A STUDY ON THE EFFECTS OF MENTAL ILLNESS ON RELATIONSHIPS AMONGST FAMILIES WITH THE MENTALLY ILL MEMBERS.

BY

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30 November 2009
DECLARATION

I, Mfanisi Welcome Magadla, student no. 9330941, declare that this thesis is a presentation of my original research work. Wherever contributions of others are involved, every effort is made to indicate this clearly, with due reference to the literature, and acknowledgement of the supportive contributors. The essay has been prepared exclusively for the University of Fort Hare, and has not been and/or will not be submitted as assessed work in any other university.

The work was done under the supervision of Mrs. N.I.N. Magadla and Dr. N. Tshotsho at the University of Fort Hare, in East London (South Africa).

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In my capacity as supervisor of the candidate’s thesis, I certify that the above statements are true to the best of my knowledge:

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Mrs. NIN Magadla                                           Dr. N. Tshotsho
Introduction: The increased abscondment of Mental Health Care Users from institutions of care, treatment and rehabilitation has prompted the researcher to conduct the study because patients who are not visited do not stand a chance of getting a Leave Of Absence (LOA).

Problem: The concern is the danger of assault, murder, rape and other high risk situations the mentally ill individuals and the community are exposed to, which is caused by frequent abscondment of mentally unstable individuals who roam around the community without proper treatment and care. This is caused by failure of the relatives in coming to request patients for leave of absence (LOA).

Purpose: The study investigated the effects of mental illness on relationships amongst families with the mentally ill members. The number or frequency of visitations by relatives to the mental health institutions is used by the researcher, to measure the nature of relationships between families and the psychiatric patients related to them.

Method: The population comprised families of the mentally ill persons admitted at Cecilia Makiwane mental health units. The sample was collected conveniently as relatives came to visit the mentally ill until the desired number was reached. The designed tool was a questionnaire which was self administered. Data were analysed manually. Tables and graphs are shown in the results.

Conclusion and Recommendations: The study revealed that approximately 100% of respondents had a lack of knowledge about mental illness and the mentally ill, in terms of care, treatment and rehabilitation hence they all need assistance in dealing with the mentally ill in the community. Findings also revealed that mental illness causes breakdown in family relationships. Recommendations regarding the enhancement of relationships between families and their mentally ill members are formulated as coping skills in the dissertation. The burden of having to deal with mentally ill person whose illness is not understood can lead the family to a state of confusion and
not knowing what to anticipate. Lack of resources compounds the problem as the family members are not able to visit the ill member due to lack of funds (Baumann, 2007:637). The families with a mentally ill member usually shoulder the greatest part of the burden of mental illness (Uys and Middleton, 2004:77); unfortunately, lack of resources pose a problem.

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CHAPTER ONE: INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

The proposed study investigated the effects of mental illness on relationships amongst families with mentally ill members in the Mdantsane area. In other words, the nature of relationships that existed between families and the mentally ill are looked at, in terms of the number of visits by the families to the mental health institution.

One cannot escape the fact of an inevitable encounter with the mentally ill individuals who are roaming around aimlessly and uncared for and whose appearance is unkempt (Kneisl & Trigoboff, 2007:217). They are found in almost every corner of Mdantsane, such as shopping centres, taxi/bus ranks, streets and even in the community areas. Some of these individuals are known to the community, others not, but are all labeled as lunatics, mad, foolish and crazy individuals and regarded as laughing stocks (my own observation). They pose a risk to themselves and their surroundings, yet ignored by the community. It is until they commit acts of violence or injure someone that supervisory measures are taken against them, which does not aid much since damages are already incurred. People with mental illness do not receive the treatment and respect they deserve because they are part of the ill-informed community. Because of their ignorance about mental illness and the mentally ill the community has a negative attitude towards the mentally ill individuals and the mental illness itself (Sohail, 2006).

It is also becoming a norm that most mentally unstable individuals, who are institutionalized for their care, treatment and rehabilitation, complain about lack of social contact with their families, relatives and friends. They become bored of long stays in hospitals. These patients are neglected by their loved ones, and verbalize their experience to the nursing staff that they feel more in prison than being in hospital. The nursing staff, social workers and social work auxiliaries perform tremendous tasks in trying to establish suitable contacts for these patients, but their efforts fail due to negative responses from families. Some family members are often very busy with job-related tasks and have no sufficient time for additional care for the mentally ill, hence institutionalization, in order to rid them of the escalating burden. Other relatives care more for the social benefits and/or grants than the patient’s well-being and safety. The above mentioned statements do not tally with Uys and Middleton (2004:76) who give a list of factors that facilitate recovery.
This is explained by families requesting a short leave of absence for the user only to collect disability grant, and they also fail to bring patient back to hospital on the stipulated date of return. A breakdown in family relationships is therefore observed by the researcher as a contributing factor to the deficit in family contacts. What has been mentioned depicts neglect and ignorance.

Other mentally challenged individuals reside far away from their institutions thus making it difficult for the family and/or relatives to visit due to lack of funds for transportation. Those not in hospitals are roaming around the community with unpleasant physical appearance, poor self-care, wearing dirty clothing, and above all feeding themselves in the dirty, bad smelling rubbish bins, which is a clear evidence of neglect by their families. Rehabilitation process is not effective if there is lack of community involvement in the caring for the mentally ill, that is, the family, relatives, friends, colleagues, and all the people in the same area to which the patient belongs. According to research studies, interviews with patients who returned to the wards after abscondment showed that psychiatric symptoms also contribute to the decision to leave, but nearly in every case patients can give additional and rational reason for absconding (Bowers, Jarrett, Clark, Kiyimba and McFarlane, 1999).

1.2 PROBLEM STATEMENT
Mental health care users abscond frequently, since they seek the outside world, and end up exposing themselves to unnecessary dangers such as assault, murder and rape in the community. This self exposure is due to failure of relatives in coming to request patients for leave of absence (LOA). According to the researcher’s experiential knowledge, records of family visitations which are kept in the nursing units show huge gaps between consecutive visits, and are very suggestive of the breakdown in social relationships between the mental health care users and their families, relatives, partners, spouses and friends (hospital records). This breakdown in relationships contributes to the long stays of patients in hospitals, resulting in overpopulation of institutions, hospital environment losing its therapeutic effect, and inadequate staff members having to treat the increased number of in-patients. The long stay also exposes the mentally ill to the danger of institutional neuroses. According to Uys & Middleton (2004) institutional neuroses increases to patients who stay in hospital for a very long time, and are caused by the loss of contact with the outside world; loss of friends, belongings and personal mementos; the unattractive, uncomfortable and unfriendly hospital environment as well as loss of opportunities outside the institution contribute to hospital neurosis.
is further alleged by Uys et al. (2004) that patients with institutional neuroses become apathetic, submissive, lack initiative, have poor self-care, and show no interest in the future or in making practical plans.

