THE FAMILY'S EXPERIENCE OF HAVING A MENTALLY ILL FAMILY MEMBER

by

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This research is dedicated to my family.

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SUMMARY

In South Africa there are a number of "risk factors" relating to mental disorders. These include poverty, malnutrition, violence, the breakup of families due to migrant labour, racism, poor pre- and post-natal services.

Facilities within mental health lag far behind other areas of health care and for the majority (e.g. the rural areas of the Eastern Cape Province) there is no care at all.

This includes a lack of knowledge amongst the families of mentally ill persons about the care of their mentally ill members. There are no community mental health care services. People are only sent to mental hospitals when they are completely out of control. When discharged these patients are sent to their totally unprepared family members who experience difficulties in accepting them back home.

It has been proven that mental illness affects the family - physically, emotionally, mentally and socially.

To explore this, the researcher studied the effects of mental illness on the family. The goal of this study is to:

- Explore and describe the experience of families with a mentally ill family member.
- Describe guidelines for the advanced psychiatric nurse specialist to assist families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

This study was undertaken within the framework of the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9), which functions in an integrated bio-psychosocial manner (body, mind and spirit), within the family or community. The parameters of nursing and beliefs about man, health, illness and nursing are also described.

A functional reasoning approach is followed based on the model for nursing research developed by Botes (1991). A phenomenological approach to nursing research was utilised. In-depth semi-structured interviews were conducted and field notes were taken with the permission of the families.

Steps were taken throughout the research to ensure trustworthiness. Data were analysed following Giorgi's and Tesch's (in Cresswell, 1994: 155) methods and the services of an independent coder were obtained. After analysis of data, follow-up interviews were conducted with some family members included in the sample. A literature control was undertaken to validate data and to compare findings with those of other research studies.

The results of this study indicate that families suffer emotional disturbances, financial losses, social discrimination and that they use destructive defence mechanisms. Despite this, the families still display a feeling of hope.

Conclusions were drawn and recommendations were made concerning nursing practice, nursing education and nursing research. Limitations of the study were also highlighted. Guidelines were given to the advanced psychiatric nurse to assist families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

USHWANKATHELO

Apha e South Afrika zininzi izinto ezingakho khelela ekuguleni ngengqondo izinto enzinje ngobuhlwempu, ukungondleki, izixholoxholo, ukohlu kana kosapho ngenxa yemisebenzi ekude, ucalucalulo ukungakhathaleleki phambi nasemva kokuzalwa.

Indlela zonakekelo lwengqondo zishiyeke emva kwezinye indlela zonyango, kwezinye indawo azikho kwaphela (njenge ndawo ezihlala abantu abantsundu zase Eastern Cape Province).

Lento ke idibanisa nolwazi olunqongopheleyo kwintsapho zabantu abagula ngengqondo ekukhathaleleni abantu babo.

Akukho lunakekelo lwabantu abagula ngengqondo emphakathini (community clinics).

Abantu bathunyelwa kwizibhedlela zabantu abagula ngengqondo xa sele begula mpela.

Xa sele bethunyelwa emakhaya basiwa kubantu abangakulungelanga ukubamkela.

Kucace ngokupheleleyo ukuba ugulo ngengqondo luyazi "bulala" intsapho ngokwasemzimbeni, emphefumlweni, engqondweni nasekuhlaleni.

Ukufumana ngokupheleleyo ngalento ndifunde ngezinto ezenziwa lugulo ngengqondo elusatsheni injongo yoluphando kukuthi:

- Explore and describe the experience of family with a mentally ill family member.
- Describe the guidelines for the advanced psychiatric nurse specialist to assist families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

Olu phando lwenziwe ngokwe migaqo ye Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9), esebenza in an integrated biopsychosocial manner (umzimba, ingqondo, nomphefumlo) elusatsheni nase mphakathini.

Imizila yokonga nenkolelo ngomntu, ngempilo, ngokugula, nokonga, nazo ziyacaciswa.

A functional reasoning approach i yalandelwa eyakhelwe kwi model for nursing research eyenziwa ngu Botes (1991). Iphenomenological approach to nursing research isetyenzisiwe. Imibuzo ngohlobo lwe in-depth semi-structured yenziwe kwaza kwathatyathwa neencukacha ngobume bendawo ngemvume yentsapho ezo zabantu abagula ngengqondo.

Kulo lonke oluphando amanqanaba athatya thiwe, ukuqinisekisa, trustworthiness.

Inkcukacha zicalu calulwe kusetyenziswa uhlobo luka Giorgi no Tesch (in Cresswell, 1994: 155) kwaza kwafunyanwa noncedo lwe independent coder.

Emva kocalucalulo lwenkcukacha ezinye zentsapho ezaziyinxalenye yesampuli ziye zalandelwa.

Ufundo ncwadi lwenziwe ukuqinisekisa inkcukacha nokuthelekisa iziphumo zayo nezo zezinye i research studies.

Iziphumo zoluphando zibonisa ukuba intsapho zihlutshwa zinkathazo zomphefumlo, zemali noku calu-calulwa nokuba basebenzisa ukhuselo ngqondo (defence mechanisms) "olubulalayo". Nangona kunjalo intsapho zisenalo ithemba ngomntu wazo.

Kufikelelwe ezigqibeni kwenziwa neengcebiso malunga nokonga, ufundiso konga, nocwaningo ngokonga, kwaze kwanikwa indlela ezinokulandelwa ngumongi wolwantwentwe ophothulekileyo (advanced psychiatric nurse) ukuncedisana neentsapho ekusebenziseni izinto abananzo ekuphuhliseni ukhuselo, nogulo, nobuyiselo lwengqondo mpilo yabo as an integral part of health (wholeness).

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 BACKGROUND AND RATIONALE

According to the study conducted by the Centre for the study of health policy, University of Witwatersrand (1991: 35) titled: "The need for improved Mental Health Care in South Africa", mental health is often seen as secondary to physical health and is relegated to fringes of health care and health planning. Facilities within mental health lag far behind other areas of health care and for the majority (e.g. the rural areas of the Eastern Cape Province) there is no care at all. This includes a lack of knowledge of the families of mentally ill persons about the care of their mentally ill members. Because of this lack of knowledge, the families tend not to accept their mentally ill members back home.

Mental health services, like all other services, are fragmented, inefficient and ill-equipped to intervene effectively. Resources are grossly mismanaged and poorly distributed. The available services are neither appropriate nor accessible to the majority of the population, the situation in the rural areas is particularly bad (New Health Act, 1997: 135). The aim of the National Health Policy is to ensure mental health for all South Africans and to enhance their ability to conduct themselves effectively in social, interpersonal and work relationships.

As mental health is determined by social and material conditions as well as by physical and emotional health, the policy will aim to eliminate fragmentation of services and ensure comprehensive and integrated mental health care (New Health Act, 1997: 135).

According to the study conducted by the Centre for the study of health policy, University of the Witwatersrand (1991: 35), there are no reliable studies examining the incidence of mental disorders in South Africa. However, there are indicators that suggest that there are probably a large number of people who require mental health intervention. In the majority of international

studies, to be between 12% and 30%. Presuming that South Africa fits within "normal parameters", there are probably between four and ten million people in need of mental health care out of the population of 42 000 000.

Studies from a number of developing countries show that around 20% of all people attending general outpatient services, do so as a result of psychological problems. The are many factors that make South Africa even more differt.

Mental health / illness is a product of genetic, developmental, political and socio-economic factors. In South Africa there are a number of "high risks" for mental disorders. These include poverty, malnutrition, violence, the breakup of families due to migrant labour, racism, poor pre- and post-natal services etc. Thus, if South Africa falls within the "normal" range of the incidence of mental disorders at all, it is likely that this would be within the upper limits of the range. There are a number of areas of mental health care where additional intervention is required.

Only about 1% of the mental health budget is spent on the prevention of mental illness and the promotion of mental health. This is grossly insufficient and the black population is the most under-served. While prevention and promotion of mental health is needed in any society and at all costs, the need for such intervention is particularly strong in South Africa today.

Reconstruction is not just a political, economic and social process, but fundamentally a psychological one. It is essential for the successful future of this country that mass efforts be directed towards building people who feel holistically safe and who can function physically, psychologically, socially and emotionally at optimal levels. For example: it would not be easy for the youth who grew up in a climate of violence and with a spirit of resistance to authority and "no compromise", to suddenly change their psychological sets and have the skills to cope with an orderly and just society. Additional help may well be required (Centre for the study of Health Policy, University of the Witwatersrand, 1991: 36).

If community care and facilities are inadequate for those who need this form of care, patients may make a nuisance of themselves and be forced into institutional care. There is a very high

"revolving door syndrome" in and out of the psychiatric hospitals in South Africa and this seems to result in part from inadequate community care. If there is not a major effort to promote "mentally healthy" living, South Africa may suffer extreme adversity as it attempts to move towards a peaceful, prosperous and democratic future (Centre for the Study of Health Policy, University of Witwatersrand, 1991: 36).

The social and economic handicap of mentally ill patients is illustrated by the proportion of patients who are single and unemployed and who do not even receive disability grants.

The solution to the rehabilitation dilemma does not lie only on making disability grants more freely available, but they can be used to enhance rehabilitation. Most of these patients live with their families who take care of them. These families lack knowledge of mentally ill patients, they therefore need assistance in the care of their mentally ill family members.

Since rural and even urban blacks live in a situation where postal, telephonic and transport links are limited or completely absent, about a third of the hospitalised patient's families cannot be reached by either the treatment team or their hospitalised family members (Ngubane, 1994: 6 - 7).

