

**EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS
IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA**

by

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DEDICATION

This dissertation is dedicated to My loving husband, my king, my pillar of strength, my best friend, my all in one, Mr Vusimuzi Trevor Daniel Nkomo; you have been with me through both turbulent and delightful moments throughout the study. Thank you for your unconditional support.

DECLARATION

I, Thembi Nkuna, declare that the mini-dissertation “EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA” hereby submitted to the University of Limpopo for the degree of Master’s in Public Health (MPH) has not previously been submitted by me for a degree at this or any other University. This mini-dissertation is my work in design and execution and all materials contained herein have been duly acknowledge.

Thembi Nkuna: _____

Date signed : _____

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ABSTRACT

Background- care of the mentally ill by family members is done with little or no supervision by skilled health workers. Therefore, the purpose of the study was to investigate the experiences of family members of patients living with mental illness in the Capricorn District of Limpopo Province in South Africa.

Objective- to explore and describe the experiences of family members caring for patients living with mental illness.

Methods- A qualitative, descriptive and exploratory design was used. Non-probability sampling of the purposive and convenient type was used to explore and describe the experiences of family members of patients living with mental illness in the Capricorn District. Data were collected from fifteen family members caring for MHCUs, by using open-ended semi-structured face-to-face interviews. Data were audio recorded and observations were done during interviews. Trustworthiness was ensured by applying credibility, transferability, confirmability and dependability. Data were analysed using Tech's open-coding method.

Results- family members experience disruptive behaviour from MHCUs and they also have to adapt to new routines that are at times unfavourable. As a result, the family members' health and quality of life are affected, thus making them susceptible to having mental illness and other medical conditions as well.

Conclusion- There is a need for family members caring for persons living with mental illness to be given emotional and social support. community projects such as support groups for family members caring for MHCUs and goal directed standard operations procedures at the Psychiatric Ward – specifically designed and implemented for family members caring for MHCUs, are recommended.

Keywords: experiences, family members, mental illness

DEFINITION OF CONCEPTS

Experiences- Experiences are contents of direct observation or participation in an event (*English Oxford Living Dictionary, 2017*). For the purpose of the study, experiences are described as an encounter or undergoing an event or occurrence that leaves an impression on someone, be it good or bad.

Family member- A family member is a person who belongs to a particular family (*English Oxford Living Dictionary, 2017*). For the purpose of the study, a family member is described as a person belonging to the MHCU's family, be it a mother, father, son, daughter, sister, brother, spouse, aunt and/or uncle, who is staying with the Mental Health Care User at home, and can also provide care to the MHCU.

Mental illness- Mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day (National Alliance on Mental Illness, 2016). Within the context of the study, the definition applies and is used as such.

Mental health care user- According to the Mental Health Care Act 17 of 2002, a mental health care user is a person receiving care, treatment and rehabilitation services or using health care services at an establishment aimed at enhancing the mental health status of a user. For the purpose of the study, a mentally ill person will be referred to as a mental health care user.

ABBREVIATIONS/ACRONYMS

CFU	Child and Family Unit
DSM- 5	Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, Text Revision
MHCU	Mental Health Care User
OPD	Out Patient Department
USA	United States of America
WHO	World Health Organisation

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CHAPTER 1

OVERVIEW OF THE RESEARCH STUDY

1.1 Introduction

There are wide range of disorders of mental illnesses such as, but not limited to schizophrenia, bipolar disorder and depression. Anyone has a certain threshold of developing mental illness and, given sufficient triggers, any person can develop mental illness (Weir, 2012). Substantially, measures such as the Mental Health Care Act 17 of 2002 are there in place to ensure provision of care, treatment and rehabilitation to mental health care users.

It is without a doubt that, caring for someone with mental illness also brings the risks of mental ill health to the carer, in the form of emotional stress, depressive symptoms or clinical depression. Subsequently yielding negative effects on the quality of life of the carer and the standard of care delivered (Shah, Wadoo & Latoo, 2010). However, the National Mental Health Policy Framework and Strategic Plan 2013-2020 stipulates that social support is valued, and that maximum support should be provided to families and carers of those with mental illness, in order to broaden the network of support and care.

Most families with a mentally ill family member live in misery as the mental health care users' behaviour gets intolerable and embarrassing. Although medication proved helpful, they usually have to plead with the patient to take it. Hospitalization of patients with mental illness helps to give liberty and relief to the caring family members (Wankiiri, Drake & Meyer, 2013).

On average, mental health accounts for less than 1% on national budgets in Africa. Moreover, in South Africa, the burden of mental illness has grown over the past twenty years (Jack, Wagner, Petersen, Thom, Newton & Stein et al., 2014). One in four people are affected by mental illness in their lives around the world. About 450 million people are living with mental illness, placing mental illness amongst the leading cause of ill-health and disability worldwide (World Health Organisation, 2001).

Significant population growth and ageing will result in an estimated 130% increase in the burden of mental illness in Sub-Saharan Africa by 2025, to 45 million. The growth in mental illness by 2050 is likely to significantly affect health and productivity in Sub-Saharan Africa (Charlson, Diminic, Lund, Degenhardt & Whiteford, 2014).

It is estimated that 1/3 of South Africans suffers from some form of mental illness and about 30.3% of adult South Africans will have suffered from common mental illness in their lifetime (Chiumia & Van Wyk, 2014). Moreover, care of the mentally ill by family members is done with little or no supervision by skilled health workers (Wankiiri et al., 2013).

The researcher has observed that most family members of MHCUs are bitter towards the MHCUs and most of them prefer their mentally ill family member to receive care at an institution than at home. Hence the researcher wanted to find out what is it that the family members are experiencing at home, which also makes some of them at times take the patients to the hospital for admission.

1.2 Research problem

The researcher observed from a clinical setting that most family members who bring their family members living with mental illness at Mankweng Hospital for readmission or for check-ups in order to collect their medication are in despair, stressed and some are bitter towards their mentally ill relative. Some family members who visit their loved ones (who are admitted in the Psychiatric Ward) also express that they do not want the patient back home but rather prefer that the patient living with mental illness be admitted to an institution rather than receive care at home. Similarly, a study conducted by Banyini (2012) found that some MHCUs tends to destroy household essentials which might explain the family members' feelings of despair and stress caused by such destructive behaviours.

1.3 Purpose of the study

1.3.1 Aim of the Study

The study aimed at investigating the experiences of family members of persons living with mental illness in the Capricorn District of Limpopo Province, South Africa

1.3.2 Objectives

- To explore the experiences of family members of persons living with mental illness in Capricorn District, Limpopo Province; South Africa.
- To describe the experiences of family members caring for persons living with mental illness in Capricorn District, Limpopo Province; South Africa .

1.4 Research question

What are the experiences of family members of persons living with mental illness in the Capricorn District of Limpopo Province in South Africa?

1.5 Methodology

1.5.1 Study site

The study was conducted in the Mankweng Hospital of the Capricorn District Municipality, Limpopo Province in South Africa, located about 27Km east of Polokwane. Specifically at Mankweng hospital, it was conducted at Child and Family unit ward.

1.5.2 Research design

A qualitative research approach that applied descriptive and explorative study designs was used to conduct the study.

1.5.3 Population and sampling

Non-probability- purposive sampling was used to select participants who have rich knowledge on the topic.

1.5.4 Data collection

The researcher used individual face to face in-depth interviews and observations as means of gathering data. The main data collection instrument used was an interview guide for interviews.

1.5.5 Data analysis

Data for this study were analysed using Tesch's eight steps of data analysis method proposed by Cresswell (2013).

1.6 Ethical considerations

Ethical clearance to conduct the study was granted by the University of Limpopo's Research and Ethics Committee. Permission to conduct the study in the department of health was granted by the Limpopo department of health. Permission to collect data at Mankweng Hospital was granted by the Chief Executive Officer of the hospital and consent was obtained from the participants prior to data collection.

1.7 Conclusion

This chapter introduces the study by providing an overview of the study, problem statement, the purpose and summarises the methodology of how the study was conducted. The preceding chapter (chapter 2) reviews the literature that is relevant to this study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Literature review is an evaluative report of studies found in the literature related to the study's selected area. The review should describe, summarise, evaluate and clarify this literature (Boote & Beile, 2005). Moreover, Brink, Van der Walt and Van Rensburg (2012) stated that literature review helps a researcher to develop relevant study methods and instruments or tools with which to measure the study variables.

2.2 Family members caring for patients with mental illness

A study conducted in Hamadan, Iran, by Shamsaei, Cheraghi and Esmaeilli (2015) found that caring for a person with mental illness is more stressful than caring for a person with a physical disability. Within the study, it was also found that all the participants identified that they experienced stress in their life due to their role as a caregiver for their family member with mental illness. A similar study conducted in Malaysia found that some families prefer that the mentally ill family member be admitted to an institution, rather than receive care at home, in order to avoid social stigma. The generalisation of stigma to families is an additional source of psychological risk for both the MHCUs and the family members (Mohammad, Subhi, Jusoff, Wan, Azreena & Chong et al., 2011).

Shankar and Muthuswamy's (2007) study, which was conducted in Australia, revealed that grandparents had restricted social lives. They had isolated themselves from their peers because of the responsibilities of caring for the young children of their mentally ill son or daughter. Often, the behaviours of their mentally ill daughter or son caused them considerable distress and financial strain.

A study done by Robinson, Rodgers and Butterworth (2008) in Australia obtained that children were affected by parental mental illness in a range of ways, with responses including, namely: confusion, fear, questions about normality, disruption of connections with sick family member and worry that they will also become sick. This also compromises the quality of their life. Living with and caring for a spouse who has mental illness can place a strain on the existing relationship.

A study done by Ildstad, Ask and Tambs (2010) in Northern Europe found that spouses of persons with mental illness scored significantly lower on subjective well-being and significantly higher on symptoms of anxiety and depression when compared to spouses of index persons without mental illness.

Sintayehu, Mulat, Yohannis, Adera and Fekade (2015) conducted a study in Ethiopia where they found that family members of patients with mental illness often receive inadequate assistance from mental health professionals. Similarly, according to Oshodi, Adeyemi, Aina, Suleiman, Erinfolami and Umeh (2012), in a study they conducted in Nigeria, caregivers of MHCUs experience objective burden, which refers to outwardly measurable demands placed on family members. These include financial difficulties, strain on interpersonal relationships, reduction in social support, physical violence, and disruption of routines of carers and in households of relatives, as well as leisure time.

A similar study conducted in Ghana by Ae-Ngibise, Doku, Asante and Agyei (2015) found that families and friends who give care to people with mental illness are affected in a variety of ways and degrees. Furthermore, caregivers undergo emotional disturbance when their mentally ill family members become aggressive or abusive to them or their friends. This is particularly worrying to caregivers when the aggression is targeted at new friends who visit their homes for the first time.

The substantial and growing public health burden arising from mental illness across the world is estimated at 14% globally, leading to continued economic burden and suboptimal productivity at the individual and national levels. Moreover, mental illness contributes significantly to global disability-adjusted life years (Ae-Ngibise et al., 2015).

According to Uys and Middleton (2014), most of MHCUs in South Africa live with their families. Furthermore, Mphelane (2006) found that many of the participants revealed that it is a problem to support mentally ill relatives, and some relatives are no longer employed in order to care for the mentally ill family member. Limpopo Province was found to be having 30.8% of all mental illnesses in life-time prevalence, also showing that the prevalence of mental illness within 12 months was 7.1% (Hermanl, Stein, Seedat, Heeringa, Mooma & David et al., 2009).

The South African government is currently supporting the mentally ill clients by giving them Disability Grants. MHCUs who are admitted in government hospitals involuntarily receive health care services for free. However, those who are admitted voluntarily are liable for payment in terms of the uniform patient fees schedule, which every South African government health institution has. This also aids to ease the financial burden at home (Chiumia & Van Wyk, 2014).

Health systems have not yet adequately responded to the burden of mental illness. As a consequence, the gap between the need for treatment and its provision is wide all over the world. A further compounding problem is the poor quality of care for many of the MHCUs who receive treatment (WHO, 2016).

2.3 Taking care of a mental health care user at home

A study conducted in the United States of America by the National Alliance for Caregivers (2016), obtained that half of the caregivers of persons with mental illness expressed that their loved one living with mental illness is financially dependent on family members or friends, thus creating financial difficulties. Family members caring for persons with mental illness often reported feeling high levels of financial strain, than family members caring for an individual without mental illness.

Chang, Zhang, Jeyagurunathan, Lau, Sagayadevan and Chong et al., (2016) conducted a study in china, of which they found that the responsibility of caring for relatives with mental illness often falls on family members. A similar study done by Chadda (2014) in India found that the family caregiver plays multiple roles in care of persons with mental illness, including taking day-to-day care, supervising medication-takings, taking the patient to the hospital and looking after the financial needs. A patient's refusal to take medication and to attend medical check-ups are some of the major difficulties experienced by families.