In the case of couples, either married or not, the rate of the break-ups is also escalated, may be due to the stigma attached to the mental illness or lack of knowledge about the condition. In some instances the spouse gets tired and cannot cope with the alien behavior of the partner, and termination of the relationship becomes the only way out of the stressing situation.

The severity of the problem discussed above forced the researcher to conduct the study in Mdantsane, a suburban area of East London resided mostly by Xhosa speaking people, where the problem is highly experienced.

1.3 PURPOSE OF THE STUDY

The aim of the study is to enhance relationships between families and their mentally ill members, and to prevent a break-up in couples with the mentally ill partners, in both in-patient and out-patient basis. Another aim is to encourage the support of families and the community from which the patient belongs on the care, treatment, and rehabilitation of the mentally ill individuals.

1.4 OBJECTIVES OF THE STUDY

The objectives of the study are to:

- Document the number of patients visited by their families in Cecilia Makiwane Hospital (CMH) mental health unit, in the period of August to October, 2009.
- Identify the number of patients not visited by their families in CMH mental health unit, and the reasons thereof, in the period of August to October, 2009.
- Document frequency of visits for those visited by their families at CMH mental health unit, in August to October 2009.
- Describe the nature of the relationships between the families and their mentally ill members, who use CMH for the care, treatment and rehabilitation during the period of August to October, 2009.

1.5 RESEARCH QUESTIONS

- What is the number of patients who were visited during hospitalization, by their families during the period August to October, 2009?
• What is the number of patients who were not visited during hospitalization during August to October 2009?
• What is the frequency of visits by family and relatives to their ill member?
• How do family members describe their relationships before and after the onset of the mental illness?
• What do families see as the effects of mental illness on their family relationships?

1.6 SIGNIFICANCE OF THE STUDY
The study is important due to the fact that it will contribute in de-stigmatization and provision of knowledge about mental illness and the mentally ill to the family and the community at large. Research results will assist mental health institutions in the formulation of new policies and strategies for involving the family and the community in dealing with the mentally ill members within their areas of residence. The study will assist in equipping health practitioners with information regarding de-institutionalization which is the current method used to treat psychiatric patients.

According to Craig & Smith, (2002) as cited in Burns & Grove, (2005), the ultimate goal of nursing is to provide evidence-based care that promotes quality outcomes for patients, families, healthcare providers, and healthcare system. Evidence-based practice as further discussed by Craig et al, (2002) involves the use of collective research findings, in promoting an understanding of patients’ and families’ experiences with health and illness, implementing effective interventions to promote patient health, and providing quality, cost-effective care within the healthcare system.

1.7 DEFINITION OF TERMS
**Act:** Refers to the Mental Health Care Act (No.17 of 2002) of the Republic of South Africa.

**Anxiety disorders:** Several disorders including phobias, obsessive compulsive disorder, and panic attacks.

**Bipolar disorder:** A major mood disorder characterized by manic and major depressive episodes, with periods of recovery generally separating the mood swings. Psychosis may be present during manic episodes. They are also known as manic-depression (Uys et al 2004 : 110)

**CMH:** Cecilia Makiwane Hospital.

**Family:** Family in the context of this study refers to two or more persons related by blood, marriage, adoption, and may not necessarily live together (Kneisl et al 2007: 645).
Institutional neuroses: It is a secondary illness to in-patients caused by the environment through losing its therapeutic effect and becoming detrimental to the mental health of the patients.

Mania: A mood disorder characterized by expansiveness, elation, talkativeness, hyperactivity, and excitability. See bipolar disorder.

Mdantsane: This is a South African township situated between East London and King William’s Town in the Eastern Cape Province.

Monoamine oxidase inhibitor (MAOI): A group of antidepressants that acts by prolonging the effect of neurotransmitters. Generally used to treat persons who do not respond to tricyclic antidepressants. They may cause a serious reaction if taken with certain other medications and foods.

NAMI: National Alliance for the Mentally Ill is a national organization dedicated to the eradication of mental illness and to the improvement of the quality of life of those people whose lives are affected by these diseases.

Psychosis: A mental state characterized by impaired perception of reality, delusions, hallucinations, and distorted thinking. It can be associated with many psychiatric disorders.

Schizophrenia: A disease of the brain, the symptoms of which include thought disorders, delusions, hallucinations, apathy, and social withdrawal.

SSDI: Social Security Disability Insurance. For persons who are retired or disabled. Dependents may be eligible if diagnosed with a disability before the age of 22.

SSI: Supplemental Security Income. For indigent, disabled persons SSDI and SSI are administered through the Social Security office.

SSRI: Selective serotonin reuptake inhibitors. These are a group of antidepressant medications which prolong the effect of the neurotransmitter serotonin.

User: This is a short form for mental health care user or mentally ill or psychiatric patient, and the words are used interchangeably throughout the essay.

1.8 OVERVIEW OF THE CHAPTER

The study was introduced. The background was presented as the mentally ill who roam around. The burden that mental illness poses was also presented. Objectives and research questions were written. The statement of the problem is the mentally ill patients who abscond and being exposed to risks. The researcher also wrote as a problem, the fact that abscondment is due to symptoms. Patients are not visited due to lack of resources as well.
1.9 CONCLUSION

Having gone through the chapter, the researcher is convinced that there is a problem both in the family and in the institution. If the users say they abscond due to symptoms, it means that monitoring was not done. If Baumann (2007) and Uys et al (2004) contend that resources pose problems, then, there is a problem. The above mentioned problems need solutions. The researcher will review literature to gather ideas from the scholars who conducted similar studies.
CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION
The literature reviewed includes mainly the studies on the importance of relationships, description of mental illness, and the effects of mental illness on relationships amongst families with the mentally ill members, which forms the basic concepts of the study. Literature pertaining the way families describe their relationships with the mentally ill member was carefully selected. Journal articles, books, online articles revolving within the same body of knowledge are selected for discussion in the study. In other words, the literature reviewed is aimed at finding out what has already been covered by other scholars on the same field of study (Mouton, 2006).

The chapter will discuss the importance of relationships, mental illness and its effects on the family relationships, and families’ views on the nature of their relationships with mentally ill individuals before and after the onset of the mental illness. Psychosocial support to families will be discussed as well.

2.2 RELATIONSHIPS
Relationships can be a source of happiness and satisfaction, but also of stress and emotional turmoil, regardless of whether one has mental illness or not. According to Sr. J. Pretorius, (Personal communications at St. Marks clinic, July 25, 2007), human beings are like social animals, whether mentally ill or mentally sound, are continuously in need of other people in their lives. Sr. Pretorius further stated that the importance of relationships included providing needs such as:

- Intimacy which means involvement in very close connections with friends, partners, and/or the community.
- To feel a sense of growth depicted by being involved in all activities and consultation within the family and the community at large.
- Companionship that is surrounded by trust, honesty, reliability and truthfulness.
- Happiness and fun to find meaning out of life evidenced by achievements and positive records.
- Security which provides personal safety.
- Growth and development in social and psychological aspects as well as,
- Sharing and healing as tensions are released.
A person’s psychological health and sense of well-being depends significantly upon the quality of his/her relationships and attachments to others, and a core issue in all close personal relationships is establishing and regulating that connection, and the failure to do that leads to a relationship disorder in both married and unmarried couples (Sadock & Sadock, 2003).