No effective education, support or integration of the family in treatment is therefore possible. No supporting history can be obtained from the family nor can the perception of families about accepting their mentally ill family members back home, be tested. One of the effects of the mentally ill family member may well be the creation of family pathology in the form of reactive depression and anxiety, as a result of daily stress because of interaction with the mentally ill family member, and an additional financial burden is assumed by the family (Kraus, 1982: 55, Aviram, 1990: 81, Wilson & Kneisl, 1988: 588).

As the mentally ill individual is a member of the family, there are certain expectations of the family from the mentally ill family member, and it becomes impossible as many mentally ill family members are incapable of fulfilling that role resulting in the mentally ill family member becoming pressurised. The family therefore needs assistance to mobilise resources to promote, maintain and

restore mental health of their mentally ill family members as an integral part of health (wholeness).

In a study conducted by Uys, Dlamini & Mabandla (1995: 25), entitled "a profile of selected psychiatric outpatients in South Africa", it was revealed that the families of psychiatric patients experience financial hardships, since so few of the psychiatric patients receive disability grants. Since most families do not visit their mentally ill family members or attend the clinic with them, the contact between them and the potential helpful professional staff seems limited.

Mentally ill individuals are mostly cared for by totally unprepared family members. It becomes the responsibility of health care workers to assist them and especially to provide them with guidelines to assist their mentally ill family members.

Because of poor patterns of interaction between the family and the mentally ill family member, the mentally ill family member may develop a lot of emotional disturbances which may result in feelings of frustration, anger, verbal and physical aggression, feelings of worthlessness and hopelessness. These feelings could interfere with the mental health restoration and maintenance phase (Haber, J. et al 1987: 225 - 253).

When the family visit the hospitalised relapsed patients, they are confronted with feelings of anger, shame, guilt and depression, which is the reaction to internal and external stimulus. This becomes part of the process of mental illness and may serve as a trigger for relapse of their discharged mentally ill family members. In other cases the family blame themselves for their family member's mental illness, and think they are responsible for the occurrence of mental illness (Poggenpoel, 1994: 55).

Adequate mental health and mental health care is a right and not a privilege and should be regarded and demanded as such (Centre for the study of health policy, University of the Witwatersrand, 1991: 36). There is therefore a need for the families with mentally ill family members to receive support from the advanced psychiatric nurse practitioner and therefore it is their duty to facilitate promotion, maintenance and restoration of the family's mental health as an integral part of health (wholeness) (Poggenpoel, 1994: 55).

1.2 PROBLEM STATEMENT

As a psychiatric nurse working in a psychiatric hospital, the researcher has observed that most of the hospital's patients are readmissions. In their case studies it is reflected that some of these patients are brought to the hospital by police, social workers, some by state escorts and the public and are perceived as being dangerous to themselves and the public.

The patients reveal the fact that when they are discharged they discontinue treatment because there are no nearby clinics. It is difficult for them to go to more distant clinics because they do not have money to use public transport.

One family told the researcher that their mentally ill family member was unmanageable at home. That was why they had to have him readmitted. They were afraid of him because he was destructive to property during the onset of his mental illness. He assaulted his wife and children. They therefore found it very difficult to accept him back home.

In lieu of the above, the researcher asked the following questions:

- *How do **families experience having a mentally ill family member?***

- ***What guidelines can be described by an advanced psychiatric nurse to assist the family in mobilising resources to facilitate promotion, maintenance, and restoration of their mental health as an integral part of health (wholeness)?***

1.3 RESEARCH OBJECTIVES

The objectives of this study are two-fold:

- To explore and describe the experience of families having a mentally ill family member (as patient).

- To describe the guidelines for the advanced psychiatric nurse to mobilise resources for the promotion, maintenance and restoration of the family's mental health as an integral part of health (wholeness).

1.4 PARADIGMATIC PERSPECTIVE

In this research study the paradigmatic perspective will be based on the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

This theory is based on the Judeo-Christian world view and philosophy, and the Bible as the source of truth. The theory reflects the focus on the whole person - body, mind and spirit - as well as the parameters of nursing service and beliefs about man, health, illness and nursing. The whole person incorporates the concepts body, mind and spirit. Assumptions in this theory i.e. meta-theoretical, theoretical and methodological assumptions, will be discussed as follows:

1.4.1 Meta-theoretical assumptions

The researcher believes that the Nursing for the Whole Person Theory forms an integral part of psychiatric nursing. That is why she also believes that a psychiatric patient is a person with body, mind and spirit, and a spiritual being who functions in an integrated bio-psychosocial manner to achieve his / her quest for wholeness. A psychiatric patient interacts with the internal an external environment and is part of his / her family.

The researcher also believes that wholeness of body, mind and spirit will promote the mental health of the psychiatric patient. The patterns of interaction between the mentally ill family member and his family determine the restoration of the patient's mental health (Poggenpoel, 1990: 8).

The researcher is of the opinion that mental health is an integral part of wholeness and that wholeness is a state of spiritual, mental and physical wholeness. Mental health can be qualitatively

described on the continuum from maximum health to minimum health.

The patterns of interaction between the internal and external environment determine the individual's health status.

In this study the patterns of interaction of the internal and external environments between the family members will determine the patient's mental health.

The researcher believes that maintenance of mental health refers to those activities directed towards continuing and preserving the health status of the family and that promotion of mental health refers to nursing activities contributing to a greater degree of wholeness of the family.

She is of the opinion that restoration of mental health refers to those activities which facilitate the return to the previously experienced levels of health of the family (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

The researcher believes that mental illness is a personal as well as a social problem. That it is personal when it is due to one's internal environment and social when it is due to one's external environment. Mental illness is a dynamic state which reflects the nature of a person's interactive patterns with stressors in his internal and external environment. Mental illness can be qualitatively described on the continuum from severe mental illness to minimum mental illness. Minimum health exist in those who are mentally ill (Oral Roberts University, 1988: 1961).

The researcher suggests that "psychiatric nursing" is a goal-directed service to assist the individual, family and community to promote, maintain and restore mental health and central to this service is the concept of Nursing for the Whole Person (Oral Roberts University, 1988 - 1990: 196).

Assumptions about Psychiatric Nursing

The researcher believes that psychiatric nursing is an inter-actional process between a psychiatric nurse and a psychiatric patient and his family, and is an integral part of nursing and that it provides comprehensive psychiatric services (promotion, maintenance and restoration) of mental health (Poggenpoel, 1994: 52).

She believes that environment includes internal and external environments and that the nature of the internal environment is body, mind and spirit and that of the external environment is physical, social and spiritual. She also believes that the patterns of interaction with the internal and external environment determine the health status of the individual (Department of Nursing, Rand Afrikaans University, 1991: 3).

1.4.2 Theoretical assumptions

The theoretical assumptions of this study will be based on the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

1.4.2.1 Theories and models

The Botes model for research will be used to guide the research process. According to this model, nursing activities take place in three interrelated orders (Botes, 1991: 19).

While conducting research the researcher will enter the field without any preset framework of reference to avoid any possible bias in the research findings.

After the results have been analysed they will be reflected within the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

1.4.2.2 Conceptual definitions

Family is a spiritual being who functions in a bio-psychosocial manner to facilitate the promotion, maintenance and restoration of health as an integral part of health to achieve his / her quest for wholeness. The family unit in the community represent a primary group which consist of close-knit, mutually independent and reciprocal memberships (Kreigh & Perko, 1998: 45). It is here that the individual establishes norms and roles and validates his thoughts, actions and feelings through continuous interaction with the primary group. This relationship should create a sense of belonging.

The advanced psychiatric nurse is a practitioner who facilitates the promotion, maintenance and restoration of the family's mental health through the health delivery system. The promotion, maintenance and restoration of mental health require the mobilisation of all resources in the internal and external environment of the family with the mentally ill member.

Psychiatric patient is a person with body, mind and spirit and is a spiritual being who functions in an integrated bio-psychosocial manner to achieve his / her quest for wholeness. He / she interacts with the internal and external environment and is part of his / her family. The wholeness of body, mind and spirit will promote mental health of the psychiatric patient and the patterns of interaction between the mentally ill family member and his family determines the restoration of the patient's mental health (Poggenpoel, 1994: 54).

Resources in the patients environment include any assets or means to assist the patient and his / her family in facilitating their quest for wholeness. Resources in the patient's internal environment include physical, mental and spiritual resources. Resources in the patients external environment include personal resources (e.g. significant others, significant activities and objects) and professional resources e.g. people and organisations (Poggenpoel 1994: 54).

Psychiatric nursing is a professional, educated and interactive goal, directed towards utilising the self as therapeutic resource in facilitating the patient's quest for mental health as an integral part of health (wholeness) (Poggenpoel, 1994: 54).

1.4.3 Methodological assumptions

The methodological assumptions of this study are in line with the research model developed by Botes (1991: 19). The central thesis of this model is that research should be functional. Nursing research should be undertaken in order to improve nursing practice. In this study, knowledge about the experience of families with a mentally ill family member will provide the basis for describing guidelines for the advanced psychiatric nurse to assist the family in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

1.4.4 Central statement

The exploration and description of the experience of families with mentally ill family members will provide the basis for describing guidelines for advanced psychiatric nurses to assist the families in mobilising resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

1.5 RESEARCH DESIGN AND METHOD

1.5.1 Research design

The design of this research will be qualitative (Burns and Grove, 1993: 28 - 29), exploratory (Mouton and Marais, 1990: 49 - 121), descriptive (Mouton and Marais, 1990: 43 - 44) and contextual in nature (Mouton and Marais, 1990: 49 - 121). This will be fully discussed in chapter two.

1.5.2 Research method

This study will be conducted in two phases. The first phase is concerned with exploring and describing the experience of families with mentally ill family members.