According to the study done in Limpopo Province, South Africa by Mphelane (2006), it was found that family life of patient's living with mental illness can be unsettled and unpredictable and it becomes difficult or often impossible to plan for family outings, vacations or even the simplest gatherings at home.

The social state and health of family members (of patient's living with mental illness) deteriorate due to the stress and overwork and these results in the patient having no on-going support system.

2.4 Intolerable behaviour

A study conducted in Europe, United Kingdom by Cooklin (2006) found that some of the intolerable behaviours that children of a MHCU experienced included, namely, when their mother smashed the television as she thought there were jokes made against her, and often attacking her children when she thought they were laughing. Other participants also expressed that their mentally ill mother would also hit them unexpectedly for no apparent reason.

In Tanzania, a study done by Iseselo, Kajula and Yahya-Malima (2016) found that some family members are scared of their mentally ill relative due to their intolerable aggressiveness, to such an extent that they have to hide sharp objects like knives out of fear of being attacked. One family also indicated that each time they want to chop something using a knife, they have to do it in a locked bedroom.

According to a study done by Monyaluoe, Mvandaba, du Plessis and Koen (2014) in the Free State Province, South Africa, it was found that some family members experienced pain, embarrassment and shame when their mentally ill family member does unacceptable things such as undressing in the public, maintaining poor personal hygiene and behaving like a child. Families felt at risk of being injured or killed by their violent and aggressive mentally ill family member, as such they lived in fear. Destruction of property was also reported as experienced by many families.

According to a study done by Mavundla, Toth and Mphelane (2009) in Limpopo Province, South Africa, participants stated that their relatives with mental illness sometimes destroy household property, as well as other people's properties, therefore a financial burden results from the money spent on repairing or replacing such property, due to their intolerable behaviour. Another study done in Limpopo Province by Banyini (2012) found that a MHCU tends to destroy household utensils and furniture, and throws them at the neighbours' houses.

2.5 Consequences faced by family members when caring for a mental health care user

Swarrop, Shilpa, Goud, Archana, Pius and Pal et al., (2013) conducted a study in the United States of America and they found that the emotional impact of any mental illness on family or primary caregiver can vary from frustration, anxiety, fear, depression and guilt to grief. Because caregiving is such an emotionally draining experience, caregivers have high rates of depression when compared to the general population.

A study done by Sabanciogullari and Tel (2015) in Turkey found that families of patients living with mental illness experience problems such as deterioration of relationships within their social circles, lack of self-sufficiency, decreases in activity levels and inability to fulfil their roles as spouses or family members.

From the study was done in East Africa by Wankiiri, Drake and Meyer (2013), it was found that caring for a MHCU was a contractual obligation, which left certain members in the family as their sole responsibility as some family members do not want to stay with the mentally ill relative.

In a similar study done in Limpopo Province of South Africa by Mathanya (2015), it was also found that the caregivers do not get any support from their extended family members, friends and relatives, which resulted in them feeling lonely and abandoned, having to be solely responsible for their mentally ill relative.

2.6 Stigma from community members

In a study done in India by Shrivastava, Johnston and Bureau (2012), it was found that individuals with mental illnesses are stigmatised. Those who did not perceive much stigmatisation appeared to do best on the use of various outcome parameters, while those who perceived stigmatisation were found to have problems with service engagement and medication-taking. Larson and Corrigan (2008), in the USA, found that family members of people with mental illness have reported experiencing negative treatment, social exclusion and avoiding social interactions.

An Ethiopian study done by Girma, Moller-Leimkuhler, Muller, Dehning, Froeshl and Tesfaye (2014) found that, due to stigma, families may resort to social self-restrictions and may also hide their sick relative, which, in turn, may lead to delay in treatment seeking and discrimination from getting services and all of these may result in poor quality of life, depression and increased emotional burden on families.

A study conducted in Zambia by Kapungwe, Cooper, Mwanza, Mwape, Sikwese and Kakuma et al. (2010), found that mental illness stigma is pervasive across Zambian society; prevailing within the general community amongst family members of persons living with mental illness, as the society or communities tend to assume that not only the individual has mental illness, but the whole family has. In a South African study, based in Limpopo Province done by Mavundla, Toth and Mphelane (2009), it was found that mental illness was conceptualised in negative terms as social ostracism of individuals also affected the caregivers as they experience isolation and humiliation from the community members.

2.7 Conclusion

This chapter outlined the detailed literature review of the research study. The subsequent chapter presents the research methodology.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents; the research design and method, study site, population and sampling, data collection, data analysis, inclusion and exclusion criteria used in the study, measures to ensure trustworthiness of the study, ethical considerations, bias and conclusion of the chapter.

3.2 Research design and method

- *Qualitative design*

The study took the form of qualitative, descriptive and explorative research design. According to National Health and Medical Research Council (2014), qualitative research involves disciplined inquiry that examines people's lives, experiences and behaviours, and the stories and meanings individuals ascribe to them. Moreover, Grove, Burns and Gray (2013) define qualitative research as systematic, interactive, subjective approach used to describe the life experiences of the participants and to give them meaning. Furthermore, Leedy and Ormrod (2010) stated that qualitative research involves viewing characteristics or qualities that cannot easily be reduced to numerical values

Qualitative design was ideal for the study as it enabled the researcher to construct exemplifications based on the subjective experiences of family members caring for mentally ill persons. Such subjective experiences cannot be reduced to numerical values as the study did not channel participants into choosing what was applicable to them, but rather having them express themselves and state what they are experiencing at home. Qualitative design also enabled the researcher to gain insight into what the participants are experiencing at home.

- *Descriptive*

Babbie (2010) expressed that, in descriptive studies, there is thus no indication of determining cause-and-effect relationships, but the aim rather is to describe situations and events and to determine accurately what the real situation is. Therefore, this study

intended to gain straight answers relevant to what are the experiences of family members of clients living with mental illness in the Capricorn District. Lambert and Lambert (2012) informed that the goal of qualitative descriptive studies is a comprehensive summarization, in everyday terms, of specific events experienced by individuals or groups of individuals. As a result, the qualitative-descriptive study design approach was purposely selected for the study in order to describe experiences of family members of patients living with mental illness.

- *Explorative*

According to Surbhi (2016), the primary objective of an exploratory research is to explore a problem to provide insights into and comprehension for more precise investigation. It focuses on the discovery of ideas and thoughts.

The exploratory research design is suitable for studies that are flexible enough to provide an opportunity for considering all the aspects of the problem. Propitiously, the exploratory method enabled the researcher to explore what the family members were experiencing, which was achieved through probing until data saturation occurred of subjective perceptions of participants.

3.3 Study site

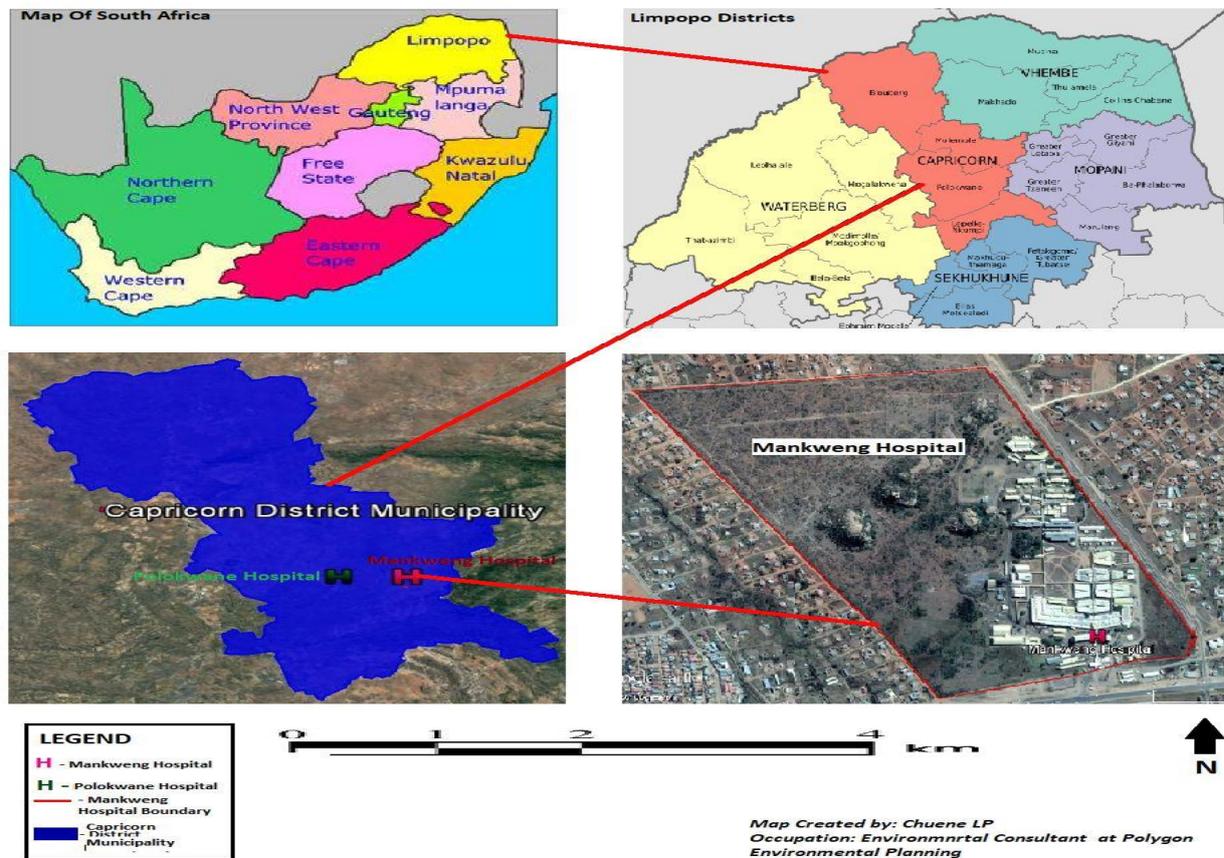


Figure 3.1 indicating Mankweng Hospital.

The study was conducted in the Mankweng Hospital of the Capricorn District Municipality, Limpopo Province in South Africa, located about 27Km east of Polokwane. Mankweng Hospital is a State tertiary academic hospital, which, likewise, provides tertiary services to all Level 1 (District) and Level 2 (Regional) hospitals in the Limpopo Province. It is also an academic hospital, which runs in collaboration with the Sefako Makgatho Health Sciences University and the University of Limpopo.

The study was conducted in the psychiatric ward known as Child and Family Unit (CFU). CFU has a bed occupancy of 20 (10 males and 10 female). There are 4 seclusion rooms, which are rooms used to place aggressive patients (2 on the female side and 2 on the male side).

It was also ideal to conduct the study at Mankweng as the hospital is a referral hospital and most patients are referred there from various hospitals. It was also convenient to

access participants when they brought their mentally ill relatives for medical check-ups or admission, or when they visit their mentally ill relative in the CFU ward.

3.4 Population and sampling

- *Population*

Yegidis and Weinbach (2009) described population as the entire population of people or elements that share some defined characteristics. In this study, the population comprised of family members of MHCUs admitted in the Mankweng Hospital, CFU ward, and those accompanying their mentally ill relative to collect medication from the Mankweng Hospital's Out-Patient Department (OPD). The family members are the most people who mostly interact with the MHCUs' and subsequently have adequate good knowledge about the MHCUs' conduct, hence they were able to give good account of the experiences they face at home.

- *Sampling*

According to Brink (2012), a sample is a part or fraction of the whole or subset of a larger set, selected by the researcher to participate in a research project. Moreover, Maree (2007) referred to sampling as the process used to select a portion of the population for the study.

The sampling procedure used in the study was non-probability- purposive sampling, which enabled the researcher to purposively select participants who have rich knowledge on the topic in order to aid in answering the research question.

The researcher purposively selected (a) family members who came to visit their family member who has mental illness in the Psychiatric Ward; (b) family members who were accompanying their mentally ill relative for readmission; and (c) family members who were accompanying their mentally ill relative for medication collection. In-depth, semi-structured face to face Interviews were then conducted with such family members till saturation point of fifteen participants was reached. This was guided by Burns and Groove (2009), who stated that, in qualitative studies, sample size is determined on informational needs, of which the guiding principle is data saturation. Grove et al (2013) further explained that, saturation is sampling to the point at which no new

information is obtained and redundancy is achieved. All fifteen participants were from fifteen different families and were caring for their respective mentally ill family member.

