

**LIFE STORIES OF ADULT DEPRESSED
WOMEN IN PERI-URBAN NAMIBIA**

by

NDAPEUA NEHALE SHIFIONA

MINI-DISSERTATION

submitted in partial fulfillment of the requirements for the degree

MAGISTER CURATIONIS



FACULTY OF EDUCATION AND NURSING

at the

RAND AFRIKAANS UNIVERSITY

Study Leader: Prof M Poggenpoel

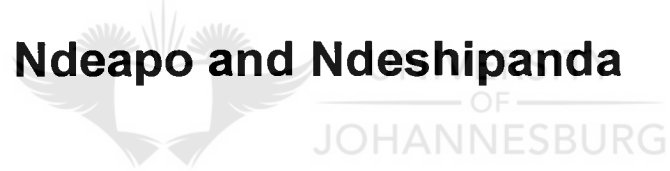
Johannesburg: November 1998

**“I WILL ALWAYS THANK YOU, GOD, FOR
WHAT YOU HAVE DONE; IN THE PRESENCE
OF YOUR PEOPLE I WILL PROCLAIM THAT
YOU ARE GOOD”**

Psalm 52: 6

This study is dedicated to my sons,

Ndeapo and Ndeshipanda



ACKNOWLEDGEMENTS

- * First and foremost, I thank God for giving me health, wisdom and determination to carry out this study.

In addition, I wish to express my sincere gratitude to the following people and institutions:

- * My family, your patience and understanding when I could not be with you because of this study.
- * To Mom and Dad for having the confidence in me.
- * Professor Marie Poggenpoel, my lecturer and study leader - your style of supervision has left a mark on my career. Your wisdom helped me see the light when it was dark. Thank you Prof for your support, motivation and inspiration.
- * The staff of the Nursing Department at Rand Afrikaans University, for their friendliness.
- * The Faculty of Medical and Health Sciences, University of Namibia for recommending my application for study leave.
- * Staff Development Committee: University of Namibia, for financial assistance.
- * Ministry of Health and Social Services: Namibia for granting me permission to conduct this study.
- * Dr N T Hamata the Regional Director for allowing me to conduct this research in his directorate.
- * Mrs H Taaru for assistance with data analysis.

- * The respondents in this study, for being cooperative and patient with me when I was collecting data.
- * Staff of Ward 16 Oshakati Hospital, for assisting me in identifying and contacting the research participants.
- * Winifred Cutter, for typing and language control.
- * Liz Klingenberg for your moral support, encouragement and assistance throughout the year.
- * Management of Sterkfontein Hospital for allowing me to use their resources, and many thanks goes to all the patients and staff in Ward 6.
- * My helper Ndategako and my sister Gwakuumbwa, for taking care of my children when I was not there.
- * Dolly for your special friendship, encouragement, support - thank you for being there.
- * All my friends for the support you have given me.
- * All those whom I might have omitted to mention for reasons beyond my control.

SUMMARY

The problems women in our community are faced with are multi-dimensional and there is absolutely no community that can be declared problem-free. Many women face the pressure of having a number of responsibilities namely working, being a wife and mother, taking care of their families and perhaps caring for aging parents. Sometimes the pressure can be too overwhelming to manage. As a result, many women become depressed.

The genuine life events that most often appear in connection with depression are various, but there is one distinguishing feature that appears in many cases, over and over: loss of self-esteem, of empowerment, of self confidence accompanied by feelings of worthlessness. In general, any life change, often caused by events beyond one's control, will damage the structure that gave life meaning.

The likelihood of becoming depressed is increased by the lack of supportive, confiding relationship with a partner, spouse, friend, stressful life events and poor communication patterns within relationships.

Studies on depression among Black-African women could not be traced. Despite the fact that considerable research on the women and depression has been done in other parts of the world, no studies have been done on similar subjects in Namibia. It was therefore considered necessary to find out how women suffering from depression from this part of the world tell their life stories.

The purposes of the study were two-fold.

- * Firstly, to explore and describe the life stories of adult depressed women in peri-urban Namibia.
- * Secondly, to use the information obtained to describe guidelines for the compilation of a health education support program for psychiatric nurses working with these patients at psychiatric outpatient clinic as well as in the community.

The research questions that were generated are: how do adult depressed women tell their life stories, and then how can the information be utilised to describe guidelines to support psychiatric nurses to assist depressed women in their quest for mental health?

The researcher used an exploratory, descriptive, contextual and phenomenological qualitative design to answer these research questions. Phenomenological interviews were conducted with ten (10) respondents who have been purposively selected. This was done after obtaining the necessary permission from the Ministry of Health and Social Services and informed consent from the research participants. The interviews were conducted by the researcher in Oshiwambo and English. Steps were taken throughout the course of the study to ensure trustworthiness. All the interviews were transcribed verbatim. Data was analysed following Tesch's method and the service of an independent coder was obtained.

The results indicate that impaired interpersonal interactions and stressful life events have a negative influence on the daily life of women leading to the development of depressive symptoms.

Guidelines intended to support psychiatric nurses were drawn up based on the themes that emerged from the raw data. These guidelines are strategies to be used by psychiatric nurses working with depressed women to assist them in managing their own depression. Possibilities for the application of the results in nursing education, nursing practice, nursing research are discussed.

It is concluded that women suffering from depression need support from the psychiatric nurses in order to facilitate the promotion, maintenance and restoration of their mental health, which is an integral part of health.

EKWATELOKUMWE

Aakiintu yomoshigwana shetu oya taalelwa komaudhigu gopendji, giili nogiili, no kakuna nande aakwashigwana yontumba taya tompolwa mo andola kaaye na omaudhigu.

Aakiintu oyendji oya taalela wo onkalo mono yo yena mo iinakugwanithwa yomaludhi ngaashi onkalo yiilonga, okukala omuhokanwa, omuvali, esiloshimpwiyu lyoofamili dhawo, nopompito dhimwe aakiintu oyo ya humbata omutenge gwokusila aakulupe oshimpwiyu. Poompito dhimwe, oothina ndhika ohadhi kala oonene noonkondo omuntu itaa vulu nande okuungaunga nadho ye mwene.

liningwanima mbyoka olwindji monkalathano hayi kwatakanithwa kumwe nuuvu mbuka womwenyo gu li moshizimbi/gwa ziyalala, oyili pamaludhi ogendji. Ihe nando ongaaka opena yimwe mbyoka ya dhindhilikwa hayi holoka olwindji momukithi nguka ngaashi: omuntu a kanitha eitulo komwaalu, uvite keena etu, keena oonkondo ("empowerment"), kee hena einekelo muye mwene na olwindji oku uvite keena ongushu.

Monkalo yokwalukehe, omalunduluko monkalo yomuntu ngoka ga etwa kiiyetithi mbyoka omuntu keena oonkondo okulundulula po sha, oha yi ka eta eyonuko mwaashoka omuntu a tala shina ongushu monkalomwenyo ye.

Ompito yokukwatwa kuuvu mbuka womwenyo gwa ziyalala/gu li moshizimbi oha yi etwa popepi unene tuu ngele kapena eyambidhidhathano pokati kaaholathani nenge okuziilila kookuume oshowo kaakwanezimo, nenge pena iithiminiki oyindji monkalathano oshowo omakwatathano pakupopya ga nkundipala.

Kapena nande omishangwa tadhi holola ekonaakono/eshiililo lyaningwa nale mokati kaakiintu aayAfrika mbono taya ehama uuvu woshizimbi shokomwenyo ("depression"). Nonando ta ku monika ngaa momishangwa omakonaakono kombinga yomukithi nguka ngono ga ningwa kiitopolwa yilwe muuyuni, ekonaakono/eshiililo lyoludhi nduka inali ningwa mo nale moNamibia.

Shika osho sha etitha ompumbwe yokuninga eshiililo lyomuule okutala kutya, aakiintu yomoshitopolwa shika shuuyuni (Namibia), mbono taa ehama uuvu mbuka womwenyo guli moshizimbi/gwa ziyalala, onkalo yawo yoyene otaye yi hokolola ngiini.

Elalakano lyeshiililo ndika olili po paali:

- * Tango, okushiilila, okuuva nokulandula onkalamwenyo yomukiintu omuNamibia eniwe kuuva womwenyo guli moshizimbi nkene ye mwene te yi hokolola, ngaashi eyi tseye no kwe yi koneka.
- * Olutiyali, oku longitha uyelele mboka tau zi meshiililo ndika oku eta po omisindalongo ndhoka tadhi ka longithwa kaapangi okutota po oopolograma dhoku yambidhidha aakiintu mbaka.

Omapulo ga longithwa meshiililo ndika ogo:

⇒ Omukiintu omukokele eniwe kuuwehame womwenyo guli moshizimbi ota hokolola ngiini onkalo ye?

⇒ Na, omauyelele ta ga ziilile meshiililo ndika ota ga ka longithwa ngiini okukwathela aakiintu mbaka muuwehame wawo moonkambadhala dhawo yene okukonga onkalonawa yili hwepo pamaiuvo?

Oonkundathana dhomuule dhokunongonona, okupotokonona nokukonaakona ekota lyuuvu mbuka odha ningwa naakiintu omulongo (10) mboka ya hogololwa nelalakano. Shika osha li sha ningwa konima sho omukonaakoni a pewa eziminino okuziilila kOshikondo Shuuhaku nOnkalonawa, oshowo ezimino ndyoka lya gandjwa koonakukutha ombinga mekonaakono ndika.

Oonkundathana odha ningwa komukonaakoni ye mwene mOshiwambo nomo Shiingilisa. Opwa kuthwa woo oonkatu dhokukwashilipaleka eineekelathano mekonaakono ndika. Oonkundathana adhihe odha ningwa pakupopya.

Oonkundathana odha ndjandjukununwa pamulandu gwa Tesch, na okwa longithwa wo ekwatho lyomundjandjukuni gumwe iili keeshi na ku shiilila.

lizemo yomoonkundathana ndhika oya ulike nkene omayamukulo-kwatathano pokati kaantu ngono gaa heli nawa, oshowo iiningwanima iiwinayi monkalo yomuntu yesiku kehe tayi vulu okweeta iilanduliko iiwinayi mbyoka tayi fala sigo omuuwehame woshizimbi.

Omisindalongo odha fanekwa po shi ikwatelela moshizemo shekonaakono ndika, opo ku kwathelwe aapangi mboka ye li mekwatatathano naakiintu ye niwe kuuvu woshizimbi ("depression") ya vule okwiikwatha mokuungaunga nuuvu wawo.

Okwa talika wo oompito dhokulongitha omisindalongo ndhika ongele melongo lyopauhaku, metulo miilonga lyoshilonga shopauhaku, oshowo meshiililo lyopauhaku.

Nohugunina okwa talikako kutya aakiintu mbono ta ya ehama uuvu woshizimbi ("depression") oya pumbwa noonkondo eyambidhidho lyaapangi opo ya vule oku longitha oonzo dhawo yene okuhumitha komeho, okukaleka po, nokugalulila po onkalo yawo yonawa.

TABLE OF CONTENTS

		Page
<u>CHAPTER 1</u>		
<u>ORIENTATION AND OVERVIEW</u>		
1.1	ORIENTATION	1
1.1.1	BACKGROUND INFORMATION	1
1.2	OVERVIEW OF THE STUDY	3
1.3	PROBLEM STATEMENT	6
1.4	PURPOSE OF THE STUDY	7
1.5	CENTRAL STATEMENT	7
1.6	PARADIGMATIC PERSPECTIVE	8
1.6.1	Metatheoretical assumptions	8
1.6.2	Theoretical assumptions	11
1.6.2.1	Nursing theory	11
1.6.2.2.	Theoretical statements	11
1.6.2.3	Theoretical definitions	12
1.6.3	Methodological assumptions	15
1.7	RESEARCH DESIGN AND METHOD	15
1.7.1	Research design	15
1.7.1.1	Characteristics of the research field/subjects	16
1.7.1.2	Assumptions of the researcher	16
1.7.1.3	Research context	16
1.7.1.4	Purpose of the research	17
1.7.2	Research method	17
1.7.3	Ethical consideration	19
1.7.4	Measures to ensure trustworthiness	19

1.8	CONCLUSIONS, LIMITATIONS, RECOMMENDATIONS	19
1.9	DIVISION OF CHAPTERS	19
1.10	SUMMARY	20
	<u>CHAPTER 2</u>	21
	<u>RESEARCH DESIGN METHOD</u>	21
2.1	INTRODUCTION	21
2.2	RESEARCH RATIONALE	21
2.3	RESEARCH PURPOSE	22
2.4	RESEARCH DESIGN AND METHOD	22
2.4.1	Qualitative	22
2.4.2	Exploratory	23
2.4.3	Descriptive	23
2.4.4	Contextual	24
2.5	RESEARCH METHOD	24
2.5.1	Phase 1: Exploration and description of the life world of adult depressed women.	24
2.5.1.1	Sampling	25
2.5.1.2	Data collection	27
2.5.1.3	Data analysis	30
2.5.1.4	Literature control	33
2.5.2	Phase 2: Description of the guidelines for the compilation of a mental health support program for psychiatric nurses to assist adult depressed women in mobilizing their resources to facilitate	

	the promotion, maintenance and restoration of their mental health as an integral part of health.	33
2.5.3	Trustworthiness	34
2.5.4	Ethical measures	36
2.6	CONCLUSIONS AND RECOMMENDATIONS	38
2.7	SUMMARY	38
 <u>CHAPTER 3</u>		39
 <u>DISCUSSION OF THE FINDINGS</u>		39
3.1	INTRODUCTION	39
3.2	DESCRIPTION OF A SAMPLE	39
3.3	RESULTS	39
3.4	DISCUSSION OF FINDINGS	40
3.4.1	Impaired interpersonal interaction	40
3.4.1.1	Poor interpersonal relationship related to impaired communication with a spouse.	41
3.4.1.2	Poor interpersonal relationship related to impaired communication with a partner.	43
3.4.1.3	Poor interpersonal relationship related to impaired communication with family, friends and others.	44
3.4.2	Stressful life events	46
3.4.2.1	Lack of personal worth related to disempowerment as evidenced in deprivation of personal freedom.	46
3.4.2.2	Lack of personal worth related to disempowerment as evidenced in inability to bear children.	47

3.4.2.3	Lack of personal worth as related to disempowerment as evidenced in inadequate emotional, financial and material support.	48
3.4.2.4	Lack of personal worth as related to disempowerment as evidenced in emotional, spiritual and physical distress.	49
3.4.2.5	Lack of personal worth as related to disempowerment as evidenced in loosing control.	52
3.5	FIELD NOTES	52
3.5.1	Appointments	53
3.5.2	Interviews	53
3.5.3	Data analysis	53
3.6	CONCLUSION	54
	<u>CHAPTER 4</u>	56
	<u>GUIDELINES, LITERATURE CONTROL, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS.</u>	56
4.1	INTRODUCTION	56
4.2	GUIDELINES FOR PSYCHIATRIC NURSES TO SUPPORT ADULT DEPRESSED WOMEN	56
4.2.1	Improval of interpersonal interaction.	57
4.2.2	Provide strategies to deal with stressful life events.	62
4.3	CONCLUSION OF THE STUDY	64
4.4	PRACTICAL PROBLEMS ENCOUNTERED - LIMITATIONS	65

4.5	RECOMMENDATIONS	66
4.5.1	Psychiatric nursing practice.	66
4.5.2	Psychiatric nursing education.	66
4.5.3	Psychiatric nursing research.	67
4.6	SUMMARY	67
	BIBLIOGRAPHY	68



LIST OF TABLES

TABLE 1.1	Number of recorded psychiatric patients admitted to Oshakati Hospital 1996 - 1997	5
TABLE 2.1	Strategies to ensure trustworthiness which will be applied in this research	35
TABLE 3.1	Major themes, categories and sub-categories	40
TABLE 4.1	Content and sequence for psychoeducational group meetings	61



ANNEXURES

ANNEXURE 1 Request for consent to conduct research

ANNEXURE 2 Request for consent to conduct research

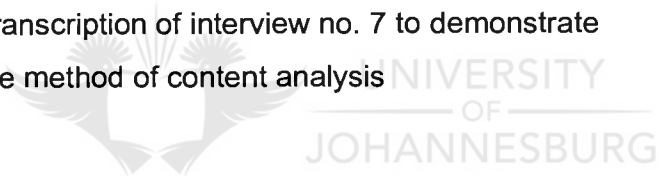
ANNEXURE 3 Request for consent from participants

ANNEXURE 4 Permission letter from the Directorate :
North West Health Region

ANNEXURE 5 Approval letter from the Ministry of Health
and Social Services

ANNEXURE 6 Protocol for co-coder

ANNEXURE 7 Transcription of interview no. 7 to demonstrate
the method of content analysis



LIFE STORIES OF ADULT DEPRESSED WOMEN IN PERI-URBAN NAMIBIA

CHAPTER 1


1.1 ORIENTATION AND OVERVIEW

In chapter one, background information about Namibia, overview of the study, problem statement, paradigmatic perspective, research design and method will be presented.

