- Tlhotlhomisa le go tlhalosa matshelo a ba ba lwalang bolwetsi jwa tlhaloganyo ka lobaka, mme ebile ba okelwa mo motseng.
- Tlhalosa ditselana tse baoki ba bolwetsi jwa tlhaloganyo ba ka di salang morago go thusa balwetsi ba tlhaloganyo ba ma mo motseng go itsetsepela mo go itireleng tse ditlhokafalang mo botshelong jwa letsatsi le letsatsi.

Motlhotlhomisi o ne a ikaegile ka "Theory for Health Promotion in Nursing (Rand Afrikaans University, 1999)", e e leng gore motheo wa yone ke sekeresete, e kgaratlhela botswerere, mme ebile e leba molwetsi wa tlhaloganyo ka ntlha tsotlhe, e sobokantse mmele, tlhaloganyo le mowa wa gagwe.

Tlhotlhomiso e ne e setse morago sekai sa ga motlhatlhelela-dithuto tse di kgolwane Botes (1994). Mo tlhotlhomisang e, go dirisitswe mofuta wa tlhotlhomisa o o dirisang mafoko (qualitataive), go tlhaloswa ka botlalo, mme ebile go lebilwe lefelo le le losi go araba dipotso tsa tlhotlhomiso. Dipotsolotso tse di kwa teng di ne tsa dirisiwa go botsa ka ga matshelo a balwetsi ba tlhaloganyo mo go ba ba neng ba na le bokgoni jwa go tsenelela ditlhotlhomiso tseo. Dipotso tsa potsolotso eo di ne di sa kwalwa, kgotsa go rulaganngwa gotlhelele (semi-structured).

Go rotloetsa babadi go ela tlhoko maduo a tlhotlhomiso e, sekai sa ga Guba (Lincoln & Guba, 1995:290) sa go dira ka boammaaruri mo ditlhotlhomisong se ne sa salwa marago.

Thanolo ya dipotsolotso e ne ya dirwa go ikaegilwe ka mofuta wa ga Tesch (in Creswell, 1994:155).

Maduo a tlhotlhomiso e a supa gore ba lwala tlhaloganyo ba ba okelwang mo motseng, mme ebile ba nnile le seabe sa go tsenelela dipotsolotso tsa tlhotlhomiso, ba hutsafetse thata-thata ka ntata ya bolwetsi jwa tlhaloganyo. Khutsafalo e kgolo ya bone e supiwa ke boitlhobogo, go ikgapha mo bathong, go fetoga ga matshelo a bone le boitseme mo go itireleng.

Go ikaegilwe ka maduo a, ditselana tse baoki ba bolwetsi jwa tlhaloganyo ba ka di salang morago go thusa le go tshegetsa balwetsi ba tlhaloganyo mo motseng go nna bo mankge mo go tsamaiseng matshelo a bone di ne tsa tlhamiwa.

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Ditshwetso di ne tsa dirwa, le dikgakololo tsa kwalwa di lebitsitswe go baoki ba bolwetsi jwa tlhaloganyo, dithuto tsa booki, batlhotlhomisi le badira-melao

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CHAPTER 1

1. OVERVIEW OF THE STUDY

1.1 ORIENTATION AND RATIONALE

Botswana is a landlocked country with an area of about 582 000 square kilometers (National Development Plan 8, 1997:14). The country shares borders with the Republic of South Africa in the south, Zimbabwe in the east, Zambia in the north and Namibia in the west. The population is currently estimated at 1,3 million (Mental Health Programme, Action Plan, 1992-1997:1). About seventy percent of the population lives in rural areas.

When Botswana gained independence in 1966, it inherited a health service that was urban-based with no consideration of the rural areas where the majority people live. Before the opening of Lobatse Mental Hospital in 1938, mental health services did not exist. The mentally ill were the responsibility of their own families and were treated by the traditional healers in the villages. The violent ones were however, put into prison and some were transferred to Igutsheni Mental Hospital in the then Southern Rhodesia or to St. Helena Hospital in South Africa (Mental Health Programme, Action Plan, 1992-1997:7).

In Botswana, like most countries, government is the chief provider of health services, with the mines, churches and private sector contributing significantly. Mental Health Services therefore fall under the Department of Hospital services in the Ministry of Health. There are two regional centers: Lobatse Mental Hospital serves as the regional centre for the south, while Jubilee Hospital Psychiatric Unit serves similar functions in the north. Below the regional centers are mental health units attached to general hospitals.

Community psychiatric nurse practitioners heading the mental health units provide consultative services and professional guidance to general nurses and family welfare educators in their catchment areas.

The Mental Health Policy is to make the services accessible and acceptable to the people through active participation of the community, in meeting their needs (Mental Health Programme, Action Plan, 1992-1997:10).

In this regard, it seems logical to involve chronic mentally ill people living in the community, in the definition of their needs through narrating their life-stories. With such understanding of what they regard as their core-life-stories, suitable guidelines can be developed for the psychiatric nurse practitioner to support them to master these daily living activities.

Of particular importance is that chronic mentally ill people in the community assume responsibility in carrying out their daily living activities, in rehabilitation services, and cease to be passive recipients of services, hence the importance to explore and describe guidelines for the psychiatric nurse practitioners to support them to master their daily living activities.

For chronic mentally ill people in the community to achieve self-determined levels of functioning and a satisfying quality of life, they must be supported. This implies creating opportunities for success in reaching goals that build individuals' confidence, and enhance self-esteem by considering the physical, psychological, social and spiritual aspects of such individuals.

1.2 SIGNIFICANCE OF THE STUDY

The exploration and description of life-stories of chronic mentally ill people in the community is essential, if relevant guidelines for psychiatric nurse practitioners to support them to master their daily living activities, are to be developed.

The study is also worth undertaking, since the results will serve as reference in nursing practice, education and research. Results can also be utilized by policy makers through following recommendations when planning and managing community mental health services.

1.3 PROBLEM STATEMENT

The year 1980 marked an important landmark in the development of mental health services in Botswana, for it was in that year when community mental health services were launched, with the view of bringing the services to the people. This was done through decentralization and integration of mental health care into the general health care delivery system as a component of primary health care (Mental Health Programme, Action Plan, 1992-1997).

The emphasis of the services is on prevention of mental-illness, promotion of mental health, treatment and rehabilitation of the mentally ill. However, specific guidelines for psychiatric nurse practitioners to follow when executing the above-mentioned services, are non-existent. The researcher has also observed that chronic mentally ill people in the community are dependent on their caretakers in meeting almost all their daily living activities. This results in frequent admissions to the psychiatric unit as the caretakers attempt to lessen the burden of having to take care of these people.

The researcher is concerned about the plight of chronic mentally ill people in the community, who are in and out of the hospital in a typically repetitive fashion. Chronic mentally ill people in the community need to be supported, so as to manage their daily living activities.

The extended family system is gradually being eroded. The negative attitude attached to mental illness tends to lead to stigmatization of those mentally affected, resulting in problems in the after-care of discharged individuals.

The researcher has observed the need to identify support of chronic mentally ill people in the community as an integral part of their daily lives and to describe guidelines to be used by psychiatric nurse practitioners in this regard. This requires exploration, gaining insight and meaning; and understanding their life-stories. Focus is on the individual's narratives.

The high dependency rate of chronic mentally ill people in the community attest to the need for suitable guidelines for psychiatric nurse practitioners to support them in mastering their daily living activities. In order to plan and implement effective community-based rehabilitation services, an understanding of these peoples' life-stories must be gained. The emphasis of this research is therefore on wholeness, focusing on the people's physical, psychosocial, cultural, spiritual and symbolic milieu.

This research is conducted to explore and describe life-stories of chronic mentally ill people in the community, who have experienced at least two years of illness. The researcher asks the following questions:

- What are the life-stories of chronic mentally ill people in the community?
- What guidelines can be utilized by psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities?

1.4 RESEARCH OBJECTIVES

From the research questions two objectives were formulated:

- To explore and describe the life-stories of chronic mentally ill people in the community.
- To describe guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

1.5 CENTRAL STATEMENT

The exploration and description of life-stories of chronic mentally ill people in the community will provide a basis for describing guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

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1.6 PARADIGMATIC PERSPECTIVE

This includes meta-theoretical, theoretical and methodological assumptions. The researcher will adopt and incorporate The Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999) as a paradigmatic perspective for this research. Its approach is Christian-based and strives towards excellence.

The researcher acknowledges unconditional acceptance of people and respect for human rights.

1.6.1 Meta-theoretical assumptions

These include person, mental health, community psychiatric nursing and environment.

- Person

  Refers to chronic mentally ill people in the community. The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated interactive manner with the environment.

- Community psychiatric nursing

  It is an interactive process where the community psychiatric nurse practitioner as a sensitive therapeutic professional, facilitates the support of chronic mentally ill people in the community through mobilization of resources.