In a typical attachment interaction, one person seeks more proximity and affection, and the other either reciprocates, rejects or disqualifies the request, and a pattern is shaped through the repeated exchanges. Distinct attachment styles, namely anxious-ambivalent and avoidant styles are the examples. Adults with the former tend to be obsessed with romantic partners, suffer from extreme jealousy and have a high divorce rate. The latter are relatively un-invested in close relationships, though they often feel lonely. They seem afraid of intimacy and tend to withdraw when there is stress or conflict in the relationship. Break-up rates are high. However, persons with a secure attachment style are highly invested in relationships and tend to behave without much possessiveness or fear of rejection (Sadock & Sadock, 2003).

Terror, helplessness, rage, and despair are some of the myriad emotions that one goes through when enduring the mental illness of a loved one. There is nothing as agonising or frustrating as watching a spouse’s mental condition deteriorate, and many marriages fail to carry on through the strain. The insecurity and heartache of mental illness are only magnified with social reactions. Unlike more commonly understood physical conditions such as cancer, etc, psychological illnesses are heavily stigmatised and misunderstood (Baumann 2007:642). The afflicted, along with his or her family, often goes through intense feelings of shame, embarrassment, and confusion over the condition. It can certainly be a backbreaking burden to live with a mentally ill husband or wife, and the frustration and pain of the caregiver spouse are often overlooked (Gillian Markson, 2009). The most frequently cited effects on families are lowered self-esteem and damaged family relationships (Wahl & Harman, 2009).

Dealing with stigma and the symptoms of mental health problems, especially so-called negative symptoms like depression can make people feel lonely and isolated, so taking steps to overcome difficulties and to build good relationships; romantic or through friendships, can be a very positive step for many people with mental illness (National Schizophrenic Company, 2009).
Nadine (2002) says that the level of family involvement helped the patient to take medication and to maintain self-care. According to Nadine families would spend leisure time with patient, redirecting inappropriate attention-seeking and socially embarrassing behavior. Many people find meeting other people a scary or intimidating prospect, and working towards a strong relationship with another person does take time and compromise which can at times be hard. There are a number of ways in which mental illness can make it more difficult to start and maintain a relationship. McDonald (2002) argues that positive social relationships between mentally unstable individuals and their families decrease the length of stay in hospitals. Mental illness needs to be described.

2.3 MENTAL ILLNESS
A mentally healthy person is believed to be in a state of being successful in social activities such as work relations, relations with family and friends, and being able to solve and cope with recurrent stressors experienced in everyday living. Mental illness is therefore experienced by the person when he or she can no longer stand to function normally due to stressors experienced everyday in the social world (Uys & Middleton, 2004:753). Other authors view mental illness as a term that refers to all types of mental disorders, including disorder of thought, mood or behavior. In order to be classified as mental illness the condition must cause distress and result in a reduced ability to function psychologically, socially, occupationally or interpersonally (The Christophers, 2007). The researcher supports the previous statement because a person who is not functioning well could not have positive relationships. Mental illness is treated by medication, psychotherapy and psycho-education.

2.3.1 MEDICATION
Psychiatrists use a wide range of medication to treat mental illnesses such as, antipsychotics for treating schizophrenia, anti-depressants for depression, anti-manic drugs for treating bipolar mood disorder, and anxiolytics for treating anxiety.

The most commonly used antipsychotics include clozapine, haloperidol (serenace), olanzepine, chlorplomazine (largactil) and stelazine (tripfluoperazine). Lithium carbonate (camcolit) is the most commonly used mood-stabiliser to reduce mood swings (Uys et al, 2004:110).
The drugs commonly used for long term are, to name a few, fluphenazine decanoate, zuclopenthixol decanoate and risperidone need to be monitored. In that way non-adherence can be detected. Other commonly use drugs are antidepressants such as fluoxetine; anti epileptic drugs which include carbamazepine (tegretol); muscle relaxants such as orphenadrine (disipal); anti-Parkisonisms such as biperiden (akineton) and disulfiram (antabuse) to combat alcoholism (Uys and Middleton, 2004:110).

2.3.2 PSYCHOTHERAPY
This is a supportive and dynamic treatment to help patients have a better understanding of their emotional and personality problems in order to make changes to lead happier and healthier lives. This is mostly used by nurses, psychologists, and social workers. This type of treatment can involve individuals, couples, families or groups depending upon the expertise and interest of the therapist. The purpose of psychoanalytic therapy is to expose the underlying conflicts which are the causes of the patient’s problems and assist the patient to overcome the problems through different constructive ways (Meyer, Moore, and Viljoen, 2003).

2.3.3 EDUCATION
While patients are treated with medication and psychotherapy there is also a need to educate the patient families, or groups depending upon the expertise and interests of the therapist. Education on medication and treatment compliance, side effects of mental illnesses and the causes thereof needs to be emphasized (Sohail et al, 2006).

2.4 EFFECTS OF MENTAL ILLNESS ON RELATIONSHIPS
There are positive as well as negative aspects to family relationships for parents with mental illness. Family members may be a primary source of social support, and a buffer against stress (Hogan, Linden & Najarian, 2001).

In an article, by Lou (2007), a bipolar sufferer himself explains how mental illness affects couples in their relationships. According to Lou, spouses of bipolar sufferers often are the caretakers and caregivers in the relationship. They are expected to hold everything together when emotional hurricanes hit their families. They hang on in-spite of everything that is flying around them just
waiting for the calm. Many people close to them expect them to be strong and almost heroically brave, but sadly, they too, have weaknesses and fears.

So many people in their community focus on the well-being of the bipolar person that they forget about the spouse. It can be very difficult to be the other half of a partnership in which someone is chronically ill. The spouse feels like all she/he ever does is put up and put out and that they never get anything back in return. It can be emotionally and physically draining when one’s spouse is continually the one that is the focus of one’s attention. The spouse often forgets to acknowledge his/her needs and wants because the spouse’s attention is completely funneled to the partner. The spouse may long for someone he/she can confide in, and someone to listen to his/her concerns. Sometimes the spouse can be resentful of the bipolar sufferer, and then, unfortunately, the relationship hits the rock (Lou, 2007).