1.1.1 BACKGROUND INFORMATION

A brief overview of the geography, population and health in Namibia will be discussed.

* **GEOGRAPHY**



Namibia is situated in the South West corner of Africa, and shares borders with Angola and Zambia in the North, Zimbabwe at the eastern end of Caprivi strip, Botswana to the East and South Africa in the South and South-East Atlantic Ocean. Namibia straddles the tropic of Capricorn, which divides the country in almost equal halves. The country has a surface area of 824,295 km² and ranks as Africa's fifteenth largest country. Namibia is geographically divided into three major regions, the Namib Desert, the Central Plateau and the Kalahari Desert. The Namib Desert is situated in the Western part of the country stretching approximately 1400 km along the Atlantic coast. The central plateau lies between the two deserts (Namib and Kalahari). This plateau comprising more than 50% of the total land area of Namibia. The plateau is the most fertile area in the country and most suitable for human settlement. The Kalahari is a semi-desert situated in the South Eastern part of the country. This part is also suitable for farming.

Rainfall is the main factor influencing the climate of Namibia. The average annual rainfall for the country is only 270 mm and 92% of the land is extremely arid, (22%) arid, or semi-arid (27%), while the remainder is sub-humid (NDHS 1992:1)

* **POPULATION**

The total population of Namibia is estimated to be 1,7 million given that in 1991 census it was 1,4 million with a 3% growth rate (Social Welfare Policies in Namibia the Draft Green paper 1997:5). The country is characterized by a large and growing youth population. Children between 0 - 14 years constitute about 42% of the total population, whilst adults 15 - 64 years are about 53% and old persons (65 and older) are about 5%. The population distribution shows that more women, children and aged live in rural areas of Namibia. More than 50% of the population lives in the northern part of the country and the remaining is scarcely distributed in the rest of the country. Twenty six percent of the population lives in the urban areas and the remaining 74% live in rural areas. Namibia is divided into 13 political regions which are further divided into constituencies, which in turn are divided into wards (Population and Housing Census, 1991:2).

* **HEALTH**

The government of Namibia has a commitment to attain the goals of the global strategy for "Health for all by the year 2000 and beyond". As a result of this commitment, many preventative as well as promotive programs addressing the plight of children and women have been put in place for example the Women and Child Protection Unit. These units provide a conducive environment for the management of all forms of women and child abuse cases.

From the geographical setting point of view, North West Health and Social Service Directorate is situated in the northern part of Namibia.

The Directorate is composed of four political regions; Oshana, Ohangwena, Oshikoto and Omusati. The total surface area is 56118 square km, population is estimated 756 051 as per projection of 1997. Population density is 13,47 per square kms. (Division Social Services - Northwest Health and Social Services Directorate annual report, 1996:3). There are 9 district hospitals and one regional referral hospital, 11 health centres and 86 clinics. This single regional hospital is also serving all the psychiatric clients and patients within the whole North West Health Directorate.

Consumers for the psychiatric services are served by a psychiatric unit within this regional hospital which has both an in- and out-patient component. Common psychiatric problems encountered in the region are psychotic disorders such as schizophrenia; psychosocial disorders often related to the stress of migration, unemployment, violence and urbanization, for example depression. Other social problems among others include alcohol abuse, women and child abuse, orphanhood, poverty and HIV/AIDS.

The state of mental health problems in the region is characterized by inadequate mental health facilities, insufficient mental health personnel like psychiatrists, psychiatric nurses, social workers, clinical psychologists, as well as lack of interest and negative attitude towards mental illness among some of the health personnel.

1.2 OVERVIEW OF THE STUDY

Women in our community are regarded as the backbone of its existence. They assume numerous responsibilities every day of their life with little recognition of the important role they play within the families as well as in the communities. On the other hand women are among the most vulnerable groups subjected to social problems such as violence, discrimination against women as well as health problems.

Recent reports on the incidence of depression indicate a preponderance of women in all age groups and in most countries. (Jones, 1994 : 29).

Evidence from various reports suggest that the rate of depression in women is twice that of men. One wonders whether this is actually the case or does this data instead reflect a higher use of mental health facilities by women? (Gordon & Ledray, 1990:13). In a study done by Weissman and Klerman (1989:4) from clinical observations; surveys of persons not under treatment; studies of suicide and suicide attempts, the data were strikingly consistent across these various populations with a 2:1 sex ratio. When compared to men, one consistent finding through the literature is that while women preponderate in a depressive population, this is accounted for almost totally by higher rates for married women (Jones, 1994:29).

Married women are consistently found to have higher rates of depression than single, widowed or divorced women, and single, married, divorced or widowed men. Marriage thus appears to have a protective effect on men (Mynard, 1993:10). A study conducted with African - American women (Warren, 1994:29) came up with the following findings:

This group is affected by their double minority status of being black and female within American society. As minority members, African - American women encounter barriers against full participation within American society and are affected by the dynamics of that society. They occasionally find themselves situated at the lower end of the economic, political system and are involved in contradictory ethnic, cultural, family and work roles. These women are at risk for depression because of the occurrence and linkage of their minority status and role contradiction. It should be borne in mind that these statistics are sometimes not reliable due to the controversy regarding misdiagnosis and the lack of clinical research. Carrington (in Warren, 1994:31) examined contextual factors in African - American women from a middle-class group. She found that all these women had incurred psychological or physical separation from their parents during their childhood years. The women developed negative (that is prolonged) patterns of grief, lowered self-concept and depressive symptoms.

Other themes identified from these studies conclude that these women express feeling down and low, feeling blue and depressed, losing control, feeling lonely, feeling suicidal, could not eat and professionals do not understand their problems.

Having the mental picture of a depressed African - American women, how does it differ from that of an African woman? What are the similarities and differences? No literature could be traced on similar studies among the urban or rural Namibian women. Besides the absence of related studies, statistics display an increase in a number of women reporting at psychiatric units with depression as a diagnosis. (Female admission register, 1996).

During 1996 (January - December) a total of 403 female psychiatric patients were admitted in Oshakati Hospital. Common diagnosis were schizophrenia, major depression, post-partum depression, manic depressive episode, suicidal ideas, alcoholic psychosis, epileptic psychosis. Out of this total, seventy one patients had major depression as their diagnosis (17,6%). In 1997 (January - December) 399 female patients were admitted whereby seventy four of them suffered from major depressive episode (18,5%). (Female admission register, 1997).

Table 1.1 Number of recorded psychiatric patients admitted in Oshakati hospital 1996 - 1997.

Year	1996	1997
Total number of female cases admitted	403	399
Number of women suffering from depression	71	74
Percentage (%)	17.6%	18.5%

Source: Females admission register - Oshakati Psychiatric units.

Depression, being a common phenomenon among the female adult population is observed to be on the increase in our communities. This is because of the high demands imposed upon women by the society we live in with little recognition. For this reason, their mental health deserves to be the focus of health care professional and researchers.

According to the narrative approach (White, 1993:35), a depressed women is regarded as an expert of her own life and that each person is responsible for the how and the writing and rewriting of her own story. It has become a priority to involve patients in their treatment program by allowing them to be co-authors

of their own life stories. It is therefore the duty of the advanced psychiatric nursing practitioner to facilitate the promotion, maintenance and restoration for mental health, which is an integral part of health/wholeness (Poggenpoel, 1994:55).

By focusing on adult depressed women, the researcher is attempting to close the gap in the understanding of these women's life world.

1.3 **PROBLEM STATEMENT**

Between 1996 and 1997 depressive episodes were common among the inpatient admission of women in Oshakati hospital psychiatric unit. Health workers at this unit reported that the problem is more common among females between 21 and 55 years of age. During the same period a high suicide rate was common in this population although the latter has affected both males and females. Many a time depression was reported being an outstanding clinical manifestation among patients with suicidal tendencies. Community members express their concern about the suicide rates. Little is being done locally to elicit answers to their questions about the disorders. The focus of this study is on adult depressed women between 21 - 55 years of age. The period has been chosen because of a number of major life changes taking place during this period.

Some of these major changes include: experience of major crisis related to marital problems, job changes, assumption of major social roles, evolution of an adult self during early and middle adulthood. According to Kaplan, (1994:57) persons in their 30's become increasingly concerned with achieving great authority, independency and self-sufficiency, and if these have not been achieved, major problems are anticipated. During middle adulthood important gender changes occurs.

Many women no longer need to nurture young children, are able to release their energy into independent pursuits that require assertiveness and a competitive spirit, traits that were traditionally considered to be masculine.

As the person approaches the age of 50, they clearly define what they want from work, family and leisure. But sometimes lack of freedom in life style, rigidly established social rules and a sense of entrapment may lead to depression and loss of confidence.

It is in lieu of the above that the researcher has come up with the following questions:

- ⇒ What are the life stories of the adult depressed women?
- ⇒ How do they write and rewrite the stories of their life?
- ⇒ How can the obtained information be utilized to describe the guidelines to develop a mental health education program to support these women?

1.4 PURPOSE OF THE STUDY

The purpose of this exploratory, descriptive study is two fold:

- ⇒ Exploration and description of the life stories of adult depressed women.
- ⇒ Description of guidelines for the compilation of a mental health education support program for psychiatric nurses to assist adult depressed women in mobilizing their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

1.5 CENTRAL STATEMENT

The exploration and description of the life stories of depressed women will provide the basis for generating guidelines to be used by psychiatric nurses when compiling a mental health education support program that will assist depressed women to mobilize resources to promote, maintain and restore mental health as an integral part of health.

1.6 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of the research study is based on “Nursing for the Whole Person/Theory” (Rand Afrikaans University, 1992:5-9) which in turn is based on the “Nursing for the Whole Person/Theory”, Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142). This theory is based on the Judeo - Christian Philosophy, which accept Biblical principles and values as the source of truth, and regards the individual as a God-created whole being who consists of body, mind and spirit. The concept “body” refers to biological processes; “mind” refers to emotional, volitional and intellectual processes and “spirit” refers to that part of the individual who stands in relation to God (Rand Afrikaans University, Department of Nursing Science, 1992:5).

The researcher acknowledges the complexity of the research phenomena and believes that the holistic approach is suitable to research a person’s experience and that equality exists between the researcher and the research respondents.

1.6.1 METATHEORETICAL ASSUMPTIONS

The researcher will support and incorporate the Nursing for the Whole Person Theory (NWPT) as a paradigmatic perspective for this research. These include person, mental health, mental illness, psychiatric nursing, environment, wholeness.

* **PERSON**

Valle, King and Halling (in Huysamen 1994:166) states that the person is viewed as having no existence apart from the world and the world as having no existence apart from persons. Each individual and his/her world are said to co-constitute one another. Thus a person derives his or her true meaning to his/her world. By life-world, is meant the world as lived by a person and not some entity separate from or independent of him/her. The person is dependent on his/her world for his/her existence.

Because of the unity between the researcher and what is being researched, the phenomenologist believes that human behaviour cannot be understood without appreciating the context in which it takes place. Phenomenologists are concerned with understanding social and psychological phenomena from the perspective of the persons involved.

Person in this study refers to the women suffering from affective disorder namely, depression, and the researcher. They are all spiritual beings who function in an integrated biopsychosocial manner to achieve their quest for wholeness. They interact holistically with their internal and external environment. Their experience of any situation will thus be seen as holistic.

* ***MENTAL HEALTH***

Mental health is an integral part of wholeness. Wholeness is a state of spiritual, mental and physical wholeness. The pattern of interaction between internal and external environment determines the individual's health status. Mental health can be qualitatively described on a continuum from maximum health to minimum health. In this study, the patterns of interaction of external and internal environments of adult depressed women determine her mental health. (NWPT, 1992 : 5 - 9).

* ***MENTAL ILLNESS***

According to Nursing for the Whole Person Theory, illness is a dynamic condition which reflects stress factors in the patterns of interaction man has both with his internal and external environment. For a depressed woman, a number of stressors exist and interferes with her quest for wholeness. However, health potential exist in an ill person. (NWPT, 1992 : 5 - 9).

* ***PSYCHIATRIC NURSING***

It is a cultural-sensitive interactional process between a psychiatric nurse and a patient which is concerned with the provision of a comprehensive mental health service (promotion, maintenance and

restoration) in assisting an adult depressed woman in her quest for mental health as an integral part of health (Poggenpoel, 1994:52).

The psychiatric nurse approaches a depressed woman as a whole person. She focuses on the woman's mental processes that influence the patterns of interaction between the internal and the external environment.

The mental processes include intellectual, volition and emotional process. Because a person is whole, his mind influences his body and spirit (Poggenpoel, 1994:12).

Promotion of mental health refers to those nursing activities that contribute to a greater degree of wholeness in an adult depressed woman.

Maintenance of mental health refers to nursing activities that are directed towards promoting and preserving the health status of an adult depressed woman.

Restoration of mental health refers to nursing activities that facilitate the return to the previously experienced levels of health of an adult depressed woman (Oral Roberts University: Anna Vaughn School of Nursing, 1990:136-142, Rand Afrikaans University: Nursing Department, 1992:7-9).

* **ENVIRONMENT**

The environment of a depressed woman is multidimensional. The internal environment comprises the body, mind and spirit, while the external environment comprises physical, social and spiritual dimensions. (NWPT, 1992 : 5 - 9).