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- Support

  Refers to nursing actions aimed at the facilitation of chronic mentally ill people in the community's mobilization of resources to master their daily living activities.

- Interaction

  It is mutual purposeful involvement between the psychiatric nurse practitioner and chronic mentally ill people in the community. In this regard, purposeful implicates scientific, continuous assessment, diagnosis, planning, implementation and evaluation in order to promote health.

- Facilitation

  It is a dynamic interactive process for the promotion of community mental health through the creation of a positive environment, mobilization of resources, as well as the identification and bridging of obstacles in the promotion of community mental health.

- Resources

  Resources in the chronic mentally ill person's environment include any assets or means of facilitation in the promotion of community mental health.

- Environment

  This includes an internal and external environment. The internal environment consists of bodily, mind and spiritual dimensions. The external environment consists of physical, social and spiritual dimensions in the community that serves as the immediate environment to chronic mentally ill people.

- Community mental health

  It is a dynamic interactive process in the chronic mentally ill person's environment. These interactions in the person's environment reflect the relative health status of chronic mentally ill persons in the community. This interaction contributes or interferes with the promotion of mental health.

1.6.2 Theoretical assumptions

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

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1.6.2.1 Nursing theory

The nursing theory for this research is Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999). Due to the qualitative nature of this research, the theory will be suspended during data collection and will be used after data analysis have been completed.

1.6.2.2 Theoretical assumptions

The chronic mentally ill person in the community is seen holistically in interaction with the environment in an integrated manner. Life-stories of chronic mentally ill people in the community should be used as a base to describe guidelines for psychiatric nurse practitioners to support them to master their daily living activities.

1.6.2.3 Definitions

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These are major concepts to be used in the study:

- Nursing process

  The process of the theory is the nursing process. The central focus falls on the promotion of mental health. This process includes assessment diagnosis, planning, implementation and evaluation. The steps of the nursing process requires knowledge, skills and values to facilitate the promotion of health by the community psychiatric nurse practitioner.

- Chronic mentally ill person

  This refers to a person who has experienced at least two years of mental illness. The whole person embodies dimensions of body, mind and spirit. The person functions in an integrated, interactive manner with the environment.

- Community mental health/psychiatric nursing

  Psychiatric nursing is an interactive process where the psychiatric nurse practitioner as a sensitive therapeutic professional, facilitates the promotion of community mental health through mobilization of resources.

- Life-story

  A descriptive narrative of how chronic mentally ill people make sense of their lives, experiences and structure of the environment.

- Community

  A population in the identified village bounded by common interests and who live in similar ways.

- Daily living activities

  This refers to the skills necessary to live independently as an adult. Included in these are self-care, learning, mobility, self-direction, receptive- and expressive language, capacity for independent living and self-sufficiency (Stuart & Sundeen, 1983:870-871).

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1.6.3 Methodological assumptions

Due to the exploratory and descriptive nature of this research, the qualitative method in which the lived experience of the phenomena is studied by the researcher from the perception of the persons experience (Talbot, 1995:421), an assumption is made that people can talk about their experiences and the meaning of those experiences in their lives.

The central methodological assumption is based on the functional reasoning approach of Botes (1994:18), which implies the application of knowledge in practice. This study must therefore address current mental health problems experienced in the community. The usefulness of research is a criteria for validity.

Within the context of this research, science is viewed as functional in that nursing research should be undertaken to solve problems as they occur in practice. The data collected from phenomenological interviews with chronic mentally ill people in the community, will provide the basis for describing guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

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Truth-value will be established by an accurate description of the data, conclusion and recommendation logically inferred from the identified themes. For justification, a literature control will be used (Holloway & Wheeler, 1996:101) and the content elicited from the data coded, categorised and constantly compared with the content of earlier data collected (Holloway & Wheeler, 1996:177).

1.7 RESEARCH DESIGN AND METHOD

1.7.1 Research design

The design of this research is both explorative and descriptive (Brink, 1996:11). A qualitative (Creswell, 1998:51) and contextual (Maxwell, 1996:59) study is undertaken in order to explore the meaning, events, situations and actions chronic mentally ill people in the community are involved with, and of the accounts they give of their lives and experiences in the community.

1.7.2 Research method

Two major phases that will structure this research will be fully discussed in Chapter 2.

In order to prevent scientific misconduct from happening, self-regulation is needed through the use of ethical measures.

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1.7.3 Ethical measures

Ethical standards for nurse researchers as outlined by the Democratic Nursing Organization of South Africa (DENOSA, 1998) will therefore be used as the guiding principles upon which the researcher conducts this study.

1.7.4 Measures to ensure trustworthiness

The researcher will apply Guba's (Lincoln & Guba, 1985:289) model to ensure trustworthiness. The model include four strategies: the strategy for establishing truth-value is credibility, transferability is used to establish applicability, consistency is demonstrated by dependability and conformability is used to obtain neutrality.

1.7.5 Phase 1: To explore and describe life-stories of chronic mentally ill people in the community

1.7.5.1 Population and sampling

In this research the population will be all chronic mentally ill people who reside in an identified village, and the target population will be those who have experienced at least two years of illness. Purposive sampling (De Vos, 1998:198) will be used for this research, where a sample that is composed of respondents who have the most characteristics and are representative of the population, will be selected for the study. This is to ensure that the findings fit into contexts outside the study situation (transferability).

1.7.5.2 Sampling criteria

The characteristics of the respondents will be chronic mentally ill adults, who have experienced at least two years of mental illness, and who are able to articulate their conscious life-stories and reside in the identified village for the study.

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1.7.5.3 Sample size

Data saturation (Talbot, 1995:529) will determine the sample size.

1.7.5.4 Data collection methods

Data will be gathered through face-to-face in-depth semi-structured interviews (Holloway & Wheeler, 1996:55) relying on the possibility of following up unanticipated leads from the respondents and of posing questions not prepared in advance (Kvale, 1996:113). Data will be recorded on a tape-recorder and

transcribed verbatim. Field notes will be taken as an additional technique for recording events as they occur (De Vos, 1998:285,299-311).

A pilot study will be carried out with one of the chronic mentally ill people in the community who meet the sampling criteria. This will help the researcher to anticipate how the interview questions will actually work in practice, how respondents will understand them and how they are likely to respondent (Wilson, 1993:15).

1.7.5.5 Data analysis

Tesch (1990 in Creswell, 1994:155) will be used as a method of choice for data analysis. Data collection and analysis will be done simultaneously. Verbatim transcription of data will be done before analysis.

1.7.6 Phase 2: Description of guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities

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During this phase findings collected from chronic mentally ill people in the community, will be used as a basis for describing guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

Results of this study will be discussed in relation to relevant literature and information obtained from similar studies.

1.8 DIVISION OF CHAPTERS

Chapters in this study will be divided as follows:

Chapter 1	:	Overview and rationale
Chapter 2	:	Research methodology
Chapter 3	:	The results of phase one: Life-stories of chronic mentally ill people in the community.
Chapter 4	:	The results of phase 2: Guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities, literature control, limitations and recommendations.

1.9 SUMMARY

The overview, rationale, problem statement, research objectives, research design and methodology and division of chapters have been stated.

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The research design and methodology will be fully discussed in chapter two.

CHAPTER 2

2. RESEARCH METHODOLOGY

2.1 INTRODUCTION

In this chapter, a description of the research rationale, purpose, research design and method will be given.

2.2 RESEARCH RATIONALE

Lack of guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities renders them dependent on their caretakers.

This research will therefore explore and describe the life-stories of chronic mentally ill people in the community and also describe guidelines to support them to master their daily-living activities.

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2.3 PURPOSE OF THE RESEARCH

The purpose of the research is two-fold:

To explore and describe the life-stories of chronic mentally ill people in their community, and based on the data from this research, describe guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

2.4 RESEARCH DESIGN

According to Mouton (1996:107) research design is a set of guidelines and instructions to be followed in addressing the research problem. In this study, the research design is qualitative, explorative, descriptive and contextual.

2.4.1 Qualitative

A qualitative design is an approach in research that focuses on understanding the phenomena as a whole (Burns & Grove, 1993:27). Within this holistic framework, qualitative research attempts to discover the depth and complexity of a phenomena.

In this research, the focus is on chronic mentally ill people in their natural setting, attempting to make sense of (Denzin & Lincoln, 1994:2), or interpret their life-stories in terms of the meanings chronic mentally ill people bring them.

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Chronic mentally ill people in the community will narrate their life-stories in a qualitative research interview. The researcher stresses the socially constructed nature of reality, how respondents make sense of their lives and experience their structure of the world (Creswell, 1994:145).