Inclusion and Exclusion criteria

- *Inclusion Criteria*

Burns and Grove (2009) defined inclusion criteria as those characteristics that a subject must possess to be part of the target population. The study included male and female family members of all patients living with mental illness, whether their mentally ill relative was an inpatient or an outpatient at Mankweng Hospital.

The study also included all potential participants who were able to speak Xitsonga, Sepedi and/or English.

- *Exclusion Criteria*

The study excluded all family members of MHCUs (in-patients or out-patients) who did not wish to participate in the study.

3.5 Data collection

Grove et al (2013) described data collection as the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions or hypothesis of a study. In this study, the researcher used individual face to face in-depth interviews and observations as means of gathering data. The main data collection instrument used was an interview guide for interviews.

The researcher ensured that interviews were conducted in a quiet office, without distractions. The researcher placed a "Do Not Disturb" note outside the door and, to minimise disturbances, the researcher also locked the office door on the inside. However, all this information was communicated to each participant, together with the reasons, prior to locking the door. This was also because, during the pilot study, such was not done and there were consequently a lot of disturbances. Interviews were conducted in a well-ventilated office; with minimal distractions, such as pictures on the wall.

Prior to the data collection, participants were informed about the purpose of the study and the nature of the confidentiality. In order to enable participants to freely express themselves and encourage participation, participants were also informed about the significance of the audio-tape recorder, and were also asked to sign consent. In-depth semi-structured face to face Interviews were conducted using the participant's home language, which enabled participants to express themselves without holding back. Observations were also made throughout the study. Below, are detailed descriptions on how data was collected:

- *Pilot study*

Polit and Beck (2012) voiced that a pilot study helps researchers to identify problems in the design of questions, sequencing of questions, or procedure for recording responses. Significantly, for this study, a pilot study was conducted prior to the actual study, at Mopani District in Letaba Hospital, with two participants who ultimately were not part of the actual study. The pilot study was a success, for it also assisted the researcher to identify how to place the tape recorder during interviews and also formulate questions accordingly.

During the pilot study, there were consequently a lot of disturbances. Therefore, it gave insight to the researcher to conduct interviews of the actual study in a locked room in order to minimise disturbances.

- *Interviews*

In-depth open-ended (semi-structured) face to face interviews were conducted. Such was essential for the study, and worked as it also allowed prompting, which aided in achieving the goal of the research and obtaining rich details and new insight, by channelling questions that answered the research question.

- *Interview Recording*

Throughout the interview, a tape recorder was utilised to record the interview in order to have the data on record, to ensure that all that was discussed during the interview was recorded, which also simplified subsequent transcription. Recording the interview also allowed the researcher to devote her full attention to listening to the participants, which enabled the researcher to probe in depth where and when necessary.

- *Probing*

According to Polit and Hungler (2013), probing is the technique used by the interviewer to elicit more useful or detailed information from a participant, than that which was volunteered in the initial reply. The researcher probed the participants by encouraging them to talk about their experiences when caring for patients living with mental illness. Because the interviews were conducted in their own language, it made it easier for participants to express themselves and explain in details, thus giving rich data, whilst follow-up questions were also asked, which were determined by the flow of the conversation, and the participants' responses during the interview.

- *Reflecting*

Reflecting is one of the communication strategies that facilitate effective communication between individuals or group of people. During interviews, the researcher reflected on what participants were expressing by engaging in dialogue with participants and repeated what they mentioned, which also gave participant assurance that the researcher was listening attentively and was interested in their experiences which they were sharing with the researcher. Reflecting also encouraged alternative explanations or interpretations.

- *Observations*

Brink et al (2012) stated that observation is a technique for collecting descriptive data on behaviour, events and situations. Furthermore, Polit and Beck (2008) stated that observations allows a researcher to gather a variety of information, including individuals' characteristics and conditions, verbal and non-verbal communication, activities and behaviour. Observations were done throughout the study. The participants' facial expressions and body language were observed throughout the interview, which also enabled the researcher to observe if what the participants were saying was in line with their facial expression and body language. Concurrently, the researcher gave verbal responses that correlated with occasional nodding in order to show the participants that the researcher was attentively listening. In turn, it also encouraged participants to explain in details.

3.6 Data analysis

As according to Brink et al (2012), data in qualitative research are non-numerical and are usually in the form of written or audio-taped information.

Data for this study were analysed using Tesch's eight steps of data analysis method proposed by Cresswell (2013) as follows:

Step 1: The researcher listened to the voice recordings, transcribed the audio recorded interviews held with the participants, which were also translated from Sepedi to English, read and re-read the verbatim transcripts thoroughly in order to familiarise self and make sense of data. Field notes from the interviews were allocated to the corresponding transcript.

Step 2: The researcher selected one verbatim transcript and went through it while thinking about the underlying meaning and writing thoughts or any impressions in the margins. The researcher also numbered all paragraphs and pages.

The researcher also made two copies of the transcripts, one was the master copy and the other was to be a copy to write the researcher's thoughts on the margins of the transcripts

Step 3: In this step, the researcher continued to analyse the transcripts one by one, until all the transcripts are analysed. The researcher then clustered together similar topics into columns. The researcher also colour coded all data using different colours, then group same colours together. From there, the researcher abbreviated the topics as codes, and wrote the codes into appropriate segments of the text.

The researcher then found descriptive wording for the topics and turned them into categories and also indicated interrelationships. Afterwards, the researcher made a final decision on the abbreviation for each category and alphabetized the codes.

Step 4: The researcher abbreviated topics into codes and wrote the codes next to the appropriate segment of text. The researcher also checked for emerging categories and codes.

Step 5: In this step, the researcher identified the most descriptive wording for the topics and turned them into categories. The researcher then

grouped the related topics into one category in order to minimise the total list of categories. The researcher also drew lines between categories in order to indicate interrelationship.

Step 6: The researcher then made a final definition about the abbreviation for each category and wrote them in alphabetic order.

Step 7: In this step, the researcher assembled data belonging to each category in one place in order to make a preliminary analysis.

Step 8: In this final step, the researcher recoded the existing data. Then made an interpretation of the findings or results.

3.7 Measures to ensure trustworthiness of the study

The following concepts were maintained in order to ensure effective trustworthiness of the study.

Credibility

Credibility is defined as the confidence that can be placed in the truth of the research findings (Macnee & McCabe, 2008). Credibility was ensured through the following ways:

- *Use of methods*

As planned and executed, the researcher ensured that the study took the form of qualitative descriptive and explorative study design. face to face in-depth, semi-structured interviews were conducted with individual participants. Participants' body language and facial expressions were also observed throughout the interviews, in order to assess whether what they were saying was in line with their body language and facial expression, which also enabled the researcher to probe further.

- *Familiarity of participants or organisations*

The researcher is familiar with the study site because it is the researcher's work place, which also served as a good opportunity for the researcher to purposively select participants.

- *Sampling methods*

The researcher purposively selected participants in order to obtain rich and relevant subjective data.

- *Triangulation*

The researcher also ensured credibility through triangulation (Viz., face to face interview and observations during interview)

- *Consent by participants*

All participants involved in the study were informed about the purpose of the study and how the interviews would be conducted, including tape recording, and they all signed Consent Forms. They all genuinely participated in the study at no cost or incentive from the researcher. The researcher encouraged all participants to be honest from the onset, and also explained to the participants that they had the right to withdraw from the study at any time. Auspiciously, there was no participant who opted out in the middle of the interview.

- *Reflective commentary*

The researcher evaluated the study as it was progressing, and also improved where the researcher realised that some of the questions had to be rephrased. In so doing, it enabled interviews to flow

- *Member checking*

The researcher enabled some of the participants who frequently visited their MHCUs to read the transcripts, of which they agreed that what was transcribed is indeed what they said during the interview.

- *Previous research documents used*

Literature control was used to support findings

Dependability

Dependability is the extent to which a study could be repeated by other researchers and that the findings would be consistent (Polit & Beck, 2008). As planned and

executed, the study took the form of qualitative study design. Semi-structured face to face interviews were conducted with all participants who consented to form part of the study. The researcher collected data at the right place and from the relevant people, and also ensured that the transcripts are in line with the audio-recorded interviews.

Confirmability

Confirmability is defined as how well the inquiry's findings are supported by the data collected (Lincoln & Guba, 1985). In this regard, the researcher avoided being bias throughout and avoided bracketing the researcher's assumptions, background knowledge, interests and perceptions with regards to the research question. The researcher used triangulation method (viz., interviews and observations). Moreover, in order to ensure effective and legit confirmability, the researcher also incorporated an independent coder. When the independent coder was done with coding, she met with the researcher to compare the researcher's themes and subthemes and those of the independent coder. Both the researcher and independent coder had similarities, which led to agreement on the final outcome, which is explained further in Chapter 4. The researcher made certain that all data collected and result findings are based entirely on the participants' subjective experiences and not the researcher's perceptions or subjective views.

Transferability

According to Bitsch (2005), transferability refers to the degree to which the results of a qualitative research can be transferred to other contexts or settings with other respondents. Data were collected at Mankweng Hospital, Child and Family Unit ward. The researcher purposefully selected participants who had rich data in order to enable the research question to be answered. The total number of participants in the study were 15, and it were only family members caring for MHCUs. Data were collected in a two weeks' period. Open-ended (semi-structured) face to face interviews were conducted with all participants, in which a tape recorder was used to record the proceedings. Each interview took approximately 20 -35 minutes.

3.8 Ethical considerations

- *Permission to Conduct the Study*

When individuals are used as study participants, care must be exercised in ensuring that the rights of the participants are protected (Polit & Beck, 2008). In this regards, the researcher first requested permission to conduct the study from the Turfloop Research Ethics Committee and from the Department of Health, Limpopo Province, South Africa, which were both granted.

The rights of the research institution (i.e., Mankweng Hospital) where participants were drawn from, were also protected by requesting permission to conduct the study from the hospital CEO, which was granted.

- *Informed Consent*

All participants involved in the study willingly volunteered to be part of the study. None of the participants were bribed or forced; they all did so on their own free will. They were all informed about the research study, and were also encouraged to feel free to quit along the way should they not feel comfortable to continue. A Consent Form was also explained in detail, and participants were asked if they understood what the Consent Form entailed prior to signing.

- *Principle of Non-Maleficence*

The researcher ensured that the confidentiality of the participants was protected at all times. Participants' real names and identity were not used, instead they were referred to as numbers. For instance, the first participant was referred to as Participant 1. The researcher also liaised with the CFU psychologist prior to conducting the study, for any intervention required, lest the study evoked any hurtful emotions, which it did for some participants, and they were accordingly referred for therapy intervention.

- *Principle of Justice*

According to Beck (2008), selection of participants should be based on research requirements and not on their vulnerability. Thus, selection criteria were strictly used when selecting participants in order to avoid being bias. Moreover, Burns and Grove (2009) state that each participant should be treated fairly. In this regard, all participants were treated equally during the study.

- *Principle of Autonomy*

Autonomy refers to the right of an individual to determine what activities they will or will not do (Adams, 2013). In order to warrant autonomy, the researcher provided participants with a written Informed Consent Form that they had to sign prior to participating in the study. The written Informed Consent Form disclosed the nature of the study, risks and benefits.

The researcher also provided the participants an opportunity to ask questions before deciding whether or not to participate, and all questions were answered openly and honestly.

- *Principle of Beneficence*

Beneficence is defined as an act of charity, mercy and kindness with a strong connotation of doing good to others, including moral obligation (Kinsinger, 2009). Brink (2012) further stated that the principle of beneficence is when the researcher needs to secure the wellbeing of the subject, who has rights to protection from discomfort or harm. The researcher told all participants prior interviews that they had the right to withdraw or terminate their participation at any time without any penalty, if they felt that continuing will result in harm e.g. stress.

3.9 Bias

In research, bias occurs when systemic error is introduced into sampling or testing by selecting or encouraging one outcome or answer over others (Pannucci & Wilkins, 2010). In this regard, the researcher made certain that information bias was avoided by keeping detailed records and recordings while conducting the study, as waiting to record the data at a later stage might have introduced errors or misinformation into the data collected. The researcher also asked open-ended questions, maintained a neutral stance and also considered every response from all participants.

3.10 Conclusion

This chapter exclusively gave details about the study design and methodology employed. The researcher described the qualitative, descriptive and exploratory study designs, where and how data were collected, who took part in the study and how data were analysed. Measures to ensure trustworthiness of the study were also discussed and also how permission to conduct the study was obtained. The next chapter fully describes and explores result findings of the study.