The second phase entails the description of guidelines for the advanced psychiatric nurse to assist the families with mentally ill family members in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

1.5.3 **Phase 1:** **To explore and describe the experience of families with mentally ill family members.**

In this phase the respondents who meet the sampling criteria, will be identified purposively to participate in the study and semi-structured, in-depth phenomenological interviews (Kvale, 1983: 184) will be conducted. Field notes (Wilson, 1989: 434) will be taken and data analysed. This will be followed by literature control to verify the results obtained.

Similar studies will be investigated in order to establish the relevance and uniqueness of this research study (Woods and Catanzaro, 1988: 135). This will be done through a literature survey on all research that has been done on the experience of families with mentally ill family members and this will assist with the evaluation of the significance of the findings.

1.5.4 **Phase 2:** **Description of guidelines for the advanced psychiatric nurses to assist the families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).**

During this phase data collected from the families will be utilised as a basis for describing guidelines for the advanced psychiatric nurse to assist families in mobilising resources in promoting, maintaining and restoring their mental health as an integral part of health (wholeness) and literature control to look at the unique aspects and differences of the research study to compare findings with that of similar studies done.

1.6 TRUSTWORTHINESS

To ensure trustworthiness of the interviews, Guba's model (in Krefting, 1991: 214 - 222) will be used. Guba identifies four criteria for trustworthiness. They are: truth value, applicability, consistency and neutrality. Truth value is ensured by using strategies of credibility, applicability by using strategies of transferability; consistency by using strategies of dependability and neutratily by using strategies of confirmability. The above-mentioned strategies will be discussed fully in chapter two.

1.7 ETHICAL CONSIDERATIONS

In this research study, ethical conduct will be ensured by the following ethical standards established for nursing practice and research by the South African Nursing Association (1991: 1 - 7). They are:

- Informed consent
- Privacy
- Anonymity
- Confidentiality
- Providing the family with results

These will be discussed more extensively in chapter two.

1.8 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

These will be highlighted after the results of the research study have been discussed.

1.9 SEQUENCE OF CHAPTERS

Chapter 1: Background and rationale

Chapter 2: Research design and method

Chapter 3: Results of phase 1: Phenomenological interviews and literature control.

Chapter 4: Phase 2: Guidelines and literature control, conclusion, limitations and recommendations.

1.10 CONCLUSION

In chapter one, the overview of the research study was given which entailed background and rationale, statement of the problem, the goals of research, the paradigmatic perspective of the study, the research design and method, data collection and analysis and the division of chapters. In chapter two, special attention will be given to the research design and method that will be used in this research study.

CHAPTER 2

RESEARCH DESIGN AND METHOD

INTRODUCTION

In chapter one the orientation and rationale of the research study were described. In this chapter a description of the research design and method will be provided.

2.1 RATIONALE

In the rural area the researcher calls home, there is only one psychiatric hospital to cater for the whole region. There are no proper psychiatric services in the community. Clinics are dominated by non-psychiatric trained nurses, who have no knowledge of mentally ill patients. Patients are sent to hospital when they are already out of control because mental illness cannot be detected early in the community. When discharged these mentally ill patients are poorly understood by their family members.

It falls on the shoulders of the advanced psychiatric nurse to assist the families with mentally ill relatives to mobilise resources for the promotion, maintenance and restoration of the family's mental health as an integral part of health (wholeness).

This brings the author to the objectives of this study.

2.2 OBJECTIVES OF THE RESEARCH STUDY

This research study has the following objectives based on the identified problem.

- To explore and describe the experience of families with mentally ill family members.
- To describe guidelines for the advanced psychiatric nurse to assist the families in

mobilising resources for the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

2.3 RESEARCH DESIGN AND METHOD

The research design and method which will be used in this study, will be discussed as follows:

2.3.1 Research design

The design of this research will be qualitative (Burns & Grove, 1993: 28 - 29), exploratory (Mouton & Marais, 1994: 43 - 44), descriptive (Mouton & Marais, 1994: 43 - 44) and contextual (Mouton & Marais, 1994: 49 - 121).

2.3.1.1 Qualitative

A qualitative study is one where the procedures are not strictly formalised, while the scope is more likely to be undefined and a more philosophical mode of operation is adopted (Mouton & Marais, 1994: 205). It seeks to gain insight into the experience of families with mentally ill family members. It is concerned with the nature of other experiences which are unique to each family eg. financial hardships and families with no knowledge of mentally ill patients. It's qualitativeness can also be explained by the fact that it is a systematic, subjective approach used to describe life experiences and giving them meaning (Burns and Grove, 1993: 28 - 29).

2.3.1.2 Exploratory

The goal which is pursued in exploratory studies is the exploration of a relatively unknown research area, the aim being to gain new insight into the phenomenon (Mouton and Marais, 1990: 43). This is done by exploring the experience of the families with mentally ill family members, as the researcher departs from a position of "not knowing".

2.3.1.3 **Descriptive**

It is the goal of the researcher 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, 1994, 43 - 44). The experience of the families with mentally ill family members will be described as well as the guidelines for assisting the families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

2.3.1.4 **Contextual**

A contextual design is one where the phenomenon of interest is studied in terms of its immediate context (Mouton & Marais, 1990: 49). This study will be contextual in that it will focus on the experience of families with mentally ill members who reside in one area of the Eastern Cape Province and whose mentally ill members are admitted to psychiatric hospitals.

2.3.2 **Research method**

This study will be conducted in two phases:

- The first phase involves the exploration and description of the experience of families with mentally ill family members in a specific black rural area in the Eastern Cape Province.

- Phase two will involve the description of guidelines based on the results of phase one for the advanced psychiatric nurse specialist to assist the families with mentally ill family members in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

When conducting this research study ethical issues will be considered as follows:

2.3.2.1 **Ethical issues**

These are standards set for nurse researchers by the South African Nursing Association, 1991: 1 - 7) that will be adhered to throughout the research process.

- **Informed consent**

Two types of informed consent will be obtained before commencing with the collection of data. These are obtaining the permission to conduct a research study from the author's supervisors and obtaining informed consent from prospective families to participate in the research study.

Consent will be obtained in writing and the following information will be conveyed to the participants:

- The title of the research.
- The objectives of the research.
- Research methods, including all the procedures that will be followed.
- The type of participation that will be required of the respondents.
- How the results will be utilised and published.
- The right of the participants to terminate their participation without being penalised.
- Potential physical, emotional, social and economic risks that might result from the research.
- Potential benefits of being a subject in the research.
- Means of communicating with the researcher when prospective participants have further questions or merely want to contact the researcher for other reasons (Burns & Grove, 1993: 105 - 106).

- **Privacy**

Privacy means that a person can behave and think without interference, or the possibility of private behaviour or thoughts being used to embarrass or demean that person later (SANA, 1991: 2 - 3). In this research study, privacy will be ensured in that the researcher will refrain from

collecting more information than is absolutely necessary, especially of a private nature, to achieve the objectives of this study.

- **Anonymity and confidentiality**

Anonymity means that the subject's identity cannot be linked - even by the researcher, to individual responses (Burns and Grove, 1993: 99). In this study numbers will be allocated to each family so that it will be possible to review the respondent's analysed interviews with them later.

Confidentiality is the management of private information, which the researcher must refrain from sharing with anyone without the authorization of the respondent (Burns and Grove, 1993: 99). In this research study confidentiality will be conferred to the participants.

The first phase of this study will now be discussed.

2.3.2.2 **Phase 1: To explore and describe the family's experience of having a mentally ill family member in a specific black rural area of the Eastern Cape Province.**

The objective of this phase is to explore and describe the experience of having a mentally ill family member.

This phase will entail the identification of families participating in the study and the collection of data by means of phenomenological interviews. Field notes will be taken, followed by verbatim transcription and analysis of the data.

- **Population and sampling**

The target population identified for this study are black families living in a rural area of the Eastern Cape Province who have mentally ill family members who are admitted repeatedly to a certain psychiatric hospital. Purposive sampling will be used to achieve saturation of data. This

This method can also be referred to as judgemental sampling and will involve the conscious selection of certain subjects to be included in the study by the researcher (Burns and Grove, 1993: 246) in order to meet the requirements of the sampling criteria.

- **Sampling criteria**

Sampling criteria are the characteristics which are essential for membership of the target population.

The sample is selected from the population which meets the following criteria::

- The participants must be families with mentally ill family members who have been admitted repeatedly to a certain rural psychiatric hospital within two years i.e. 1995 and 1996 because the aim of this research study is to explore the lived experiences of having a mentally ill family member and the family must have been with the mentally ill member for at least two years to be able to share these experiences.
- They must be families who live in a specific black rural area because this study can be compared with the experience of families with mentally ill family members in the urban areas to correlate the extent of readmissions.
- They must be families who can understand and speak English because the researcher, the supervisors and the independent coder speak and understand English.
- The sample size will be determined by the saturation of data by means of repetitive themes.

- **Data collection**

Data will be collected through in-depth, semi-structured phenomenological interviews and field notes. This will be discussed in more depth, later in this chapter (page 22).

The role of the researcher

Qualitative research is primarily concerned with the processes rather that outcomes or products, with emphasis being placed on meaning - how people make sense of their lives, experiences and the structures of their world (Creswell, 1994: 145). Thus, the author, as a qualitative researcher will be functioning in this capacity - a human instrument, in an effort to explore how families who meet the sample criteria of this study perceive their experience of having a mentally ill family member.