The researcher will listen comprehensively, encouraging respondents to narrate their whole life-stories in their own language (Talbot, 1995:476), for "if you want to know how people understand their world and their life, why not talk with them?" (Kvale, 1996:1).

2.4.2 Explorative

The focus of this research is to explore life-stories of chronic mentally ill people in the community. Qualitative researchers engage in explorative studies to get richer understanding of the phenomena of interest (Polit & Hungler, 1993:19).

In this study, the researcher takes the 'emic' perspective (Holloway & Wheeler, 1996:4) to uncover meanings chronic mentally ill people in the community give to their experiences and the way in which they interpret them.

The researcher departs from a position of 'not knowing' and is willing to investigate this relatively unknown area (Mouton & Marais, 1990:49) of the life-stories of chronic mentally ill people in the community.

2.4.3 Descriptive

Qualitative research is descriptive in that the researcher is interested in process, meaning and understanding gained through words (Creswell, 1994:145).

In this research, chronic mentally ill people in the community will describe their life-stories in a qualitative and explorative interview. The aim is to obtain uninterpreted descriptions in that the respondents will describe as precisely as possible what they experience and feel, and how they act (Kvale, 1996:32).

The researcher will gather descriptions of the relevant themes of the respondents' life-stories that are as rich and pre-suppositionless as possible since "... the deliberate naïveté and absence of presuppositions advocated here implies an openness to new unexpected phenomena" (Kvale, 1996:32-33). The researcher will therefore develop an awareness of the lived experiences without forcing prior expectations or knowledge in the process (Brink, 1996:120).

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2.4.4 Contextual

This research is contextual in nature. Mouton and Marais (1985 in Mouton, 1996:133) state that contextual research studies phenomena, because of its intrinsic and immediate contextual significance. The primary aim of the researcher is to produce an extensive description of life-stories of chronic mentally ill people in their specific context (Mouton, 1996:133).

Attention to the social context will be taken into consideration in that the researcher will know what surrounds the focus of the study. The researcher will also take into consideration the time at which the research is being done, and the setting with a specific socio-political system in which the respondents find themselves, relating to their life-stories, and that events, actions and meaning are shaped by the unique circumstances in which they occur (Maxwell, 1996:19; Neuman, 1997:331).

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2.5 RESEARCH METHOD

Two major phases will structure this research:

- Phase one will explore and describe the life-stories of chronic mentally ill people in the community.
- Phase two will describe guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities.

Ethical issues have to be considered in all research methods. The researcher will therefore apply the principles which protect the respondents in the research from harm or risk (Holloway & Wheeler, 1996:39-50) as laid down by the Democratic Nursing Organization of South Africa (DENOSA, 1998).

2.6 ETHICAL MEASURES

The following aspects will be covered:

- Competency of the researcher

The researcher has ensured that she is competent and adequately skilled to undertake this research (De Vos, 1998:30) by studying research methodology and interpersonal skills. Additionally, this research is supervised by two professionals experienced in qualitative research.

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- Relationship with participants

The researcher intend on projecting herself in a way that will evoke the least resistance in the respondents. The respondents will be informed of the particulars that attest to the researcher's credentials for reassuring them that they are dealing with a bona fide researcher (De Vos, 1998:301).

The aim of the proposed investigation, as well as the envisaged utilization of the results will be set out clearly (De Vos, 1998:302).

Practical aspects of the research, such as the use of a tape recorder, the interview venue, time that can be devoted for the interview, as well as the advantages and disadvantages of tape recording the interviews, will be discussed with the respondents (De Vos, 1998:302).

Permission to record the interviews on tape in order to ensure accurate recall, will be sought from respondents.

The name, address and telephone number of the researcher will be made available to the respondents, should they wish to make additions, have questions or complaints about the research.

- Protection of human rights

The rights of respondents must be protected to the fullest possible extend (Brink & Wood, 1988:184). To ensure this, the researcher will follow the Ethical Standards for Nurse Researchers as outlined by the Democratic Nursing Organization of South Africa (DENOSA, 1998).

- Rights of respondents

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The researcher will make every effort to protect chronic mentally ill people from any physical or psychological harm. Due to the narrative and explorative nature of the study, temporary psychological discomfort that is no more than what would be encountered in daily life and that would cease with termination of research, might be experienced by the respondents. Informed consent will therefore be sought from respondents and thorough documentation done, to make it possible to monitor the above aspect.

- Informed consent

It is not enough to get permission from the respondents, they need to know what they are being asked to participate in, so that they can make an informed decision (Neuman, 1997:450).

To ensure that informed consent is gained, the respondents will be informed of confidentiality and anonymity, privacy, fair treatment, procedures that will be followed, the type of participation expected from them and sample selection:

- Confidentiality and anonymity

  Respondents will be assured that their individual identities will not be linked to the information they provide and will never be publicly divulged. If anonymity is threatened, all research records will be destroyed.

- Privacy

  The respondents will be informed of their rights to behave and think without the researcher's interference, and that there is no possibility of their private thoughts being used to embarrass or demean them later.

- Fair treatment

  The researcher will not collect more data than are absolutely necessary to reach the objectives of the study. Respondents will be informed of their rights to withdraw or remain in the study, should they wish to.

- Procedures which will be followed

  Respondents will be given information on all the procedures that will be followed in research, including the depth of the interview, the use of a tape-recorder, field notes and that the interview sessions will last for approximately one hour.

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- The type of participation expected from respondents

Respondents will be informed that they are expected to answer the researcher's questions as honestly as possible.

- Sample selection

Respondents will be informed that they have been purposively selected to take part in the research because they are likely to provide the researcher with the most comprehensive understanding of the phenomena being studied and that they met the research criteria.

- Gaining access

Permission to conduct research in the identified community with chronic mentally ill people will be sought from The Office of the President, Botswana. A letter requesting permission, accompanied by the research proposal that details procedures in the project will be submitted.

2.7 TRUSTWORTHINESS

To persuade the audience that the findings of this research are worth paying attention to and worthy of confidence, Guba's (Lincoln & Guba, 1985:290) model of trustworthiness will be used.

According to this model, trustworthiness has four criteria, which must be applied using research strategies. These are truth-value, the strategy of which is credibility, applicability, the strategy of which is transferability, consistency ensured by the strategy of dependability and neutrality using the strategy of confirmability.

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2.7.1 Credibility

The criteria will be obtained by presenting such accurate descriptions or interpretations of life-stories of chronic mentally ill people in the community, so much so that even the respondents themselves would recognise the interpretations.

Techniques that make it more likely that credible findings and interpretations will be produced (Guba & Lincoln, 1985:301) are as follows:

- Prolonged engagement

The researcher has spent two years supervising students' practicals in community mental health and psychiatric nursing in the community. More time will be spent with the respondents before data collection, building trust and testing for misinformation introduced by distortions either of the self, or of the respondents.

The researcher will guard against over-rapport (going native) by being aware of own feelings and constantly reminding self of the research objectives.

- Persistent observation

The researcher will identify those characteristics and elements in the community that are most relevant to the life-stories of chronic mentally ill in the community and focussing an them in detail. Continuous engagement and tentative labeling of what seem salient factors and then exploring them in detail, will be done.

- Triangulation

Methodological triangulation will be done by using two methods during data collection. A tape-recorder will be used during the interviewing process, and at the same time the researcher will take field notes on the observations made. The two methods of data collection will supplement each other.

- Peer examination

The research supervisors, as well as the external coder, will be used as peer examiners.

- Member checks

Respondents will review, validate and verify the researcher's interpretations and conclusions, to ensure that the facts have not been misinterpreted.

- Reflexivity

Reflexivity will be achieved through the use of a tape-recorder and field notes. The researcher acknowledges that because of the reflexivity involved, she will be part of the research and cannot be separated from it.

- Structural coherence

The focus of this research is on "life-stories of chronic mentally ill people in the community" and the researcher will only focus on that. The results will be reflected within the Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999).

2.7.2 Transferability

Research meets this criteria when the findings fit into context outside the study situation, that are determined by the degree of similarity or goodness or fit between the two contexts (De Vos, 1998:349). The researcher will employ the following strategies to accomplish transferability:

- Thick description

A dense description as necessary, to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility, will be done. Thus a complete description of design and methodology, including accompanying literature control for the purpose of clarity, will be done.

- Nominated sample

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Purposive sampling will be used (Talbot, 1995:253).

2.7.3 Dependability

Since there can be no credibility without dependability, a demonstration of the former is sufficient to establish the latter. According to Robson (1993 in Holloway and Wheeler, 1996:58), a qualitative research study that establishes credibility will also be dependable. Ways in which this study will be shown to be dependable are through thick description (Lincoln & Guba, 1985:301) of life-stories of chronic mentally ill people in the community and peer examination which have already been discussed under paragraphs 2.7.1 and 2.7.2 respectively.