Professionals may be exhausted after being on call 24 hours, and this may be coupled with frustration and anger from family members when professionals are unable to accomplish what the family sees as basic: prompt diagnosis and treatment, and assistance to help their relative regain a productive life. It is not "unloving" to feel resentment in response to the behavior of the relative with mental illness. Realizing the person is ill does not always overcome the hurt, dismay, and anger felt by those trying to help. He/she may rebuff attempts to reach them, and may be fearful or accusatory towards those trying to help. Understandably, families, friends, and co-workers have problems with these symptoms, yet a hostile reaction will almost certainly intensify or lengthen the episode. It is natural and necessary to grieve for the person who used to be. But strength and determination are needed to meet the coming challenges. Mental illness can weave a web of doubt, confusion and chaos around the family. Unwittingly, the person with mental illness can dominate the entire family through control and fear or helplessness and incapacity. Like a bully, the mental illness bosses the primary sufferer as well as the loved ones. Instability, separation, divorce and abandonment are frequent family outcomes of mental illness (Markson, 2006).

According to research studies, relationships between individuals whether mentally ill or not are important and should be maintained at all times for individuals to live a better life. Studies also point out that once problems exist, relationships are doomed to fail, especially if knowledge deficit and failure in accepting the mental condition are still a problem. Not a single study in this perspective has been conducted in the disadvantaged communities of this country, such as Mdantsane and other
communities of the black people, whereas research would add new knowledge to the citizens. Mental illness has an impact on both the social and emotional aspects of the affected people. The success when working with a mentally impaired person be it assisting with basic human needs, formal therapy, treatment or emotional support, depends solely upon the nature of the relationship the helper has with the patient (Harris, Williams and Bradshaw, 2002).

2.5 PERCEPTIONS OF FAMILIES ABOUT THEIR RELATIONSHIPS WITH THEIR MENTALLY ILL.

At times the mentally ill relative may embarrass his or her family members in front of friends and neighbours. Because it is sometimes difficult for the families to talk about their relative’s problems with people outside the immediate family, they may not offer to an explanation. Many families unfortunately decide to give up their social lives when a relative becomes mentally ill because they are nervous about inviting people in their home. In a Malaysian study aimed at exploring the meanings of lived experiences that Chinese family care givers ascribed to the care they provided to relatives with severe and persistent mental illness, 19 criterion selected families were studied in 2002. The findings showed the impact of the stigma of the relative’s mental illness on family care-givers and families is pervasive and strong such that the family and care-givers tried to avoid talking about their relatives’ mental illness with extended families and friends in order to protect their families from stigmatisation. The public and the families lacked information about the mental ill-health, and also coping skills regarding stresses and stigmatisation (Chang & Horrocks, 2006).

One hundred and eighty-three patients who were considered for relocation and 130 family members of these patients were interviewed to examine the differences in perspectives of the severely and persistently mentally ill patients on key aspects of community-based care to help inform community service planning and development. Among the 130 family pairs, 41 percent disagreed about the desirability of relocation, with fewer patients favoring relocation than families. Forty-nine percent of the pairs disagreed about the desired proximity to the family of the relocated patient, with the patient desiring closer proximity than the family member in about half of these cases. Fifty-three percent of the pairs disagreed about the amount of financial and emotional support that the family would provide after relocation. In half of these cases, patients believed the family would provide a higher level of support than the family indicated it could (Holley & Jeffers, 2000).
A study to assess the information and educational needs of family members of adults with mental illness and their preferences regarding how to address those needs, 308 of 962 responded. Results showed that average family members reported a substantial number of unmet needs and the experience of stigma, and having an ill relative with a more recently occurring condition or with a disabling condition were significantly associated with a greater number of unmet needs. 63% of families preferred that mental health providers to address their needs on an as-needed basis which measured 58%. Their needs included mainly the ongoing provision of information and support tailored to meet their individual needs (Dapraski, Marshall, Seybolt, Medoff, Peer, Leith & Dixon, 2008).

In a study investigating the family members’ concerns regarding community placement of their mentally ill or disabled relatives discharged from a long-term psychiatric facility due to the closing of the hospital. Comparisons of concern of families regarding the community placement and their views of their relatives’ readiness for community living shortly after one month’s release and a year later showed that the major shift from hospital-based to community-based care for mentally disabled persons has resulted in increased burden to family members (Solomon & Marcenko, 1992).

Families experienced profound burdens as they interacted with the mental health care system in regard to negotiating crises situations, acting as patient advocates and case managers, obtaining adequate community resources, continuity of care and information, dealing with legal barriers, and communicating with mental health professionals. This resulted from a study where eighty-six care givers were interviewed regarding their perceptions of burden care for chronic mentally ill relatives. Recommendations methods for reducing family burden and improving the care of the mentally ill in the community include family education about mental ill-health, involving family in treatment decisions, changes in current mental health laws, redirection in professional training, and the development of mobile crisis team (Francell, Victoria & Gray, 2002).

2.6 PSYCHOSOCIAL FAMILY INTERVENTION

Relationship problems are common when a psychiatric diagnosis is present. Criticism and blame may be a typical theme. Couple-oriented approaches are clearly indicated in the treatment of mental illness. In addition to improving relationships and the quality of life in the mentally ill and their spouses, interventions can make a significant impact on the outcome of the illness.
Inadequate information and support for families with the mentally ill members can be said to have a detrimental effect on both the patient and the caregiver’s well being. Psychosocial interventions as summarized by Harris et al (2002) include that mental health practitioners should, in providing psycho-social to families:

- Always provide the family with support.
- Help them understand the illness and how its symptoms manifest themselves in the patient’s behavior.
- Assist the family to develop ways of coping with problems associated with the illness.
- Help the family strike a balance between encouraging and supporting the patient while avoiding making critical comments or doing too much for themselves.
- Assist family members to manage their own stress.
- Assist the family by discouraging them from sacrificing all their own interests and activities in an effort to care for mentally ill member.
- Be trained to understand that the mentally ill people will often not seek help.
- Family carers have rights too, and that mental illness in a close relative can infringe those rights.

2.7 COPING STRATEGIES FOR FAMILIES

Families are viewed as valuable source of help to the patient in their recovery and the role of the psychiatric nurse is to help the family in their efforts to support the patient. One of the reasons that makes family a valuable asset in helping patients is the frequency of relapse for mentally ill persons that increases because of the patients’ sensitivity to the stress they experience in the household environment (Harris et al, 2002).

It is stated that, not all relationships involving the bipolar suffers and spouses are doomed to fail. These relationships survive because the two people involved are fully aware of the illness they share. They see their situation as a team effort, and make every effort to learn about and understand this disease together. The established limitations and boundaries they set for themselves are respected in order for the relationship to exist and prosper. Honesty and willingness to be open about the issues involved with manic depression is vital to these people, and most of all, they focus on the fact that they love each other enough to commit to the relationship in the first place (Lou, 2007).