* **WHOLENESS**

Health and wholeness are used interchangeably. Wholeness/health refers to physical wholeness, mental wholeness and spiritual wholeness. The achievement of wholeness is a goal that is sought by all individuals. The objective of nursing care is to facilitate the wholeness of the individual, family and community. Wholeness in this research study implies the quest for mental health of a depressed woman through effective nursing care by a knowledgeable psychiatric nurse. (NWPT, 1992 : 5 - 9).

1.6.2 **THEORETICAL ASSUMPTIONS**

The following are the theoretical assumptions guiding the conduct of this study.

1.6.2.1 **NURSING THEORY**

The underlying nursing theory in this research is the Nursing for the Whole Person Theory (Oral Roberts University: Anna Vaughn School of Nursing, 1990:136-142; Rand Afrikaans University: Nursing Department, 1992:7-9). However, the theory will be suspended during data collection and will be used after data analysis has been completed, to reflect the results of the research. The following statements which are deduced from this theory are, therefore, taken for granted:

1.6.2.2 **THEORETICAL STATEMENTS**

- ⇒ An adult depressed woman is a spiritual being who functions in an integrated bio-psychosocial manner to achieve her quest for wholeness.

- ⇒ An adult depressed woman interacts holistically with her internal and external environment.

⇒ The Whole Person Nursing approach to individuals, focuses simultaneously on spiritual, mental, physical and social aspects of wholeness.

⇒ The advanced psychiatric nursing practitioner, through the health care delivery system, facilitates promotion, maintenance and restoration of the mental health of an adult depressed woman.

1.6.2.3 THEORETICAL DEFINITIONS

Some concepts and statements have already been identified, organised and defined in Nursing for the Whole Person Theory. The following statements will be defined as follows:

* ***FACILITATION***

In nursing, facilitation is a combination of processes and actions which empower nurses to restore, promote and maintain health for individuals, families and communities. The nurse creates a positive, therapeutic climate for the attainment of nursing goals and objectives. The central purpose of facilitation is to alter human behaviour. Facilitative processes in nursing should instill within humans the desire to attain health and internalize responsibility for health (Kozier & Erb, 1992:290-291). The relevance of this definition to the study is that the process of communication constitute the backbone in interpersonal relationships of depressed women.

* ***SUPPORT***

To support someone is to help that person maintain his strategies for interaction. This interaction ensures coping with the circumstances of his life and includes daily coping mechanisms which respond to the demands of daily adaptation.

This includes verbal and non-verbal communication, the mobilization of resources (psychological, social, emotional, spiritual, financial/material). Respect for the choices of the individual and his autonomy are ensured (Kozier & Erb, 1992:290-290).

Guidelines for the support of psychiatric nurses to assist adult depressed women will form the second phase of this research.

Support as intervention includes providing comfort with interpersonal and physical care dimensions. The emphasis will be placed on decreasing anxiety and enhancing self esteem, empowering depressed women as well as assisting them to find meaning in their life.

* ***LIFE STORIES***

It is a description of the important events and experiences in a person's life told in ways that capture the person's own feeling, views and perspectives. Life stories and the reactions of others to them are of central importance to the patient. Such stories maintain or threaten their personal well being (Marshall & Rossman, 1995:88).

* ***DEPRESSION***

Being clinically depressed is very different from the down type of feeling that all people experience from time to time. Occasional feelings of sadness are normal part of life and it is unfortunate that such feelings are often colloquially referred to as "depression". There are things in everyone's life that are possible causes of sadness, but people who are not depressed manage to cope with these things without becoming incapacitated. As one might expect depression can present itself as feeling sad or "having the blues". However, sadness may not always be the dominant feeling of a depressed person.

According to DSM IV (APA, 1994:162) definition, a major depressive episode is characterised by the following:

⇒ depressed mood most of the day, nearly every day as indicated by either subjective report or observation made by others.

⇒ diminished interest or pleasure in all activities of the day.

⇒ appetite and/or weight loss or over eating and weight gain.

⇒ decreased energy, fatigue, being “slowed down”, restlessness, irritability, difficulty concentrating, remembering, making decisions.

⇒ Feelings of guilt, worthlessness or excessive or inappropriate guilt nearly everyday.

* **PSYCHIATRIC NURSE**

This refers to a professional person who is educated to interact with a patient in a goal directed way in assisting him/her to mobilize his/her resources to facilitate his/her quest for mental health as an integral part of wholeness. (Poggenpoel, 1994:54). She must be registered with the Namibian Nursing Board as a psychiatric nurse.

* **ADVANCED PSYCHIATRIC NURSE**

Refers to a clinical nurse specialist, who has advanced expertise in a psychiatric nursing speciality, who understands a broad range of theories that apply to clinical practice, who maintains patient care as a primary focus, continues to excel in practical skills, articulates and demonstrates how specialist nursing practice makes a difference (Bousfield, 1997:253), and has a Masters or Doctoral degree in psychiatric nursing as a speciality and other additional experiences (Hamilton, 1992:62).

* **RESOURCES**

This includes any assets or means of assisting the patient to facilitate his/her quest for wholeness. Resources in a depressed woman's internal environment include physical, mental, spiritual resources and those in the external environment include personal resources such as significant activities, others, and objects and professional resources such as people and organizations (Poggenpoel, 1994:13).

1.6.3 METHODOLOGICAL ASSUMPTIONS

The assumptions according to Botes model (1992:19-23) is that scientific development and professional advancement in nursing should arise from a functional approach. Therefore, any scientific advancement in nursing is for contextual application of any knowledge gained, thus advancing the practice of nursing.

Validation of the research findings is found in the applicable utility in nursing practice and in the improvement of that practice. In the context of this study, the ultimate goal is to provide quality nursing that support adult depressed women in their quest for wholeness. Both researcher and practitioners have a co-responsibility to apply the knowledge generated by research.

1.7 RESEARCH DESIGN AND METHOD

1.7.1 RESEARCH DESIGN

The research design for this study is qualitative, exploratory, descriptive and contextual in nature. This design follows the research model in nursing outlined by Botes (1992:12). According to Botes (1995:6), nursing activities takes place at three orders which are interrelated and which influence one another.

The first order is the nursing practice, which is the research domain for nursing and has certain characteristics which serve as determinants for research decision.

The second order represents the theory of nursing and research methodology. Research methodology is the research decisions which are taken within the framework of the determinants of the research decisions. The determinants of research are: the characteristics of the research field, assumptions of the researcher, the research objectives and the research context.

The third order represents the paradigmatic perspective of nursing. In nursing, more than one paradigm may be involved. In the context of this research, the Nursing for the Whole Person Theory, provide the meta theoretical and theoretical components of the paradigm.

1.7.1.1 CHARACTERISTICS OF THE RESEARCH FIELD / SUBJECTS

The research field is the specific cultural context wherein adult depressed women live. These women come from geographical areas where psychiatric facilities and services are not readily available. They all rely on the only facility within the Regional Hospital which is also a referral hospital for all psychiatric patients within the whole North West Health Directorate of Namibia.

1.7.1.2 ASSUMPTIONS OF THE RESEARCHER

They emanate from the paradigmatic perspectives on which the research is based and have already been discussed under 1.6.

1.7.1.3 RESEARCH CONTEXT

The context of this study pertains to adult depressed women residing in the peri-urban set-up of Oshakati, Northern Namibia. The study is confined to black adult depressed women.

1.7.1.4 PURPOSE OF THE RESEARCH

This was discussed in section 1.3 of this study.

Based on these determinants of research, the following decisions were made with regard to the design: qualitative, exploratory, descriptive, phenomenological and contextual.

1.7.2 RESEARCH METHOD

A phenomenological method of data gathering utilizing narrative story telling will be used. In phenomenological method, the researcher approaches the subject and the experience with an open mind accepting whatever data is given. In addition, no data is ignored because of conflicts with the established criteria, operational definitions or theoretical frameworks. The goal of phenomenological method is an accurate description of the experience under study. This method requires the researcher to let the experience unfold as it exists for the subject in an unbiased way. While recognizing that the quality of descriptions may vary and that the more criteria identified, the better the final results for the researcher, helpful clarifications by the researcher are discouraged so that the resulting description is truly the experience as the subject experiences it (Omery, 1988:57).

Two major phases will structure the research:

Phase 1: The exploration and description of the patterns in the life stories of adult depressed women. The sample will be selected using the non-probability, purposive, convenience method and participants will need to meet specific criteria. The sample will be purposive because the participants will be deliberately selected. The choice of the participants will be non-selective because depressed women between the age 21

and 55 meeting the criteria for selection will be included and not only ideal participants. The sample population will consist of black, female, adult depressed women who attend outpatient psychiatric clinic at a regional hospital. Patients who are not severely depressed and able to tell their life story freely. Ten (10) adult depressed women will be conveniently selected for an in-depth interview.

Justification of the sample size

This is an in-depth semi-structured interview which has to be undertaken over a limited time frame. Data is gathered in this method in a lengthy interview that may be continued when validating the descriptions of the phenomena with some of the respondents. Because of the length of the data gathering interview(s) and the detail of the complete descriptions the sample size is usually small (Omery, 1988:56).

Data collection will be done utilizing phenomenological interviews and observation. Audiotape recording will be made of the interviews that will be transcribed during data analysis.

Literature Control

Previous studies will be investigated to establish similarities as well as to determine the uniqueness of the present study.

Phase 2: Description of the guidelines for psychiatric nurses to assist in the compilation of a mental health education support program when rendering nursing care to adult depressed women. The guidelines will be generated from the results of the life stories which will be discussed with experts in the field of mental health for the purpose of refining them.

1.7.3 **ETHICAL CONSIDERATION**

Ethical consideration will be made based upon the position paper of ethical standards (South African Nursing Association: 1991). This includes obtaining consent from the hospital management to conduct research in their institution and obtaining willing and informed consent from all participants. Interviews are to be conducted in a non threatening way in an environment free of both physical and mental harm.

Participation will be voluntary and participants will retain the right to withdraw at any time without any pressure or coercion. Participant anonymity will be ensured and human rights will be protected.

1.7.4 **MEASURES TO ENSURE TRUSTWORTHINESS**

Guba's (in Lincoln & Guba, 1985:250 & Krefting, 1991:214) Model of Trustworthiness will be adhered to.

See complete discussion on strategies to ensure trustworthiness in Chapter 2.

1.8 **CONCLUSIONS, LIMITATIONS, RECOMMENDATIONS**

Conclusions will be formulated, limitations discussed and recommendations made in respect of findings in the research project for psychiatric nursing education, practice and research.

1.9 **DIVISION OF CHAPTERS**

Chapter 1	:	Overview of the study and rationale
Chapter 2	:	Research design and methods
Chapter 3	:	Results and literature control
Chapter 4	:	Guidelines, conclusions, limitations and recommendations

1.10 **SUMMARY**

The overview, problem statement, paradigmatic perspective, research design and method has been stated. The research method and design will be fully described in Chapter 2.



CHAPTER 2

RESEARCH DESIGN AND METHOD

2.1 INTRODUCTION

Qualitative research forms the basis of this research design and method. It is used as a vehicle for studying the empirical world from the perspective of the subject, not the researcher. Qualitative methods allow exploration of a human by humans in ways that acknowledge the value of all evidence, the inevitability and worth of subjectivity, the value of a holistic view, and the integration of all patterns of knowing (Streubert & Carpenter 1995:50). With this approach a systematic inquiry is implemented which is concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings. The application of a qualitative research strategy is almost the natural result of interest in answers to specific types of questions guided by the problem and the aim set by a researcher (Myburgh & Poggenpeol, 1995:5). The strategy aims to gather data on numerous aspects of a situation and to construct a complete picture of the social dynamics of the particular situation or setting (Cresswell, 1994:145).

In chapter 1 an overview of the research study was discussed. In this chapter, a description will be given of the rationale, objectives, research design and method for this study. Trustworthiness will also be addressed. The task of the psychiatric nurse is to use a scientific method to promote mental health and prevent mental illness in the community where she finds herself. She has an important role to play in the promotion of mental health and prevention of depression in women.

2.2 RESEARCH RATIONALE

Depression being the most commonly diagnosed mental illness among women, has an adverse effect on the social life of women, which manifest itself in impaired marital and parenting relationships, repeat visits to the physician and increased hospitalization.

At the same time, very little, if any, social support is available for these women. This research will look at their life stories and on its impact on their quest for mental health as an integral part of health.

2.3 RESEARCH PURPOSE

The study has the following purposes based on the identified problems:

- ⇒ to explore and describe the life stories of adult depressed women in a peri-urban in Namibia.
- ⇒ to describe guidelines for the compilation of mental health support program for psychiatric nurses to assist adult depressed women in mobilizing their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

2.4 RESEARCH DESIGN AND METHOD

A research design is defined as a set of guidelines and instructions to be followed in addressing the research problem (Mouton, 1996:107). The design used in this study will be qualitative, exploratory, descriptive and contextual.

2.4.1 QUALITATIVE

It will be a qualitative study in that it is aimed at the best possible understanding of the context of the life story of a depressed woman. A method whereby the unique and dynamic nature of respondents can be understood. This gives meaning to the whole (Burns & Grove, 1993:28-29). Schmid (in Krefting, 1991:214) defines qualitative research as the study of the empirical world from the viewpoint of the person under study. Emphasis is placed on the subjective meanings and perceptions of the subject, therefore it is the researcher's responsibility to access these.

With this approach people are being observed in their own territory and interacting with them in their own language, on their own terms.

The study seeks to gain insight into the life story of adult depressed women. It is concerned with the nature of these experiences which are unique to each individual. Its qualitiveness can also be explained by the fact that it is a systematic subjective approach used to describe life stories and giving them meaning (Burns & Grove, 1993:28-29; Kvale, 1996:30-33).

2.4.2 **EXPLORATORY**

The research study will be an exploratory study with the purpose of increasing insight and generating meaning regarding the experience and life stories of adult depressed women. The researcher will depart from a position of "not knowing" and this will enable her to gain insight into the phenomenon (Burns & Grove, 1993:28-29)

2.4.3 **DESCRIPTIVE**

The study is descriptive because it is directed towards understanding and describing the life stories of the patient in question. The intention of the researcher is to obtain unique, subjective information from the patient in order to describe the reality of the phenomenological experience and not the reality as the researcher believes it to be. It is the researcher's goal to describe that which exists as accurately as possible by collecting accurate information or data on the domain phenomena which are under investigation (Mouton & Marais, 1990:43-44)

The life stories of depressed women will be explored and described. The saturated themes will provide guidelines intended to develop a support program for psychiatric nurses assisting depressed women to mobilise their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (Swanson-Kauffman & Schonwald, 1988:99).

2.4.4 CONTEXTUAL

A contextual study is one where the phenomenon of interest is studied in terms of its immediate context (Mouton & Marais, 1990:49). The person has a world which is the meaningful set of relationships, practices, and language that we have by virtue of being born into a culture. The body, the world and the concerns, unique to each person, are the context within which that person can be understood (Burns & Grove, 1990:65). This study is contextual in that it deals with adult depressed women in their unique environment in the peri-urban set-up of Oshakati, Northern Namibia. Context implies the conditions and situations of an event, the cultural and historical situation which is important for an understanding of a phenomenon and the meaning which participants give to it (Holloway & Wheeler, 1996: 1992).