CHAPTER 4 DISCUSSION OF THE RESULTS

4.1. Introduction

The previous chapter outlined the research methodology, approach, design and methods used to address the research problem, through addressing the research objectives. This chapter therefore presents the findings as obtained during interviews. The findings assisted in answering the research question, namely: What are the experiences of family members of patients living with mental illness in the Capricorn District?

4.2 Demographic information

Demographics of participants are outlined in the graph below.

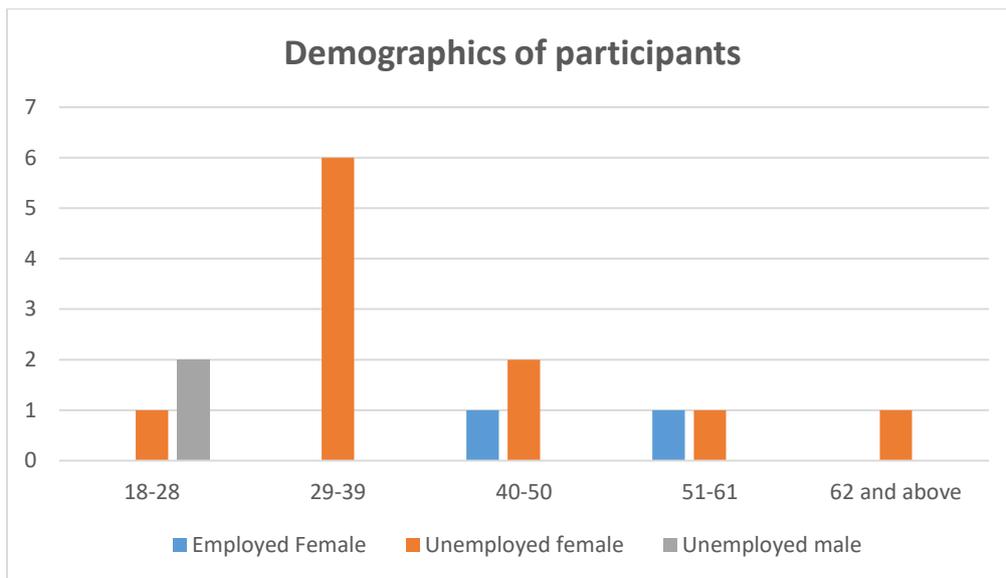


Figure 4.1 Demographics of participants

The above graph indicates the demographics of the study participants. Out of 15 participants, only two are employed. Out of the 15 unemployed participants, only two are still studying, 1 is in high school in Grade 9 (male participant) and the other one is doing final year in the university (male participant). Thus indicating that majority of the family members caring for the MHCUs are unemployed and are female, and most of them are between the ages of 29-39 year olds.

4.3. Themes and Subthemes

After analysis, the study yielded four themes and 10 subthemes, which are indicated in the table below.

THEMES	SUBTHEMES
1. Family members develop both negative and positive family coping strategies to care for a mental health care user	1.1 Restrictive and shrewd measures to cope with handling a mental health care user. 1.2 Supervision and positive aspects for medication-taking compliance
2. An increased level of burden on the family members caring for a mental health care user	2.1 Increasing level of financial burden 2.2 Negative impact on family members' social life 2.3 Health effects from increased stress 2.4 increased burden of losing valuables
3. Victims of mental health care users' symptomatic and violent behaviour	3.1 Experiences of violent attacks and aggression from the mental health care user 3.2 Fear of the mental health care user's abnormal behaviour and violent tendencies
4. Influences related to preferred treatment for mental illness	4.1 Family, religious and cultural influences to seek care 4.2 Perception on institutionalisation of the mental health care user

Table 1: Themes and sub-themes

4.3.1. Theme 1: Family members develop both negative and positive family coping strategies to care for a mental health care user

This theme is about coping strategies that were explored and are practised by family members as a result of their experiences when caring for the MHCU at home. As a result, the theme yielded two subthemes, which are further explained below.

4.3.1.1 *Subtheme 1.1: Restrictive and shrewd measures to cope with handling a mental health care user*

Some of the participants expressed that it becomes challenging when caring for their MHCU at home to a point where they resort to restrictive and shrewd measures to cope with handling the patient. Moreover, this goes to a point where some participants stated that they crush medication into the MHCU's food, tie down the patient and put sleeping pills into the MHCU's drink.

A sister-in-law, who takes care of her mentally ill brother-in-law, shared her experiences on the shrewd measures she deploys to assist her to cope with handling her mentally ill brother-in-law by voicing thus:

“Eix! I ended up coming with a plan, I just crush his medication and put it in his soft porridge or relish so he doesn’t see. But, at times, when he tastes the food and be able to taste the medication in his food, he stops eating”.

(Participant 6, 35 year-old female)

A wife to a mental health care user husband also shared the measures she incorporates when caring for her husband, as a way of handling him by sharing that:

“When I maybe come home and his playing music, very loud, so what I do is I take a glass of water then I put some sleeping pills inside so he can drink and all of us can be able to rest for the night. I don’t know if it’s safe, but someway somehow, it gives us peace because we are able to sleep at the end of the day.”

(Participant 8, 36 year-old female).

A sister to a mental health care user brother voiced her experiences on the restrictive measures she employs when handling her mentally ill brother at home thus:

“I remember this other time, my sister and I held him and we beat him. I had anger towards him and, at that point, I did not care if my unborn child was going to be hurt in the process, and we defeated him. When he realised that we conquered, he would run away and we got used to it.”

(Participant 2, 30 year-old female)

When caring for a MHCU at home, it often becomes challenging for the care givers, especially when the MHCU becomes disruptive. Hence family members end up developing certain coping skills in order to cope with the MHCU at home. Janardhana, Raghunandan, Naidu, Saraswathi and Seshan (2015) also conducted a similar study in India, where it was also found that family members of MHCUs also came up with tricks, like mixing the medication with food, as a coping strategy to ensure medicine intake.

For some family members, the strategies they use comes at a great cost because they are uncertain of the health implications of their methods, it, however, serves as a short term solution and because they get the desired results, it becomes a norm. However, Glynn, Kangas and Pickett (2018) found that medication can be helpful, although it can, however, take a while to become effective. But medication alone is often not enough to keep the mental illness in check. Moreover, family members can encourage the MHCU to participate in peer-support groups, Cognitive Behavioural Therapy or social training skills.

4.3.1.2 Subtheme1.2: Supervision and positive aspects for medication-taking compliance

Most participants expressed that they had to personally ensure that their family member with mental illness complies with medication intake as some stated that they monitor the medication intake. One participant had to de-register her child from a certain university to a distance-learning institution in order to supervise the medication intake. And also that, when they ensure compliance, the patient becomes better to an extent that they even send the patient to run errands and are also able to converse efficiently.

A sister to a mental health care user female sibling shared her experiences on how supervision of medication-taking is conducted when caring for her mentally ill sister at home, she stated that:

“We monitor her medication intake every day, we always count her medication so we know if she took it or not. When we tell her to take her medication, after taking it, the moment she sits, our mother goes to her bedroom to count the medication in order to check if she indeed took her medication”.

(Participant 3, 30 year-old female)

One participant, whose only son and a university student is a mental health care user, reported thus:

“We applied for distance learning so he can study while at home so I can supervise his medication intake”.

(Participant 1, 47 year-old female)

One participant also expressed how the situation at home becomes when the mental health care user complies with medication-taking, by saying that:

“When he complies with his medication and also when he eats the food which I put his medication in, he becomes a good person, we are able to have a good conversation with him at home, all is well and I am even able to send him to the shops.”

(Participant 6, 35 year-old female)

One participant, who is a son to one of a MHCU, recounted how he ensures that his mother complies with medication-taking and the results thereof, and stated that:

“When I become firm and force her to take her medication, she becomes better.”

(Participant 13, 24 year-old male)

Most caregivers have experienced the disruptiveness of the MHCU when they do not comply with the medication intake, hence they try by all means to ensure that they assist their MHCU to comply with the medication intake. According to a similar study conducted in India by Chadda (2014), it was found that family members of MHCUs play multiple roles in the care of persons with mental illness, including supervising of medication-taking in order to ensure compliance.

This is also because, according to Avasthi (2010), non-adherence still remains a major obstacle in the treatment of MHCUs. Although, according to Kane, Kishimoto and Correll (2013), long-acting injectable antipsychotics are theoretically a very powerful tool to assure adherence and signal non-adherence, recent results from randomized controlled trials failed to show superiority compared to oral antipsychotics. Thus stating the reason why most patients will still continue to be on oral medication intake than injectable.

Avasthi (2010) further states that families can also play a role in increasing treatment-adherence in patients with mental illness. This is done by providing medication to the patient; supervising and monitoring the drug intake; taking the patient to doctor's chamber at regular intervals; getting serum level of the psychotropics checked; so on and so forth.

This then insinuates that family members also have to adapt to a new routine and be actively involved as they have to monitor their MHCUs medication intake every day and on time because, should they not monitor, the MHCU will not comply. Certainly, family members also get a sense of purpose, satisfaction and fulfilment when they ensure medication-taking compliance on a daily basis as they can also see the difference between when the patient complies and when the patient does not comply.

4.3.2 Theme 2: An increased level of burden on the family members caring for a mental health care user

This theme is about how much of a burden it is that which the family members are experiencing at home when caring for their MHCUs. This theme yielded four subthemes which are further explored below:

4.3.2.1 Subtheme 2.1: Increasing level of financial burden

Most participants experienced financial burden in a form of having to resign from work in order to take care of their MHCU at home, whilst for some participants it is found that the MHCU was the bread winner and lost his or her job due to being non-functional at work, therefore increasing the level of financial burden at home.

A sister to a mental health care user female sibling shared her experiences with regards to increasing level of financial burden and recounted that:

“I was in Johannesburg when my mom called, which lead me to resign at work and come back home, because at home it was just my mentally ill sister and both parents, of which my parents were struggling to take care of her as the situation was bad, so I had to leave my job, resign and come back home in order to help my parents take care of my mentally ill sister”
(Participant 3, 30 year-old female)

One participant whose elder daughter is a MHCU expressed that:

“She was the one who was taking care of us financially, she had small jobs, doing people's laundry and such. That's how we survived, but now that she is sick, I also had to resign because I'm taking care of her baby. There is no one to take care of her bay while I'm working. Getting someone to help will mean I have to pay them of which I don't have money, and her baby is 3 months old”.

(Participant 14, 41 year-old female)

Most families are already struggling financially. As such, when one of the family members who is employed is suddenly diagnosed with mental illness, it becomes a financial tragedy and a burden for a standard family setting, adding more expenses into the household. Similarly, when a bread winner in a family has to ensure proper and quality care of the MHCU, leading to resigning at work – which was a source of income that exacerbated the already near impossible situation – it also becomes a financial tragedy as compromises have to be made and in most cases, which also comes with after effects because it will then mean that a major change of lifestyle is forced into the lives of the family members.

A study conducted in Iran by Shamsei, Cheraghi and Esmaeilli (2015) concurrently found that family members caring for MHCUs at home also reported financial constraints of which most family members depended on charity and others were obliged to quit their job so they could take care of their mentally ill relatives.

4.3.2.2 Subtheme 2.2: Negative impact on family member's social life

When caring for the MHCU at home, it tends to also affect family members' social life as some tend to isolate themselves from their social life, some have to relocate in order to avoid stigma from their respective communities and some have to neglect their activities which they use to engage in. For some, it is due to stigma, but some is because they have to take care of their MHCUs at home.

A participant whose female sibling is a MHCU recounted on the negative impact on her social life as a result of caring for her younger sister at home, she detailed that:

“We moved as a family from where we were staying to a new place because people were already starting to talk about my sister, so we had to move to start a new life. Eix! It's tough because we grew up there and it's our home but we had no choice but to move to a new place, new environment where they do not know my sister, so she can start a new life”.

(Participant 3, 30 year-old female)

A participant whose only daughter is a MHCU commented on how her social life has been affected and stated that:

“You know I am educated neh, I never thought for a single day that any of my children can have mental illness, I started isolating myself, no longer visiting my friends, even at work I would spend most of the time alone, praying, even at work, I did not tell anyone that my daughter has mental illness I am scared of the stigma”

(Participant 11, 60 year-old female)

Caring for a mentally ill family member takes more than adapting to new daily routines. A study conducted in Iran by von Kardorff, Soltaninejad, Kamali and Shahrabaki (2016) found that some caregivers of MHCUs expressed that they feel restrained in their freedom, and also experienced various restrictions in everyday life, and they had to give up things that they previously enjoyed doing. Some family members of MHCUs are often subjected to such because, without sound mental health, one will not have quality life, and the fear of non-disclosure and stigma from community members often subjects family members into a socially debilitating environment.