When mental illness strikes in a family, it is like being struck by lightning. It is unexpected and it is devastating. By being aware of the factors which could have the potential to cause difficulties in
relationships, one can take action to minimise these risks where possible. It can be through helping one’s partner to be informed about one’s mental condition, and recognising and discussing patient with close relatives or friends, how his/her illness can affect the partner. According to the study on experiences of caring for a seriously mentally ill family member among Hispanics, the family is viewed as the primary care giver for seriously mentally ill family members (Guarnaccia, Deschamp, and Argiles, 2004).

Other coping strategies include mutual support groups, important issues to be shared with relatives, knowledge about resources for care

Four important issues that can be shared with relatives, is that families should:

- Avoid placing blame and guilt. The family did not cause the illness, nor did the person experiencing the illness. Self-blame and blame leveled by others, including mental health professionals, are destructive. Focus instead on the future and on what can be done to develop supportive living arrangements that will enhance the possibility of rehabilitation for one’s family member.
- Seek the support, understanding and relief one needs. Keep oneself healthy and able to cope because one is needed to provide the support his/her relative needs. One should continue his/her own outside interests. Schedule time for ones’ self.
- Remember other family members (siblings, grandparents) are affected, too, and they probably are experiencing depression, denial and guilt just as one may be. One should also keep communication open by talking with them about this.
- Should learn all they can about the illness. Find out about benefits and support systems when things are going well. They should not wait for a crisis (Nami Michigan, 2004).

2.7.2 MUTUAL SUPPORT GROUPS

Social support consists of natural support and formal support where the former includes support from family and friendship networks, and the latter referred to the support provided by professionals such as mental health and medical professionals. Group interventions that provided support through family and/or friends proved to be beneficial by using patient’s natural support system. In a study, the support intervention was evaluated with friends recruited by the participants, as well as with teams of other three people whom the participants had not previously met. The results showed improved maintenance of weight loss for those recruited with friends than those who were not. The
study indicates that support from friends is more beneficial than support from previously unknown persons when used in conjunction with behavior therapy (Hogan, Linden & Najarian, 2000).

Mutual support may have significant impacts on long-term psychosocial and nursing interventions for both patients with severe mental illness and their families in community mental health care. From the 25 studies from 1985 to 2007 describing the review of mutual support groups for families of people with schizophrenia and other psychotic disorders, showed a consistent evidence of the immediate or short term positive effects of mutual support groups on the physical and psychosocial health conditions of patients and their families (Chien & Norman, 2009).

2.7.3 SUPPORT GROUPS FOR CONSUMERS
Self-help groups for persons with mental illness can offer an important source of support. Many psychosocial clubhouses offer support in addition to social, educational, and vocational opportunities. Some of the support groups available for consumers are:

• Depression and Bipolar Support Alliance 313/557-5773 in Michigan. For South Africa, there is South Africa Depression and Anxiety Group – Anonymous Helpline (011) 2626396, contact Cassey or SA Depression and Anxiety Support Group
  P.O. Box 652548
  Benmore
  2010
  Phone: 27 11 783 1474/6...Contact Lynda Woods. Website: www.anxietypanic.com/southafrica.html

• Self Help Association of Paraplegics at:
  314 Oxford Street
  East London
  5201.

• Schizophrenics Anonymous, Randburg, Gauteng Province.
2.7.4 RESOURCES FOR CARE

- **Mental health professionals**
  
  Any of the following may be involved in assessment and planning for treatment and care. Each has specific tasks but is also a part of the treatment team. The duties and responsibilities will vary in different agencies.

- **Psychiatrists**
  
  These are physicians (M.D. or D.O.) with specific training in psychiatry. They assess, make the diagnosis, and prescribe medications and possibly other treatment. They work with the treatment team to plan for care in the hospital and after discharge. They may provide psycho-therapy, either individually or with groups.

- **Psychologists**
  
  They are trained and licensed to diagnose and provide treatment services, especially “talk therapies” like psychotherapy, group therapy, cognitive behavioral therapy and family therapy. Masters' level psychologists often administer psychological tests or perform other duties similar to those described for psychiatric nurses and social workers (Ritchie & Lewis, 2003).

- **Psychiatric nurses**
  
  These nurses have specific training in psychiatry. They generally have major responsibility for direct care in the hospital, day treatment program, or Community Mental Health clinic. They also do individual or group counseling.

- **Social workers**
  
  Social workers with the individual, family and community in the context of the person's total life situation. They may offer individual or group counseling. The social worker ordinarily serves as liaison between the treating agency and the family.

- **Case managers**
  
  These are client services managers coordinate care and services in the community. They help their clients to receive needed treatment and services from a variety of community agencies. They assist in obtaining access to housing, rehabilitation services, and income programs such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). They generally work for Community Mental Health or an agency under contract to Community Mental Health. The term case manager is sometimes used interchangeably with social worker, although education, experience and responsibilities are somewhat different. Whatever the approach to be used the rights of the user to confidentiality are considered.
- **Community Mental Health Services Programs (CMHSPs)**

Because serious mental illness is likely to require treatment over a long period of time, or for an entire lifetime, most persons sooner or later use the services of their local Community Mental Health Services Programs. CMHSPs may be involved in the initial assessment, and will certainly be involved if treatment is involuntary. The entry point for services may be by appointment with an intake worker (social worker and/or psychiatrist), through crisis or psychiatric emergency services, through the commitment process, or by referral from a jail or homeless shelter.

Once a person is determined to be eligible for services, a case manager (client services manager) is ordinarily assigned to assist with such services as crisis intervention, medical diagnosis and treatment, income support, rehabilitation services, and sometimes counseling (therapy) and outreach services. CMHSPs may also offer residential and vocational services to eligible individuals. There may in addition be a family education program to provide support and information to family members (Nami Michigan, 2004).

Payment for Community Mental Health services is based on ability to pay. Parents are not ordinarily financially responsible for their children after they have reached the age of 18 years.

- **Hospitals**

A mental hospital is a medical institution specialising in providing in-patient care for psychological disorders, may also provide out-patient services for patients on therapeutic maintenance programme. Hospitals may be sought for emergencies, for voluntary hospitalization, or for involuntary hospitalization (Nicholas, 2008).

If the choice is private care rather than through Community Mental Health, there are several issues to consider which are as follows:

- The family can expect to have difficulty finding a private psychiatric hospital willing to accept involuntary admission. Most private psychiatric hospitals and licensed psychiatric units in general hospitals readily accept voluntary patients but are reluctant to admit individuals under a court order. All of the CMHSPs, however, have contractual arrangements in place with both state hospitals and some local general hospitals to provide both voluntary and involuntary inpatient treatment services.