2.5 RESEARCH METHOD

In this section the method in which the study will be carried out will be closely examined, that is, the ways in which the reliability and validity of the method used will be determined, definition of the target population and sample, discussion of the method of sampling, the method of data gathering and analysis, the discussion of results in comparison with relevant literature and compiling guidelines for a support program for psychiatric nurses to assist the adult depressed women in their quest for health. The study will be conducted in two phases.

2.5.1 PHASE 1: EXPLORATION AND DESCRIPTION OF THE LIFE WORLD OF ADULT DEPRESSED WOMEN

The objective of the first phase of the research is to explore and describe the life world of adult depressed women in a peri-urban area. A phenomenological research approach as described by Burbank (1992:30) will be used to guide this study because it is well suited to studying lived experiences.

The guiding theme of phenomenology is to go back to the things themselves, that is, to go to the everyday world where people are living through various phenomena in actual situations (Giorgi, 1985:58). According to Omery (1983:50) the researcher must approach the phenomenon to be explored, that is, life world of depressed women with no preconceived expectations or categories. The researcher has no preconceived operational definitions.

2.5.1.1 **SAMPLING**

Sampling is the process of selecting groups of people with whom to conduct research (Burns & Grove, 1993:58). This will be the target population to which the researcher has reasonable access. Burns & Grove (1993:236) describes target population as the entire set of individuals who meet sampling criteria. This is the population of subjects available for sampling, often a non random subset of the target population whose characteristics are well known.

In this study, the target population will be adult depressed women who have been discharged from the hospital and who live in the community in and around Oshakati town.

Sampling Criteria

Sampling criteria are the characteristics which are essential for membership of the target population. The sampling criteria are designed to make the population as homogenous as possible, or to control for extraneous variables (Burns & Grove, 1993:236).

The sample will be selected from a population which meets the following criteria:

- ⇒ They must be females diagnosed with depression, discharged from the hospital and currently attending a psychiatry outpatient clinic.
- ⇒ They should reside within or around Oshakati town so that it will be possible to keep contact throughout the study and to facilitate interpretation of findings.
- ⇒ Female patients between 21 and 55 years of age.
- ⇒ Patients with a diagnosis of major depression, confirmed by a psychiatrist and over the acute phase of depression. The researcher took this as a developmental phase whereby major changes are taking place and women being exposed to high demands of life, but also a reliable age limit for people to be able to remember and give a report on their experience of a situation like depression.
- ⇒ They should be able to communicate in vernacular, that is, Oshiwambo, Afrikaans or English, as those are the languages in which the interviewer can communicate.
- ⇒ Participants will be prepared to participate in the research; such participation elicited by their written consent.
- ⇒ Participants will agree to the interview session being taped and transcribed.

Sampling Method

Purposive sampling will be used in this study. Contextuality is enhanced with purposive sampling. The aim is to select a homogenous stratum of the population.

Guba & Lincoln (1985:200) states that the more homogenous stratum of the population the better the inference that can be made. This stratification implies that the sub units are more alike contextually. Participating respondents will be selected by means of purposive sampling. Seaman (1987:244) describes purposive sampling as the process of picking cases that are judged to be typical of the population, restricting observations to sub groups. As suggested by Burns & Grove, (1993: 82-83) the researcher will also seek patients who are willing to describe their experiences of being depressed. They must understand and be prepared to express and share their inner feelings and subsequent experiences.

Sample Size

The question which arises here is what size sample should be used? For pragmatic reasons, the sample size in qualitative research tends to be small. Seaman (1987:244) explain it further that the size of the sample may be smaller if the population is known to be homogenous: in this case the sample may be expected to represent the population. By its nature, qualitative research is time intensive (Minichiello et al, 1991:200). In this study, the sample size will be achieved when data is saturated, demonstrated by repeating themes (Burns & Grove, 1993:247).

2.5.1.2 DATA COLLECTION

Data collection is the process of selecting subjects and gathering data from these subjects (Burns & Grove, 1993:423).

Data in this study will be collected by means of in-depth phenomenological audio taped interviews, field notes, use of communication techniques and the role of the researcher.

Phenomenological studies are studies in which human experiences are examined on the basis of detailed descriptions by the people being studied - understanding of the lived experiences.

The procedure involves studying a small number of subjects through intensive and prolonged engagement to develop patterns and relationship of meaning. Through this process the researcher “brackets” his or her own experiences in order to understand those of the informants (Cresswell, 1994:12).

In this study respondents will be interviewed at the outpatient psychiatric clinic or in their homes or a place convenient to them. Interviews will be tape recorded and transcribed verbatim (Burns & Grove, 1993: 578-581). One central question will be asked during the interview:

“TELL ME YOUR LIFE STORY”

Each interview will last approximately 60 to 90 minutes. Follow up interviews will be conducted with some of the participants to validate the information. The reason for selecting this method is that it guides the researcher to gather descriptions of the life world of the interviewee, and respect the interviewer’s interpretation of the meaning of the phenomenon to be described. It makes it possible for the interviewees to organise their own descriptions emphasizing what they themselves find important in their own life world - their opinions and actions, in their own words (Kvale, 1983). It goes beneath the surface to explore a sense deeper than the common sense. Great emphasis is placed on interviewer sensitivity and creativity.

*** THE ROLE OF THE RESEARCHER**

According to Polit and Hungler (1991:350) data collection in qualitative research requires a minimum of researcher - imposed structure and a maximum of researcher involvement. The use of researcher’s personality is a key factor in qualitative research.

Empathy and intuition are deliberately used and skills in these areas are activated by the researcher (Burns & Grove, 1993:80). It is necessary that the researcher does everything possible to create a conducive atmosphere that will encourage the patient to talk freely.

* **USE OF COMMUNICATION TECHNIQUE**

Non-directive communication techniques such as probing, paraphrasing, summarizing, minimal responding, reflecting and clarifying to encourage respondents who are interviewed to freely articulate their views and findings (Okun, 1987:76).

⇒ **Probing** refers to the interviewer's ability to help the respondents identify and explore experiences, behaviours and feelings that will help them engage more constructively in any of the steps of the communication (Madel, 1991:18).

⇒ **Paraphrasing** is a method of restating the interviewee's basic message in similar, but usually fewer words. This is used by the interviewer to test her understanding of what the interviewee has said (Brammer, 1988:76).

⇒ **Summarizing** involves putting together into one statement several ideas and feelings at the end of a discussion unit or the end of an interview. The main purpose is to give the interviewee a feeling of movement in exploring ideas and feelings, as well as awareness of progress in communication (Brammer, 1988:76).

⇒

⇒ **Reflecting** involves expressing in fresh words the interviewee's essential feelings stated or strongly implied (Brammer, 1988:76).

⇒ **Clarifying** means bringing vague material into sharper focus. The interviewer makes a guess regarding the interviewee's basic message and offer it to the interviewee or he/she (the interviewer) may also ask for clarification when he/she cannot make sense of the interviewee's response (Brammer, 1988:71).

⇒ **Minimal Responding** - the interviewer adopts a less active role and allows more time for the respondent to talk (Stuart & Sundeen, 1983:122).

* **FIELD NOTES**

A researcher needs a system for remembering observations and, even more importantly, retrieving and analyzing them (Wilson, 1989:434). Field notes will be made immediately after each interview to describe the whole situation of the interview and the researcher's impressions. A good set of field notes not only relieves the researcher of some of the burdens of remembering events, but also constitutes a written record of the development of observations and ideas to be used in future publications of the research findings and methods. In this research study, field notes will be utilized in data analysis, together with the information from the interviews.

It will be explained to each individual interviewed that the purpose of the interview that is tape recorded is to explore her previous life world of being depressed, to be able to compile guidelines for a supportive action and also that the audiotape will be transcribed by me and the contents wiped off thereafter.

2.5.1.3 **DATA ANALYSIS**

The tape recorded interviews will be transcribed verbatim and then analyzed according to methods suggested by Tesch (in Cresswell, 1994:155).

In qualitative research, data analysis proceeds simultaneously with data collection, data interpretation and narrative reporting (Cresswell, 1994:153). Latent content analysis (Woods & Catanzaro, 1988:438) will be used to analyze the data. In latent content analysis, the researcher is concerned with the meaning within each passage of the textual material.

The analysis of data will proceed as follows:

⇒ ***Assembling and organizing data:***

The data collected via the audio tapes will be transcribed verbatim and the data collected in the notebook will be organised into personal and analytical logs. A personal log contains a descriptive recollection of the interviewee's non-verbal cues, reflective notes on the field work experience and methodological issues. An analytical log contains a detailed examination of questions asked as well as ideas as the study progresses (Guba & Lincoln, 1985:327).

⇒ ***Method of data analysis***

Tesch in Cresswell (1994:155) will be used as a method of choice for data analysis. After all the interviews have been transcribed, a sense of a whole is obtained by reading through all the transcripts. Tesch recommends the following: jot down the ideas as they come to mind. Pick the most interesting interview and ask the following questions: What is it about? What is the underlying meaning? Write your thought in the margin. Complete this task for all the interviews and make a list of all the topics. Cluster similar topics together. Form these topics into columns that might be arranged as major topics, unique topics and leftovers. Take the list and go back to the data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text. Try out this preliminary organising scheme to see whether new categories and codes emerge.

Find the most descriptive wording for topics and turn them into categories. Try to reduce the total list of categories by grouping together topics that are related. Perhaps draw lines between categories to show inter relationship. Make a final decision on the abbreviation of each category and alphabetize these codes. Assemble the data material belonging to one category in one place and perform a preliminary analysis. If necessary re-code the existing data. Always be on the look out for unusual or useful quotes that can later be incorporated into qualitative story. Major and minor themes can also be categorized and another list can then show contrasting themes.

Triangulation of the data will be made by consulting a nurse researcher (independent coder) who will analyze the interviews independently of the researcher.

The independent coder is a nurse researcher who is familiar with conducting qualitative data analysis. A protocol describing the method of data analysis will also be provided to the independent coder. The protocol contains no pre-ordained themes or categories and is therefore known as open coding. After the interviews have been analyzed, the researcher and the independent coder will meet for a consensus discussion. After consensus has been reached, the results will be translated into English.

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

After data has been analyzed, examples of patterns of interaction between the internal and external environment of the respondent

will be given according to the Nursing for the Whole Person Theory (Oral Roberts University: Anna Vaughn School of Nursing, 1990: 136-142; Rand Afrikaans University Department of Nursing, 1992: 7-9).

2.5.1.4 LITERATURE CONTROL

The results of the research will be discussed in the light of relevant literature and information obtained from similar studies. Referential checks enhance the scientific trustworthiness of the study. This is a strategy used to ensure trustworthiness by means of triangulation.

2.5.2 PHASE 2: DESCRIPTION OF THE GUIDELINES FOR THE COMPILATION OF A MENTAL HEALTH SUPPORT PROGRAM FOR PSYCHIATRIC NURSES TO ASSIST ADULT DEPRESSED WOMEN IN MOBILIZING THEIR RESOURCES TO FACILITATE THE PROMOTION, MAINTENANCE AND RESTORATION OF THEIR MENTAL HEALTH AS AN INTEGRAL PART OF HEALTH.

The objectives of phase two is to describe guidelines for psychiatric nurses to assist depressed women in mobilizing their resources to deal with their problems. During this phase data collected from respondents will be used through deduction as a basis for describing guidelines for psychiatric nurses to be used when assisting adult depressed women to mobilize resources in promoting, maintaining and restoring their mental health as an integral part of health.

After analyzing the results and their implications for nursing actions, a literature review will be used as a tool to help formulate the guidelines. Guidelines will be presented in the format of advisory strategies to be implemented. Finally, discussion of the findings and formulated guidelines will be conducted with psychiatric nurses and respondents, for the purpose of validating them.

2.5.3 TRUSTWORTHINESS

The researcher will strive to adhere to the principles of trustworthiness throughout the two stages of research. Guba & Lincoln (in Krefting, 1991:215) regard trustworthiness as the method of ensuring rigor in qualitative research without sacrificing relevance. The researcher will adopt Guba's model (in Krefting, 1991:217) which identifies the following four criteria and strategies for establishing trustworthiness.

Truth Value

Truth value is usually obtained from the discovery of human experiences as they are lived and perceived by informants. The strategy for establishing truth value is credibility. This is achieved through the following: prolonged and varied field experience, time sampling, reflexivity, member checking, peer examination, interview technique, establishing authority of researcher, structural coherence, and referential adequacy (in Krefting, 1991: 215-217). Applicability refers to the extent to which findings can be applied to other contexts and settings or with other groups.

Transferability is the strategy employed to attain applicability. This is obtained by using a purposive sample, working contextual, time sampling and dense descriptions (Krefting, 1991: 216-217). Consistency of the data refers to whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context. Dependability is a strategy used to establish consistency. This is achieved by keeping a dependability audit, providing a dense description of research methods,

step wise replication, triangulation, peer examination and code re-code procedure (Krefting, 1991:217). Neutrality refers to the extent to which the findings are a function solely of the informants and conditions of the research, and not of other biases, motivations and perspectives Guba's Model (in Krefting, 1991: 214-222). Confirmability is the strategy used to ensure neutrality. See table 2.1 : 35 for the application of these strategies in this study.

Table 2.1 Strategies to ensure trustworthiness which will be applied in this research.

STRATEGY	CRITERIA	APPLICABILITY
Credibility	Prolonged and varied field experience	Contact in psychiatry outpatient clinic with adult depressed women when reporting for follow up. Initially spend time with respondent before interview to build rapport. Interviewer will allow respondents to verbalize their experiences during the interview.
	Reflexivity	Field notes will be taken by the researcher
	Member checking	Follow up interviews will be held with respondents. Literature control on themes and its impact on guidelines will be discussed.
	Peer examination	The service of a colleague will be acquired
	Authority of researcher	The researcher had undergone previous training in research methods. This study is supervised by a doctorally prepared psychiatric nurse who has experience in research
	Structural coherence	The focus of research will be on individual depressed women's life world and their experiences of their life world. The results will be reflected within Nursing for the Whole Person Theory
Transferability	Nominated sample	The sampling method will be purposive no prior selection
	Dense description	Complete description of methodology including literature control to maintain clarity will be used
Dependability	Dependability audit	Personal logs and reflexivity notes will be used and kept
	Dense description	Research methodology will be fully described
	Peer examination	Independent checking by a colleague and supervision by experts
	Code re-code procedure	Consensus discussion between researcher and independent expert
Confirmability	Audit trial	Independent coder
	Reflexivity	Field notes taken

Adapted (with permission) from a table used by Poggenpoel, Nolte, Dorfling et al. (1994:132).