Consequently, the society excommunicates them as they are no longer comfortable to associate themselves with other people at either their workplace or at home. Unfortunately, this leads to families having to face issues that come with caring for a MHCU in isolation. According to Larson and Corrigan (2008), the stigma associated with mental illness may cause a family to fear repercussions or shaming from others in their social or community network. McBride (2016) further states that the family of MHCUs may isolate themselves to protect the ill member or to protect the family reputation.

4.3.2.3 Subtheme 2.3: Health effects from increased stress

Most participants also reported to have been diagnosed with chronic illness or symptoms attributed to the experiences they face when caring for the MHCU at home. Mostly expressed that they were diagnosed with hypertension, some with depression as a result of caring for their MHCU at home, and for some it has also affected their children’s performance at school.

A wife to a mental health care user husband shared her experiences on health effects from increased stress and stated that:

“You know I’ve... ever since he became that way ne, I’ve developed high blood pressure, and it’s too much to cope with both sicknesses, so it’s not that easy, and my children are also affected because I’ve noticed that they are not performing well anymore at school”.

(Participant 8, 36 year-old female)

A participant, who is a mother to a son and wife to a husband who have mental illness, recounted how the condition of her husband and son has affected her health, by stating that:

“I was diagnosed with high blood in 1999 when my husband was diagnosed with mental illness. It also went up now that my son was also diagnosed with mental illness”.

(Participant 1, 47 year-old female)

A wife, whose husband has mental illness also conveyed how her husband’s mental ill has affected her health, said:

“I recently went to the clinic as I was not feeling well, they checked my blood pressure and I was told that I might be having high blood pressure but they told me to go back to the clinic for review, I do not sleep at night, I am always stressed and worried because of him”.

(Participant 7, 54 year old woman)

Another wife of a MHCU also reported on how her health has being affected, by saying:

“Eish! this situation does not sit well with me because my heart is mostly beating fast, constantly having severe headaches and not understanding what is wrong with me until I went to the clinic, when I got there the nurse asked me if I am ok, I then explained my story to her, then she told me that she is suspecting that I might be having high blood pressure, she then checked me and indeed found that I am suffering from high blood pressure”.

(Participant 6, 35 year-old woman)

Based on the participants’ responses, it is without a doubt that caring for a mentally ill family member can negatively affect the carers’ health, thus compromising their health and wellbeing as well for the reason that they have to take care of their own health whilst taking care of their MHCU at home. According to Perlick, Rosenheck, Miklowitz, Kaczynski, Link and Ketter (2008).

Caregiving strain has been associated with compromised health and mental health among caregivers of patients with mental illness. Lester, Tritter and Sorohan (2004)

established that caregivers of MHCUs are at higher risk themselves, not only for physical illness but also for poorer mental health.

A study conducted in the Free State Province, South Africa, by Monyaluoe, Mvandaba, Plessis and Koen (2014) also found that some families were affected by the negative experiences of living with a mentally ill family member, this resulting in some health problems common amongst the family members. The participants in the study reported that they suffered different health problems, in so much as that some of them are even receiving treatment. The health problems mentioned include confusion, stress, depression and hypertension.

It is one thing to be diagnosed with a chronic illness due to nature and other factors, it is however devastating to be diagnosed with a chronic illness due to adverse effects of caring for a family member, as being diagnosed with chronic illness insinuates that one has to take medication on a daily basis, every day of their life, which is something that no one aspires. Furthermore, a study done in Zimbabwe by Marimbe, Cowan, Kajawu, Muchirahondo and Lund (2016) found that some family members of persons living with mental illness also expressed that they were diagnosed with hypertension as a result of caring for the mentally ill person at home.

A similar study conducted by Monyaluoe, Mvandaba, Plesis and Koen (2014) in the Free State Province, South Africa, also found that health problems, as a result of caring for the mentally ill at home, were common amongst the family members. They reported to have been suffering from hypertension, depression, stress, etc., and that some of them are even receiving treatment.

It is human nature to aspire to have quality life, and to live a healthy life without any medication-taking. Equally, it is devastating to have to live on medication intake and compliance as a result of caring for a family member. Family members tend to prioritise the health of their MHCUs and neglect their own health.

4.3.2.4 Subtheme 2.4: Increased burden of losing valuables

Some participants also reported that their MHCUs always give away valuable assets from home and some destroy those valuables, which becomes a burden to them.

A wife to a MHCU shared her experiences on increased burden of losing valuables when caring for her mentally ill husband at home. She said:

“What he does is that, most cases when I’m not around at home, when I come back, yho! I find that the television is gone, and when I ask him that, all he tells me is that he gave it to someone else an ey, its very daunting.”
(Participant 8, 36 year-old female)

A participant, whose husband is a MHCU and always gives away home assets also shared her experiences of losing home valuables by saying:

“He always gives with the assets at home, our fan broke, we then bought a new one, which he now borrowed his friend. It is hot now and we do not have a fern as he borrowed his friend. We also bought a new laptop for our son, he took it to church, saying that he wants to borrow his pastor.”
(Participant 7, 54 year-old female)

A son, whose mother is the MHCU, also shared his experiences with regards to losing valuables, he stated that:

“Upon my return, my suitcase was on the street opposite my house, along with my clothes and my little sister’s clothes. I had to pick them before going into the yard. I was so angry. I then asked her why she threw them on the streets, then she said she doesn’t want them in her house, the clothes have been bewitched”.
(Participant 13, 24 year-old male)

Most MHCUs’ have impaired judgment, especially when they do not comply with medication-taking. Losing valuables at home due to such behaviour can be devastating, thus implying that the MHCUs with poor judgment should not be left alone without supervision. According to a study conducted by Vicente, Mariano, Buriola, Paiano, Waidman and Marcon (2013), in Brazil, family members of patients living with mental illness also expressed experiencing losing valuables at home as some family members also reported that their MHCUs do damages in the house, such as breaking things and damaging the only car they had.

4.3.3 Theme3: Victims of mental health care users’ symptomatic and violent behaviour

This theme is about what the family members experience when the MHCU starts to be violent which they end up being violent. It therefore yielded two subthemes that are further explained below:

4.3.3.1 Subtheme 3.1: Experiences of violent attacks and aggression from the mental health care user

Most family members have reported to have been victims of violent attacks by the MHCUs at home, whereby they reported to have been physically abused and some were even burned with hot iron.

A mother to a daughter who has mental illness shared her experiences of being a victim of violent attacks by her daughter thus:

“When she was psychotic, she used to hit us, even slamming doors at us”.
(Participant 15, 46 year-old female)

Another mother whose daughter has mental illness also expressed that:

“She also became aggressive towards me and hit me, also hitting her children with no apparent reason, she also broke my finger and I had a fracture as a result.”
(Participant 12, 71 year-old female)

A wife to a mental health care user husband also shared her experiences of being a victim of violent attacks by her husband and voice that:

“Ey! Whenever he gets sick, he starts to throw tantrums and he starts beating me up. As you can see I have a scar here of an iron that he once used on me while it was still hot. Well he will strangle me in front of my kids and it wasn't really good. So ya he would strangle me in most cases.... Yoh! sesi, even in front of my neighbours.”
(Participant 8, 36 year-old female)

Being violently attacked at home does not only bring physical pain, but it also leaves a permanent scar in the heart, it was also observed that when all participants shared their experiences of being a victim of violent attack by their mentally ill family member they became emotional. Even for those who experienced it a year ago, they also

became emotional to indicate that indeed it has left a scar in their heart, which has not yet healed.

The study findings also concur with the study conducted in Zimbabwe by Marimbe-Dube (2013) where it was found that, in the process of care, some patients were described by participants as being physically and verbally aggressive to their caregivers. Discussions with caregivers of MHCUs' family members also suggested that they experienced physical harm in the form of assault, especially when the patient relapses. Moreover, a study done by Murray and Miller (2013) in Jamaica also found that family members of patients living with mental illness reported being victims of violent attacks by their MHCU.

On the other hand, Iseselo, Kajula and Yahya-Malima, (2016) stated that caregivers have to learn and understand the patient's characteristics and behaviour. Coping with symptoms such violence may often require lengthy, complex and distressing negotiations. Thus family members will end up being victims of violent attacks.

4.3.3.2 Subtheme 3.2: Fear of the mental health care users' abnormal behaviour and violent tendencies

Family members of patients living with mental illness tend to develop fear due to the MHCUs' abnormal behaviour and violent tendencies as some family members expressed that they do not feel safe around the MHCU and would also ensure that they do not leave their children alone with the MHCU. They therefore stated the following:

A daughter of a patient with mental illness shared her experiences of fearing her mother's abnormal behaviour and violent tendencies as a MHCU. She voiced that:

"I have to take the kids with me everywhere I go because I can't leave them alone with my mother. Plus one of my kids is disabled. I also don't go to places like town when she is at home, because I can't leave my children with her, I fear that she might relapse and hurt them."

(Participant 10, 24 year-old female)

A female participant detailed how she lives in fear at home due to the MHCU's abnormal behaviour and violent tendencies at times. She shared that:

“This other night we did not sleep at all, he just woke up in the middle of the night, started swearing and breaking things in the house, when I called out to the male neighbours who usually assist me when he tends to be like that, they were not at home. So you see my life is at risk because one day he will kill me and my children, I do not feel safe around him at times, especially when he does not take his medication”.

(Participant 6, 35 year-old female)

A home is a place where one is ought to feel safe, free and at ease. However, when a family member caring for the MHCU at home does not feel safe in the presence of the mentally ill thus being fearful and living in fear, it brings a sense of discomfort and poor quality of life as family members always have to be vigilant and ensure that children are safe at all times and are not in the same space with the MHCU without supervision.

McBride (2016) concurs, as found according to the research done, that mentally ill family members can have a formidable impact on the families in which they reside and that the family home risks becoming a place of sadness, intrusion, or conflict rather than a sanctuary. Some patients with mental illnesses violate personal boundaries and are continually annoying or disturbing.

A study conducted in the Free State Province, South Africa, by Monyaluo, Mvandaba, Plessis and Koen (2014), also revealed that family members caring for a MHCU at home felt at risk of being injured or killed by their violent and aggressive mentally ill family members and they also live in fear.

Fear is also a huge obstacle for acceptance of a patient in the family and community because it limits interpersonal relationships. Moreover, it also suggests that family members do care about their MHCUs because, if it were not the case, they would then leave them uncared for and find their own place to stay. But due to their obligations of caring for their MHCU, they endure and live in fear. As much as it is a disorder, living in fear has become a norm for many participants.

According to McBride (2016), such families living in fear can be assisted. McBride (2016) states that family physicians can intervene in powerful ways when they are

sensitive to those who are mentally ill and their families and can provide much needed compassionate support, by being a catalyst for getting the family to a counsellor, to a psychiatrist, or into community support.

4.3.4 Theme 4: Influences related to preferred treatment for Mental Illness

This theme is based on the experiences of family members that have influenced their preferred treatment for their MHCUs. It yielded two subthemes, which are further explained below:

4.3.4.1 Subtheme 4.1: Family, religious and cultural influences to seek care

With regards to seeking care for the MHCUs, most families would first consult traditional healers and some opt for churches, however, when it gets worse they resort to hospitals for management. Adversely for those who are married, they follow their cultural ways of doing things, such as having to inform their husbands' family before taking major decisions concerning their husbands' health. Some have to seek their religious help in hiding without the knowledge of their partner.

A wife to a MHCU also shared her experiences on cultural influences to seek care for her mentally ill husband, she said:

"I then told his parents about his problematic behaviour, his sister came, spoke to him and also realised that my husband might be having a problem then suggested that we take him to the prophets, who gave us water, tied our waists with wools and told us that he was bewitched. From then, it became a bit better but it became worse after a short period of time."

(Participant 7, 54 year-old female)

A sister to a mentally ill female sibling shared her experiences with regards to influences to seek care, and stated that:

"The elders in the family took her to the sangomas for some days, which made it worse, then the school she is attending advised us to take her to a charismatic pastor in Pretoria. We then took her there, when she came back she was better as she was able to write her Grade 12 final year examination, after her exams, she relapsed, they then took her back to the sangoma."

(Participant 3, 30 year-old female)

A mother to a mentally ill son also expressed her experiences when having to seek care for her son and the influences thereof, she stated that:

“I take my son to church without my husband’s knowledge, because he said if I take our son to church, he will stop doing things in the house and stop helping financially. But I first wait for him to go to work, then go to church so that they can pray for my son because I am a Christian and do not believe in sangomas”.