Other strategies include the following:

- Dependability audit

The process of this research is being continuously audited by two research supervisors who are making external checks at every step of the research.

The product of the study, which encompasses the raw data, findings, interpretations and recommendations, will be examined to attest that interpretation and recommendations are supported by data and are internally coherent.

- Code/recode procedure

After data collection the researcher and the independent coder will each analyse the interviews separately. The researcher and the independent coder will then discuss and reach consensus on the data. The independent coder for this research will be an experienced, qualitative researcher and an advanced psychiatric nurse specialist.

2.7.4 Confirmability

This means that the data are linked to their sources for the reader to establish that the conclusions and interpretations arise directly from them (Holloway & Wheeler, 1996:168). To ensure confirmability, the researcher will do the following:

- The audit trail

A residue of records stemming from this research will be kept so that a trail of events can be followed.

- Reflexivity.

As discussed under paragraph 2.7.1

2.8 PHASE ONE: LIFE-STORIES OF CHRONIC MENTALLY ILL PEOPLE IN THE COMMUNITY

In this phase, the following procedures will be followed:

2.8.1 Sampling

Sampling is the process of selecting a portion of the population to represent the entire population (Polit & Hungler, 1993:654). Purposive sampling will be used for this research. Selection of the respondents will be based entirely on the judgement of the researcher, in that a sample will compose of respondents who have the most characteristics representative of the population (Talbot, 1995:254-255). The researcher will select a sample of chronic mentally ill people in the community that she believes will yield the most comprehensive understanding of the study (Rubin & Babbie, 1993:369).

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2.8.1.1 Population

A population is a group whose members possess specific attributes that the researcher is interested in studying (Talbot, 1995:241). The target population, which is the population to which the researcher wishes to transfer the findings (Guba & Lincoln, 1985:297) is chronic mentally ill people in the community. The population that the researcher has accesses to and will actually study, will be part of the target population (Brink, 1996:132).

The accessible target population will be chronic mentally ill people in the community. The target population mentioned, will constitute the sample.

2.8.1.2 Sampling method

A purposive sample of chronic mentally ill people in the community will be obtained for this research. Respondents to be chosen are those who best represent the phenomenon being studied (Talbot, 1995:255).

- Sampling criteria

This involves the listed characteristics in individuals that will make them eligible to be included in the research (Burns & Grove, 1993:246). The characteristics of the respondents will be chronic mentally ill adults who have experienced at least two years of illness, able to articulate their conscious life-stories and reside in the community.

- Sample size

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The determinant of sample size is the saturation of data. The researcher will therefore continuously purposively select respondents for inclusion in the research, until information is seen to be repeated and a pattern emerging (Talbot, 1995:255).

2.8.1.3 Role of the researcher

Qualitative research is an interpretative research, (Creswell, 1994:147) as such, the biases, values and judgements of the researcher will be minimized through the use of peer examiners. Ethical measures as discussed under paragraph 2.6 will be maintained throughout the research project.

Furthermore, the researcher will write letters seeking permission to the gatekeepers (Wilson, 1993:218).

Furthermore, the researcher will write letters seeking permission to the gatekeepers (Wilson, 1993:218).

2.8.2 Data gathering

The focus of this qualitative research is the lived world of chronic mentally ill people and their relation to it. The purpose is to describe and understand the central themes, the respondents experience and live toward (Kvale, 1996:29).

In this research, life-stories are the central theme in the world of chronic mentally ill people, and the researcher will seek to describe and reflect the meaning (Kvale, 1996:29-30) life-stories have on chronic mentally ill people, through interviews.

An in-depth phenomenological interview will be conducted (Kvale, 1996:43). Chronic mentally ill people in the community will therefore tell stories, narratives about their lives, using language as an interviewing tool.

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Semi-structured interviews will be conducted without imposing any prior categorization that may limit the field of inquiry (Rubin & Babbie, 1993:374). The goal of semi-structured, one-to-one interviews is understanding. It therefore becomes of paramount importance for the researcher to establish rapport. Thus the researcher will put herself in the role of the respondents and attempt to see the situation from their perspective (Denzin & Lincoln, 1994:367).

The researcher will also use empathy to understand the respondent's feelings, their views of reality and the special meaning of what the researcher observes in them (Rubin & Babbie, 1993:362). The researcher will also use introspection to examine own thoughts and feelings while experiencing the respondents' views on their lives.

Interviews will allow the researcher to get at chronic mentally ill people's complex feelings and perceptions, producing interesting and prolific life-stories and narratives (Talbot, 1995:476).

The researcher's first question during one-to–one, in-depth interviews will introduce life-story as the theme of the interviews, and the remaining questions will depart from the respondent's answers, in order to keep focus and ask for clarification of different aspects of chronic mentally ill people's life-stories (Kvale, 1996:28).

The central question will be: "Tell me the story of your life."

All the questions will be open-ended to allow respondents to express their own perspectives in their own words.

Field notes are detailed recordings of a variety of information collected in the field that the researcher will write as part of the data collection process (Talbot, 1995:479). Notes will be taken on observation by the researcher. A field journal will therefore be kept. The notes will include both the empirical observations and interpretations on them. All the interviews will be tape-recorded and later transcribed verbatim.

A pilot study will be carried out with one of the chronic mentally ill people in the community who meet the sampling criteria. This will help the researcher to anticipate how the interview questions will actually work in practice, how respondents will understand them and how they are likely to respond (Wilson, 1993:15).

2.8.3 Data analysis

Data analysis in qualitative research is an ongoing process that occurs simultaneously with data gathering (Creswell, 1994:153; Maxwell, 1996:77 and Talbot, 1995:479).

The interviews will be transcribed verbatim and the written field notes will serve as the material for the subsequent interpretation of meaning (Kvale, 1996:27).

The themes as they emerge in the interviews and interpreted by the researcher, will be discussed with the respondents in the follow-up interviews. This is to ensure that information obtained is representative of what the respondents meant.

The first basic analytical step is open coding. During open coding, the data are broken down into discrete parts, closely examined, compared for similarities and differences (De Vos, 1998:271). Questions about life-stories as reflected in the data, will emerge at this stage.

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Tesch (1990 in Creswell, 1994:155) will be used as a method of choice for data analysis. Eight steps will be considered:

- Getting a sense of the whole by reading through all the transcriptions carefully and jotting down some ideas as they come to mind.

- One document, the shortest and most interesting, will be picked and the researcher will go through it, thinking about its underlying meaning. Thoughts will be written in the margin.

- Having completed all the documents, the researcher will make a list of all topics, clustering similar ones together, and arranging them into major topics, unique topics and leftovers.

- The researcher will now take this list and go back to the data. Topics will be abbreviated as codes, and codes written next to the appropriate segments of the text.

- The most descriptive wording for the topics will be found and turned into categories. Topics that relate to each other will be grouped. Lines may be drawn between categories to show interrelationships.

- A final decision on the abbreviation for each category will be made and codes alphabetized.

- Data material belonging to each category will be assembled in one place and preliminary analysis done.

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- Existing data will be recorded.

- Transcribed data will be sent to an independent coder who is a specialist in psychiatric nursing for open coding. A protocol to be followed during open coding will also be sent.

The researcher and the independent coder will later discuss and reach consensus on the findings. The results will be translated into English and will be reflected within the Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999:3-6).

2.8.4 Literature control

The results of this research will be discussed in relation to relevant literature and information obtained from similar studies.

Phenomenologists believe the literature should be reviewed after data collection and analysis so that the information in the literature will not influence the researcher's objectivity (Burns & Grove, 1993:142).

After data analysis, the information from the literature will be compared with findings from this study to determine similarities and differences (Burns & Grove, 1993:142), the findings will then be combined to reflect the current knowledge of life-stories of chronic mentally ill people in the community.

2.9 PHASE 2: DESCRIPTION OF GUIDELINES THAT CAN BE UTILIZED BY PSYCHIATRIC NURSE PRACTITIONERS TO SUPPORT CHRONIC MENTALLY ILL PEOPLE IN THE COMMUNITY TO MASTER THEIR DAILY LIVING ACTIVITIES.

To accomplish this phase of the research, data collection, analysis and literature control will be done.

2.9.1 Data collection

Identified central themes of life-stories of chronic mentally ill people in the community will be used as a framework to describe guidelines for psychiatric nurse practitioners to support chronic mentally ill in the community to master their daily living activities (Stuart & Sundeen, 1983:876-885).

2.9.2 Data analysis

The described guidelines under paragraph 2.8.3 will be followed by a literature review as discussed under paragraph 2.8.4 and will also be discussed with the chronic mentally ill people in the community.

2.10 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

Conclusions, limitations and recommendations of this research will be made based on the study findings. Recommendations will be made for community psychiatric nursing practice, nursing education, nursing research and policy making.