2.5.4 **ETHICAL MEASURES**

Conducting the research ethically starts with the identification of the research topic and continues through the publications of the study (Burns & Grove, 1993:89). Ethical code and regulations provide the researcher with guidelines for protecting the rights of human subjects, balancing benefits and risks in a study, obtaining informed consent (Burns & Grove, 1993:89). The following ethical measures will be adhered to:

****Competence of the researcher***

The researcher has undergone training in research methodology and interpersonal skills. Furthermore, the study will be supervised by a doctoral nursing researcher, who is actively involved in qualitative research. Competence of the researcher will be nurtured and assessed by the nurse research specialist with the view of facilitating a morally just nursing research and social justice (Minichiello et al, 1991: 236-244). Interaction with these nurse specialists will be effected at short periodical intervals.

****Researcher/interviewee relationship***

The researcher will try to make the research as transparent as possible. The rationale is to maintain an egalitarian relationship between the researcher and informants. This will be achieved by informing respondents about the study and its purpose as well as the possible inconvenience to respondents during the course of the study, such as time investment. Participants will be given the option whether or not to participate in the study and they will be allowed to withdraw at any time.

Permission will be asked to record interview sessions on the audiotape. Procedure to safeguard identifying information or raw data will be described and participants will be informed about people who are likely to have access to raw data. They will be given information about where and how to contact the researcher should they wish to do so.

****Informed consent***

This is the process whereby information is given about the title of the research, the research purpose, methods, objectives, potential risks, benefits and input on the part of the participants and ensuring that they agree to participate in the research without any element of force, fraud, duress or other form of constraint or coercion (Burns & Grove, 1993:104). The researcher will obtain informed consent. Consent is the prospective participant's agreement to participate in the study.

Two types of informed consent will be obtained before commencing with the collection of data. These are, obtaining the permission from the hospital mental health unit to conduct the research in the institution and from the participants. Consent will be obtained in writing and the following information will be conveyed to the participants.

●Gaining access

A formal letter (care of the Rand Afrikaans University) will be written to the hospital management committee. A short informational motivation will accompany this letter.

●Non-coercion disclaimer

The subjects will be informed that participation is voluntary and that they are free to withdraw at any stage, should they wish to do so.

●Assurance of anonymity and confidentiality

The subjects will be informed that whatever transpire between them and the researcher will be kept confidential. The reason for supervision and the need for an independent coder will be given. Steps will be taken to disguise personal information.

●Statement of the research purpose

The respondents will be given information on the purpose of research, the short and long term benefits expected from the research, benefits to the researcher and the respondents.

2.6 CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations will be made on the strength of the research findings and these will be applied to nursing practice, nursing education and nursing research.

2.7 SUMMARY

In chapter two, a description was given of the rationale, objectives, research design and method of the study.

In chapter three, a discussion of the results of the research data will be given.



CHAPTER 3

DISCUSSION OF THE FINDINGS

3.1 INTRODUCTION

In the previous chapter methodology followed in conducting this study was discussed. In this chapter, analysis of the data will be discussed and the identified themes will be verified with a literature control. The results will be presented and discussed according to identified themes, categories and sub-categories.

3.2 DESCRIPTION OF A SAMPLE

The sample for this study is comprised of ten adult women who had at one time been hospitalised with a diagnosis of major depression. The participants are between the ages of 21 and 55, with a mean age of 37,4 years. Six of these women are married while four are single. Four out of the ten women reported four or more hospitalisations for the treatment of depression. All of the women were discharged on antidepressants and have continued taking it up to date. All the respondents are literate with the highest standard being grade 12 and the lowest, grade seven. Eight speak Oshiwambo and two speak both Oshiwambo and English. During the audiotaped interviews, the respondents were encouraged to talk about their life story. Data was found to be saturated on completion of the tenth in-depth, semi-structured phenomenological interview with women suffering from depression.

3.3 RESULTS

The following themes, categories and sub-categories emerged from the women's descriptions of their life stories. See Table 3.1 Page 41.

Table 3.1 MAJOR THEMES, CATEGORIES AND SUB-CATEGORIES

MAJOR THEMES		CATEGORIES AND SUB-CATEGORIES
Impaired interpersonal interaction	1.1	Poor interpersonal relationship related to impaired communication as evidenced in the following relationships: ⇒ marital ⇒ partnership ⇒ family, friends and others
Stressful life events	1.2	Lack of personal worth related to disempowerment as evidenced by: ⇒ deprivation of personal freedom ⇒ inability to bear children ⇒ inadequate emotional, financial and material support ⇒ emotional, spiritual and physical distress ⇒ loosing control

3.4 DISCUSSION OF THE FINDINGS

The discussion of the findings will be based on the themes, categories and sub-categories set out in Table 3.1 (page 41). In discussing results, relevant data from the literature will be incorporated.

3.4.1 IMPAIRED INTERPERSONAL INTERACTION

Impaired interpersonal interaction made the daily lifestyle functioning of a depressed woman difficult and at time intolerable. Because interpersonal relations serves as a centre post of all biological activities, it's impairment leads

to depressive symptoms in a woman. There is dynamic movement among the categories, and some categories were experienced simultaneously by the women. These women suffer varying degrees of impaired feelings in their daily lives including unhappiness, withdrawal, loneliness, uselessness, hopelessness, emotional pain, anger and frustration. Relationships can be broken apart by the stresses of depression's changing moods and unpredictable behaviour. Even if these women did not want the illness to affect their relationships that way, sadly it did with some.

Following here is a discussion of how impaired interpersonal interaction influenced the life of the woman in this study.

3.4.1.1 POOR INTERPERSONAL RELATIONSHIP RELATED TO IMPAIRED COMMUNICATION WITH A SPOUSE

Respondents have indicated severe relationship problems experienced during married life. Impaired communication has been observed as a stumbling block between them and their spouses.

This is evident from the following accounts:

“... Omusamane wange mwene-mwene oye a etela nge oudjuu, katu uditafane nande-nande ...”

(“... my own husband is the source of my problems, we don't understand each other at all ...”)

Another respondent states it as follows:

“When I came back home I found another woman in the house. What came to my mind was that probably she is visiting because I did not know her. To my greatest shock and disappointment I was told that she will be a second wife whether I like it or not”.

A poor interpersonal relationship is supported in the literature by Heifner, (1996:5) whereby women's depression has been described as related to their ordinary, daily life issues such as the emphasis on the relationship as defining success or failure as a woman, the burdens of marriage and child rearing which fall much more heavily on women. This type of relationship contribute to women becoming more submissive to a dominant other, especially the spouse, leading to increased feelings of helplessness and hopelessness. In the absence of a positive or promising relationship between two partners, it becomes very difficult for spouses, families and friends to understand depression and to realise its impact on an individual.

In another study on connection and disconnection in abusive relationships Weingourt (1996:16) concluded that women assume full responsibility for the caring in relationships, often attending to the needs of others at the expense of their own. In unequal domestic relationships, the woman's attempts to grow, succeed and excel are perceived by the man as an attempt to demean him, and ultimately, leave him.

In order to protect and nurture the man she loves, she must ignore, deny and even work against her own needs. This will eventually result in anger and frustration which is again suppressed by that particular woman. Suppression will therefore lead to feelings of helplessness, weakness, unworthiness and inferiority.

One respondent expresses it as follows:

“... shaa nda geya ihandi popi nande, ohandi yi ashike mondunda tandi ipatelema ...”

(“... when I am angry, I don't talk at all, I go to my room and lock myself inside ...”)

Weingourt (1996: 17-18) further emphasises that a poor interpersonal relationship negate the woman's experience. She will try to make herself acceptable by denying and redefining large parts of her experience as bad, wrong and unacceptable. In the end she loses feelings of self worth, she feels powerlessness, a distorted sense of self and diminution of her ability to understand others. At this point, loneliness, isolation and fear of abandonment dominate. In the words of one woman:

"Nda tidhwa mo megumbo lyaantu, onda li ndu uvite nda ekelwahi, otandi yi peni nokaana kandje?"

("I was chased out of the house, I felt abandoned, where will I go with my baby?")

It is this kind of desperate, lonely periods felt by most women in moments of crushing hurt, ruin and deepest despair (Younger, 1995:59). In the depths of suffering, people may see themselves as abandoned and forsaken by everyone. That which gave life its meaning has become empty and void.

3.4.1.2 POOR INTERPERSONAL RELATIONSHIP RELATED TO IMPAIRED COMMUNICATION WITH A PARTNER

Respondents expressed how their relationships were severely affected by unhealthy communication patterns. This is evidenced by the following excerpts from the text:

"Onda li noluhodhi ethimbo olindji okutala monkalo ndi li mo nomauvaneko nde ga ningilwa, naashi ka pena shi nda mona po, onda li ndi uvite nda ekelwahi"

("I felt very sad most of the time when looking at the situation I found myself in and all the unfulfilled promises; I felt abandoned")

Another respondent describes the relationship as a disappointing one: "... he dissociated himself from us, was not just there, I was very unhappy, frustration and anger were my main problems ..."

Remarks from another respondent: "He was very unfaithful and cruel, had several girlfriends, it was very painful, you are all alone". Obviously all these women were alone in their fragile relationships. Any strain in this kind of relationship may result in inability to care for one's physical and emotional needs resulting in stress. Feelings of neglect, hurt, bitterness, unfairness were common among these women.

One woman stated it as follows: "Tatekulu gwomusamane ka kwa li a pumbwa ndje nande megumbo lye, okwati nandi zemo, nandi ta le mpo tandi ka kala ...". ("My father-in-law didn't want me in his house, he chased me out saying that I must look for accommodation somewhere"). She was rejected, and this again portrays how poor communication patterns can lead to disruptive relationships between partners. Prolonged disruptive relationships lead to anxiety, and if it remains unresolved, it will eventually result in depressive episodes.

3.4.1.3 POOR INTERPERSONAL RELATIONSHIP RELATED TO IMPAIRED COMMUNICATION WITH FAMILY, FRIENDS AND OTHERS

Some respondents attributed their problems to poor understanding of their condition by the people with whom they live. The latter is supported by the following extract:

"... oosuwala yandje oya kala nokuhokola ndje, okuyola, nokutuka ndje ..."

("... my brothers and sisters in-law kept on gossiping about my illness, laughing and swearing on me ...").

Neighbours make statements such as "... leave her alone, she is mad/crazy ...". During conversations, one's comments or suggestions are not always accepted because you are regarded as a "crazy woman".

Parents refuse to offer support to one respondent to further her studies, because they believe that paying school fees for her will be a waste of money. As one respondent puts it, "... aniwa itandi futilwa oshoka koskola itandi ka ninga ko sha, omupwidhi ..." ("... fees will not be paid, because I will not manage at school, being mad ...").

The respondents felt demoralised by this negative attitude from her parents. Her uniqueness and capabilities were not considered at all. This makes her feeling small and worthless with low self esteem.

Warren (1997:109) explains it further that persons with low self esteem view themselves as deficient and inadequate, although it is unclear as to whether low self esteem is a casual factor or symptom of depression. Disconnected family relationships have resulted in fear and disillusionment among the respondents. This is evidenced in the following extract:

"... hangame tandi humbata omukundu gwokaana koye, inda hu we ka pewa ..."

("... I'm not going to carry the burden of your child, go where you got him").

The respondent felt being pushed away by her mother.

It should be noted that the self esteem emerged from interpersonal relations. In relationships that are disintegrating, there is usually a mounting level of anxiety that is shared by the person and significant others - family members, friends and others (Beeber, 1996: 154-155).

As interpersonal relationships are regarded as connections between people, its absence leads to poor interpersonal relations as experienced by almost all the women in this study.

3.4.2 **STRESSFUL LIFE EVENTS**

Stressful life events are stress based experiences that cause individuals to change or readjust their behaviour. Research has indicated that the presence of stressful life events may place women at risk to develop depressive symptoms (Warren, 1997:108). All the respondents have gone through one or more stressful life event.

Warren (1997:109) further describes how continued bombardment of stress may alter a woman's cognitive appraisal ability so that she views each life event as being harmful or threatening and not a challenge she can manage.

Categories discussed here are:

- * Lack of personal worth related to disempowerment as evidenced in:
 - ⇒ deprivation of personal freedom;
 - ⇒ inability to bear children;
 - ⇒ inadequate emotional, financial, and material support;
 - ⇒ emotional, spiritual and physical distress; and
 - ⇒ loosing control.

3.4.2.1 **LACK OF PERSONAL WORTH RELATED TO DISEMPOWERMENT AS EVIDENCED IN DEPRIVATION OF PERSONAL FREEDOM**

Powerlessness, a universal symptom experienced by depressed women, is related to disruption of the self system and control in the face of external or internal stressors. Loss of personal power is

usually a precursor to feelings of hopelessness, helplessness and despair experienced by a depressed woman. Some women felt that being sick had evoked in them feelings of being stripped of own personal dignity, autonomy and personal worth.

One woman describes it as follows:

“Lining up for food and medication was extremely humiliating and painful experience for me”.

Another respondent comments on the labeling process:

“... mad/crazy people ...”, the respondents feel that this attitude is humiliating and depriving them from personal freedom and value as individuals. They believe their personal worth is not respected at all.

3.4.2.2 LACK OF PERSONAL WORTH RELATED TO DISEMPOWERMENT AS EVIDENCED IN INABILITY TO BEAR CHILDREN

In many societies, infertility is regarded as a woman's problem and in some cultures a man is permitted to divorce his wife if she is infertile.

One respondent revealed how she is suffering the humiliation because of infertility:

“I could unfortunately not bear my own children; culturally as soon as you fail to fall pregnant, then you are nothing ... I live under pressure from my husband, in-laws and neighbours, my husband has now extra marital affairs and I am not allowed to utter a word on his behaviour”.

Another woman: “I’m told, without a child I’m nothing”.

This is supported in literature (Atwood & Dobkin, 1992:389) that the major emotional toll is a deep sense of loss of which in some women include loss of self esteem and personal worth due to feelings of failure to become pregnant. The respondent expressed further that the future looks bleak and sees no reason to continue with such a relationship or to be alive.

3.4.2.3 LACK OF PERSONAL WORTH AS RELATED TO DISEMPOWERMENT AS EVIDENCED IN INADEQUATE EMOTIONAL, FINANCIAL AND MATERIAL SUPPORT

The absence of emotional as well as financial support was raised by most respondents during the interview.

In the words of one woman: “... he was not just there for us, we needed his support so much ...”

Another woman said: “I struggle alone with my child, but I did not have courage to report him for support ...”

One respondent describes it as follows:

“Onda hala ndi kwathelwe openzela opo ndi vule okwiikwatha, ngame ndi kwathele wo aamwandje moskola, kapena ngu te ya kwathele”

(“I am asking for a disability grant to support myself and my children who are still schooling, no one is supporting them”).

These women were burdened by their suffering and at the same time constrained by the activities of their daily lives. The resources to support them are curtailed or non-existent. Absence of support

has lead to an insecure lifestyle as most of them expressed uncertainty about their own personal worth and future.

3.4.2.4 LACK OF PERSONAL WORTH AS RELATED TO DISEMPOWERMENT AS EVIDENCED IN EMOTIONAL, SPIRITUAL AND PHYSICAL DISTRESS

Respondents reported a variety of emotional and spiritual experiences as they go through depressive episodes. They lived their lives with a sense of dissatisfaction, little understanding, and a degree of chronic unhappiness.