(Participant 3, 47 year-old female)

It is without a doubt that human beings are spiritual beings and, in most cases, when a family member starts to show signs of mental illness, the first things that most families resort to is their spiritual and cultural beliefs. They will pay a lot of money for various spiritual and cultural beliefs and when there is no change, they then resort to medical interventions. However, even after being discharged from the hospital, they still return to seek for spiritual or cultural assistance even though they tried it at first and did not work out. Concurrently, a study conducted in Dar es Salaam, Tanzania by Iseselo, Kajula and Yahya-Malima (2016) found that different consultation is sought as a way of finding solutions or treatments for their loved one. Some were advised to seek treatment from traditional healers but when they found no relief, they turned back to God and sought hospital services.

4.3.4.4 subtheme 4.2: Perception on Institutionalisation of the mental health care user

With regards to institutionalisation of the patient, many participants were relieved when their MHCU was admitted in hospital even though it is for short term. However, other participants stated that they would prefer their MHCUs to reside at a home where MHCUs are cared for. But most of the unemployed participants preferred their breadwinner MHCUs to be at home rather than staying at an institution. This is done with the hope that they will get better and be stable enough to look for employment and provide for their families.

A wife to a MHCU shared her views on institutionalisation of her mentally ill husband thus:

“To tell you the truth I want him at home. The problem is that when he becomes dangerous, it scares me. hence, I say he was sick for a year and I was the only one taking care of him that whole year, until he started being aggressive. I don’t mind being with him at home, also because I am unemployed and depend on my children’s social grant, when he is better, he does piece jobs and provide for us.”

(Participant 4, 29 year-old female)

A sister-in-law to a man who has mental illness voiced her views on institutionalisation by saying:

“Yhii! I have a big problem with him staying with me, if there is such a place where mentally ill people stay and are taken care of I would be very happy, it will also save my marriage because now my husband wants to divorce me because of his mentally ill brother as he says that I do not take care of him hence he relapses”.

(Participant 6, 35 year-old female)

Taking care of a family member with mental illness can at times be burdensome for family members, especially when the patient relapses and does not cooperate. Furthermore, family members have to take care of their own personal needs and that of their MHCU family member and at times it becomes challenging having to balance their personal needs and those of the patients. Hence most family members felt that institutionalisation is vital as it will enable them to have quality life. A study conducted in Malaysia by Mohammad, Subhi, Jusoff, Wan, Azreena and Chong et al. (2011), found that some family members of MHCUs prefer that the MHCU be admitted to an institution rather than receive care at home.

However, for those who are unemployed and are dependent upon the MHCU for financial obligations, ideally they would opt for institutionalisation but realistically, they have to endure and continue taking care of them at home. And, also, some MHCUs receive Disability Grant, which also serves as a source of income. Hence, should the MHCU be institutionalised, it would mean that the Disability Grant will be contributed to the institution in order to cater for the needs of the MHCU. As such, they therefore prefer the MHCU to be hospitalised for short stay when they relapse.

4.4 Conclusion

This chapter outlined the results findings from the research study, outlining the themes and subthemes and further explored and described all themes and subthemes, also incorporating other similar studies that were done with regards to all respective themes and subthemes. The following chapter concludes the study and also states limitations that were encountered during the period of the study and the recommendations based on the outcome of the research study.

CHAPTER 5

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

The previous chapter was about the findings of the research study and the responses shared by the study participants. This chapter therefore concludes the result findings, and as well provide limitations of the study and recommendations.

5.2 Research design and method

With due consideration of the study's aim and objectives, the study took the form of qualitative study design in order to obtain and construct exemplifications based on the subjective experiences of family members of persons living with mental illness. Furthermore, descriptive study design approach was purposely used in order to describe the experiences of family members of persons living with mental illness. Explorative study design was also used to explore the experiences of family members of persons living with mental illness, which was achieved through probing, until data saturation occurred of subjective perceptions of participants.

5.3 Summary of interpretation of the research findings

The research study was successful in answering the research question of: What are the experiences of family members of patients living with mental illness in the Capricorn District? It was therefore found that family members caring for patients living with mental illness in the Capricorn District experience a whole lot of situations that are overwhelming when caring for their MHCUs. They experience issues such as, namely, being victims of violent attacks; having to develop restrictive and shrewd measures to cope with handling patient; an increasing level of financial burden; negative impact on their social life; negative health effects from increased stress; and increased burden of losing valuables, amongst other experiences.

Most participants were diagnosed with chronic medical conditions due to strenuous circumstances that come with the package of caring for their MHCU at home. Thus meaning that the burden of chronic diseases is on the rise on daily basis. It was also noted that most participants are not equipped with skills or adequate knowledge to assess the signs and symptoms of their MHCU. It is only when their MHCU becomes

disruptive that they then take action by taking the MHCU to the hospital. Unfortunately, by then, the patient would have done major damages such as being violent and aggressive towards family members amongst other aspects experienced by family members caring for MHCUs at home. Some participants, however, also stated that when they become firm when supervising medication intake, MHCUs become better, and MHCUs who have jobs are subsequently able to function at work – some with minimal supervision and some with limited supervision, which brings a sense of fulfilment to the family members.

5.4 conclusions

It is without doubt that mental illness affects an individual's mood, thinking, affect and behaviour. However, mental illness has always been a neglected area in the health care sector, because its economic and other results are not immediately observable, adversely, without sound mental health, living a healthy quality of life is challenging, especially in the absence of essential support and care such as family. As a result, family members caring for MHCUs at home experience various occurrences, some are positive and most are negative as reported by family members who participated in the study.

5.5 recommendations

Community projects: It is recommended for the State to provide community projects such as support groups for the family members caring for MHCUs at home. This is because almost all participants reported health effects as a result of caring for their MHCU and most of them are diagnosed with a chronic medical condition. It is therefore believed that, with such support, health effects can be minimised, and the quality of care can be improved. This is essential because family members are the ones to provide care to the MHCU once discharged from the hospital. Therefore, when family members are taken care of, they will, in turn, take care of the MHCUs, thus minimising relapses and negative experiences.

Psychological support: Healthcare providers are encouraged to assist family members caring for MHCUs through a process of acceptance and by providing

educational information. This is because, upon discharge of MHCUs, family members are instructed by healthcare providers to ensure that the MHCU complies with medication-taking, but in the same token neglecting the care of the family members. This can also be done by providing family members with family psychotherapy, along with the MHCUs, whilst the MHCU is still at the hospital. Therefore, standard operations procedures and policies must be developed and make it mandatory for family members to be provided with psychotherapy.

Standard operational procedure: protocols, standard operational procedure and policies for family support groups can be formulated, implemented and reinforced in hospitals whereby they can dedicate a day during the week and the weekend. Upon admission of patients or visitation of patients, family members can be told about the support group, the purpose of it, how it will assist the family members and all relevant information required. This can be done with all family members coming to visit their MHCUs at the hospital. It will assist family members to debrief and this will be therapeutic for them as well.

Income-generating community projects: which can be run by occupational therapists and nurses can be designed and implemented for MHCUs. This is because MHCUs spend most of their leisure time unconstructively, hence they become destructive at home, and, concomitantly, family members will have to go through all negative and health implications. Therefore, the income-generating community projects will equip MHCUs with skills, and it will also keep occupied the MHCUs constructively. This, in return, will enable family members to have quality of life, and will ease the burden of care and minimise all the negative experiences of having to care for the MHCU at home.

Institutions: The State should construct institutions, which will be equipped with health professionals to care for the health needs of the MHCUs because most families do not feel safe when staying with their mentally ill relatives, and would rather have them institutionalised for eternity. However, protocols should be put in place such that the MHCUs will be allowed for home weekend visits, festive season visits and special-occasions visits. This will enable family members to have quality life, and MHCUs will be in the best care of qualified and trained health professionals.

Further research: more research is essential on this topic, especially a quantitative study, in order to quantify the experiences of family members caring for MHCUs.

5.6 contributions of the study

The findings of the study can assist to influence health managers and relevant stakeholders to

Family members- for family members' to support each other and form support groups for emotional and psychological wellbeing, so they do not isolate themselves but rather find solace in people who also go through what they go through as they will understand better. They will also assist each other with coping skills which they employ and how best they can support each other.

Mental health care user-

Community- to raise awareness about the family members' experiences to the people in the community in order to provide essential support to family members. This will aid the community to work together as a whole.

Department of health- to raise awareness and bring insight into what the family members of mental health care users are experiencing at home, in order to formulate realist, goal directed, mental health policy that will be inclusive of family members and find innovative methods that will design appropriate, meaningful and purposeful service provision, by incorporating family therapy, which will involve mutual on-going support and to also serve as baseline data for further research study.

5.7 Limitations

The majority of the participants were females and there were only two males, as a result, the study mostly indicates the experiences of female family members caring for MHCU at home. Consequently, it was also observed that most family members accompanying their patients for readmission, medication collection and also for a visit majority were females. Obviously, should there have been an equal amount of males compared to females, data would have been diversified. Moreover, the study cannot be generalised due to the study design as it is a qualitative study.

5.8 concluding remarks

Family members play a vital role in the care of persons living with mental illness, which often comes with responsibilities and experiences which can at times be devastating due to the nature of the illness. Under unfavourable conditions when caring for a MHCU, family members tend to neglect their own health as they have to prioritise that of the MHCU. A need for the family members' psychological support as well as other recommended aspects are crucial for the health and wellbeing of the family members.

REFERENCES

- Adams, L.A. (2013). *Research Ethics*. University of Washington School of Medicine.
- Ae-Ngibise, K.A., Doku, V.C.K., Asante, K.P., & Owusu-Agyei, S. (2015). The Experience of Caregivers of People Living with Serious Mental Disorders: A study from rural Ghana. *Global Health Action*.
- Avasthi, A. (2010). Preserve and Strengthen Family to Promote Mental Health. *Indian Journal of Psychiatry*, 52(2), 113–126
- Babbie, E. (2010). *The Practice of Social Research*. London: Wadsworth Cengage Learning
- Banyini, N.C. (2012). Experiences of Family Members Caring for a Long Term MHCU at Letaba, Limpopo Province.
- Bos, A.E.R., Kok, G., & Dijker, A.J. (2001). Public Reactions to People Living with HIV/AIDS in the Netherlands. 13(3):219-28
- Boote, D.N., & Beile, P. (2005). Scholars before Researchers: On the centrality of the dissertation in literature review in research preparation.
- Bitsch, V. (2005). Qualitative Research: A Grounded Theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75-91.
- Brink, H.I., Van der Walt, C., & Van Rensburg, G. (2012). *Fundamentals of Research Methodology for Health Care Professionals*, 3rd edition. Cape Town.
- Chadda, R.K. (2014). Caring for the Family Caregivers of Persons with Mental Illness. *Indian Journal of Psychiatry*. 56(3): 221–227
- Chang, S., Zhang, Y., Jeyagurunathan, A., Lau, Y.W., Sagayadevan, V., Chong, S., & Subramaniam, M. (2016). Providing Care to Relatives with Mental Illness: Reactions and Distress among Primary Informal Caregivers. 16:80
- Charlson, F.J., Diminic, S., Lund, C., Degenhardt, L. & Whiteford, H,A. (2014). Mental and substance use disorders in Sub-Saharan Africa: predictions of epidemiological changes and mental health workforce requirements for the next 40 years.
- Chiumia, S., & Van Wyk, A. (2014). <https://africacheck.org/reports/do-a-third-of-south-africans-really-suffer-from-mental-illnesses/#sthash.Eq8IbJSz.dpuf>
- Cooklin, A. (2006). *Children of Parents with Mental Illness, Children in Family Contexts*, 2nd edition. The Guilford press.