- Private insurance may cover a short hospitalization. It is important to check carefully to see how much of the cost is covered; most policies have very limited coverage for psychiatric problems. A check must be made with one’s insurance company about continuing the son’s or daughter’s coverage after the age when coverage generally stops (usually 24). It may be possible to continue coverage past that age on a parent’s policy (Nicholas, 2008).
• Medical aid may cover hospitalisation. The Community Mental Health case manager can assist with applying for Medicaid.
• Community Mental Health may have crisis residential services which provide an alternative to hospitalization in an acute episode, thus avoiding commitment and hospitalization.
• Individuals being discharged from a hospital admission arranged by a community mental health services program will ordinarily have priority for services such as Assertive Community Treatment, specialised residential services and other support services. If medical or inpatient psychiatric hospital care has been privately arranged, these services may not be so readily available when it is time for the person to be discharged.
• Families that maintain contact and responsibility for their relative who is mentally ill are a vital part of the treatment team. They need to learn what is necessary to carry out their responsibilities, just as other caregivers do. As soon as possible after admission to the hospital, an appointment must be made with the treatment team to discuss the diagnosis, treatment plan, specific symptoms, and side effects to be watched. Instructions to the patient about medication, and frequency of the meetings between health care givers and patient family, and discharge plan will also be discussed (NAMI Michigan, 2004).

• **Ongoing treatment**

Serious mental illness is usually a long-term condition. Families should plan ahead even if they are fortunate enough to have to deal with only one or two episodes. Families who have lived with mental illness for a long time often describe how carried away they were at the time of the first episode and how they sometimes imprudently committed themselves to expensive treatments in expectation of a cure that was never to be realized.

What most individuals do need is medical diagnosis and treatment, a safe, stable place to live, and a chance to develop or relearn social and vocational skills. The best place to look for services over a long period of time is through your local Community Mental Health Services Program. If such services do not seem to be available, you may need to speak up, contact your county and state elected representatives, or even seek legal advice. Also contact one’s local support groups affiliate; it may be able to help. The ability of the person with mental illness to learn about his/her illness and to take responsibility for identifying and managing his/her symptoms is important in progressing toward recovery. An understanding of the mental illness, symptoms and treatment; social skills; and problem solving should be a part of both inpatient and outpatient care (Nami Michigan, 2004).
2.8 INDIVIDUALS WITH MENTAL ILLNESS IN THE COMMUNITY

- **Community mental health services**

Community Mental Health Services Programs (CMHSP) in other countries offer services based on ability to pay, but in South Africa the services are rendered free by the government. They often give priority for services (especially residential and outreach services) to persons being discharged from the hospital, but they also have responsibility for mentally ill people who have not been hospitalized. The CMHPS may be able to provide information about other community resources such as peer support groups, drop-in centers, or services for special populations. Services range from short term in-patient care, out-patient therapy, and emergency services based on crisis intervention to education and consultation with other healthcare agencies (Nicholas, 2008).

- **Housing**

All persons with mental illness have a right to safe, affordable, decent housing. All individuals should have some choice in where and with whom they will live. There is no issue that comes up more often among families of persons with mental illness than housing. Housing options that Community Mental Health may be able to assist in gaining access to include:

  - Community mental health group homes or community living facilities. Operators of these homes have a contract with the Community Mental Health Services Program (CMHPS). They offer group activities and rehabilitation services. They are generally considered transitional, and are often reserved for those being discharged from state hospitals, or from community hospitals under contract with CMHSP (Nami Michigan, 2004).
  - Fair-weather lodges. These are small group homes designed for a group of individuals who learn to live together, run a home cooperatively, and operate a business for profit with outside assistance as needed. Residents share chores such as cooking and maintenance of the home, and may also jointly operate a small business such as a shop or cleaning service.
  - Adult foster care homes

These homes are licensed by the Department of Social Services to provide 24 hour care and supervision of residents, but generally offer little in the way of planned activities or rehabilitation services. Cost is covered by SSI or SSDI payments.

  - Independent living with community mental health outreach services.

Residents may live separately in rooms or apartments, or may share an apartment with others. Intermittent supervision and outreach services are provided by Community Mental Health staff or
through an agency under contract to the Community Mental Health Services Program. Rental subsidies may be available through the federal Section 8 rental subsidy program. Relatives of the patient should contact their local housing authority for information.

- Independent living (alone or with family)

This arrangement is generally satisfactory only for persons who are fairly self-sufficient. If there is a Center for Independent Living in your community, they may be helpful with housing arrangements or in securing the assistance needed for independent living.

There are homes for the aged (62 years or over), licensed by the Department of Social Services, and the nursing homes which may admit persons who have mental illness if there are other medical problems as well, or if the diagnosis is dementia. The core of these arrangements is rehabilitation (Nami Michigan, 2004).

- **Rehabilitation**

Psychosocial rehabilitation programs should include the following: recreational opportunities, social skill training, employment-related training and assistance, and assistance toward independent living. Limited rehabilitation services are available through Community Mental Health Services Programs and some private hospitals (Uys et al, 2007).

- **Financial considerations**

In order for the relationships to improve, financial support is needed to relieve external burden from families in caring for the mentally ill at home in the community.

2.9 CONCLUSION

Having reviewed the literature pertinent to the study, knowledge regarding mental illness, family relationships, and effects of mental illness on relationships has been gained. Views of families regarding their relationships regarding mental illness has been covered by the scholarly. Coping strategies and mutual support systems, and resources for care are mentioned in the reviewed scholarship. It is therefore time to get to the fieldwork, to report how the study was conducted in relation with the approach, the methods, and the instruments used to collect data, the research setting and the ethics considered when conducting the study. This brings us to the methodology chapter.
CHAPTER 3. METHODOLOGY

3.1 INTRODUCTION

Permission to conduct the study was obtained by the researcher from the Directorate for Research and Epidemiology of the Department of Health in Bhisho. The authorities were informed of the research by making the research proposal available to them. The letter granting permission to conduct the study is made available in the appendices, together with the approval of the ethics committee of the institution where the study was conducted.

The purpose of the study is to enhance positive relationships between families and their mentally ill members, and to prevent a break-up in couples with the mentally ill partners, in both in-patient and out-patient basis. Another aim is to encourage the support of families and the community from which the patient belongs on the care, treatment, and rehabilitation of the mentally ill individuals.

A description of the specific techniques employed, specific measuring instruments utilized, and the specific series of activities conducted in making the measurements are provided in this section of the thesis. These include research paradigm, research design, research setting, population and sampling, data collection procedures, data analysis, and ethical considerations.

3.2 RESEARCH PARADIGM

The study follows a quantitative research approach. Quantitative research gathers information dealing with numbers and anything that is measurable. Tables, graphs and statistics are often used to present results of the study conducted using quantitative methods. The approach is relevant to the study since it is viewed as objective and relying heavily on statistics, whereas the qualitative one which is subjective and preferring description. Quantitative research approach is funded and commissioned by public bodies and businesses which use its methods and results in designing and developing their policies and practice. Even those who funded qualitative research approach make extensive use of quantitative data (Ritchie & Lewis, 2003).

3.3 RESEARCH DESIGN

The most relevant research design used in the study is a cross-sectional survey, in which information was gathered from the respondents, through the use of a questionnaire.