Qualitative research is interpretative research (Cresswell, 1994: 147), and it is for this reason that assumptions and judgements are stated in chapter one to facilitate the execution of a valid and reliable study. The qualitative researcher attempts to gather descriptions of relevant themes (Kvale, 1994: 176) which in this study relates to those themes extracted from the stories told by the participating families. The qualitative interview allows and requires an openness to new and unexpected phenomena (Kvale, 1982: 176). A curiosity and sensitivity to what is, and what is not being said, should be displayed. This facilitates the discovery of different nuances and depths of themes of interviews (Kvale, 1982: 176). During an interview the participants may sometimes be ambiguous, with expressions implying several possibilities of interpretation and it is suggested that it is the task of the researcher to clarify, as far as possible, whether the ambiguities and contradictory statements are due to a lack of communication in the interview situation, or whether they reflect real inconsistencies, ambivalences and contractions by the participants (Kvale, 1982: 177). It is important to remember that the aim of qualitative interviews are not to end up with unequivocal and quantifiable meanings about themes focused upon (Kvale, 1982: 177), rather, the aim is to describe precisely the inherently contradictory meanings expressed by the participants being interviewed. These contradictory statements in the interview situation may not only be due to faulty communication, but may be a reflection of objective contradictions of the world in which they live (Kvale, 1982: 177).

It is expected that the interviews may be experienced by the family members as threatening and evoking anxiety and resistance. It is also possible that the interview situation may be clouded by an air of mistrust and suspicion. It is for this reason that contact will be made with family

members prior to the period of data collection. A pilot study will be conducted with families who meet the sampling criteria to identify any possible problems which may be encountered during the first phase.

- **Use of communication techniques**

Non-directive communication techniques which include minimal response, probing, clarifying, reflecting, summarising and paraphrasing will be used by the researcher to encourage the family being interviewed to freely articulate their views and findings.

- **Minimal responding**

Minimal responding means that the interviewer adopts a less active role and allows the respondent more time to talk (Stuart and Sundeen, 1983: 122).

- **Probing**

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

- **Clarifying**

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

- **Reflecting**

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

- **Summarising**

Summarising involves the tying together into one statement several views and feelings at the end of the discussion or interview. The main purpose is to give the interviewee a feeling of movement in exploring ideas and findings, as well as to create awareness of progress in communication (Brammer, 1988: 79; Madela, 1994: 38).

- **Paraphrasing**

This is a method of restating the interviewee's basic message in similar, but usually fewer words. This is used by the interviewer to test his / her understanding of what has been said (Brammer, 1988: 70).

- **Interviews**

The family of each mentally ill member will be interviewed in their home environment. Data will be collected by means of an in-depth semi-structured phenomenological interview which will be recorded using a dictaphone. The interviews will then be transcribed verbatim (Burns and Grove, 1993: 578 - 581). The purpose of these interviews is to gather uninterrupted descriptions of the life-world of the participants with respect to interpretation of the meaning of the described phenomena (Kvale, 1983: 174). The participants describe as accurately as possible what they experience, feel and how they act (Kvale, 1983: 176). This highlights the specific nature of the qualitative interview as a method of data collection. Thus, with reference to this study, the interviews will describe how families living in a specific black rural area of the Eastern Cape Province experience having a mentally ill family member. The semi-structured nature of the qualitative interview indicates that the interview is neither free of conversation nor a highly

structured questionnaire (Kvale, 1983: 174). Within the area focused upon, it is then up to the participants to bring forth dimensions which they consider important, with the task of the interviewer being to focus on, or guide towards themes, without guiding the participants towards certain options regarding the themes (Kvale, 1983: 176).

Considering the above, the semi-structured in-depth phenomenological interview in this study will start with the following central question:

"Please tell me how you experience having a mentally ill family member?"

- **Field notes**

A field researcher needs a system for remembering observations made and, even more importantly, for retrieving and analysing them (Wilson, 1989: 434). In this research study, field notes will be written after each interview has been conducted to describe the underlying themes, dynamics and situation during the interview. This will help the researcher to remember all aspects of the interview situation (Wilson, 1989: 436). A good set of field notes not only relieves the researcher of some of the burden of remembering all the events which occurred during the interview, but also constitute a written record of the development of the observations and ideas to be used in future publications of the research findings and method. In this research study, field notes will be utilised in data analysis, together with the information obtained from the semi-structured interviews. Field notes can be recorded in a format which demarcates observational, theoretical, methodological and personal notes.

- Observational field notes are descriptions of events experienced through watching and listening. They contain the who, what, where and how in a situation and as little interpretation as possible (Wilson, 1989: 434). In this research study, observational notes will contain the number allocated to the particular interview, observations during the interview, the setting of the interview and the way in which the interview is being conducted, with some form of simple interpretation being attached.

- Theoretical field notes are purposeful attempts to derive meaning from observational notes (Wilson, 1989: 435). In this research study, the researcher will interpret, infer, conjecture and hypothesize to structure her analytic scheme.

- Methodological field notes are instructions to oneself, critique of one's tactics and reminders about methodological approaches that might be fruitful (Wilson, 1989: 435). In this research study the researcher will evaluate her conduct during the interview against the proposed research design and method.

- Personal field notes are notes about one's own reactions, reflections and experiences (Wilson, 1989: 435). In this research study the researcher will try to adopt the role of the respondents or participants and be introspective. During data analysis, the field notes will also be analysed in relation to the interview and to determine categories (Wilson, 1989: 38).

■ **Data analysis**

The tape-recorded interviews will be transcribed verbatim and then analysed according to the descriptive analysis method suggested by Tesch (in Cresswell, 1994: 155). Data analysis requires that the researcher is comfortable with developing categories, making comparisons and forming contrasts. It also requires an openness to possibilities and to see contrary or alternative explanations for the research findings. Tesch (in Cresswell, 1994: 155) provides eight steps to consider:

1. Get the sense of the whole. Read through all the transcriptions carefully, perhaps jotting down some ideas as they come to mind.

2. Select one interview - the most interesting and the shortest - and go through it, asking, "What is this about?" Think about the underlying meaning and write thoughts in the margin.

3. When this task has been completed for several informants, make a list of all the topics. Cluster together similar topics. Arrange these topics into columns headed: major topics, unique topics and leftover topics.

4. 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 test. Try out this preliminary organising scheme to see whether new categories and codes emerge.

5. Find the most descriptive wording for he topics and turn them into categories. Try to reduce the total list of topics by grouping together related topics. Perhaps draw lines between categories to show inter-relationships.

6. Make a final decision about the abbreviation for each category and alphabetise these codes.

7. Assemble the data belonging to each category in one place and perform a preliminary analysis.

8. Record the existing data

Researchers may want to develop their lists of categories that effect major and minor themes in the data. Raw data will be sent to an independent coder for open coding. The coder is a specialist in psychiatric nursing and an expert in the field of qualitative research. Consensus discussions will then be held between the researcher and the independent coder, with the focus on the placing of themes and identifying their inferences. After consensus discussions, themes will be reflected within Nursing for the Whole Person Theory (Oral Roberts University, Ann Vaughn School of Nursing, 1990: 136 - 142, Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

□ **Literature control**

The results of the research will be discussed in the light of relevant literature and information obtained from similar studies, to verify the research studies and to establish the relevance and

uniqueness of the research (Woods and Catanzaro, 1988: 135).

This will be done through reading literature on all that has been recorded on the experience of families with mentally ill members and will assist with the verification of the significance of the findings.

2.3.2.3 **Phase 2:** **A description of guidelines for the advanced psychiatric nurse to assist the families with mentally ill family members in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).**

The objective of phase two is to describe the guidelines for advanced psychiatric nurses to assist the families in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

During this phase, data will be collected from the informants and literature control will be used as a basis for describing guidelines for psychiatric nurses to be used when assisting the families to mobilise resources in promoting, maintaining and restoring their mental health as an integral part of health (wholeness). These guidelines will then be discussed with family members for the purpose of validating them.

2.4 TRUSTWORTHINESS

Agar, as summarised in Krefting (1991: 214) suggests that a different language is needed to fit the qualitative view - one that will replace reliability and validity with terms such as credibility, accuracy of representation and authority of the writer. Similarly, Leininger also summarised in Krefting (1991: 214) claims that the issue is not whether the data is reliable or valid, but how the terms reliability and validity are defined. Guba's model as summarised in Krefting (1991: 215 - 222) is based on the identification of four aspects of trustworthiness, namely truth value, applicability, consistency and neutrality. These terms are explained as follows:

Truth value is usually obtained from the discovery of human experiences as they are lived and perceived by informants - strategy: credibility.

Applicability refers to the extent to which findings can be applied to other contexts and settings, or with other groups. It is the ability to generalise the findings to larger populations - strategy: transferability.

Consistency of data refers to whether the findings would be consistent if the inquiry were replicated with the same subjects or in a similar context - strategy: dependability.

Neutrality refers to the extent to which the findings are a function solely of the informants and the conditions of the research and not of other biases, motivations and perspectives (Guba's model in Krefting, 1991: 214 - 222) - strategy: confirmability. Table 2.1 summarises the strategies which will be utilised to ensure trustworthiness.

Table 2.1: Strategies to ensure trustworthiness

Strategy	Criteria	Applicability
Credibility	Prolonged engagement	Contact the patients as readmissions in a psychiatric hospital. Trace their families, spend time with family members before the interview to build rapport. Allow time for the respondents to verbalise experiences.
	Reflexibility	Taking field notes.
	Member checking	Follow-up interviews with participants. Literature control on caring for mentally ill patients and its impact on the guidelines.
	Peer examination	The services of colleagues will be acquired.
	Authority of research	The researcher has undergone previous training in research methods. The study will be supervised by a person with a doctorate in psychiatric nursing and a co-supervisor who is a professor in psychiatric nursing and has extensive experience in conducting qualitative research.
	Structural coherence	The focus will be on families experiences. Results will be reflected within the Nursing for the Whole Person Theory.
Transferability	Nominated sample	The sampling method will be purposive - data source regarding the experiences of having a mentally ill patient in the family.
	Dense description	Complete description of methodology and literature control to maintain transparency.
Dependability	Audit trail	Keeping personal logs and reflexibility notes.
	Dense description	Research methodology fully described.
	Peer examination	Independent checking and supervision by experts.
	Code-recode procedure	Consensus discussion between researcher and independent coder for placing of themes and identifying inferences.
Confirmability	Audit trail	As mentioned above.
	Reflexibility	As mentioned above.