2.11 SUMMARY

In this chapter, the research design and methodology has been described.

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CHAPTER 3

RESULTS AND DISCUSSION OF RESULTS

3.1 INTRODUCTION

In the previous chapter, the methodology followed in this research was discussed. In chapter three, results will be presented and discussed according to themes and categories identified in the life-stories of chronic mentally ill people in the community.

3.2 DESCRIPTION OF THE SAMPLE

The sample comprised ten chronic mentally ill people in the community, all adults. They were from one village. The sample size was determined by data saturation. The average illness experience of the respondents was between five and twenty years. Four of the respondents were males, with the remaining six being females.

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All ten respondents were fluent in Setswana during the interviews. The interviews were conducted until data was saturated with repeating themes.

3.3 RESULTS

Life-stories of chronic mentally ill people in the community were categorised into one central theme, categories and subcategories that show patterns of interrelation. A central theme identified within the data is "depression related to mental illness."

3.4 DISCUSSION OF THE FINDINGS

The discussion of the findings will be based on the identified central theme, categories and subcategories in life-stories of chronic mentally ill people in the community. The theme will be highlighted by direct quotations from respondents, supported by a literature control and reflected within The Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999). The discussion of the findings will be based on graphic representation of the data in Table 3.1.

Table 3.1: An overview of the central theme, categories and sub-categories of life-stories of chronic mentally ill people in the community

THEME	CATEGORIES AND SUB-CATEGORIES
1. Depression related to mental illness	1.1 Hopelessness related to negative self-concept. • Feelings of worthlessness and self-hate • Extreme feelings of sadness • Suicidal ideation • Feelings of inadequacy and low self-esteem • Self-blame and guilt feelings. 1.2 Social isolation related to stuckness in self. • No sense of belonging • Labeling that the experience of mental illness brings • Re-definition of self • Avoidance of social interaction • Loneliness in the presence of others

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	1.3 Lifestyle changes related to stigma attached to mental illness • Feelings that diagnosis is 'labeling'. • Devaluing transformation following diagnosis • Self-doubt and lack of confidence • Dependent on other people • Frustrated as a result of changes brought by illness. 1.4 Dependency syndrome related to inability to master activities of daily living • Sense of defeat • Physical discomforts experienced • Feelings of incapacitation • Lack of self-confidence

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3.4.1 Depression related to mental illness

Within the context of this research, depression is defined as an abnormal extension or over-elaboration of sadness (Stuart & Sundeen, 1983:288) that is maladaptive, incapacitating in nature and characterised by hopelessness, social isolation, lifestyle changes and dependency syndrome.

3.4.1.1 Hopelessness related to negative self-concept

Chronic mentally ill people in the community expressed difficulties in managing losses and role changes brought by chronic illness. They also expressed that they are suffering deeply, their hopes for living full and valuable lives have been shattered.

The interviews were characterised by extreme feelings of sadness. One respondent threw her hands in the air to emphasize her point: *"ke latlhilwe ke banna ka ntata ya bokoa. Fake ima fela, ka kgwedi ya bo four ba a ntatlha ebe gore ke ipolaye le ene ngwananyana yo ke mmolae". (I lost boyfriends because of illness. Whenever I'm four months pregnant, men leave me saying I'm mad, then I get extremely sad and think of killing the baby and myself).*

Another woman also expressed self-hate as is reflected by the following quotation: *"... Ke a ikila, tota gake ithate ka ga ke sa rate botshelo jwame." (I hate myself, I really do not like myself because I don't like my life.)*

Deegan (1993:8) supports this when narrating the story of her life, following being diagnosed as mentally ill in that she lost the will to live, wasn't suicidal but wanted to die because nothing seemed worth living for. Her hopes, dreams and aspirations had been shattered.

Haber (1997:614) proposes feelings of hopelessness with no chance of improvement; the person with depression sees suicide as a logical solution.

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The world as seen by chronic mentally ill people in the community is overwhelming, and because of that, they feel helpless, thereby increasing their extreme feelings of worthlessness.

One woman with an inferior and subservient tone said: *"Ke moitlhokinyana fela, gake ineye sepe, ga kena boitiro." (I am destitute, I cannot support myself, I am helpless).*

Carson and Arnold (1996:1030-1031) point out that helplessness is associated with profound depression and is most likely to occur when people believe the situation to be long-term.

The belief that now they have no value, supports the experiences of hopelessness by chronic mentally ill people in the community. Their view of the future is pessimistic as one woman who had long been allocated a plot (in 1986) said: *"Dipampiri tsa me di teng mo tsa setsha, di boletse teng motlung mo". (My papers for plot allocation are here, rotting in this house).*

Hopelessness as expressed by chronic mentally ill people is also accompanied by feelings of inadequacy: *"Goromente o bonye gore ke yo ke tshwanetseng go utlwelwa botlhoko." (Government has realised that I must be pitied).* This implies a negative evaluation of self in that individuals feel less competent and therefore should be pitied upon and shouldered.

Feelings of entrapment and futility also prevail, leaving them convinced that what is expected by society is beyond reach: *"Ke leka gore ke itire motho ke gore go a pala ka gore ke atsenwa." (I try to make myself somebody but it is difficult because I'm mad).*

A negative view of the self and low self-esteem in chronic mentally ill people developed as a consequence of the meaning given to mental illness, as one respondent said: *"Ba nkgataka ka gore ke motlhofo. Kana ke motlhofo." (They do not respect me because I am weak. By the way, I am weak).* Weakness in this context refers to low social status.

Another one said: *"O fitlhele ke ipotsa gore a ke motho sentle ... le nna o kare nkabo ke le motho." (Usually I question myself about my personhood, I wish I were a person).*

Perko and Kreigh (1988:386) contend that the mentally ill experience self-destructive behaviour and that they express their feelings in terms of uncertainty, helplessness, hopelessness and self-criticism.

Chronic mentally ill people in the community also hold the conviction that their illness represents punishment for having sinned against God: *"Ga ke itse gore ke leofetse Modimo mo go kanang kang ..." (I don't know to what extent I have sinned against God ...).* They thus have guilt feelings about their illness.

3.4.1.2 Social isolation related to stuckness in self

Chronic mentally ill people in the community verbalized an inability to receive a satisfying sense of belonging and social network. Social isolation arises as a consequence of the way in which chronic mentally ill people in the community cope with and adapt to the experience of mental illness, together with other social disadvantages, such as rejection and labeling that the experience of mental illness brings.

One woman remarked that: "*Ga nke ke nna mo lwapeng ka gore, ga ba mpatle. Fa ke bua fela gatwe o simologetswe ke botsenwa." (I never stay home because they don't want me. Whenever I complain they say I've started being mad).* Bradley and Thompson (1985:204) support this by stating that social withdrawal and social isolation were common among long-term patients in the community.

With chronic illness also comes the definition of self as 'mad' and the culture of 'madness', that situates the 'mad person' in relation to significant others as isolators whom 'the mad person' fears to interact with.

A quotation in this regard is: *"Jaaka ke boletse fela, nna, ke setsenwa. Jaanong le ba ke bapileng nabo ke go tlhoka kutlwano fela. Ga ke ka ke kare ke ba kopa sukirinyana ampo letswainyana." (As I've told you, I am mad. Now I don't even get on well with my neighbors. I can't even ask them for a small amount of sugar or a pinch of salt).*

Because the individual expects negative outcomes in interaction with others, he or she avoids developing and sustaining relationships. There is the cognitive effort to detach oneself from neighbors and significant others, as one respondent said: *"... mme fela fa ba ntena ke tla mo lelwapeng le ka gore le nna ke nale maikutlo a gore ke ka ba koba mo ga ntate hakere? Nka ba koba." (Once they irritate me, I come home because I also have feelings that I can chase them away from my father's house, you know. I can chase them away).*

White (1995:14) supports this by stating that people live by the stories that they have about their lives, constitute their lives and that they 'embrace' the lives of people.

Chronic mentally ill people in the community have deep senses of loneliness that they attribute to isolation imposed on them by the society, once their mental illness status becomes known.

Pickens (1999:31) argues that in comparison with individuals not identified as having psychiatric disorders, the network of people with psychiatric illnesses tended to be smaller.

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3.4.1.3 Lifestyle changes related to stigma attached to mental illness

Chronic mentally ill people in the community not only confront new experiences and new roles, but are also saddled with stigma. Stigma sometimes takes place at work, once the person has been 'labeled' mentally ill, thus preventing him or her from achieving valued roles in the society. One woman who lost her job after being diagnosed mentally ill said: *"Ke ne ke ruta bana ke ise ke lwale, mme ka ntshiwa mo tirong ke bokoa." (I was a teacher, but I lost my job due to illness).*

Another man said: *"Ga go intumedise, ke bona ke sotlega fela ka lone lebaka la go senyegelwa ke botshelo, ka lone lebaka la go lwala bolwetsi jo." (I am not happy about his, I find myself suffering because of having lost life due to this illness).*

In support of chronic mentally ill people in the community's life-stories, Deegan (1993:8) contents that, once labeled mentally ill, the individual sees no way to achieve the valued roles once dreamed of, as the future has been reduced to the prognosis of doom one has been given. She further explains that it is as if the whole world has put on a pair of warped glasses that blind them to the person one is and leaves them seeing one as an illness.