One woman expressed it as follows:

“... kanda li ndi shiwo kutya oshike sha puka mungame, onda lombwelwa kaakwanezimo yandje kutya otandi ehama, nashika osha uvitha ndje nayi komwenyo ...”

(“... I did not know what was wrong with me, my relatives told me that I’m sick, uuh! I felt bad, you know!”).

Depressed women shared a sense of being incomplete and unintegrated, as though something of their selves were missing. They live in a conflictual relationship and were conflicted within their selves as they tried to live out expectations they felt others had of them.

As one woman described: “Ekwatathano pokati ketu olya li ta li te ya po omutima gwomuntu, kehe esiku kandina ombili, ihe molwaasho omulumentu okwa li ndi mu hole, kakwa li nda hala oku mu etha” (“Our relationship was heartbreaking, was marked by unhappiness every day, but because I love this man, I did not want to leave him”).

This was supported in literature by Schreiber (1996:166) that the women's decisions were based on a narrow understanding of their lives and their relationships. The following feelings were common:

* Bitterness and blame:

- ⇒ blaming self about the pregnancy;
- ⇒ inability to bring about changes on infertility;
- ⇒ inability to bring about changes within the relationship from a negative to a positive and acceptable one;
- ⇒ inability to care for self and the children

* Sadness and hurt:

- ⇒ women express feelings of sadness. In the words of one woman: "I felt hurt and very angry, I was betrayed and being used by this man".

* Defeat and helplessness:

- ⇒ Respondents express feeling of helplessness. As one woman shared: "Onda kambadhala oku mu tompela omaihumbato ge, ihe ina hala okupulakena ndje, okwa dhengagula ndje nayi"

("I tried to confront him about his behaviours, but he does not want to listen to me, instead he beats me up severely").

* Alienation from others:

- ⇒ Respondents experienced feelings of alienating self from others. As one woman described: "... kandi hole paantu, onda hala ando ondi li ongame awike ..." ("... I don't like being with others, I prefer to be alone ...").

* Anxiety and worry:

⇒ Women experienced anxiety over their condition as well as what the future held for them. As one woman stated: “Paife ohandi vele, ame nghina oilonga, omakwafo oo handi mono inaa wana, onkalo yange yokomesho oya laula ...” (“Now I am sick, I am not employed, the support I am getting is not sufficient, my future looks dark ...”).

* Shame and being stigmatized:

⇒ Women felt ashamed about themselves and the stigma attached to them as individuals. One woman explained it as follows: “I did not want my colleagues to know that I am depressed”.

⇒ Another one said: “... You know! I hid this pregnancy for a long time”.



According to Younger (1995:61) an experience of shame is isolating, highly personal and results in feelings of loss of control, inferiority, abandonment and rejection.

What is exposed in shame is oneself, - I am ashamed of what I am. Shame is the pain of feeling unloved and unlovable. Shame and stigmatization was a common expression during the interviews.

* Respondents were also complaining about a number of physical distress symptoms such as dizziness, loss of appetite, headaches and lack of energy. These symptoms were a reflection of the condition they are suffering from namely depression.

3.4.2.5 LACK OF PERSONAL WORTH AS RELATED TO DISEMPOWERMENT AS EVIDENCED IN LOOSING CONTROL

A woman in this phase of her depressive experiences, is in a crisis situation, confronting the fact of her depression.

She sees herself losing control of her life and is afraid that she is unable to stop the process.

Many of them spoke about being in a “dark cloud”.

One woman said: “... ohandi kala nda siikililwa komilema omiluudhe, kandi shiwo mpoka ndi li, esiku limwe onda tokola ndi ki imangeleke, oshoka onakuyiwa yandje yokomeho oya luudha ...”

(“... I have been covered by dark shadows, I did not know where I was and one day I decided to hang myself because my future was just dark”.)

At this stage, the woman sees that she has got no future. It is a terrifying experience for the woman and the fear she feels when thinking about these heavy clouds, leaves her with despair and apprehension.

Jambunathan (1996:28) concluded that at this stage, the woman had no confidence, no feeling of esteem, no self pride, no personal worth. This is the time when the woman will develop thoughts about committing suicide.

3.5 FIELD NOTES

Field notes will be described according to different stages of data collection.

3.5.1 APPOINTMENTS

The researcher did not experience practical problems with the initial setting of appointment dates. Except two respondents, others preferred being interviewed at the psychiatric outpatient clinic. Because of the noise at the clinic, a private room was secured within the hospital premises for this purpose.

3.5.2 INTERVIEWS

All the respondents were open and keen to express themselves about their life stories. During the initial contact I spent sufficient time with each woman explaining the interview to them. The consent letter where the purpose of the study is explained, was translated into Oshiwambo and this has made it easier for them to follow all the explanations.

After the initial contact respondents had a time interval of two to three weeks, sufficient enough to pose any queries to the researcher, before the appointment date. All respondents signed a written consent in their own names and surnames which the researcher interpreted as confidently wanting to partake in the study.

The interviews were conducted by the researcher using an audiotape. Except two, interviews were conducted in Oshiwambo. The transcriptions were done by the researcher in Oshiwambo and the translation to English took place after the themes, categories and subcategories were identified.

Listening to the audiotapes was very time consuming as word-by-word need to be heard and transcribed to ensure accurate and trustworthiness of the data.

3.5.3 DATA ANALYSIS

Because both the researcher and the independent coder are familiar with

Oshiwambo, it was not difficult to analyse the data. The consensus discussion was conclusive for both researcher and independent coder and no major dissimilarities were experienced.

3.6 **CONCLUSION**

In response to a central question “Tell me your life stories as an adult depressed woman”, a rich description of the women’s experiences of their life stories was made available from the obtained data. This was developed into two major themes, categories and sub-categories illustrating the women’s description of their experiences of being depressed. Through narrative story telling the researcher has been placed in a position to capture the contextuality of these women’s situations within the larger socio-historical background.

The first theme dealt with impaired interaction which was viewed by these women as an obstacle in their relationships. Impaired interaction has resulted in poor interpersonal relationship between the women and their spouses/partners, family, friends and others. A number of factors were identified within their daily lives which were regarded as core to the main problems. These predisposing factors include among others, unfaithful partners, poor understanding of the woman’s condition, disappointing relationship, unsympathetic family members, neighbours and friends; disconnected family relationship.

Women felt abandoned, rejected, hopeless within these relationships. Communication was very superficial and sometimes non existing. Women were unable to express their needs because of the submissive role they often assume and in the process keep on suppressing their anger and frustrations until such time that they cannot endure the pain anymore.

The second theme describes the stressful life events in these woman’s lives which lead to loss of personal worth as a valued unique individual. Loss of personal worth is related to the following attributes: deprivation of personal freedom, inability to bear children, inadequate emotional, financial and material support; emotional and spiritual distress and losing control on her life. Women

consequently felt disempowered and display the following emotions: bitterness, sadness, helplessness, alienation, anxiety and worry as well as shame.

Feelings of powerlessness, hopelessness and disillusionment also pervade due to persistent poor relationship and continuous exposure to stressful life events.

It is in the light of these findings that guidelines will be described for the psychiatric nurse to support depressed women in their quest for health and assist them in mobilising their own resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health and wholeness.



CHAPTER 4

GUIDELINES, LITERATURE CONTROL, CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter three the results of this study were discussed and compared with relevant literature. In this chapter, guidelines will be described for supportive actions by the psychiatric nurse when assisting adult depressed women to mobilise their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health and wholeness. A literature control will be done to validate and verify the proposed guidelines for this study. Some practical problems encountered during the conduct, and execution of the study will be described. Limitations, conclusions and recommendations will be presented.

The women who participated in this research related stories of problematic interpersonal relations throughout their lives. They demonstrated in their narratives that women who live in a non-supportive environment are more vulnerable to a number of adversities affecting their mental health. In these particular relations they found themselves alone, frustrated, hurt and insecure. They are overwhelmed by lifes' problems and are unable to bring about changes in such situations. Impaired communication is their main problem. With the formulated guidelines, I strive to explore opportunities that will facilitate and enable the women towards better understanding of themselves and their relationship with others so that they will be able to meet the demanding challenges in life.

4.2 GUIDELINES FOR PSYCHIATRIC NURSES TO SUPPORT ADULT DEPRESSED WOMEN

The guidelines are based on the themes from phenomenological interviews and observations of adult depressed women (see table 3.1 : 40).

Impaired interaction and stressful life events which is experienced by a depressed woman, forms the basis for the formation of guidelines for psychiatric nurses. A depressed woman in this study is viewed as a whole person who is a spiritual being and functions in an integrated bio-psychosocial manner to achieve her quest for wholeness. She seeks to interact with her internal and external environment in a holistic manner. Patterns of interaction between these environments will be considered during the writing of these guidelines sensitising the nurse and depressed woman to the factors that play a role in the health and illness (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136-142; Rand Afrikaans University, Department of Nursing Science, 1992: 7-9).

Common interactive patterns within these relationship consisted mainly of withdrawal, loneliness as well as unhappiness. Prolonged frustrations resulting from A poor interpersonal relationship between a depressed woman and her spouse/partner has lead to feelings of hopelessness, helplessness and a sense of worthlessness among these women. It is a fact that interpersonal relations of depressed individuals reflect usually a markedly negative social interactions, social skills impairment, and overall social support decrements. Of particular interest, marital distress and low spousal support have been found to be predictive of depression onset as it emerges clearly from this study. It is in respect of these demoralising experiences and distress where psychiatric nurses can have a greater input by mobilising resources which will assist depressed women or any other women who will find themselves in similar relationships.

The following guidelines are suggested for use by psychiatric nurses in assisting depressed women, in their quest for mental health and wholeness.

4.2.1 IMPROVAL OF INTERPERSONAL INTERACTION

Studies of family functioning in the presence of a depressed family member have shown that impaired family communication, decreased ability to solve problems, and a general dissatisfaction with overall family functioning are common outcomes (Zauszniewski, 1994:20).

Impaired interpersonal interaction can then be addressed through modification of presenting stressors.

The appropriate strategy for improving the situation is for psychiatric nurses to make use of psychoeducation approach when addressing the problem. The term psychoeducation refers to the training of individuals in psychological knowledge or skills, therefore a psychoeducational program will be useful to depressed women. Women encounter problems with multiple and conflicting roles and expectations while receiving messages that their contributions are not as highly valued by society as those of men. According to Maynard (1993:9) a psychoeducational group program will provide a more comprehensive intervention framework for women who are depressed. The emphasis will be placed on addressing issues such as changing cognitive patterns, improving interpersonal communication as well as increasing self-esteem. Knowledge and skills are taught through this program that can prevent depressive symptoms from becoming severe enough to require hospitalization. For those who have been in hospital, the group provides outpatient support and assistance to help prevent or reduce recidivism. The use of medication as the primary treatment for depression reinforces the passive role of women and teaches that they must look to someone or something outside themselves for assistance. It is therefore imperative to empower these women with knowledge and skills to be able to help themselves.

In the psychoeducational model, providing information and skills training are the major helping functions. The aim is to assist depressed women toward autonomous functioning. Schreiber (1996:168) emphasises that efforts must be directed towards facilitating women to develop skills of self management and teaching them to alter patterns of helplessness and dependency. This approach can restore feelings of independence and self-confidence and break the cycle of helplessness that has been identified as a factor in depressed women.

FRAMEWORK OF A PSYCHOEDUCATIONAL PROGRAM

The framework of a psychoeducational program will be discussed under the following headings: group format; psychiatric nurses and psychoeducational groups and psychoeducational content.

*** GROUP FORMAT**

The format for the proposed approach is a small group consisting of 8 to 10 depressed women. This group will then allow discussion of issues, such as anger, abandonment, rejection and dependency as experienced within relationships. The group can provide positive identification with other women, an increase in realistic self-assessment and feelings of empowerment, and ultimately - an improvement in heterogenous relationship. Within the group, depressed women provide feedback to one another leading to a built-in support system. Sharing with other women furnishes the opportunity to learn that their unique experiences are shared by others and they are not alone.

*** PSYCHIATRIC NURSES AND PSYCHOEDUCATIONAL GROUPS**

Within these groups a psychiatric nurse is expected to implement group leadership skills that will facilitate the progress of the group. Psychoeducational groups facilitated by psychiatric nurses could become a cost effective strategy for the increasing population of depressed women (Maynard, 1993:12).

The objectives of the group will include the following:

- ⇒ to emphasize the importance of social factors in the development of depression;
- ⇒ to teach information related to the development and symptoms of depression;

⇒ to help depressed women identify self-defeating thoughts and replace them with positive ones;

⇒ to help the women develop the following: assertiveness and coping skills;

⇒ to teach methods of increasing self-esteem in depressed women.

PSYCHOEDUCATIONAL CONTENT

This framework is provided in table 4.1 (page 61).



Table 4.1: Content and Sequence for Psychoeducational Group Meetings

MEETING NO	TOPIC	CONTENT
1	Depression	Give information about depression (ie nature of depression, symptoms of depression, causes of depression, social factors related to depression in women)
2	Role of social factors in depression	Identify factors in society that are oppressive for women and how they affect their lives, identify factors that can be changed, discuss marital and parenting relationship, discuss how current social expectations of women influence feelings, discuss multiple roles women have and its effect on their relationship
3	Goal setting	Discuss types of goals to be met by them, share goal setting with the group
4	Self-esteem	Discuss with the group issues related to self-esteem eg: nature development. Share techniques for improving self-esteem in an individual.
5	Assertiveness	Share information about characteristics of assertive behaviours, discuss and practice skills for accepting and giving criticism, communicating needs and saying no.
6	Stress management	Provide information about stress and its role in depression, discuss physiologic and psychologic responses to stress and teach stress management strategies.
7	Review and terminate	Share positive feelings and experiences from the group meetings, discuss what they have gained from the meetings.

This proposed framework can provide depressed women with the skills necessary to manage the life events and role demands that have long been implicated in the development and maintenance of their depressive symptoms.

Participation by depressed women in this intervention strategy will therefore improve feelings of security, self reliance, self-esteem, independence and self respect.

- ⇒ In a psychoeducational model, meetings become structured units focusing on the following area:
- ⇒ group development whereby depressed women are assisted to focus on information about themselves so that level of trust can be established.
- ⇒ knowledge development with the assistance of the psychiatric nurse
- ⇒ skill development through provision of handout so that women can refer to it later. Practice and feedback from group members will enhance learning.

The psychiatric nurse should make herself available after the termination of the last session should the group require further discussion on an individual basis. It is hoped that the experiences gained from the group meetings would improve interpersonal relationships with partners. Conflict management, stress management and assertive skills groups can be shared by group members with the psychiatric nurse which will ultimately help them to deal with difficulties in their relationships.

4.2.2 PROVIDE STRATEGIES TO DEAL WITH STRESSFUL LIFE EVENTS

The identification of stressors in life by depressed women will enable them to implement appropriate strategies to deal with such stressors.

The focus should be placed on empowering depressed women to maintain patterns that will support growth, and change patterns that will create problems in their daily life. Women who are depressed can be helped by examining who they are as compared to who they believe they are.