The study is designed to explore the nature of relationships between families and their mentally ill members that existed before and after the beginning of the mental illness. Cross-sectional studies are useful for evaluating relationships between exposures that are relatively fixed characteristics of
individuals such as sex and ethnicity and outcomes. In the study the relationships evaluated are those experienced by the family members and psychiatric patients before and after the onset of the mental problem (Joubert et al, 2007).

3.4 RESEARCH SETTING
According to the Urban Renewal Programme announced by former President Thabo Mbeki during the State of the Nation Address in 2001, aimed at speeding up service delivery and improving the quality of life of communities living in eight identified townships, Mdantsane was one of the nodes selected. It is situated at about 25km east of East London, and a vital part of the Buffalo City. The key of the programme according to Mdantsane Renewal Programme Overview (2009) was: “To fight poverty and underdevelopment through job creation, infrastructure development, and the stimulation of growth”.

Mdantsane, which is reputed as the second biggest township in South Africa after Soweto, has its roots in the apartheid era. It was located within an apartheid structure, which was then known as Ciskei. In the 1950’s the East London City Council undertook to move the majority of the black inhabitants of East and West Bank to a dormitory township, 25 km outside the city. The aim was to create a fully-fledged town, semi-autonomous but economically integrated into white urban areas. In 1962, 300 low cost homes were built near to a textile factory, which marked the birth of Mdantsane township. Between 1964 and 1970, thousands of families were resettled in Mdantsane, but the envisaged development into a city never materialized. In its place there was instead a growth in unemployment and poverty, along with violence and crime.

The township is divided into 18 zones, which are still expanding with the newest unit known as Unit P. The central market is in N. U. 2 (native unit 2 or zone 2), called “The Highway”. The majority of Mdantsane residents subsist below the living wage. According to Statistics South Africa, the area still has a very high unemployment rate. With the advent of the Mdantsane Urban Renewal there is a growing middle class in Mdantsane. The township now houses the second biggest shopping mall in the Eastern Cape, opened in 2008, known as Mdantsane City (Mdantsane Renewal Programme Overview 2009).

The study of this nature was never conducted in this area whereas the severity of problem discussed above is experienced a lot.
3.5 RESEARCH POPULATION

Study population is all visiting family members who have their mentally ill members admitted in the hospital wards of CMH mental health unit during the period of the study, from August to October 2009. Those not visited during the stated period, together with those missed by the research team in the same period are not studied /excluded from the study. The total number of visited patients during the specified period is 50, and only sixty per cent was intended to be studied.

3.6 SAMPLING TECHNIQUE

Sampling is defined as the process of selecting a portion of the population that has the same characteristics as the population from which they are selected, to represent the entire population. A sample viewed as the subset of the population and the entity that make up the samples and populations are elements. In nursing research, the elements are usually humans (Lippincott & Wilkins, 2006).

The sampling technique used by the researcher is convenient sampling. Convenient sampling is non-random, which means that the population elements have no equal chances of being selected to participate. Joubert & Ehrlich (2007) defined convenient sampling (also known as haphazard sampling) as referring to selection of people who are easily available to participate and will almost introduce bias.

3.6.1 CALCULATING THE SAMPLE SIZE

The description of the sampling plan which involves the justification of the sample size is empirical in the quantitative research approach. This is viewed as a technical matter since it involves the balancing of cost and access against the level of precision required in relation to the variability of the population on the characteristics being measured (Punch, 2006).

Out of 74 patients including both males and females in CMH mental health unit, 50 were visited regularly by their relatives in the period from August to October 2009. The researcher focused on the visited ones where the sample size comprising of 60% of the total population of 50 visited patients was agreed upon by the institution and the researcher to be studied. No funding was allocated for the study and the sample size was accepted by the university.
3.6.2 PROCEDURE FOR SELECTING PARTICIPANTS
The respondents were chosen conveniently when coming to visit their mentally ill members in the mental health units at Cecilia Makiwane hospital. Both male and female wards were studied. All the respondents in the study were aged 18 years and above. Aims of the study, methods to be used, participant’s rights, expected results and confidentiality of the study were explained to each subject encountered before being selected. Self administered questionnaires were distributed conveniently to the 30 consented families encountered by the researcher and the research team, during the period from August to October, 2009.

3.7 DATA COLLECTION INSTRUMENT
Questionnaires are used to collect the necessary data to the study. A questionnaire is a set of questions usually with a choice of answers written for a survey or statistical study, which indirectly measure the variable under investigation. They are cheap, easily distributed to the respondents, and are time-effective. (Joubert et al, 2007).

3.7.1 MEASUREMENT
The most important variable measured is the nature of relationships amongst families with the mentally ill members within. The relationships between families and the mentally ill are measured by the frequency of visits by families; hence the number of visits is also measured in the study. More visits according to the researcher suggest improved or good relationships between families and their mentally ill members, and a few visits show the existence of poor relationships. In a nutshell, 9 (nine) variables measured included:

- Ages and gender of families and patients,
- Number of visits by families,
- Length of stay of patients in hospital,
- Relationship (closeness) of family member to patient,
- Employment status of the relatives,
- Nature of relationships between patients and families before and after the occurrence of the mental illness.
- Acceptance of the mentally ill by their families and
The family perceptions about patient, that is, whether the patient is a threat or not to the community.

3.7.2 VALIDITY AND RELIABILITY
Piloting was done to test the validity and reliability of the research tool, by providing questionnaires to families with the mentally ill members utilising community psychiatric services, other than Cecilia Makiwane Hospital.

3.8 DATA COLLECTION PROCEDURE
The first step the researcher took when collecting data was the construction of questionnaires. During the construction pitfalls were identified and avoided. Close-ended types of questions were used in the questionnaire. These types of questions are easier to be answered, often more appropriate for sensitive questions, have much clearer meaning, easier to code and analyse, and their answering standards are clear and easier to compare (Mouton, 2006).

3.8.1 PRIOR DATA COLLECTION
The researcher and the research team informed the respondents about the purpose and nature of the investigation, the nature of the instrument to be used, and the types of response to be expected in order to obtain their consent. Anonymity and confidentiality were ensured to the participants. Voluntary consent, in the research project means that the prospective research participant has decided to take part in a study out of his or her own volition without coercion or any undue influence. Voluntary consent is obtained after the prospective participant has been given essential information about the study and has shown comprehension of this information. Therefore researchers should be more persuasive, not coercive when attempting to obtain consent from respondents (Burns et al, 2005).

3.8.2 DURING DATA COLLECTION
The researcher and his team kept continued contact with the subjects to ensure that their consent is still voluntary. They ensure that the subjects are still the willing participants and try to assist by interviewing groups in order to speed up the data collection procedure and reduce the amount of time the respondents has to take in responding to the questionnaires. The ultimate purpose is to
avoid harm therefore the researcher is normally expected to minimise risks and promote the well-being of participants (Haralambos & Holborn, 2008).