2.5 CONCLUSION OF CHAPTER 2

In chapter two a description was given on the research design and method, the objectives, data collection and ethical considerations as well as measures to ensure trustworthiness.

In chapter three the results of the experiences of families with mentally ill family members and the literature control will be described.

CHAPTER 3

THE DISCUSSION OF RESEARCH FINDINGS

3.1 INTRODUCTION

Chapter two of this short dissertation dealt with the full description of the research design and research methods. This chapter deals with the research findings. The results are discussed using an open coding approach at the beginning of the chapter (Wainwright, 1994: 45 - 50; McKenzie, 1994: 50 - 54). The same results are reflected within the Nursing for the Whole Person Theory at the end of the discussion within this chapter. This is done to structure the findings. Findings are also discussed in the light of previous research findings in order to identify similarities and differences of this research compared to previous studies.

3.2 DATA COLLECTION AND ANALYSIS

Since data gathering was to be carried out through field work in the home setting of families with mentally ill family members, permission had to be obtained from potential families. The actual period of data collection began in July 1997 and was concluded during the same month.

Some difficulties were encountered during this period since some families insisted on having their mentally ill family members present during the interview. Other interviews had to be repeated. Some families did not provide a private place for interviews resulting in interviews being interrupted by visitors. Other families were under the impression that the researcher came with financial support.

The researcher initially went to all families with mentally ill family members to gain permission and introduced herself as a research student. The research topic and benefits to the families with mentally ill family members were introduced. The response was positive and these families volunteered to take part in the research study. Appointments for interviews in their homes were finalised.

The pilot interview was conducted with a coloured family instead of a black family as mentioned in chapter two. The reason being the fact that the tape had to be reviewed by the researchers' supervisors who could not understand Xhosa. During this interview the researcher could not focus on her questions as the father figure kept on blaming the son-in-law for the mental illness of his daughter. The researcher continued rephrasing her questions, but no information could be obtained from the father regarding their experience of mental illness in the family. Information from other family members could only be obtained once the father left with visitors. His wife was now free to share her experience of having a mentally ill family member. This interview had to be repeated.

Coding took a long time because of some problems experienced by the researcher and sometimes because of the independent data coder. Themes identified by the researcher were similar to those identified by the independent data coder who is an advanced psychiatric nurse and well versed in qualitative research.

3.3 SAMPLE DESCRIPTION

Interviews were conducted until saturation of the data. The sample of this study comprised a total of five families. All families had mentally ill family members who were readmitted to a certain psychiatric hospital in the rural black area of the Eastern Cape Province.

The interviewed families displayed the following characteristics:

- All families lived in a certain rural black community in the Eastern Cape Province.
    - One family comprised of both parents and a brother of the mentally ill family member.
    - One was a single parent family with only the mother present.
    - Another comprised a daughter and grand children of the mentally ill family

member.

- ♦ Another family consisted of a brother and the wife and children of the mentally ill patient.

- ♦ The last family comprised grand parents, their son and daughter who was the mother of the mentally ill child.

- Their mentally ill family members have been admitted repeatedly in a certain rural psychiatric hospital in this Province during 1995 and 1996.

- They all spoke and understood both English and Xhosa.

- The families were living and have lived with their mentally ill relatives.

3.4 RESULTS

Table 3.1 shows an overview of the major stages, themes and categories from the family's description of their experiences of having a mentally ill family member.

- The first stage is the onset of mental illness in the family.

- The second stage is when the family take action such as sending the mentally ill member for help to eg. traditional healers and psychiatric hospitals.

- The third stage is when the mentally ill family member is discharged from hospital.

Although a considerable amount of research has been conducted on dealing with mental illness, no research specifically focused on the experience of families with mentally ill family members.

Table 3.1: An overview of stages, themes and categories of the experience of families with mentally ill members.

Stages	Themes		Categories
First stage: the onset of mental illness in the family.	1.1	Negative emotions related to mental illness in the family.	• Shock • Fright • Anger • Guilt
	1.2	Social effects related to behaviour displayed by the mentally ill member.	• Isolation from other families, friends and significant others. • Stigmatisation.
	1.3	Sense of loss related to loss of responsible member. Loss of money spent on treatment. Loss of property due to the destructive behaviour displayed by the mentally ill family member.	• Loss of property. • Financial loss. • Loss of responsibility. • Loss of property due to destructive behaviour.
	1.4	Psychological defence mechanisms related to finding ways to cope with the stressful situation.	• Denial • Blaming
Second stage: seeking help for the mentally ill family member.	2.1	Negative emotions related to suspicion, burden, fear for their life and doubt.	• Feeling of persecution • Frustration • Distrust • Uncertainty / insecurity • Hope
	2.2	Physical exhaustion related to lack of sleep and rest. Anxiety of not knowing what is going to happen next.	• Chasing and restraining a person who is restless, aggressive and who will not sleep.
	2.3	Financial loss related to money spent on person's treatment.	• Money spent on traditions healers. • Transporting a mental person to and from treatment areas.
	2.4	Helplessness related to lack of funds and not knowing what to do next.	• Despair
Third stage: Post-treatment of the family member and back home with his / her family.	3.1	Emotions related to previous assault by the mentally ill family member.	• Fear • Mistrust
	3.2	Social effects related to broken relationship. Relationship problems with family members related to negative behaviour he / she displayed in the family.	• Lack of trust. • Doubting if completely cured. • Cannot be responsible anymore.

3.5 DISCUSSION OF FINDINGS

The discussion of findings will be based on stages, themes and categories as set out in table 3.1.

In discussing the results, relevant data from the literature will be incorporated, although in the literature no studies were found that focused specifically on the family's experience of having a mentally ill family member.

The findings are discussed below.

3.5.1 First stage

3.5.1.1 Negative emotions

- All families experienced shock during the onset of the mental illness of their family member since they described it as very unexpected. ***"Great shock, yes it was a great shock. We couldn't believe it."*** Another family described it as follows: ***"We never knew it could happen to us."***

This shock is supported by Searle (1995:28) stating that there are many people suffering from mental illness and their sometimes shocking behaviour is no more than a symptom of their affliction.

- All families were frightened by the behaviour of their mentally ill family members. Some of the families described it as follows: ***"Her aggressive and assaultive behaviour frighten us. She was aggressive to her mother and assaultive to children in so much that I had to be available as a father to protect them from her."***

This fright is described by Searle (1995: 131) stating that many families have the frightening experience of realising that they have no control over their mentally ill family member especially if he / she is assaultive towards them.

- Anger related to destructive and assaultive behaviour displayed by the mentally ill family member and also feelings of guilt on the part of the family. All families experienced guilt towards their mentally ill family members and themselves. They described this as follows: ***"To me is as if this mental illness should never have started if she was at home. It started when she was out to these salvation churches. I even told her, look at this salvation of yours. I've told you long ago that I do not like this salvation business but you would never listen to me. Look at what you are now."***

The anger and frustration experienced by the families are also normal. It is very common for families of mentally ill patients to feel intensely angry, not only with their mentally ill family members, but also with each other (blaming), God, and anyone they can think of to blame (Searle, 1995: 131).

3.5.1.2 Social effects

Social effects related to behaviour displayed by the mentally ill family member such as undressing in public, physical and verbal aggression.

- All families experience isolation or distancing by their extended family, friends and significant others. They describe their feelings as follows: ***"We felt as if we were alone in an island, there was nobody to turn to, friends and family were at distance, there was no one visiting us."***

The researcher acknowledges the social isolation families experience because there are still myths, especially in the rural black community, that mental illness is infectious. Mental illness in the rural black communities is still associated with possession by demons and people are therefore afraid to come near a mentally ill person. They fear that they might also be affected. There is no literature control supporting this theory.

There is a stigma related to abusive language and assaultive behaviour of the patient. This sub-category of social isolation is described by Rawlins, William & Beck (1993: 63) as any attribute

that differs or discredits, in the categorization scheme employed by all societies - large and small. The mentally ill, as well as many others who do not meet selected norms of social groups, are prominent in the discredited group. Mental illness is incorrectly portrayed as flamboyant and unmanageable, with none of the sympathy accorded in other chronic situations. He further states that it is no wonder that families are embarrassed and uncomfortable with the difficulties related to mental illness and it is equally understandable when they try to prevent this by withdrawing from social situations (Fawcett, 1993: 348).

- They describe stigmatisation as follows: ***"As she is reporting that at school they look at her as if she is still mentally ill, and this is troubling her. I am afraid that this is going to affect her as this attitude is worrying her a lot."***

3.5.1.3 **Sense of loss**

- All families experience the loss of loved ones who cannot be held responsible for their actions anymore as well as a loss of trust and a loss of money spent on treatment. ***"I've loss my mother and my father and my brother was the only one I could discuss my problems with. I trusted him and he trusted me. Now there he is, I've no one to turn to."*** One family said: ***"My daughter was responsible for her children when she was still alright. She was working, feeding her own children. Now I am alone. I am only earning R350,00 per month. I feel as if I am in an island."***

Rawlins, William and Beck (1993: 238) support the loss by saying it is an inevitable dimension of the human experience. Loss is an actual or potential state in which a valued object or person is lost or changed. They go on saying the manner in which each individual perceives loss depends on the value placed on the object or person.