Labeling someone as mentally ill, which according to chronic mentally ill people is the so-called diagnosis, often damages their reputations. The damage include isolation by others and personal feelings of self-doubt and inadequacy as is reflected by the following quotation: *"Ke iphapha mo bathong ka go tshaba one mantswe a bone a a tlhabang a ... Ee, aa nyenyafatsa hakere, abo a mpaya ko tlase." (I isolate myself from people as a way of avoiding their hurting comments. Yes, they devalue and lower my self-esteem).*

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Another woman whose daughter is also mentally ill said: *"Ke gore jaaka fare tlaabo re gatile gore reye go ja dipilisis jaana, re nale leina le le maswe la botsenwa." (Once we've been to the clinic for tablets, we acquire a bad name of madness.)*

Degaan (1993:7) supports this by stating that she underwent the radically dehumanizing and devaluing transformation from being a person to being an illness the day she was diagnosed with major mental illness.

This, she further states, was accompanied by a profound sense of loneliness due to the fact that people around were only interested in talking to her about the symptoms but none about surviving mental illness, as well as the possibility of building a new life for herself.

Chronic mentally ill people in the community also indicated that the diagnosis of mental illness marked a major turning point in their lives and also shifted their attention to the new definition of selves, as the immediacy of patienthood rendered them helpless, hopeless and dependent on other people.

One man said: *"Ke itlhobogile, jaanong tota ke kopa fela gore le mphakise. Go itlhoboga mma, ke ne ke bona go lwala jaaka ke ntse ke fokola." (I have lost hope, and what I'm only asking now is to be given ration. I lost hope mama, due to being sick, as I'm now weak).*

Another woman said: *" Ke ne ke etle ke itshwarele di piece-job. Jaanong ke tshela fela ka ene rre yo ke nnang nae yo." (I used to hold piece-jobs. Now I am dependent on this man I'm living with).*

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Lifestyle changes are viewed by the chronic mentally ill people in the community as really frustrating as one woman, with tearful eyes, said: *"Ag! Go maswe tota, ke a sotlega ka gore ga ke sa tlhole ke kgona botshelo mo lwapeng." (Ag! It's really bad, I'm suffering because I no longer manage home-life).*

Haber (1997:821) supports this by stating that persons with mental illness are treated as if they have earned and deserve their disease, as if the illness itself is a disgrace and a reproach. Stigma is not part of mental illness, it is an additional independent cost assigned by society.

Stigma attached to mental illness transforms the lives of those affected, leaving them with little or no confidence in themselves, thus rendering them dependent and frustrated in areas where they were once competent.

3.4.1.4 Dependency syndrome related to inability to master daily living activities

Within the context of this research, dependency refers to reliance on another individual for support in almost all daily living activities. Chronic mentally ill people in the community are convinced that they are incapable of functioning independently and thus describe themselves as requiring constant assistance.

They define themselves in terms of mental illness, which renders them defeated in just those areas in which they had previously sensed themselves to be competent: *" ... ke jone bolwetsi fela bo ntira gore ke nne setshwakga."* *(It is the illness that makes me lazy).*

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Another woman said: *"Fa gongwe lefa ke apeile jaana mo isong ke palelwa ke go kgotletsa, pitsana, ee mma."* *(Sometimes even when cooking, I find it difficult to keep the fire alive, yes, ma'm).*

Fortinash and Holoday-Worret (1996:690) established that the majority of people with chronic mental illness live with their families in a parasitic and apathetic way. Chronic mentally ill people also stated that even routine activities are very difficult for them and that they perform below their own expectations. This they partly attribute to the physical discomfort they experience, as a result of long-term medication they find themselves subjected to.

In one interview, a man spoke of his inability to perform any physical activity: *"Ga gona maatla. Mo dipilising mo ke boroko fela, gare o nne fela."* *(There is no energy. With tablets you just feel sleepy and lethargic).*

Another woman said: *"Sengwe le sengwe se a retela. Ga ke kgone go itirela, le maoto ke kgona go a tlhoka." (Everything is impossible. I cannot do things for myself, even my legs at times won't carry me).*

They believe that they are incapacitated and this prevents chronic mentally ill people in the community from attaining competency in self-care activities: *"Mo go ikolomakeleng go a pala. Ga ke tshware. Mabogo ame fa kere ke suga phenti jaana a a pala, ke dule sereneke fela." (Keeping my surrounding clean is impossible. I cannot handle anything. My hands won't even allow me to wash my panty, I am incapacitated).*

In the literature, Mantswe (1994:39-41) who did a case study on after-care services for persons with long-term mental illness living in the Gaborone community found out that the majority of the clients could not participate in household tasks because they were incapacitated. It was also revealed that family members of chronic mentally ill people said incapacitation of the ill family member demanded a lot of time and attention from them, as the mentally ill could not even attend to their personal hygiene.

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Rawlins et. al. (1993:306) contend that dependence creates unhealthy limitations, such as being unable to function occupationally if the job requires any independent working, or limit social contact with those whom they depend on. One man told the story of his life as: *"Ke nna fela, esale jaaka ke tlogela botshelo jwa tiro gake bone thuso gope." (I do nothing. Ever since terminating work, I have never received assistance from anybody).*

These results reflect patterns of interaction between chronic mentally ill people in the community's internal and external environment. Results have been reflected within the Theory for Health Promotion in Nursing (Rand Afrikaans University, Department of Nursing, 1999).

3.5 FIELDNOTES

Field notes will be discussed in relation to appointments, interviews and transcription of tapes.

3.5.1 Appointments

It was not easy for chronic mentally ill people in the community to keep appointments. At times the researcher walked long distances from the respondent's home in search of the respondent on the day scheduled for the interview.

3.5.2 Interviews

Chronic mentally ill people in the community were eager to share their life-stories with the researcher. They expressed gratitude and asked the researcher to keep up a good job: *"O nne o re lekole fela jaana." (Keep on checking us like today).* This was due to the fact that support was given at the end of interviews because most of them were characterised by emotional outbursts as painful, hurting experiences were related.

Some respondents sobbed during the interviews, making the researcher a bit uncomfortable about the nature of her study. However, constant assessment of one's feelings and keeping research objectives in mind, assisted the researcher to stay focused and avoid engaging in psychotherapy.

3.5.3 Transcription of tapes

Interviews were conducted in the respondents' homes. In some instances, noise from the respondents' children who also wanted to be 'taped', affected the sound of tapes.

3.6 CONCLUSION

The researcher, through observation and analysis of transcribed interviews, found out that chronic mentally ill people in the community are not happy with the way they live. They feel very down (depressed) because of the physical, psychosocial and spiritual negative changes they underwent, and are still experiencing, because of mental illness.

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CHAPTER 4

GUIDELINES, LITERATURE CONTROL, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter three, the results of the research were discussed and supported/verified by literature control. In this chapter, guidelines will be described for the psychiatric nurse practitioner to support chronic mentally ill people who reside in the community to master their daily living activities through mobilisation of resources.

Guidelines, logically inferred from the results of the interviews will be validated and supported by the literature control, and presented as: Guidelines for supportive action for psychiatric nurse practitioners. Chronic mentally ill people in the community identified in the study, are depressed because of the physical, psychosocial and spiritual negative changes they are experiencing, because of mental illness. The depression is evidenced by hopelessness, social isolation, lifestyle changes and dependency syndromes.

Of all members of the mental health team, the psychiatric nurse practitioner is the first to come into contact with clients brought to the health facility. Since they are also with clients on a relatively constant basis, psychiatric nurse practitioners need guidelines for supportive action, to mobilize resources, as well as the identification and bridging of obstacles in the promotion of chronic mentally ill people's mental health.

Chronic mentally ill people in the community, in this research, are seen holistically in interaction with the environment in an integrated manner. Guidelines will subsequently be presented.

4.2 DESCRIPTION OF GUIDELINES

Guidelines for supportive action by psychiatric nurse practitioners are described in the form of nursing process, which encompasses the health diagnosis, aim and nursing interventions or supportive actions for chronic mentally ill people in the community to master their daily living activities.

4.3 AN OVERVIEW OF GUIDELINES TO SUPPORT CHRONIC MENTALLY ILL PEOPLE IN THE COMMUNITY

4.3.1 Experience

Depression related to mental illness as evidenced by hopelessness, social isolation, lifestyle changes and dependency syndrome.