Feelings of powerlessness as experienced by women in this study can be reduced by using cognitive therapy principles that guide the psychiatric nurse in promoting the discovery and recovery of the women's real personal power (Drake et. al. 1996:35). Since the major predisposition to depression is low self-esteem, exploration of the women's self image as a basis for recovery is central and fundamental. Empowerment will enable depressed women to make choice in her life. This will include valuing the self, self determination and a sense of accomplishment. Valuing the self will allow the individual to recognise the value of herself and her rights resulting in increased self respect.

Self determination will allow a depressed woman to make decisions regarding present and future plans and gain an internal locus of control over events in their life (Brage, 1995: 46-50).

In this study the identified events are: deprivation of personal freedom, inability to bear children, lack of financial and material support, emotional and spiritual distress, and loosing control on their life.

Psychiatric nurse should assist depressed women to establish support group which will provide a venue for women to explore their feelings and to learn about what others consider to be normal. These groups can also be an excellent venue for the exploration of the stigma of depression, so that women can have support in establishing how much stigma they are able to reject.

Patient education brochures on various topics related to depression can be made easily available to them. Problem solving skills and conflict management should be addressed in this group. Psychiatric nurses should assist women in building confidence through counseling on an individual or group basis.

The group is recommended because of its cost effectiveness and its power to reinstate the individual in her rightful social unit by fostering a sense of belonging.

Financial and material distress can be reduced if psychiatric nurses use their interactive and facilitative skills to work with organisations, professional and non-professional groups and assert their efforts in lobbying for upgrading of community infrastructures. Women should be encouraged to start income generating projects so as to eliminate dependency syndrome.

All depressed people have talents and abilities that they can share with others. It is then the task of the psychiatric nurse to identify and explore these talents with depressed women and utilise it for the benefits of the depressed woman. Family support and educations, family therapy and couple counseling can help depressed women and families address inter-personal conflicts.

It is hoped that these proposed guidelines for psychiatric nurses will provide support to depressed women and assist them in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health and wholeness.

4.3 CONCLUSION OF THE STUDY

The study arose from the following observations:

First, there is an increased rate of adult depressed women being admitted to a psychiatric unit and a high number seen at the psychiatric outpatient clinic.

Secondly, the observation was that a study needed to be conducted which would highlight the life story of adult depressed women themselves rather than the story as told by others (relatives, health professionals).

The purpose of this study was two fold: First, to explore and describe the life stories of adult depressed women in a peri-urban Namibia, and secondly to describe guidelines for the compilation of a mental health support program for psychiatric nurses to assist adult depressed women in mobilizing their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health and wholeness.

The central questions posed for this study were:

- ⇒ What are the life stories of adult depressed women?
- ⇒ How do they write and rewrite the stories of their life?
- ⇒ How can the obtained information be utilised to describe the guidelines to develop a mental health education program to support these women?

A qualitative, exploratory, descriptive, and contextual research design was used to find answers to these questions. In-depth phenomenological interviews were conducted with depressed women who met the sample criteria of this study. The results of both the phenomenological interviews conducted indicate the occurrence of negative experiences in their life. Two main themes were identified namely impaired interpersonal interaction and stressful life events. The results of the findings will guide the formulation of the guidelines.

With the suggested psychiatric nursing guidelines it is hoped that adult depressed women will be assisted to strive for the promotion, maintenance and restoration of their mental health.

4.4 **PRACTICAL PROBLEMS ENCOUNTERED - LIMITATIONS**

Interviews could not be conducted in participants home as planned except two, because of transport problems and long distances between the clinic and participant's homes. Member checking was also not possible with all participants because all of them could not be reached because of the problem

stated earlier. Communication was also not possible with all participants (no telephones). Interviews were conducted in the vernacular (Oshiwambo).

Since this study is conducted in English, it was then necessary to translate the data into English. This translation might have resulted in losing and distorting the originality of the participants' everyday life as expressed in the original language, therefore only the main themes, categories and subcategories were translated into English.

4.5 RECOMMENDATIONS

The recommendations from this study will be made with specific reference to psychiatric nursing practice, psychiatric nursing education and further nursing research.

4.5.1 PSYCHIATRIC NURSING PRACTICE

It is clear from the research results that adult depressed women require professional help and support in dealing with their experience of depression. Psychiatric nurses should be involved in counseling sessions by applying the guidelines proposed for this study to facilitate the promotion and maintenance of the women's mental health. Other health personnel should be involved in early identification and prompt referrals to appropriate agencies for further management. Community resources such as churches need to be mobilised so that they can offer assistance through counseling to depressed women.

4.5.2 PSYCHIATRIC NURSING EDUCATION

The guidelines generated from the findings can be considered in designing in service education programmes for all health workers and curricula for the training of psychiatric nurses at under- and post graduate level.

4.5.3 **PSYCHIATRIC NURSING RESEARCH**

Further research needs to be conducted to assess whether the guidelines provided in this study were effective in improving the patterns of interaction between the internal and external environment of a depressed woman.

4.6 **SUMMARY**

The research focused on the nature of the women's experience about depression, the way they relate their life stories and the "window" through which they see themselves as individuals. Contributory factors to depression were also addressed. It is therefore incumbent upon the psychiatric nurse to beware of the presence of the negative factors and its impact on the mental health of the woman and to assist the women in mobilising their resources in promoting, maintaining and restoring their mental health as an integral part of health. The guidelines and recommendations suggested here are intended to empower psychiatric nurses and others who come into contact with this target group, with necessary knowledge and skills.

It is hoped that these guidelines will be implemented during interactions with women suffering from depression.

BIBLIOGRAPHY

AMERICAN PSYCHIATRIC ASSOCIATION. 1994: DSM-IV: Diagnostic and statistical manual of mental disorders. Washington.

ATWOOD, J.D. & DOBKIN, S. 1992: Storm clouds are coming: ways to help couples reconstruct the crisis of infertility. *Contemporary family therapy*. 14 (5), October 1992: 385-403.

BEEBER, L.D. 1996: Pattern integration in young depressed women: Part 1. *Archives of Psychiatric nursing*. 10 (3), June 1996: 151-156.

BOUSFIELD, C. 1997: A phenomenological investigation into the role of the clinical nurse specialist. *Journal of advanced nursing* 25: 245-255.

BOTES, A.C. 1995: The operationalization of a research model in a qualitative methodology. *Raucur* 1 (1), July 1995: 4-9.

BRAGE, D.G. 1995: Adolescent Depression: A review of the literature. *Archives of psychiatric nursing*. 9 (1) February 1995: 45-55.

BRAMMER, L.M., SHOSTROM, E.L. & ABREGO, P.J. 1988: *Therapeutic psychology: fundamentals of counseling and psychotherapy*. New York: Prentice Hall.

BURBANK, W. 1992: Life events, symptom course, and treatment outcome in unipolar depressed women. *Journal of Consulting and Clinical Psychology*. 51: 604-610.

BURNS, N & GROVE, S.K. 1993: *The practice of nursing research, conduct, critique and utilisation*. Philadelphia: E.B. Saunders.

CENTRAL STATISTICS OFFICE. 1992: 1991 Population and housing census: Preliminary report. Windhoek: National Planning Commission.

CRESSWELL, J.W. 1994: Research design: qualitative and quantitative approaches. London: Sage Publications.

DIVISION SOCIAL SERVICES. 1996/97: Northwest Health and Social Services Directorate: Annual Report, 1996/97: 2.

DRAKE, R.E., PRICE, J.L. & DRAKE, R.E. 1996: Helping depressed clients discover personal power. Perspectives in psychiatric care. 32 (4). October - December 1996: 31-34.

GIORGI, A. ed. 1985: Phenomenological and psychological research. Pittsburgh, P.A.: Duquesne University Press.

GORDON, V.C. & LEDRAY, L.E. 1990: Depression in women: the challenge of treatment and prevention. Journal of psychosocial nursing and mental health services. 23 (1): 26-34.

HAMILTON, P.M. 1992: Realities of contemporary nursing. California. Addison - Wesley: Canada.

HEIFNER, C.A. 1996: Women, Depression, and biological psychiatry: Implications for psychiatric nursing. Perspectives in psychiatric care. 32 (3), July - September, 1996: 5-9.

HOLLOWAY, I & WHEELER, S. 1996: Qualitative research for nurses. London: Blackwell Science.

JAMBUNATHAN, J. 1996: Depression: Dealing with the darkness. Perspectives in psychiatric care. 32 (1), January - March 1996: 27-29.

KAPLAN, H.I., SADOCK, B.J. & GREBB, J.A. 1994: Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences clinical psychiatry. Baltimore: William & Wilkins.

KATJIUANJO, P., TITUS, P., ZAUANA, M. & BOERMA, J.T. 1993: Namibia demographic and health survey. Ministry of Health and Social Services, Namibia. Columbia: Macro International Inc.

KOZIER, B., ERB, G. & BLAIS, K. 1992: Concepts and issues in nursing practice. California: Addison - Wesley.

KVALE, S. 1983: Qualitative research interviews. A phenomenological and hermeneutical mode of understanding. *Journal of phenomenological psychology*, 14: 171-196.

KVALE, S. 1996: Interviews: An introduction to qualitative research interviewing. London: Sage Publications.

KREFTING, L. 1991: Rigor in qualitative research: the assessment of trustworthiness. *American Journal of occupational therapy*. 45 (3), March 1991.

LINCOLN, Y.S. & GUBA, E.G. 1985: Naturalistic inquiry. Beverly Hills: Sage Publications.

MADELA, E.N. 1991: Guidelines for supportive action by the psychiatric nurse in a community exposed to violence. Mini dissertation for the degree Master Curations. Johannesburg: Rand Afrikaans University.

MARSHALL, C. & ROSSMAN, G.B. 1989: Designing qualitative research. Newbury Park: Sage Publications.

MAYNARD, C. 1993: Psychoeducational approach to depression in women. *Journal of psychosocial nursing*. 31 (12): 9-14.

MINICHELLO, V., ARONI, R., TIMEWELL, E. & ALEXANDER, L. 1991: Indepth interviewing: researching people. Melbourne: Longman Chesire Ltd.

MOUTON, J. 1996: Understanding social research. Pretoria: Van Schaik.

MOUTON, J & MARAIS, H. 1989: Concepts in the methodology of social sciences. Human Science Research Council: Pretoria.

MYBURGH, C.P.H. & POGGENPOEL, M. 1995: A qualitative research strategy: and what now? RAUCUR 1 (2) 1995: 6-9.

OKUN, B.F. 1987: Effective helping: interviewing and counseling techniques. California: Brookes/Cole Pub. Co.

OMERY, A. 1983: Phenomenology: A method for nursing research. Advances in Nursing Sciences. 5 (2): 49-63.

ORAL ROBERTS UNIVERSITY: Anna Vaugh School of Nursing 1990: Nursing for the Whole Person Theory. 136-142.

POGGENPOEL, M., NOLTE, A., DORFLING, C., GREEF, M., GROSS, E., MULLER, M., NEL, E. & ROOS, S. 1994: Community views on informal housing environment: implications for health promotion. South African Journal of Sociology 25 (4). November 1994: 131-136.

POLIT, D.F. & HUNGLER, B.P. 1991: Nursing research: principles and methods. Philadelphia: J.B. Lippincot.

RAND AFRIKAANS UNIVERSITY DEPARTMENT OF NURSING. 1992: Nursing for the Whole Person Theory. Johannesburg: Rand Afrikaans University.

SCHREIBER, R. 1996: Understanding and helping depressed women. Archives of psychiatric nursing. 10 (3), June 1996: 165-175.

SEAMAN, L. 1987: Role strain and depression: a causal inquiry. Journal of Psychosocial nursing. 19 (12): 20-27.

SOCIAL WELFARE POLICIES IN NAMIBIA. 1997: The Draft Green Paper. Ministry of Health and Social Services, 1997.

STREUBERT, H.L. & CARPENTER, D.R. 1995: Qualitative research in nursing, advancing the humanistic imperative. Philadelphia: J.B. Lippincott Co.

STUART, G.W. & SUNDEEN, S.J. 1983: Principles and practice of psychiatric nursing. St Louis: C.V. Mosby.

TESCH, R. 1990: (in Cresswell, J.W. 1994): Research design: qualitative and quantitative approaches. London: Sage Publications.

THE SOUTH AFRICAN NURSING ASSOCIATION, 1991: Ethical standards for nurse researchers. Pretoria. Position Paper: South African Nursing Association.

YOUNGER, J.B. 1995: The alienation of the sufferer. *Advances in nursing science*. 17 (4): 53-71.

WARREN, B.J. 1997: Depression, stressful life events, social support, and self-esteem in middle class African-American women. *Archives of psychiatric nursing*. 10 (3), June, 1997: 107-117.

WEINGOURT, R. 1996: Connection and disconnection in abusive relationships. *Perspectives in psychiatric care*. 32 (2) April - June, 1996: 15-19.

WEISSMAN, M. & KLERMAN, G. 1989: Sex differences and the epidemiology of depression. *Archives of general psychology*. 34: 98-111.

WHITE, M. 1993: *Narrative means to therapeutic ends*. New York: W.W. Norton.

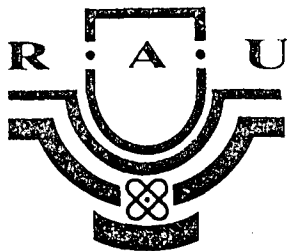
WILSON, H. 1989: *Research in nursing*. New York: Addison - Wesley Publishing Company.

WOODS, N.F. & CATANZARO, M. 1988: Nursing research: theory and practice. St Louis: Mosby.

ZAUSZNIEWSKI, J.A. 1994: Potential sequelae of family history of depression: identifying family members at risk. Journal of psychosocial nursing. 32 (9), 1994.



RANDSE AFRIKAANSE UNIVERSITEIT
Posbus 524 Auckland Park 2006
Republiek van Suid-Afrika
Tel: (011) 489 2911
+ 27 - 11 - 489 2911



RAND AFRIKAANS UNIVERSITY
PO Box 524 Auckland Park 2006
Republic of South Africa
Fax: (011) 489 2191 (Faks)
+ 27 - 11 - 489 2191

DEPARTMENT OF NURSING SCIENCE

Telephone : (011) 489-2860

1998-04-22

The Research Committee
Ministry of Health and Social Services

Dear

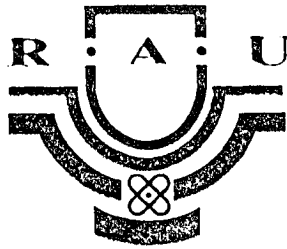
REQUEST TO UTILIZE OSHAKATI PSYCHIATRY OUTPATIENT CLINIC TO ACCESS POTENTIAL RESEARCH CLIENTS

Ndapewa Nehale Shifiona, a post graduate student in the Department of Nursing Science, Rand Afrikaans University, Johannesburg request permission to enlist the co-operation of clients and nurses in Oshakati Psychiatry outpatient clinic towards data collection for her research. The research is towards a dissertation for a M. Cur. (Psychiatric Nursing) under the supervision of Professor Marie Poggenpoel.

The clinic and staff will only be used to identify potential respondents and to set-up appointments to interview the latter at the clinic or in their homes. A brief copy of the research proposal is enclosed to facilitate your decision-making. A summary of the findings will be made available, if requested.