- Another family explained this loss as: ***"I've lost a lot of money taking my brother to many places because I thought he was going to be cured. I've taken him even to a psychiatric hospital hiring a car because it is very difficult to transport a mentally ill somebody using public transport. I've seen him coming home in hospital attire. This***

was during the nurse's strike. Now I have no means of taking him back to the hospital because I am not working and therefore I have no source of income."

3.5.1.4 Psychological defence mechanisms as a way of coping with stressful situations.

Perko and Kreigh (1998: 117) define defence mechanisms as intra-psychic devices that serve as the first line of ego protection and defence. They are adjustment and coping techniques that provide the individual with a ready-made constructive means to maintain emotional equilibrium. The primary functions of these coping devices are to facilitate the resolution of emotional conflict; provide relief from stress; cushion emotional pain; avoid or alleviate anxiety. Denial is viewed as avoidance and a protective mechanism that permits the individual either to disregard or transform the implication or consequences of situations. It enables the individual to remain unaware of unpleasant reality as if it did not exist (Perko and Kreigh, 1998: 119).

- All families felt that they could not cope with their situations. They therefore used denial as a way of coping with their stressful situations. One family described this as follows: ***"I couldn't believe this. I really could not believe that our daughter was mentally ill, especially after spending a lot of money on her education. How can she be like this after passing standard ten?"***

Rawlins, Williams and Beck (1993: 902) state that denial is a defence mechanism used to resolve emotional conflict and allay anxiety by disowning thoughts, feelings, wishes, needs or external reality factors that are consciously intolerable. Blaming is a coping strategy used to shift responsibility to someone or something.

- All families blame themselves for the occurrence of mental illness in their families. One family described this as: ***"We didn't know what wrong have we done so that this child is like this. Maybe it is this church because she fell ill while she was attending this salvation church of hers."*** Families could not bear the pain of having a mentally ill member, to cope with this situation they use blaming to protect themselves.

SANCA (1987: 3) supports this by saying the condition is not denied, but its cause is placed on someone else or something. In this way the responsibility is shifted to someone or something.

3.5.2 **Second stage of seeking help for the mentally ill member.**

- Families experienced feelings of persecution related to suspicion, burden, fear for their lives and doubt. One family felt that they were being persecuted by people who were jealous that their child never failed up to standard ten. They describe these feelings as follows: ***"Why is it that whenever we are having an educated child we are going to loose that child? Our two children have died suddenly being knocked by cars. Now this one has survived that, they see that she must be mentally ill. They are bewitching us, they do not want us to have anything beautiful."***

This is supported by Searle (1995: 130) when she says families may even fear for their own safety.

- All families experience frustration because of expenditure and the behaviour displayed by their mentally ill members. They describe this as follows: ***"I've taken my brother to many places for help, I even took him to a mental hospital but he absconded during nurse's strike. I don't have any money to take him back to hospital."*** The families felt frustrated because they could not assisst their families because of lack of funds.

Sidelau (1992: 60) describe frustration as an unpleasant affect characterised by build-up emotional energy when needs, wishes and / or desires are obstructed by others, one's own ability or a given situation.

3.5.2.1 **Negative emotions**

- Distrust, uncertainty and insecurity related to assault are experienced. All respondents experience mistrust, uncertainty and insecurity towards their mentally ill family members. They describe this as follows: ***"I was shocked when I saw her coming home. I thought***

it was still early for her to be discharged. I couldn't trust her because she was aggressive towards me." and ***"That I am staying here, I am hiding away from him. He chased me with a knife last Christmas. I don't trust that he cannot do me any harm once he knows that I am staying here."*** Trust was lost during assaults by the members.

Johnson (1993: 71) states that just one betrayal may create distrust and, once established, distrust is extremely resistive to change.

- The families hope rises if their mentally ill family member is entrusted to hospital care as opposed to other forms of caring. All respondents experienced a sense of hope despite their negative feelings about their mentally ill members. They describe this as: ***"I hoped my brother would be cured if he stayed in hospital. He would be discharged with treatment so that he continues taking it. He is not so bad that he cannot be cured. He does not undress in public as other mentally persons would do."*** Despite all negative emotion families have hope for their members.

Rawlins and Beck (1993: 264) say a person who hopes, perseveres and that perseverance is the ability to keep on working toward solutions that will ease distress or change one's condition.

3.5.2.2 **Physical exhaustion**

- Physical exhaustion due to lack of sleep and rest were experienced. All families experienced physical exhaustion due to lack of sleep and rest, chasing and restraining someone who is restless. They describe this as follows: ***"We couldn't sleep days and nights. We were watching her as she wanted to run away. I had to be next to her mother for protection as she wanted to bite her."***

3.5.3 Third stage

Other themes on the third stage have already been described in other stages. Only the sub-category of social effects i.e. relationships, will be discussed here.

3.5.3.1 Social effects

- Relationship problems with family relate to negative behaviour he / she displays in the family. The relationship was disturbed between the family and their mentally ill family member because of lack of trust, and doubt if the patient was completely cured. This is described by the families as follows: ***"I don't trust him, I don't want him anymore here at home. Even if he can be said to be cured I don't trust him. My body is full of scars from stab wounds because of him. Here at home I've got small children. What if he comes while we are not there and injure a child?"***

Searle (1995: 124) states that mental illness can wreak havoc in a family. The destructive behaviour of a mentally ill family member can cause trauma, tension, guilt, envy and bitterness. It can tear marital relationships to shreds and cause resentment and even hatred between siblings.

3.6 PATTERNS OF INTERACTION WITHIN NURSING FOR THE WHOLE PERSON THEORY

There are certain patterns of interaction between internal and external environments that are implied in the Nursing for the Whole Person Theory (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9). These patterns of interaction reflect the mental health status of the family as indicated by the following:

- Emotional disturbance as evidenced by feelings of shock, fright and anger. ***("Great shock yes. It was a great shock... We couldn't believe it.")***

- Fear for their own lives ***("One has to be careful he doesn't want to see a child he would take a child and bang her head against the wall, as for me, he doesn't want even to look at me.")***

- Broken relationships as evidenced by distrust of the mentally ill member by his family ***("That I am staying here. I am hiding away from him, he chased me with a knife last Christmas. I don't trust that he cannot do me any harm once he know that I am stay here.")***

- One family member does not want her mentally ill family member back home because of stabbing his sister in law.

- Change in their financial state as evidenced by spending money on the mentally ill family member's treatment.

3.7 UNIQUE CONTRIBUTIONS OF THE STUDY

Nowhere in the literature could evidence be found of a similar study of the experience of families with mentally ill family members. Secondly, most of the literature discuss the effects of mental illness on the family touching only a few aspects such as relationships and communication. In the third place, a considerable amount of literature suggest guidelines for the family of the mentally ill member. Thus the research study described and explored the experiences of families told by the families themselves. Many negative feelings were explored. There were also positive feelings such as feelings of hope, although they were marred by negative feelings. Examples of such emotions are:

- Feelings of persecution
- Distrust.

The use of defence mechanisms by families such as denial and blaming were also evident.

3.8 CONCLUSIONS OF CHAPTER 3

In South Africa today, especially in the rural areas, mental health services are gradually incorporated to other health services at primary level. Research studies are conducted on the needs of clinic nurses and the community with regard to mental health.

This leads us to the next chapter in which the guidelines for the families with mentally ill family members will be discussed.

CHAPTER 4

GUIDELINES, LITERATURE CONTROL, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

In chapter three, the research results were discussed and relevant literature incorporated as control for the findings. In this chapter, guidelines will be described for the advanced psychiatric nurse to provide support to the families having a mentally ill family member and who live in a black rural area of the Eastern Cape Province, to assist them in mobilising their resources to facilitate promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

A literature control will be carried out to validate and verify the proposed guidelines for this study. Thus the guidelines will be described as follows: **Guidelines for the advanced psychiatric nurse to assist the families identified in this study.**

The results of this study have been tabulated in table 3.1 and illustrate the following categories and themes. In brief: the families experience various external factors. These factors are emotional pain, loss, social isolation, feelings of persecution, frustration, uncertainty and insecurity, distrust and physical exhaustion. Their perception of mental illness is that a person cannot be cured from it and therefore he / she cannot be trusted anymore. They question the future of their mentally ill members. They would rather have them kept in a psychiatric hospital for ever. They see them as useless people who cannot be responsible. However, despite these negative feelings, they still hope that they can be cured if they can be kept in hospital for a period of time and discharged with treatment. Various emotions were experienced by all families who participated in this study and it was found that use was made of defence mechanisms in an effort to cope with their feelings. Thus, the guidelines for the advanced psychiatric nurse will be described in an effort to assist the families with mentally ill family members in the black rural areas

of the Eastern Cape Province to mobilise their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).The families in this study are viewed as a whole (i.e. body, mind and spirit) and function in an integrated bio-psychosocial manner to achieve the quest for wholeness. The family seeks to interact with the internal and external environment in a holistic manner.

Patterns of interaction between these environments will be considered during the writing of these guidelines synthesizing the nurse and the family to the factors that play a role in health and illness. (Oral Roberts University, Anna Vaughn School of Nursing, 1990: 136 - 142; Rand Afrikaans University, Department of Nursing Science, 1992: 7 - 9).

Guidelines for this study propose the development of support groups **for** families **by** families.

These guidelines are described in the form of nursing processes that is the health diagnosis, aim, and nursing intervention or strategies used to intervene with the existing family problems.

In table 4.1 below the guidelines are set according to category of experiences, aim and strategies.

Table 4.1 Guidelines for families with mentally ill family members.