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4.3.2 Aim

To provide a supportive environment that promote chronic mentally ill people's quality of life.

4.3.3 Supportive actions

- Provide an environment that chronic mentally ill people will experience as supportive, positive, safe and constructive. This also involves an atmosphere of sharing, acceptance and of being heard and understood (Wilson & Kneisl, 1996:121-125; Yalom, 1995:463).

- Build working relationships by creating a climate of trust, that reduces mentally ill people's fear of isolation and rejection and promote tolerance, patience, respect, empathy and confirmation (Johnson, 1997:74-84; Seloilwe, 1997:213).

- Appreciate what chronic mentally ill people in the community have been going through and provide a context that contributes to the exploration of other ways of living and thinking, by conducting individual, group and/or family psychotherapy (Yalom, 1996:xiv; White, 1995:21).

  - In individual psychotherapy, encourage 'externalizing conversations' that encourage chronic mentally ill people to separate themselves from the effects that problems are having on their lives and relationships (White, 1995:21-25).

  - In group psychotherapy, encourage the use of therapeutic factors, such as instillation of hope, universality, imparting information, altruism, development of socializing techniques and interpersonal learning (Yalom, 1995:1-96).

  - Conduct family therapy with emphasis on the relationship between the family members (Wilson & Kneisl, 1996:766).

- Assist chronic mentally ill people to identify and understand what goes wrong in their interactions and interpretations of life events, and ultimately change those maladaptive patterns (Yalom, 1996:xiv).

- Review with chronic mentally ill people ways to promote self-esteem, e.g. setting of realistic goals (Johnson, 1997:375).

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- Recognise and point out manifestations of self-destructive or self-undermining thinking and behaviour.

- Involve all the stakeholders, families and the business community, in modifying the environment to enable chronic mentally ill people to function at an optimum level in their own home and community.

  < Advocate for the establishment of Day Centers, Rehabilitation Programmes for those able to return to work, and Sheltered Employment or occupation.

  < Incorporate a rehabilitation philosophy that maximizes opportunities for developing specific skills (e.g. interpersonal skills, money management and job interviewing skills) chronic mentally ill people need to interact more effectively (Wilson & Kneisl, 1996:531).

  < Place emphasis on improving the capabilities of people with chronic mental illness, and encourage them to accept help form others as needed, while maintaining independence within the limitations of the illness.

- Discuss self-help techniques and encourage the use of diaries to schedule activities.

Hopefully, the described guidelines will be used by psychiatric nurse practitioners to support chronic mentally ill people in the community in mastering their daily living activities.

The guidelines were found to be relevant and practical after being discussed with chronic mentally ill people in the community and psychiatric nurse specialists.

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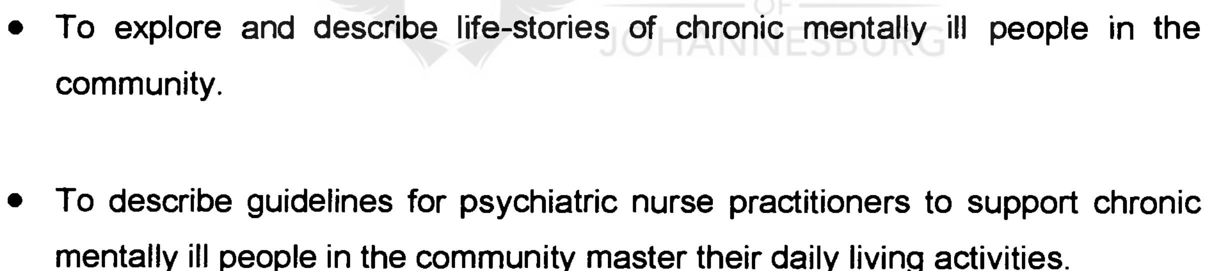
4.4 CONCLUSION OF THE STUDY

This study resulted from the observation that chronic mentally ill people in the community are dependent on their care-takers in meeting almost all their daily living activities. In this regard, it seemed logical to ask the two research questions:

- "What are the life-stories of chronic mentally ill people in the community?"

- "What guidelines can be utilised by psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities?"

From these research questions, two objectives were formulated:



- To explore and describe life-stories of chronic mentally ill people in the community.

- To describe guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community master their daily living activities.

A qualitative, explorative, descriptive and contextual research design was used to answer the research questions. In-depth, semi-structured, phenomenological interviews were conducted with chronic mentally ill adults, who have experienced at least two years of illness, able to articulate their conscious life-stories and who reside in the identified village for this research.

The results of this study show that chronic mentally ill people in the community, who were identified as respondents in this study, are depressed due to mental illness.

Based on these results, guidelines were developed for the psychiatric nurse specialist to support chronic mentally ill people in the community to master their daily living activities. It can therefore be concluded that the research objectives have been met, research questions answered and the problem statement of the study supported.

4.5 PRACTICAL PROBLEMS ENCOUNTERED/LIMITATIONS

It was not easy for chronic mentally ill people in the community to keep appointments. At times the researcher walked long distances in search of respondents on the day scheduled for the interview.

The interviews were conducted in Setswana and verbatim translation of the tapes was done. Idiomatic expressions and metaphors used might have during translation into English, lost the original meanings of life-stories of chronic mentally ill people. In the discussion of the findings, the researcher used quotations from the interviews and translated them into English.

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4.6 RECOMMENDATIONS

The recommendations based on the results of this study will be made with specific reference to psychiatric nursing practice, education, research and policy making.

4.6.1 Psychiatric nursing practice

Psychiatric nursing practitioners should create a context that contributes to the free expression of feelings and concerns by chronic mentally ill people in the community. Support should be employed as an intervention to reinforce the mentally ill people's defenses.

Workshops and seminars should be organized on a regular basis to keep psychiatric nurse practitioners informed on current issues related to their field. Networking with local non-governmental organisations, government organisations and international psychiatric nursing organisations should be done in order to improve the standards of practice in Botswana.

Psychiatric nurse practitioners should also employ a holistic approach when dealing with clients, considering their physical, psychosocial, social and educational aspects. They should also be the mouth-piece of their clients and those in the community settings to liaise with the hospital staff, so as to ensure proper follow-up of clients from the hospital on discharge and effective re-integration into the community. Chronic mentally ill people in the community are part of particular families. This aspect should therefore be taken into consideration during intervention.

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4.6.2 Nursing education

Emphasis for nurses specializing in psychiatry and mental health should be placed on psychotherapy. It is evident from the results of this study that psychotherapy for individuals, families and groups should be made available and accessible to the community. The current education system that majors in pathophysiology and pharmacotherapy should be reviewed so as to incorporate psychotherapy as a major component in the curriculum for mental health and psychiatric nursing. The public should also be educated so that acceptance and understanding of the mentally ill prevails, be it at home or at a health facility.

4.6.3 Nursing research

Since nursing is a human science, nurses should be clear of the "what and why" of their actions. Nurses should therefore conduct research and develop models that will be the basis of their practice.

Due to the small sample of this research, it is necessary to conduct further studies in relation to:

- A larger sample to validate the results of this study.

- Evaluate the implementation of supportive actions by psychiatric nurse practitioners once the recommended guidelines have been implemented.

The research also recommends that a study be conducted on "The impact of community mental health nursing: Psychiatric nurse practitioners' experience". Results can then be incorporated, together with the described guidelines, to improve the quality of psychiatric nursing practice, since research is the basis for practice.

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4.6.4 Policy making

Policy makers should seriously consider building sheltered homes or Day Centers for chronic mentally ill people in the community. They should also lobby for part-time employment of chronic mental ill people in the community by the business people.

4.7 CONCLUSION

The study focussed on the life-stories of chronic mentally ill people in the community. The results of the study are that chronic mentally ill people in the community are depressed by the social, psychological, spiritual and physical negative changes collectively known as mental illness, hence leaving them unable to master their daily living activities.

The researcher therefore described guidelines for psychiatric nurse practitioners to support chronic mentally ill people in the community to master their daily living activities. Conclusions were drawn from the finding, recommendations made with respect to psychiatric nursing practice, education, research and policy-making. Practical problems encountered were also highlighted.

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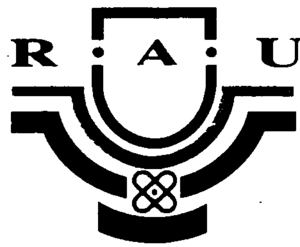

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DEPARTMENT OF NURSING SCIENCE
Telephone : (011) 489-2860

1999-03-18

OFFICE OF THE PRESIDENT
~~Ministry of Foreign Affairs~~
Private Bag 00368
GABORONE
Botswana

Dear Sir

PERMISSION TO CONDUCT RESEARCH

I am requesting permission to conduct research in the community with the chronic mentally ill people. Results of this research will be read both in Botswana and South Africa. My research topic is "Life stories of the chronic mentally ill people in the community."