**N.N. SHIFIONA RN., BNSc (Hons)
M. CUR. (PSYCHIATRIC NURSING) STUDENT**

Marie Poggenpoel
**MARIE POGGENPOEL RN., Ph.D
PROFESSOR: NURSING SCIENCE
SUPERVISOR**



RANDSE AFRIKAANSE UNIVERSITEIT
 Posbus 524 Auckland Park 2006
 Republiek van Suid-Afrika
 Tel: (011) 489 2911
 + 27 - 11 - 489 2911

RAND AFRIKAANS UNIVERSITY
 P.O. Box 524 Auckland Park 2006
 Republic of South Africa
 Fax: (011) 489 2191 (Faks)
 + 27 - 11 - 489 2191

DEPARTMENT OF NURSING SCIENCE

Telephone : (011) 489-2860
 Fax : (011) 489-2257

1998-04-22

Dear Madam

REQUEST FOR CONSENT FROM PARTICIPANTS

I am a M. Cur. (Psychiatric Nursing) student at the Rand Afrikaans University in Johannesburg, presently engaged in a research project entitled "Life stories of *adult* depressed women in *pe-ti* urban Namibia", under the supervision of Professor Marie Poggenpoel of the Department of Nursing Science.

The purpose of this study is to explore and describe the life world of *adult* depressed women in *pe-ti* urban Namibia; also to use the information obtained to describe guidelines for the compilation of a mental health support programme for psychiatric nurses to assist depressed women in mobilizing their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

If you agree, a period of an hour or two will be made available for you to tell your life story. An audio-tape will be used with your permission, and to verify and validate the interview content, the tape recorder will be played back to you. The audio-tapes will be destroyed after completion of the research project.

To protect your identity, no names will be used or refer to during the whole phase of the interview. You have the right to withdraw your consent at any time during the phases of the research project, it is clearly understood that you are under no obligation to participate in this project. Arrangement will be made with you once permission has been granted by you as to the place where the interview will be conducted within a private, comfortable area free from disturbances at your clinic or in your in your own home.

Research results will be made available to you. Should you have any question with regard to this project, feel free to contact me at:

Tel. No.: 264 6751-20417 or 264 6751 20211 Ext. 2241 or
Fax No. 264 6751 21390, Attention N. Shifiona, College of Nursing.

Thank you

Yours faithfully



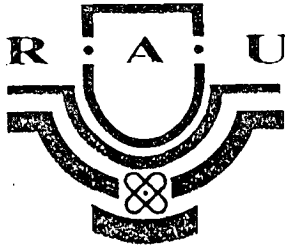
MS. N.N. SHIFIONA RN., BNSc. (Hons.)
M. CUR. (PSYCHIATRIC NURSING) STUDENT



UNIVERSITY
OF
JOHANNESBURG



MARIE POGGENPOEL RN., Ph.D
PROFESSOR: NURSING SCIENCE
SUPERVISOR



RANDSE AFRIKAANSE UNIVERSITEIT
 Posbus 524 Auckland Park 2006
 Republiek van Suid-Afrika
 Tel: (011) 489 2911
 f. 27 - 11 - 489 2911

RAND AFRIKAANS UNIVERSITY
 PO Box 524 Auckland Park 2006
 Republic of South Africa
 Fax: (011) 489 2191 (Faks)
 f. 27 - 11 - 489 2191

DEPARTMENT OF NURSING SCIENCE

Telephone : (011) 489-2860
 Fax : (011) 489-2257

1998-04-22

REQUEST FOR CONSENT TO CONDUCT RESEARCH

I am a M. Cur. (Psychiatric Nursing) student at the Rand Afrikaans University in Johannesburg, presently engaged in a research project entitled "Life stories of *adult* depressed women in urban Namibia", under the supervision of Professor Marie Poggenpoel of the Department of Nursing Science.

The purpose of this study is to explore and describe the life world of *adult* depressed women; also to use the information obtained to describe guidelines for the compilation of a mental health support program for psychiatric nurses to assist depressed women in mobilizing their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health.

For these objectives to be achieved, I will collect data from selected *adult* depressed women through your mediation! I need to conduct interviews with these women for approximately 60 to 120 minutes duration. Participants will be interviewed at the psychiatric outpatient clinic or a place convenient to them. The findings of the transcribed audio taped material obtained during the interview sessions will be verified by an independent coder. The identity of participants will be protected by omitting the use of names and places. The erasure of the audio taped material on completion of transcriptions by the researcher, will ensure confidentiality. Participants in this research study will give informed consent and have the right to withdraw their consent at any stage during the phases of the research procedure (see attached example of request for consent from participants). Research results will be made available to the participants, your department and the hospital, on request.

I will be pleased to answer any further questions about this project, if any. Tel. No.: 264 6751-20417 or 264 6751 20211 Ext. 2241 or Fax No. 264 6751 21390 Attention N Shifiona, College of Nursing.

Thank you

Yours faithfully

MS. N.N. SHIFIONA RN., BNSc. (Hons.)
 M. CUR. (PSYCHIATRIC NURSING) STUDENT

MARIE POGGENPOEL RN., Ph.D
 PROFESSOR: NURSING SCIENCE
 SUPERVISOR



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

DIRECTORATE NORTH WEST HEALTH REGION

Office of the Director
Private Bag 5538
OSHAKATI

Tel No: (06751) 20211 x 2234
Fax No. (06751) 20303

Enquiries: Dr N.T. Hamata

22 May 1998

Ms N.N. Shifiona
UNAM Division
Oshakati Regional Hospital
P/Bag 5501
Oshakati


Dear Ms Shifiona

REQUEST TO UTILIZE OSHAKATI PSYCHIATRY OUTPATIENT CLINIC TO ACCESS POTENTIAL RESEARCH CLIENTS

Thanks for your letter you sent on 19 May 1998

I have no objection to the study except that studies/researches must be recommended by the Research Committee of the MOHSS at Head Office (contact Ms Zauana, Directorate Planning & HRD) and approved by the permanent secretary when approval is granted there are usually conditions attached.

Yours sincerely


Dr N.T. Hamata
Regional Director

cc: Dr P. Nakangombe
Ms L.S. Nunes



Republic of Namibia

Ministry of Health and Social Services

Private Bag 13198 Ministerial Building Tel: (061) 2032824
 Windhoek Harvey Street Fax: (061) 227607
 Namibia Windhoek 264 61 227607
 Enquiries: Ms. T. Hoffmann Date: 01 July 1998

OFFICE OF THE PERMANENT SECRETARY

Ms. N. N. Shifiona
 Medical & Health Sciences of Faculty
 University of Namibia
 Oshakati Division
 Private Bag 5501
 Oshakati

Dear Ms. Shifiona

RE: RESEARCH PROJECT ON LIFE STORIES OF ADULT DEPRESSED WOMEN
 IN URBAN NAMIBIA.

1. The protocol of the above mentioned research project has been submitted to the Ministry. The application has been processed for review and recommendations.
2. The Ministry in principle agrees with your research project and you are hereby granted permission to implement the project under the following conditions.
 - 2.1 The research project has to be revisited and the attached recommendations incorporated.
 - 2.2 The finalised protocol has to be forwarded to the Ministry. You are kindly advised to refer to attached out-line as guide.
 - 2.3 Progress reports should be submitted to the Ministry at the following stages.
 - Stage 1: Completion of fieldwork
 - Stage 2: Completion of Data Analysis
 - Stage 3: Pre-liminary report for preliminary dissemination
 - 2.4 A written approval from the Ministry be sought prior to dissemination of findings.
 - 2.5 Final Report to be submitted to the Ministry.

3. Adherence to the above requirements is crucial and actions could be taken if not adhered to.

4. Wishing you all success in your envisaged project.


DR. K. SHANGULA
PERMANENT SECRETARY



UNIVERSITY
OF
JOHANNESBURG

RAND AFRIKAANS UNIVERSITY

DEPARTMENT OF NURSING SCIENCE

PROTOCOL FOR CO-CODER

Dear Colleague

Please follow the steps below to analyse the data of the transcribed interviews.

“LIFE STORIES OF ADULT DEPRESSED WOMEN IN PERI-URBAN NAMIBIA”

1. Read through all the transcription carefully while “bracketing” and “intuiting” to get a sense of the whole. Bracketing means placing preconceived ideas within brackets and intuiting means focusing on the life stories of adult depressed women.
2. Do the same with field notes.
3. Identify the major categories represented in each universum as you read through the transcripts and field notes.
4. Underline units of meaning that are related to the identified major categories.
5. Identify subcategories within the major categories.
6. Make a comparison of all transcriptions and indicate in each category how many subject (respondents) use the same words and themes.
7. Identify interrelationships between major categories and subcategories.

Thank you

N.N. SHIFIONA

M.Cur. (Psychiatric Nursing Student)

TRANSCRIPTION OF INTERVIEW NO 7 TO DEMONSTRATE THE METHOD FOLLOWED IN ANALYSING UNDERLYING THEMES.

KEY: R = RESPONDENT
I = INTERVIEWER

Research question: ***“TELL ME YOUR LIFE STORY”***

I : It is my pleasure to welcome you here and again for keeping our appointment. The other day you told me you are more comfortable with English, am I correct?

R : Sure, you are correct !

I : Madam, tell me your life story !

R : Yeeh ! (silence) This is not an easy task. Do you think I'll remember everything? Or where do you want me to start?

I : Tell me everything that you will remember about your life story.

R : Well, I'll try. I grew up with my parents and other older brothers and sisters at home. Being a last born in my family, I used to enjoy everything that my heart was yearning for. I had few problems during my early childhood, but I was somehow spoiled by my parents. Yes, I had a good time then, I so wish I can return to those yester years!

I : Did you say you were spoiled?

R : Of course yes ! I was really spoiled because I was almost the centre of all the attention. I did not really do much because my elder brothers and sisters were there.

We were a sort of well-to-do type of family and our parents made efforts to care for us. Everything was fine before 1981. Then I went into exile with

some of my friends, because by then going into exile was like a fashion. You go because everyone else is going.

I : Eeh ! What happened thereafter?

R : Things changed immediately. Being used to the comfort at home and having and getting what I wanted, I had so many problems there. Most of the time I felt lonely, homesick. It took me sometimes to get used to the new environment. I wanted to come back home which was not possible. In the process I was sent to school in another country where I obtained a certificate. After four years I came back to Angola. But, you know, even with that certificate I was not just happy. I had always internal conflicts with myself, blaming myself for leaving home. I could unfortunately not just cope with what I was doing. Being in exile, one has to learn to suppress some of the feelings. Others must not see that you are not happy or you want to go back. They will think you are a coward or there is something wrong with you. There was a lot of struggle deep down in my heart. During the night when I am alone, uuh. I cried a lot. But this was the only means of consoling myself. The years I spent in exile were sort of hell to me, because I did not just enjoy it.

I : Mh !! Seems to me you really had a tough time abroad?

R : Yes (looking down for a while) because I did not just enjoy life there. I came back in 1989 a very unhappy woman. Back home, my father was no more there because he passed away in 1985. One of my three brothers was killed by an unknown gunman in front of his business. My two sisters were all married. My mother was staying with two grandchildren and a helper. By then I was twenty nine, single with no child. In 1992 I met my husband-to-be, a co-exile fellow and we tie a knot in November 1993. From exile I did not have a promising job, except security work at one local company.

I : Mh ... What was it like for you to be a security guard?

R : Hey !! It was more frightening ! But remember I took up this job because I need money as well as employment, otherwise I did not really enjoy the job. I continued with this job even after the wedding.

I : Eeh ... !

R : But my husband did not like my work and this was another source of my frustrations. He wanted me to sit at home looking after his elderly parents and his two children born in exile. What makes matters worse was the fact that I could not fall pregnant. I consulted doctors around hoping that the problem could be identified but this did not bear any fruit. As you know culturally, after a wedding if you fail to bear children then you are regarded as useless, you are nothing. The first three years of our marriage was rather hell to me. I was forced to stop work by circumstances I found myself in. I lived under severe pressure from my husband as well as my in-laws. I was like their servant. In June 1996 I went off to see my mother for a week. When I came back home I found another woman in the house. I first thought she was visiting because I did not know her. To my greatest shock and disappointment I was told that she will be a second wife whether I like it or not, you see ! (long pause). That time it felt as if I was hit hard in the face, you know ! I never suspected this to happen to me. I did not even hear of any rumours about his extra-marital affairs, you know Hey ! it was a blow. It felt as if the world was turning its back against me.

I : Surely, this was difficult to come to terms with.

R : Hey, it was bad. That night I did not sleep at all. I felt useless, hopeless. That whole week I was literally shattered. I did not know whether to pack or to stay. For me it was meaningless to hang on if I'm told that without children I am nothing. It hurt very much.

The situation is beyond my control but nobody understands. I wished I could bring in some changes. This problem works continuously on my nerves. I kept on thinking how I'm gonna deal with it. Unfortunately I'm a bit reserved. I do not really share my problems with others. I discuss it sometimes with my Mom who told me to hang on. But my main worry was - hang on for what because I'm told I'm nothing. Our relationship, I mean between me and my husband, deteriorated. We had little to talk with one another. Surely, I reached a stage where I cannot take it anymore. You know, one day, I was told, my neighbours found me alone two kilometres away from home in the

bush. I was not talking, I was not responding to their questions. The only word I was verbalizing was my husband's name. "Oh M... why did you do this to me?"

I : Mh !!

R : They took me home and then I was taken to the hospital. The first week I was not just myself at all. I felt as if there was a dark cloud hanging over me. It felt as if I was sinking down into a deep sea, I had no appetite at all, I felt very tired but I can't sleep. I cried a lot !

I spent a month in the hospital being treated for depression. You know, this man did not even visit me while in hospital. I heard that he said he does not want to be associated with crazy people. Fortunately my mother stood by me all the times. After discharge I went straight to my mother because our relationship was not working at all.

I : Mh ... What happened then thereafter?

R : I stayed with my mother until now. We are not yet divorced but I just don't care at all. I was not getting anything from him except troubles, you see. (Very long pause).

You see, at the moment when I look at my whole life story and what I have gone through, it makes me mad. When I start thinking about my future, things look bleak and dark. Nothing is promising. My entire life is mere frustrations. I have got nothing to tell with pride as an achievement. I had failed in almost everything.

I : Mh !! What does all this mean to you?

R : Well, it means I have been a failure throughout - no doubt about it - you see! The relationship is gone and I do not just have energy to start with another relationship. It is gone for good and I do not want to see that man anymore. If it was not because of my Mom and my sisters I could have gone for good long ago !

I : Me'm, what actually do you mean by 'gone for good'?

R : I once thought of committing suicide but I did not carry the act out.

I : Tell me what happened?

R : I kept an amount of the pills I was taking, but my Mother did observe my unusual behaviours, we discussed it over and over again.

I : Do you still have those ideas?

R : Not recently, but I'm not so sure whether I am free from such feelings. Anyhow I am better now. I thank God for keeping me alive up to now.

Well I think I have given you my story. Thank you too for talking to me !

I : I thank you too for being so open. Keep well.