Experience	Aim	Strategy
Shock related. The onset of mental illness in the family as evidenced by the family. The family not accepting that the family member is really mentally ill.	To accept their mentally ill family member without any prejudice	Supportive counselling for the family; this will enable them to verbalise and express their feelings (Okun, 1992: 142 - 149, 220; Egan, 1986: 139 - 140; Gerald, 1993: 98 - 116; Corsini and Wedding, 1989: 155 - 196, 285 - 320; Brammer, Shortstrom and Abrego, 1989: 94 - 96.
Fright related to verbal and physcial aggression as evidenced by some of the family members - running away from home and looking for hiding places elsewhere.	To be relaxed and to be able to take constructive action.	Edmonds and Wilcocks (1995: 64) suggest that families should remain calm, seek professional help from doctors, counsellors and psychologists. Talk to someone about how they feel and join support groups for families in the same situation.
Anger related to assault from the mentally ill family member as evidenced by the family members. Not accepting the mentally ill back home.	To be able to channel anger the correct way.	Encourage the family to release their anger verbally in the safety of a psychiatric nurse specilists' environment. Teach them how to channel their anger in future (Geldard, 1993: 150 - 151).

Isolation from significant others, other families and friends related to destructive behaviour of the mentally ill family member as evidenced by their family. Not visited by people.	To have lasting relationships and to rebuild the lost ones.	Families should build relationships within themselves. During counselling sessions they should be able to learn how to handle negative relationships and to verbalise and express their feelings. Families should be encouraged to attend support groups. Johnson (1993: 16) suggests the following ways of finding positive relationships: • Simply wait until someone finds you and want to be your friend. • Simply ask other people to be your friend. • Give your friendship to others.
Sense of loss relating to the onset of mental illness as evidenced by loss of property, loss of responsibility, and having no one to turn to as well as financial loss.	To ventilate the feeling of loss of a mentally healthy member in the family.	Support groups with other families in the same situation will encourage the families to share their losses of different natures. This sharing enables them to feel belonging and that they are not alone (Yalom, 1985: 464).

Physical exhaustion related to lack of sleep and restraining a person who want to run away as evidenced by them feeling sleepy and looking tired.	To rest mentally, physically, emotionally and socially.	The family members are advised to take turns in caring for the mentally ill family member. To seek help from professional people. To have a person admitted if out of control. This is done to safeguard both the family member and the mentally ill member from over-exhaustion. No literature to support this.
Distrust, uncertainty and insecurity related to previous assaults as evidenced by no acceptance of the member back home.	Rebuild broken trust. Feel secure.	Families who confront the situation in an honest, open manner, talking about their own helplessness, guilt, fear and anger are more likely to gain the member's trust. (Bescher and Friedman, 1986: 188).
Denial related to disbelief that has occured in the family as evidenced by avoiding reality.	Acceptance of their mentally ill family member.	The time to act is now. Do not waste time by saying it cannot be in my family. Seek professional help. Find more information on mental illness. Join support groups immediately (Okun, 1992: 149 - 220; Corsini and Wedding, 1989: 155 - 196). Attend group therapy (Yalom, 1985: 456 - 485). "To be able to start acting constructively and with strength and conviction, you will have to stop fooling yourself" Searle (1995: 128).

The purpose of group therapy is to facilitate positive and creative change (Rawlings, William and Beck, 1993: 561). Developing an awareness of self and encouraging positive and creative change is supported by challenging some of the truths (in a group situation) that are believed to be reality (Van Reenen 1994: 84 - 87). Family members are encouraged to learn new ways of seeing their reality and a way to deal with it.

Thus awareness concerning some of the categories and themes highlighted in this study could be explored in a group therapy context where the psychiatric nurse specialist could reflect on the influence mental illness has on the family. The psychiatric nurse specialist could also reflect on some feelings the family experience and encourage them to verbalise those, as well as their use of defence mechanisms and what meaning and functions these might serve.

The psychiatric nurse specialist should make herself available after termination of the last session should the group require further discussion and / or individual family therapy. Yalom (1985: 464) identified that talking in a group therapy helps and that relief is to be gained from sharing pain and being heard, understood and accepted by others.

It must be noted that these guidelines for support are not exclusive to those family members who met the criteria of this study. They should be made available to all families with mentally ill members in this black rural area.

4.3 CONCLUSION OF THE STUDY

This study arose from three observations:

- In the first instance, working in a rural psychiatric hospital in the Eastern Cape Province, the researcher found that some patients are admitted repeatedly to this hospital.

- Secondly, once admitted, they are never visited.

- Finally, when they are discharged, they are seen wandering in the streets. There appears

a need for these patients to be supported by a psychiatric nurse specialist and other health professionals and have them meet their families and assist them in mobilising their resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness).

The purpose of this study is two fold:

- Firstly, to explore and describe the experience of families with mentally ill family members in a certain black rural area of the Eastern Cape Province.

- Secondly, to describe the guidelines for the advanced psychiatric nurse to assist the families in mobilising resources for promotion, maintenance and restoration of the families mental health as an integral part of health (wholeness).

The central questions posed for this study were:

How do families experience having a mentally ill family member?

What guidelines can be described by an advanced psychiatric nurse to assist the family in mobilising resources to facilitate the promotion, maintenance and restoration of their mental health as an integral part of health (wholeness)?

A qualitative, exploratory, descriptive and contextual research design was used to find answers to these questions. In-depth, semi-structured phenomenological interviews were conducted with families who met the sample criteria of this study. The results of both the phenomenological interviews conducted and field notes taken during the interviews suggest the occurrence of both positive and negative experiences by the families who participated in the study as tabulated in chapter three. (Refer to table 3.1).

The results of this study show that the families experience emotional pain, use destructive defence mechanisms, lost money and are socially discriminated against by significant others. (See table

3.1). The family experiences repercussions of each turn of the mentally ill process. Families can be torn apart, intimidated and suffer untold emotional anguish because of their mentally ill family member.

Based on these results guidelines were developed for the advanced psychiatric nurse to assist the families to mobilise resources to facilitate promotion, maintenance and restoration of their mental health as an integral part of health (wholeness). It can thus be concluded that the research question of this study have been answered and objectives achieved. The central statement of the study has also been supported.

4.4 PRACTICAL PROBLEMS ENCOUNTERED - LIMITATIONS

The families were seen at their homes which are vastly distributed. At times one would find them not at home or having visitors, despite the fact that appointments were made.

Other families would want their mentally ill family members to be present during the interview. The results were that the interviews were postponed those days because the mentally ill family member could not be extracted.

At times one family member would want to dominate the interview, not allowing other members to contribute towards the interview.

There were some interruptions during interviews, children crying, visitors coming and children wanting to be cared for.

4.5 RECOMMENDATIONS

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

4.5.1 **Nursing practice**

It is clear from the research results that families with mentally ill family members need professional help and support. The advanced psychiatric nurses play a major role here because they are the first people to come into contact with patients. Thus, during this stage they will be able to assess the needs of the families and support them.

4.5.2 **Nursing education**

The nursing curricular should include topics on mental illness and the experiences of families with mentally ill family members, as well as the effect of mental illness on the family. Nurses should take responsibility for educating the community about mental health and mental illness eg. mental health awareness campaigns.

4.5.3 **Nursing research**

The small population size utilized necessitates further research with respect to:

- a large population to validate the findings;
- effects of support by the advanced psychiatric nurse; and
- effects on the entire family (including siblings and the extended family members, i.e. grandparents, aunts and uncles) and the society.

4.6 **CONCLUSION**

Family members experience emotional pain, therefore they need support from the advanced psychiatric nurse to assist them to facilitate promotion, maintenance and restoration of their mental health as an integral part of their health.

Lo mhobe ulandelayo uxinzelela lento

Nantso ke midaka kowethu
Lwenziwe uphando lwaphengululwa
Zifumanekile iziphumo zaginisekiswa
lcekwa likuni ke Bongi nabongikazi
bolwantwentwe bomzi ka Phalo.
Kucacile lo mntu ugula ngengqondo naye uzelwe
kwaye uyathandwa ngaba kowabo
Sukani nime ke ngoko ninike inkxaso
Kwezintsapho zijongene nentlungu
yokugulelwa ngengqondo.
Kaloku namhla ndim ngomso nguwe.
Ncincilili!!

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ANNEXURE A

REQUEST FOR CONSENT TO CONDUCT RESEARCH

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DEPARTMENT OF NURSING SCIENCE
Telephone : (011) 489-2722

1997-05-14

Dear Sir/Madam

REQUEST FOR CONSENT TO CONDUCT RESEARCH

I am a M. Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, presently engaged in a research project entitled "The experience of families with mentally ill family members" under the supervision of Dr. A. Gmeiner and the co-supervision of prof. M. Poggenpoel, of the Department of Nursing Science at RAU.

The objective of the study is to explore and describe the experiences of families who have mentally ill family members and to describe guidelines for the psychiatric nurses to assist these families in mobilising their resources to support them in caring for their mentally ill family members.

Families who meet the following criteria will be interviewed:

* They must be families whose mentally ill members have been admitted repeatedly in a certain psychiatric hospital in the rural black area of the Eastern Cape Province within two years i.e. 1995 to 1996.

* They must be families who live in this specific black rural area.

* They must be able to speak either English or Xhosa.

The researcher will conduct interviews of approximately 45 - 60 minutes with a minimum of five families and a maximum of 10 families. The families' experience with mentally ill family members will be explored and described. These interviews need to be audiotaped for verbatim transcription and verification of findings by an independent psychiatric nurse specialist.

The researcher intends to keep the respondents anonymous by omitting the use of names and places. The erasure of the taped material on completion of the transcriptions by the researcher, will ensure confidentiality.