Data collection is envisaged for the period April to July this year. Please find enclosed proposal for all the details of this research.

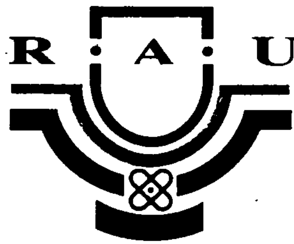
UNIVERSITY
OF
JOHANNESBURG

Yours faithfully

N. MOTSHWANE (MRS)
RESEARCHER

Marie Poggenpoel
MARIE POGGENPOEL, RN., Ph.D
PROFESSOR AND SUPERVISOR

C P H MYBURGH HED., B.Sc Hons. M.Com. D.Ed
PROFESSOR AND CO-SUPERVISOR



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DEPARTMENT OF NURSING SCIENCE
Telephone : (011) 489-2860

1999-03-18

Ministry of Health
Private Bag 0038
GABORONE
Botswana

Dear Sir

PERMISSION TO CONDUCT RESEARCH

I am requesting permission to conduct research in the community with the chronic mentally ill people. My research topic is "Life stories of the chronic mentally ill people in the community."

Data collection is envisaged for the period April to July this year. Please find enclosed proposal for all the details of this research.

Yours faithfully

UNIVERSITY
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N. MOTSHWANE (MRS)
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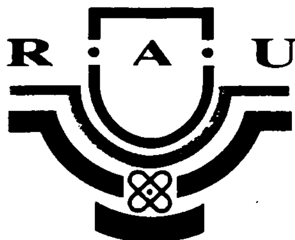

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DEPARTMENT OF NURSING SCIENCE
Telephone : (011) 489-2860

1999-03-18

Dear Respondent

PERMISSION TO CONDUCT RESEARCH

I am requesting your consent to include you in this research. The purpose of this research is to explore and describe the life stories of the chronic mentally ill people in the community and based on the data from this research, describe guidelines to support the chronic mentally ill people in the community to master their activities in daily living.

Participation in the study is voluntarily and your anonymity will be safeguarded in that your identity will not be linked to the information you provided.

This research is worth doing since the results will be incorporated to improve nursing practice, utilised by the policy makers and most importantly will benefit the chronic mentally ill people by describing guidelines to support them function at their optimal level in carrying out their activities of daily living.

You have been purposively selected for inclusion in this research because I believe that you will yield the most comprehensive understanding of the study.

During data collection, I will interview you for about one hour. All our interviews will be tape recorded. As a respondent, you are expected to answer the researcher's questions comprehensively and honestly.

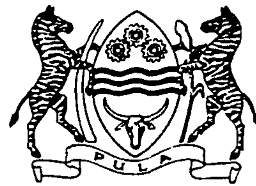
Sincerely

N. MOTSHWANE (MRS)
RESEARCHER

MARIE POGGENPOEL, RN., Ph.D
PROFESSOR AND SUPERVISOR

C P H MYBURGH HED., B.Sc Hons. M.Com. D.Ed
PROFESSOR AND CO-SUPERVISOR

TELEGRAMS: PULA
TELEPHONE: 350800
TELEX: 2655 BD



REPUBLIC OF BOTSWANA

OFFICE OF THE PRESIDENT
PRIVATE BAG 001
GABORONE

REF: OP 46/1 LXXIII (97)

4 May, 1999

Mrs N. Motshwane
P. O. Box 3405
GABORONE

Dear Madam,

RE: GRANT OF A RESEARCH PERMIT:
N. MOTSHWANE

Your application dated 31st March 1999 refers.

UNIVERSITY OF JOHANNESBURG

We are pleased to inform you that you have been granted permission to conduct research on "Life Stories of the Chronic Mentally ill people in the Community". The study will be conducted at Molepolole for a period not exceeding ten (10) months, with effect from the 3rd May, 1999.

The permit is granted subject to the following conditions:

1. Copies of any papers written as a result of the study are directly deposited with the Office the President, National Archives (2 copies each), National Library Service, National Institute for Research and Ministry of Health.

2. You work in liaison with the local authorities at your place of study.

3. The study is conducted according to the particulars furnished in the application.

4. The research comprises only Mrs N. Motshwane.

5. The permit does not give authority to enter any premises, private establishment or protected area. Permission for such entry should be negotiated with those concerned.

Yours faithfully,

A. MATLHAKU
for/PERMANENT SECRETARY TO THE PRESIDENT

UNIVERSITY
OF
JOHANNESBURG

cc. Permanent Secretary. Ministry of Health
Director, National Institute for Research
Director, National Library Services
Government Archivist
Librarian, University of Botswana
District Commissioner, Molepolole
Council Secretary, Molepolole
LandBoard Secretary, Molepolole

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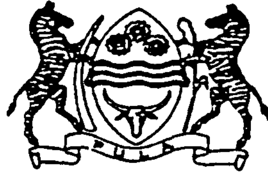


MINISTRY OF HEALTH,
PRIVATE BAG 0038,
GABORONE.

Ref 13/18/3

REPUBLIC OF BOTSWANA

7th May 1999.

Mrs. N. Motshwane
P.O.Box 3405
Gaborone.

Dear Madam,

GRANT OF A RESEARCH PERMIT:

Your application dated 31/03/99 refers.

We are pleased to inform you that you have been granted permission to conduct research on

"Life stories of the chronic Mentally ill people in the Community" in Molepolole.

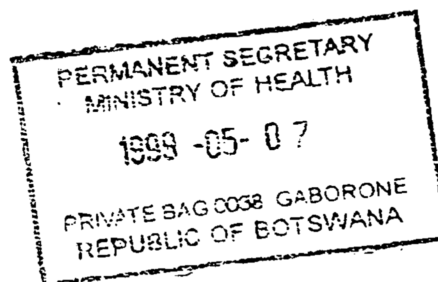
The permit however, does not give authority to enter any premises, private establishment or protected area without permission of concerned parties. Such Permission should be negotaited with those concerned. You may also need to request permission from other relevant authorities like Chiefs, Headmen, DHT, Clinics etc.

UNIVERSITY OF JOHANNESBURG

The permission is also subject to you submitting a copy of the findings of your study to the Ministry of Health, Health Research Unit.

Yours sincerely

Mrs. A.T. Moyo
For Permanent Secretary.



ANNEXURE F

TRANSCRIPTION OF VERBATIM TRANSLATED PART OF INTERVIEW NO. 6 TO DEMONSTRATE HOW THEMES WERE IDENTIFIED.

Research question: "Tell me the story of your life".

Key: I = Interviewer/researcher
R = Respondent

I: Tell me the story of your life.

R: My life... in my life I used to be a teacher and lost my job due to illness. The story is that one day at work I became very, very sad and started crying, throwing books about, in front of school children. This continued for two days, and on the third day, the head teacher sent me back home, till today.

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My life has never been the same ever since that day, I started suffering. This continued till today. Ever since 1985, when I lost my job, my life has never been happy and normal. The main problem is the ailing heart. My heart is sick ma'am. Sometimes I just feel like crying or even chasing my children around, for no apparent reason. My admissions to the mental hospital are frequent. This is what is happening, it doesn't even stop. Although I am taking tablets I got from the hospital, this illness does not get better.

I: In other words you lost your job due to illness?

R: I lost my job because of this illness that pounced on me when I was at school, not knowing where it originates from… I wen back home because the principal said I should, but till today I have never been better, then I lost my job. What I'm saying is that I lost life because of this illness (silence).

I: It must be really hard for you.

R: Ag! It is really bad. I am suffering because I cannot even manage my life here at home. I am not happy the way I live, and the way my children live. When I look at my children I become very sad. Though they have a father, I am not satisfied at the way they live. It would be different if I was working, supporting them and myself as well.

This is where my weaknesses are. I am not happy. I am suffering, really suffering because of having lost life, because of this illness. This illness makes me and my children suffer. Whenever they are with me, they are frightened and hurt. Sometimes the youngest will just run away in anticipation that my illness is starting.

Sometimes when they run away, it is in the middle of the night, being hungry and naked. This in turn makes me very sad, and I remain like that. Then I will be exactly as you see me. (Throwing hands in the air). I am not leading a normal life, I am in extensive sadness that I suspect can kill a person. Sometimes I even think of committing suicide, and then decide otherwise (sobbing).

My life is really bad, as I've told you that at times I feel like taking all these tablets at the same time, so as to end my life because there is absolutely nobody helping me.

I: If I understand you correctly, you want to be assisted?

R: Yes! The problem is nobody is assisting me. I have never been supported ever since becoming sick. Ever since leaving work, I have never received any kind of support. I am just helpless.