- Creswell, J.W. (2013). *Research Design – Qualitative, quantitative and mixed methods approach*, 4th edition. Sage publications Inc., Thousand Oaks, CA.
- Diagnostic and Statistical Manual of Mental Disorder*, Fifth Edition. (2016). Text Revision.
- English Oxford Living Dictionary*. (2017). Oxford University press.
- Girma, E., Moller-Leimkuhler, A.M., Muller, N., Dehning, S., Froeshl, G., & Tesfaye, M. (2014). Public Stigma against Family Members of People with Mental Illness: Findings from the Gilgel Gibe Field Research Centre, Southwest Ethiopia. 14(2)
- Glynn, M.S., Kangas, K., & Pickett, S. (2018). *Supporting a Family Member with Serious Mental Illness*. American Psychological Association. Washington, DC
- Grove, S.K., Burns, N., & Gray, J.R. (2013). *The Practice of Nursing Research: Appraisal, synthesis and generation of evidence*, (7th ed). St. Louis, Mo: Saunders Elsevier.
- Herman, A. A., Stein, D.J., Seedat, S., Heeringa, S.G., Mooma, H., & Williams, D.R. (2009). The South African Stress and Health (SASH) Study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal*. 99(5):225-231
- Idstad M., Ask, H., & Tambs, K. (2010). Mental Disorder and Caregiver Burden in Spouses: The Nord-Trondelag health study. *BMC Public Health*, 10, 516.
- Iseselo, M.K., Kajula, L., & Yahya-Malima, K.I. (2016). The Psychosocial Problems of Families Caring for Relatives with Mental Illness and Their Coping Strategies: A Qualitative Urban Based Study in Dar es Salaam, Tanzania. *BMC Psychiatry*. 16
- Jack, H., Wagner, R.G., Petersen, I., Thom, R., Newton, C.R., Stein, A., Kahn, K., Tollman, S., & Hofman, K.J. (2014). Closing the Mental Health Treatment Gap in South Africa: A review of costs and cost-effectiveness. *Global Health Action*. 7
- Kane, J. M., Kishimoto, T., & Correll, C.U. (2013). Non-Adherence to Medication in Patients with Psychotic Disorders: Epidemiology, contributing factors and management strategies. *World Psychiatry*, 12(3), 216–226
- Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., Lund, C., & Fisher, A.J. (2010). Mental Illness – Stigma and discrimination in Zambia. *African Journal of Psychiatry*. 13

- Kinsinger, F.S. (2009). Beneficence and the Professional's Moral Imperative. *Journal of Chiropractic Humanities*. 16(1):44-46
- Larson, J.E., & Corrigan, P. (2008). The Stigma of Families with Mental Illness. *Academic Psychiatry*. 32(2):87-91
- Leedy, P.D., & Ormrod, J.E. (2010). *Practical Research: Planning and Design*. Upper Saddle River, NJ: Prentice Hall.
- Lester, H., Tritter J.Q., & Sorohan, H. (2004). Managing Crisis: The role of primary care for people with serious mental illness. *Fam Med*. 36(1): 28–34
- Lambert, V.A., & Lambert, C.E. (2012). Editorial-Qualitative Descriptive Research: An Acceptable Design. *Pacific Rim Journal of International Nursing Research*. 16(4)
- Lincoln, Y.S., & Guba E.G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage
- Macnee, L.C., & McCabe, S. (2008). *Understanding Nursing Research: Using research evidence-based practice*. Philadelphia, PA: Lippincott Williams & Wilkins.
- Maree, k. (2007) *First step in research*. Pretoria. Van Schalk publishers.
- Mathanya, M.E. (2015). *Experiences of Families towards Psychiatric State Patients During Leave of Absence in Lepelle Nkumpi, Capricorn District of Limpopo Province*. Mini dissertation. University of Limpopo.
- Mavundla, T.R., Toth, F., & Mphelane, M.L. (2009). Caregiver Experience in Mental Illness: A perspective from a rural community in South Africa. *International Journal of Mental Health Nurse*. 18(5):357-367
- McBride, J.L. (2016). Family Physician Support for a Family with a Mentally Ill Member. *Annals of Family Medicine*, 14(5), 460–462.
- Medical Dictionary*. (2009). Farlex and partners.
- National Mental Health Policy Framework and Strategic Plan 2013-2020.
- Mohammad, S.M., Subhi, N., Jusoff, K., Azreena, W.J., Chong, S.T., Fauziah, I., & Alavi, K. (2011). Psychological Outcomes of Family Caregivers of Mental Illness Patients. *World Applied Sciences Journal*. 12: 1-6.
- Monyaluoe, M., Mvandaba, M., du Plessis, E.D., & Koen, M.P. (2014). Experiences of families living with a mentally ill family member. *Journal of Psychiatry*. 17(5)
- Mphelane, M.L. (2006). *The Role Played by Families in Support of Their Mentally Ill Relatives in a Rural Community in Limpopo Province*. Unpublished MA (Health Studies) dissertation. Pretoria: University of South Africa.

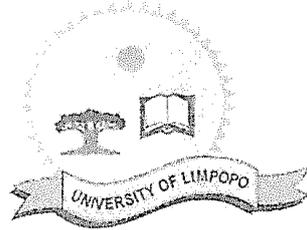
- National Alliance for Caregivers (2016). *On Pins & Needles: Caregivers of adults with mental illness*. USA.
- National Health and Medical Research Council (2014). Chapter 3.1: Qualitative methods. <https://www.nhmrc.gov.au/book/chapter-3-1-qualitative-methods/> accessed on 24/03/2017
- Oshodi, Y.O., Adeyemi, J.D., Aina, O.F., Suleiman, T.F., Erinfolami, A.R., & Umeh, C. (2012). Burden and Psychological Effects: Caregiver experiences in a psychiatric outpatient unit in Lagos, Nigeria. *African Journal of Psychiatry*. 15(2)
- Pannucci, C.J., & Wilkins, E.G. (2010). Identifying and Avoiding Bias in Research. *Plastic and Reconstructive Surgery Journal* 126(2):619-625
- Perlick, D.A., Rosenheck, R.A., Miklowitz, D.J., Kaczynski, R., Link, B., & Ketter, T. (2008). Caregiver Burden and Health in Bipolar Disorder: A Cluster Analytic Approach. *The Journal of Nervous and Mental Disease*. 196(6), 484–491.
- Polit, D.F., & Beck, C.T. (2012). *Nursing Research: Generating and assessing evidence for nursing practice*, 9th edition. Philadelphia: Wolters Kluwer, chapter 14, measurement & data quality.
- Polit, D.F., & Hungler, B.P. (2013). *Essentials of Nursing Research: Methods, Appraisal and Utilisation*. 8th Edition, Philadelphia: Wolters Kluwer/ Lippincott Williams and Wilkins.
- Robinson, E., Rodgers, B., & Butterworth, P. (2008). Family Relationships and Mental Illness: Impacts and service responses. Australian National University. 4:1-19.
- Sabanciogullari, S., & Tel, H. (2015). Information Needs, Care Difficulties and Coping Strategies in Families of People with Mental Illness. *Neuroscience Journal*. 20(2): 145-152.
- Shah, A.J., Wadoo, O., & Latoor, J. (2010). Psychological Distress in Carers of People with Mental Disorder. *British Journal of Medical Practitioners*. 3(3): 327
- Shamsaei, F., Cheraghi, F., & Esmaeilli, R. (2015). The Family Challenge of Caring for the Chronically Mentally Ill: A phenomenological study. *Iran Journal of Psychiatry Behavioural Science*. 9(3):1-7
- Shankar, J., & Muthuswamy, S.S. (2007). Support Needs of Family Caregivers of People Who Experience Mental Illness and the Role of Mental Health Services. *The Journal of Contemporary Social Services*. 88(2): 302-310
- Shrivastava, A., Johnston, M., & Bureau, Y. (2012). Stigma of Mental Illness-1: clinical reflections. *Mens Sana Monogr*. 10(1): 70-84

- Sintayehu, M., Mulat, H., Yohannis, Z., Adera, T., & Fekade, M. (2015). Prevalence of Mental Distress and Associated Factors among Caregivers of Patients with Severe Mental Illness in the Outpatient Unit of Amanuel Hospital, Addis Ababa, Ethiopia, 2013: Cross-sectional study. *Journal of Molecular Psychiatry*. 3(9)
- South Africa. Mental Health Care Act 17 of 2002. Cape Town: Government printers 1-78.
- Surbhi, S. (2016). Difference between Exploratory and Descriptive Research. <http://keydifferences.com/difference-between-exploratory-and-descriptive-research.html#Definition/accessedon24/03/2017>
- Swarrop, N., Shilpa, R., Goud, R.B., Archana, M., Pius, T.M., Pal, A., Virmal, J., & Jayaram, G. (2013). Burden among Caregivers of Mentally-Ill Patients: A rural community-based study. *International Journal of Research & Development of Health*. 1(2): 29-34
- Uys, L., & Middleton, L. (2014). *Mental Health Nursing a South African Perspective*, 6th edition. Cape Town: Juta.
- Vicente, J.B., Mariano, P.P., Buriola, A.A., Paiano, M., Waidman, M.A.P., & Marcon, S.S. (2013). *Acceptance of Patients with Mental Illness: A Family Perspective*. 34(2)
- von Kardorff, E., Soltaninejad, A., Kamali, M., & Shahrababaki, M.E. (2016). Family Caregiver Burden in Mental Illnesses: The case of affective disorders and schizophrenia – a qualitative exploratory study. *Nordic journal of psychiatry*. 70(4)
- Wankiiri, M., Drake, K.B., & Meyer, K.R. (2013). The Lived Experience of Families with a Mentally Ill Family Member. *Journal of Research in Nursing and Midwifery*. 3(4): 58-66
- Weir, K. (2012). The Roots of Mental Illness: How much of mental illness can the biology of the brain explain? *Monitor on Psychology: American Psychological Association*. 43(6):30-33
- World Health Organisation. (1998). *Health Promotion Glossary*. Geneva. <http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf/accessedon23/03/2017>
- World Health Organisation. (2001). *Mental Health: World health report*. Geneva. http://www.who.int/whr/2001/media_centre/pressrelease/en/accessedon23/03/2017

- World Health Organisation. (2004). A Glossary of Terms for Community Health Care and Services for Older Persons. Ageing and health technical report. Japan. http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf/accessedon23/03/2017
- World Health Organisation. (2016). Mental Disorders. Fact sheet. Geneva. <http://www.who.int/mediacentre/factsheets/fs396/en/>accessedon23/03/2017
- Yegidis, G.H., & Weinbach, M.M. (2009). Psychiatric Impairment, Social Contact and Violent Behaviour. 33(4): 86-94

APPENDIXES

Appendix A: Letter from TREC



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

**TURFLOOP RESEARCH ETHICS
COMMITTEE CLEARANCE CERTIFICATE**

MEETING: 31 August 2017

PROJECT NUMBER: TREC/213/2017: PG

PROJECT:

Title: Experiences of family members of persons living with mental illness
In Capricorn District, Limpopo Province, South Africa

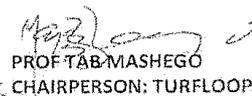
Researcher: T Nkuna

Supervisor: Mr MP Kekana

Co-Supervisor: N/A

School: Health Care Sciences

Degree: Masters in Public Health


PROF TAB MASHEGO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol.
PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

Appendix B: Application to Department of Health Limpopo

P O BOX 765
LETABA
0870

The Head of Department
Department of Health
Private bag X9302
POLOKWANE
0700

Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am a student at the University of Limpopo, currently registered for Master's in Public Health. I hereby request permission to conduct a research study.

The title of the research is: EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA

The research proposal and ethical clearance certificate from the University of Limpopo are included.

Regards

Nkuna Thembi

Date

Appendix C: Permission from Limpopo Department of Health



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stols M.L (015 293 6169)

Ref:4/2/2

Me. T.Nkuna (LP 2017 09 011)
P.O. Box 765
LETABA
0870

Greetings,

RE: Experiences of Family Members of Persons Living with Mental Illness in Capricorn District, Limpopo Province, South Africa.

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
 - Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
 - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.
 - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.


Head of Department

13/10/2017
Date

Appendix D: Application for Pilot Study at Letaba Hospital

PO BOX 765
LETABA
0870

THE CEO
Letaba Regional Hospital
Private bag X1430
Letaba
0850

Sir/ Madam

I hereby request permission to conduct a pilot research study at the Psychiatric Ward for research purposes. The study is titled: EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA

I am currently a Master's in Public Health (MPH) student with the University of Limpopo. Attached is the Ethical Clearance Certificate from Ethics Committee. Approval to conduct the study was also obtained from the Department of Health, Limpopo Province.

The benefit of the study to the hospital is that the summary of the research findings might be used to formulate effective, purposeful and meaningful guidelines for the support of family members caring for mentally patients.

Hoping that the request will be considered.

Regards

Nkuna Thembi (MPH student-UL)

Date

Appendix E: Permission from Letaba Hospital



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
LETABA REGIONAL HOSPITAL**

REF: S5/3/1/2
FROM: Acting Quality Manager
DATE: 10 November 2017

TO: Nkuna T
University of Limpopo

**SUBJECT: APPROVAL FOR CONDUCTING RESEARCH ENTITLED:
EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL
ILLNESS IN CAPRICORN DISTRICT: LIMPOPO PROVINCE; SOUTH AFRICA**

1. The above subject matter refers.
2. You are granted permission to conduct research at Letaba Regional Hospital as per permission granted by the Head of Department, Limpopo Department of Health.
3. Hoping that you will find this to be in order.