The immediate benefit of the study to families will be that they will be given the opportunity and attention to verbalise their experiences of caring for their mentally ill family members. Long term benefits are that the research findings will be used to formulate guidelines for supportive action that would help families to care for their mentally ill family members.

A summary of the research findings will be made available to you.

Thank you

Signed at _____ this _____

day of _____ 1997

N.M. NGQOBOKA, B.A. CUR.
M. CUR. (PSYCHIATRIC NURSING SCIENCE)
STUDENT RESEARCHER

A.C. GMEINER (DR)
STUDY LEADER
LECTURER : PSYCHIATRIC NURSING SCIENCE

M. POGGENPOEL (PROF)
CO-STUDY LEADER
PROFESSOR : PSYCHIATRIC NURSING SCIENCE

ANNEXURE B

REQUEST FOR CONSENT TO PARTICIPATE IN THE RESEARCH

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1997-05-14

Dear Sir/Madam

REQUEST FOR CONSENT TO PARTICIPATE IN RESEARCH

I am a M. Cur. (Psychiatric Nursing Science) student at the Rand Afrikaans University, presently engaged in a research project entitled "The experience of families with mentally ill family members" under the supervision of Dr. A. Gmeiner and the co-supervision of prof. M. Poggenpoel, of the Department of Nursing Science at RAU.

The objective of the study is to explore and describe the experiences of families who have mentally ill family members and to describe guidelines for psychiatric nurses to assist these families in mobilising their resources to support them in caring for their mentally ill family members.

To complete this study I need to conduct interviews of approximately 45 - 60 minutes duration which will be audiotaped for verification of findings by an independent psychiatric nurse specialist. In this matter, I undertake to safeguard your anonymity omitting the use of names and places. Confidentiality will be ensured by erasure of taped material on completion of transcribing the tapes. The transcribed tape material will only be shared by myself and another independent psychiatric nurse specialist. You will give your informed consent to these proceedings and reserve the right to cancel at any state of the proceedings. It is understood that you are under no obligation to participate in this study.

The direct benefit to you for participating in this study is that you will have the opportunity to verbalise your experiences of caring for their mentally ill family members. Long term benefits are that the research findings will be used to formulate guidelines for supportive action that would promote mental health of the family.

A summary of the research findings will also be made available for your perusal.

Thank you

Signed at _____ this _____

day of _____ 1997

N.M. NGQOBOKA, B.A. CUR.
M. CUR. (PSYCHIATRIC NURSING SCIENCE)
STUDENT RESEARCHER

A.C. GMEINER (DR)
STUDY LEADER
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M. POGGENPOEL (PROF)
CO-STUDY LEADER
PROFESSOR : PSYCHIATRIC NURSING SCIENCE

ANNEXURE C

TRANSCRIPTION OF AN AUDIO-TAPED INTERVIEW

TAPE D

This is part of the interview held with one family.

Key: **N = Interviewer**
R = Respondent

N: Good afternoon.

R: Good afternoon, Margaret.

N: As we have arranged this meeting I would like to ask you to please tell me how is it like to have a mentally ill member in the family?

R: OK. I'll explain. My problem is this, eh... I've got a problem here, now. My son-in-law has got no house, is staying all over the show, he can't make a home for himself and his wife is up and down.

N: What I would like to know is, how do you feel about the mental illness of your daughter?

R: I am feeling a lot of burden because these children are cared for here at home, and they are having three children.

N: It must be very hard for you to care for them.

R: I am, I am having a problem and, and I am a pensioner. I am getting R370.00 and my wife is only working for R350.00 and now I am suffering with my daughter and her children and his husband.

N: It really seems very hard for you.

R: I really do not know what to do.

N: You say you don't know what to do about this extra family?

R: Yes. Yes. I am feeling burdened because before this mental illness she was working for her children even if her husband was not supporting, my daughter was very responsible for her children.

N: If I hear you well, you say you have an added responsibility now that she is no more working?

R: Yes, my daughter was supporting her children but she fell ill because when this man is drunk he fights her.

N: How does this make you feel?

R: I am. I am very angry because if my daughter was not married to this man she would still be all right.

N: Oh, what you are saying is that you are partly blaming him for the onset of your daughter's mental illness.

R: I am totally blaming him because my daughter was not like this before.

N: Now that she is mentally ill how do you experience her?

R: Nurse, her behaviour has completely changed. She is shouting at us and as for her mother, she want to assault her.

N: How does this change of behaviour make you feel?

R: As a father I feel angry especially when she want to assault her mother at the same time I feel pity for my daughter because before this, she has never even answered back to her mother when there is a quarrel. As a mother I feel scared when she want to assault me at the same time I am not feeling happy when she is not at home, roaming in the streets.

N: It sounds as though you are having mixed feelings of anger, fear, pity for your daughter.

R: Yes, yes, we have all these feelings because she is our child.

N: You have mentioned that you are not feeling happy when she is not at home, could you tell me more about this?

R: I am not happy when she is not at home because she also shouts to other people and assaultive even to children in the streets. My fear is that she might also be assaulted by other people. Another thing is that whenever she is going out she takes her baby with her.

N: It sounds as if you are also worried about the baby?

R: Yes, because if she fights she threw stones to people so the baby can also be injured. When she is not at home we are forced to go out following her and look for her. When I am working I am always worried about her and her baby.

N: So, what you are saying is that you are always worried about her even if you are not at home.

R: I am always very unhappy because I don't know what I am going to find when I got home.

N: It seems very hard for you.

R: It is really hard because even here at home I don't have anybody to help me with house work. When I come back from work I am supposed to do everything in the house. If I

don't find her home I must look for her first.

N: How does this make you feel?

R: Hey nurse, I am always exhausted even at work because I've got no time to rest because, because even at night I have to watch her as she often slips out of the house; even during the night.

N: This must be really tough for you.

R: It is really tough nurse in so much that I wanted that she be admitted to a far hospital where she cannot escape because she is never discharged from hospital, she always escape - comes back without treatment.

N: How do you think that being admitted to a far hospital will help you as a family.

R: I hope that if she is admitted to a far hospital she will not be able to escape therefore she will have enough time to recover and be discharged with treatment to take; even when at home.

N: It seems as if you are desperate that she must be admitted to this far hospital.

R: Yes, yes in so much that I've been to a psychiatric doctor at your hospital several times requesting that she be admitted at Pietermaritzburg.

N: Hmm.

R: The doctor there has written me a letter so that I take her to Fort Napier hospital. I have not taken her yet because I have no money to take her there. I am only earning R350,00 a month and that is the only money we have because my husband is also drinking a lot.

N: How does this make you feel?

R: I feel, I am alone in an island because there is nobody who wishes to help me because even her husband does not care about her and the children .

N: It sounds as if you have experienced having a mentally ill family member a hard way.

R: A lot, a lot. It was very hard to believe that my daughter is mentally ill especially that I've never seen mentally ill person even at my biological home. I never thought it would happen to me. It was a shock, a big shock, especially that she started by being depressed. That is she would sleep very late and wake up very early. I had to stay with her until very late and woke up early. I had to care for the baby at the same time I had to go to work.

There were days where I could not leave her alone at home. It was only better when she was admitted. I got some relief because at least I knew that she was safe at the hospital, the only burden was the little one. I had to go to my sister-in-law to baby-sit for me during the day and collect the child after work. I used to sleep... very tired. At times I was threatened even at work because I was absenting myself.

N: Do you still feel the same even now?

R: No, it is better know. I have learnt to live with it. Another thing is that the child has grown older now and that her husband is no more living with us. I don't know where he is.

N: It sounds as if it is better that your son-in-law is no more staying with you.

R: Oh yes. Yes, it is much better because when he comes home he would be drunk and fight my already disturbed daughter. Now that he has left my daughter does not go out often and she cares for her baby though she is still disturbed. She takes her baby with her when she goes out and comes back with him. But I still want her to be admitted because she

is not cured, she is not on any treatment to take while here at home.

N: You seem desperate that she be admitted to hospital.

R: Oh ja. I have a feeling that she could do well with continuous treatment that is why I want her to be admitted.

ANNEXURE D

FIELD NOTES TAKEN OF INCLUDED TRANSCRIBED INTERVIEW

FIELD NOTES

OBSERVATIONAL

This is a coloured family. I visited them on Saturday at 15:30. They are staying in a 2-bedroom house with a kitchenette and a small sitting room. Bathroom facilities are not there, there is a small pit privy outside the house.

The house is fenced with only two rails of plain wire.

Outside at the front side, there is a drain of dirty stinking water from other yards. They use a coal stove therefore the walls are not clean with smoke.

THEORETICAL

I've found the mother of this family outside the house doing washing and the father was inside the house in their small sitting room with two small sofas and small old coffee table. He seemed drunk in so much that he was dominating the interview. His wife had little chances of contributing towards the interview. She seems also scared to answer questions when they were directed to her. The mentally disturbed daughter was around i.e. between the kitchen, bedroom and the sitting room.

She would sometimes interfere with them when they were answering questions. In the middle of the interview there comes a car full of a group coloured males and females. All of them were drunk and they were visiting this man. They were allowed in during the course of interview.

It was only after they have left that the mother was able to ventilate her experience of having her daughter being mentally ill.

METHODOLOGICAL FIELD NOTES

On my first interview I failed to get that family's experience of having a mentally ill family member. I tried several times to rephrase my question but in vain. We were also interrupted by the presence of their daughter yet I had made it clear that she must not be present during interview. I had to go back to that family for another interview.

PERSONAL FIELD NOTES

I felt it was very difficult to focus on my question as this man couldn't answer relevantly. He would talk about the son in law as the cause of his daughter's mental illness. In the first interview I felt I didn't do anything especially on the side of the father.