CHIEF EXECUTIVE OFFICER

2017/11/10

DATE

Appendix F: Application Research at Mankweng Hospital

P O BOX 765
LETABA
0870

THE CEO
Mankweng Hospital
Private bag X117
SOVENGA
0727

Sir/ Madam

I hereby request permission to conduct a research study at Child and Family Unit for research purposes. The study is titled: EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA

I am currently a Master's in Public Health (MPH) student with the University of Limpopo. Attached is the Ethical Clearance Certificate from Ethics Committee. Approval to conduct the study was also obtained from the Department of Health, Limpopo Province.

The benefit of the study to the hospital is that the summary of the research findings might be used to formulate effective, purposeful and meaningful guidelines for the support of family members caring for mentally patients.

Hoping that the request will be considered.

Regards

Nkuna Thembi (MPH Student-UL)

Date

Appendix G: Permission to conduct study from Mankweng Hospital



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

MANKWENG HOSPITAL

Ref: S5/3/1/2

Enq: Makola M.M

From: HR Utilization and Capacity Development

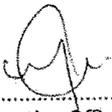
Date : 20 October 2017

TO: Nkuna T
University of Limpopo
Turfloop Campus

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT MANKWENG HOSPITAL

1. The above matter has reference.
2. This is to confirm that Nkuna T has been granted permission to conduct research on **"EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE, SOUTH AFRICA"**.
3. She will be conducting research as from 01 November 2017 to March 2018.
4. The research will be guided by the Head of Department approval.
5. Attached please find her application letter, approval letter from Provincial Office, Turfloop Research Ethics Committee Clearance Certificate, Research Proposal and Questionnaire.

Thanking you in advance


.....
Chief Executive Officer



2017/10/20
Date

Appendix H: Interview Guide - English

Central question:

- What are your experiences when caring for your mentally ill family member?

Biographical questions to ask potential participants:

- Age of the participant
- Marital status
- Relation to the MHCU
- How old is the patient?
- How long have you been caring for the MHCU?
- Do you know the diagnosis of your relative?
- How long has your mentally ill relative been sick?
- Are you employed?
- Was your mentally ill relative employed before he got sick? Is he still employed?

Appendix I: Interview Guide - Xitsonga

Xivutiso hulu:

- Xana I yini leswi u hlanganaka na swona loko u karhi u hlayisa no tshama na munhu wa ka n'wina loyi angana vuvabyi bya miehleketo?

Swivutiso swa hala ku nga na vatswari swo vutisa vanhu lava nga kumekaka va ri ku suhi:

- Malembe ya muteki wa ndhawo
- Munhu waka nwina loyi a nga na vuvabyi bya miehleketo u na malembe ma ngani?
- Xana xiyimo xa vukati bya wena i yini?
- I Vuxaka muni bya wena na munhu waka n'wina loyi a vabyaka vuvabyi bya miehleketo?
- Xana i nkarhi wo tani hi kwini u ri karhi u hlayisa kumbe ku tshama na munhu waka nwina loyi a nga na vuvabyi bya miehleketo?
- Xana vuvabyi bya munhu waka n'wina loyi a nga na vuvabyi bya miehleketo wa byi tiva ke?
- Xana i ku sukela rini munhu waka nwina loyi a nga na vuvabyi bya miehleketo a karhata hi vuvabyi bya miehleketo?
- Xana wena wa tirha?
- Xana munhu waka nwina loyi a vabyaka vuvabyi bya miehleketo a tirha loko mavabyi ya miehleketo ya nga si sungula ke? Xana wa ha tirha?

Appendix J: Interview Guide - Sepedi

Potšišo ya motheo:

- Ke maitemogelo a fe ge o hlokomela molwetši wa bolwetši bja monagano lelokong la geno?

Dipotšišo mabapi le bophelo go motšeakarolo:

- Mengwaga wa motšeakarolo
- Molwetši wa lena wa bolwetši bja monagano o na le mengwa ye mekae?
- O nyetše goba o nyetšwe?
- Le tswalana bjang le molwetši wa bolwetši wa monagano?
- Ke lebaka le le kaakang le hlokomela molwetši wa monagano?
- Le tseba leina la bolwetši bja monagano bja leloko la lena?
- Ke lebaka le le kaang moleloko wa lena wa bolwetši bja monagano a lwala?
- Le ya šoma?
- Molwetši wa lena wa bolwetši bja monagano o be a šoma pele a ka lwala goba o sa šoma naa?

Appendix K: Consent Form

CONSENT FORM

PROJECT TITLE:

Experiences of Family Members of Persons Living with Mental Illness in Capricorn District, Limpopo Province; South Africa

PROJECT LEADERS/SUPERVISORS: Mr MP Kekana

I, hereby voluntarily consent to participate in the following project:

Experiences of Family Members of Persons Living with Mental Illness in Capricorn District, Limpopo Province; South Africa

I realise that:

1. The study deals with experiences of family members of persons living with mental illness.
2. The procedure or treatment envisaged may hold some risk for me that cannot be foreseen at this stage.
3. The Ethics Committee has approved that individuals may be approached to participate in the study.
4. The research project, i.e., the extent, aims and methods of the research, has been explained to me.
5. The project sets out the risks that can be reasonably expected as well as possible discomfort for persons participating in the research, an explanation of the anticipated advantages for myself or others that are reasonably expected from the research and alternative procedures that may be to my advantage.
6. I will be informed of any new information that may become available during the research that may influence my willingness to continue my participation.
7. Access to the records that pertain to my participation in the study will be restricted to persons directly involved in the research.
8. Any questions that I may have regarding the research, or related matters, will be answered by the researcher/s.

9. If I have any questions about, or problems regarding the study, or experience any undesirable effects, I may contact a member of the research team or Ms Noko Shai-Ragoboya.
10. Participation in this research is voluntary and I can withdraw my participation at any stage.
11. If any medical problem is identified at any stage during the research, or when I am vetted for participation, such condition will be discussed with me in confidence by a qualified person and/or I will be referred to my doctor.
12. I indemnify the University of Limpopo and all persons involved with the above project from any liability that may arise from my participation in the above project or that may be related to it, for whatever reasons, including negligence on the part of the mentioned persons.

SIGNATURE OF RESEARCHED PERSON

SIGNATURE OF WITNESS

SIGNATURE OF PERSON THAT INFORMED
THE RESEARCHED PERSON

SIGNATURE OF PARENT/
GUARDIAN

Signed at _____ this ____ day of _____ 2017

Appendix L: Independent Coder's Report



TO WHOM IT MAY CONCERN

17 AUGUST 2018

RE: CONFIRMATION OF INDEPENDENT CODING

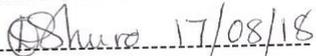
RESEARCH TITLE: EXPERIENCES OF FAMILY MEMBERS OF PERSONS LIVING WITH MENTAL ILLNESS IN CAPRICORN DISTRICT, LIMPOPO PROVINCE; SOUTH AFRICA

This letter serves to confirm that I conducted extensive independent coding for Thembi Nkuna in April 2018. Transcripts were thoroughly reviewed and analysed to develop independent codes, subthemes and themes.

We then exchanged the themes, subthemes and codes with Thembi Nkuna and met to discuss. The discussion involved comparing what had been developed and what she had until we agreed on final themes and subthemes.

Yours sincerely

Linda Shuro



Independent coder

ROUNDSADDLE
11 BOSBOK AVENUE, FAUNA PARK POLOKWANE
TEL: 083 244 3371/ 078 744 1989
EMAIL: lindashuro@gmail.com

Appendix M: Example of Conducted Interview

Participant 10

Interviewer: How are you related to person you came to visit here in the Psychiatric Ward?

Interviewee: She's my mother.

Interviewer: How old are you?

Interviewee: I'm 24.

Interviewer: How old is your mother?

Interviewee: She's 49

Interviewer: Do you have a job?

Interviewee: I'm not employed.

Interviewer: Are you married?

Interviewee: I'm not married.

Interviewer: Do you stay with your mother full time?

Interviewee: Yes

Interviewer: Do you have your own children?

Interviewee: Yes

Interviewer: How many children do you have?

Interviewee: I have 2 children.

Interviewer: Do they also stay with you and your mother?

Interviewee: Yes.

Interviewer: Does your mother has a job?

Interviewee: No.

Interviewer: Did she have one before she was diagnosed with mental illness?

Interviewee: Yes, she used to work at, eix! I forgot the place, but they cook for kids

Interviewer: When did she start being sick?

Interviewee: She is coming for the second time this year

Interviewer: When did she start being sick?

Interviewee: She started last year 2016.

Interviewer: What are you experiencing at home, with regards to her condition?

Interviewee: When she started being sick. Like she just starts singing then she changes and starts tearing own the curtains, the carpets and everything. Then she goes outside and swears at people, using very vulgar terms. Then she invites people over, like when we had my uncle's funeral, she just left in a weird way. So people started enquiring about her.

Interviewer: Is it on a daily basis?

Interviewee: Most of the time. When she's ill, she would behave like that every day, but when she's better, she doesn't do those things.

Interviewer: How do you make sure that she complies with her medication-taking?

Interviewee: I would be lying. The 1st time she came here, my grandmother was the one who was explained to about the treatment when she picked her up after she was discharged. I was not around that time. My grandmother told me that my mother should come back and collect her medication on a monthly basis, unfortunately my mother would refuse to come get her medication, saying she would drink the church tea.

Interviewer: Upon her first episode, what was your first line of treatment?
Interviewee: We took her straight to the hospital when she started.

Interviewer: Have you ever been a victim of violent attack from your mother?
Interviewee: She swore at the whole family mostly. There was this uncle of ours who took it to heart.

Interviewer: Do you have any external support?
Interviewee: No one is supporting us. I am the one who takes care of her because she lives with me, my brother and my younger sibling. There's no one else or an elder or family relative who comes to assist us, me and my siblings are on our own

Interviewer: Do you understand the kind of mental illness that your mother has?
Interviewee: I wouldn't say I understand the illness, because when she starts, I get surprised too and my best solution is always to call the ambulance.

Interviewer: Does the ambulance respond in time when you call?
Interviewee: Yes. They respond. But last time they came, they initially said they couldn't take my mother to the hospital because she was too aggressive and said that I had to call the police as well, then they left. I then called the police, when the police arrived, I again called the ambulance and they came back again to pick her up.

Interviewer: How did it make you feel, having seeing your mother being picked by the police?
Interviewee: I was very saddened. I felt like crying. Fortunately because I have an infant, they told me not to cry.

Interviewer: Are there any meaningful activities that you no longer engage in as a result of your mother's condition or any adaptations as a result of such?
Interviewee: I have to take the kids with me everywhere I go because I can't leave them alone with my mother. Plus one of my kids is disabled. I also don't go to places like town when she is at home, because I can't leave my children with her, I fear that she might relapse

Interviewer: What is your perception of mental illness?
Interviewee: I just tell myself that it mostly stressed people that get the illness.

Interviewer: Who reminds her to take her medication?
Interviewee: She takes the medication herself.

Interviewer: Have you told anyone about your mother's condition?
Interviewee: We have never told them. Only family knows. My friends don't know either. Even know when they enquire about my mother been in hospital, just tell them she's just not feeling well.

Interviewer: Why don't you confide in them?
Interviewee: It's kind of embarrassing and being scared of people judging me.

Interviewer: What are the coping skills that you are employing at home?
Interviewee: I haven't tried anything. When she starts being ill and she becomes a hand full, we just open the windows and take off the curtains. Then lock her in the house, in her bedroom. Then we just go in to feed her.

Interviewer: Has she ever broken any windows?
Interviewee: She has never broken any windows, she just tears down the curtains.

Interviewer: And how does she react when you lock her in her bedroom?
Interviewee: She swears at us. She looks out the windows and starts swearing at people in the street too. After she came back the first time, she didn't

take the meds they gave here at the hospital. If we had been aware that she wasn't taking the pills, then she might not have needed to come back the second time.

Interviewer: True, well atleast you now have an idea of how to care for your mother. I wish you well, and thank you for your willingness to being part of the study. Thank you for sharing your experiences when caring for your mother. Take good care.

Interviewee: Thank you. It was a pleasure.

Appendix N: Editor's Letter

Mr MM Mohlake
University of Limpopo
Turfloop Campus
Private Bag x 1106
Sovenga
0727

22 August 2018

To Whom It May Concern

EDITING CONFIRMATION: Ms THEMBI NKUNA'S DISSERTATION

This letter is meant to acknowledge that I, MM Mohlake, as a professional editor, have meticulously edited the dissertation of Ms Thembi Nkuna (Student Number 201612847) entitled "Experiences of Family Members of Persons Living with Mental Illness in Capricorn District, Limpopo Province; South Africa".

Thus I confirm that the readability of the work in question is of a high standard.

For any enquiries please contact me.

Regards



Mosimaneotsile M Mohlake
Freelance Professional Editor
072 1944 452
<mosimaneotsile.mohlake@ul.ac.za>