3.9 DATA ANALYSIS
Data analysis involves “breaking up” the data into manageable themes, patterns, trends and relationships, and the aim is to understand the various constitutive elements of one’s data through an inspection of the relationships between concepts, constructs or variables, and also to see whether there are any patterns or trends that can be identified or isolated or to establish themes in the data. Actual information desired by the investigator was gathered, using questionnaires that have been constructed, as unprocessed or raw data. The raw data are then categorized, scrutinized, cross-checked and interpreted. Tables, text and graphs are used to present systematic arrangement of data, and to organize findings (Mouton, 2006).

3.10 DATA MANAGEMENT
The format of the tables was well planned and has provided for all data relevant to the study. Results were integrated and report-writing was done. Based on the conclusions, the researcher made suggestions for future research that will provide more insight to the topic. To establish implications, the findings were then generalized as far as is appropriate to the investigation and suggested the meaning of the findings to the profession, administration and the faculty (Mouton, 2006).

3.11 LIMITATIONS OF THE STUDY
The researcher presented the study limitations by stating explicitly what is excluded and included in the study. Inclusion and exclusion criteria are mentioned

Inclusion criteria indicate that families should:
- consist of two or more members excluding the mentally ill member.
- have a family member who is a psychiatric in-patient admitted at Cecilia Makiwane hospital.
- be related to the psychiatric patient in terms of consanguinity, marriage, adoption, and/or long term relationship.
- be willing participants to the research.
- have verbal ability to answer questions meaningfully during the interview.
- be able to speak Xhosa or English.
- be encountered by one of research team members for interview in the period from August to October, 2009.

According to exclusion criteria the following conditions regarding the family are considered:

- Family is restricted only to the description in the study sample inclusion criteria.
- Family studied is only those who visited during the time of the study, those not visited at the same time are automatically excluded.
- No other wards except for the mental health utilized for the research in CMH.
- Other institutions that offer care, treatment and rehabilitation of psychiatric patients, such community psychiatric services are excluded from this study.

3.12 ETHICAL CONSIDERATIONS

It is the policy of the International Development Research Center that research work involving human subjects is carried out in accordance to high ethical standards.

The signature of the researcher on the Research Agreement signified that the recipient fully complies with the standards. The recipient shall immediately report to the Health Science Research Ethics Committee should there be any difficulties he encountered in complying with the ethical standards described below.

3.11.1 INFORMATION GATHERING

The recipient/researcher collected data using questionnaires. The recipient has agreed to comply with the principles aimed at protecting the dignity and privacy of every individual who, in the course of the research work carried out under the project has provided personal valuable information about him/herself or others, and are referred to as participants of the research. Such principles are as follows:

a) Before individuals became subjects of research they were notified of:

i. The aims, methods, anticipated benefits and potential hazards of the research.

ii. Their rights to abstain from participating in the research and their rights to terminate participation at any time.

iii. The confidential nature of their responses.
b) All individuals were given the notice in the preceding paragraph and they provided a free consent that they individually agreed to participate. No pressure or inducement of any kind was applied to encourage an individual to become a participant.

c) The identity of individuals from whom information is obtained in the course of the project is kept strictly confidential. At the conclusion of the project any information that reveals the identity of individuals who were participating in the research shall be destroyed unless the individual has consented in writing to its inclusion beforehand. No information revealing the identity of any individual is included in the final report on the dissertation.

3.12 CONCLUSION
The scenario of the fieldwork has been explained in the previous chapter, methodology. The research setting, population, sample and instrumentation used to conduct the study. Protection of research participants was also discussed. The following chapter on data analysis will extensively explain how data was converted to information, thorough description of the sample, and variables. Tables, figures, text, or a combination are used repeatedly to clarify relationships between variables.
CHAPTER FOUR: DATA ANALYSIS

4.1 INTRODUCTION
Data collected was then converted to information as it was processed through data analysis. Tables, graphs and text were used extensively to clarify relationships between variables. The description of the sample and variables, including association between variables are discussed in the data analysis chapter.

4.2 DESCRIPTION OF THE SAMPLE
Out of 74 patients including both males and females in CMH mental health unit, 50 were visited regularly by their relatives in the period from August to October 2009. The researcher focused on the visited ones.
From the total population of fifty, a sample of 30 (60%) relatives visiting these patients was selected conveniently, with a response rate of 96%; i.e. twenty-nine questionnaires were completed and returned. One questionnaire was not returned. The sample for the present analysis comprised of 18 female participants and 11 males, that is 62% and 38% consecutively. Visited patients comprised of 11 females and 18 males with percentages of 38 and 62 respectively. The mean and mode for each variable is identified. Text, tables and graphs are used to describe each variable measured.

4.3 DESCRIPTION OF VARIABLES
Variables measured in the study include ages of patients and relatives, gender, length of stay in hospital, frequency of visits by relatives, relationship to patient, nature of relationship that existed between patients and family members before and after the occurrence of the mental illness, perceptions of relatives about whether patients pose threat to their communities or not, and the employment status of the relatives.

4.3.1 AGES OF VISITED PATIENTS
Age range: 20 to 61
Mean: 38
Median: 20, 21, 21, 22, 25, 27, 27, 28, 29, 31, 33, 33, 34, 35, 40, 42, 44, 45, 45, 46, 48, 50, 51, 51, 52, 55, 57, 61, 72. The median is 40.

Mode: 21, 33, 45, 51. All these ages appear twice in the sample.

- **Frequency distribution**

Out of 29 studied families, the highest number of visited patients belongs to the adults (20 - 40), which constitute 52%, followed by the middle aged (41 – 59), constituting 41%, and the least being the aged, with 7% of the sample. According to high frequency of visits, that is, 4 to 5 times a month 61 adults are leading, followed by the middle aged and lastly, the old aged. This can be caused by loss of hope that the patient will never become mentally stable again. The more aged the patient is, the less visits by his/her family. **Key to the graph:** Y axis represents the frequency of visits in numbers per month, and X axis, is the age ranges of visited patients.

**Figure 1:** Frequency Distribution graph of patient ages and frequency of visits.
Figure 1 is the graphical presentation of the frequency of visits by families to different age groups of patients, clearly shown in the bar graph by different set of colours. The less frequent visits (1 – 3) are coloured blue and the more frequent (4 – 5) are red. The age group (41 -59) has the highest number of visits (less frequent), which is 9 in the bar graph and more frequent visits (4 – 5) of 3 times a month. Age group (20 – 40) has 8 less frequent and 7 more frequent visits. Sixty (60) and above age group has the least visits for both less and more frequent visits, with 2 in less frequent visits, and zero more frequent visits.

4.3.2 AGES OF VISITING FAMILY MEMBERS
Ages as per study: 68, 43, 58, 60, 46, 33, 50, 38, 52, 42, 63, 67, 52, 49, 50, 42, 40, 29, 60, 29, 31, 57, 35, 61, 67, 53, 48, 32, 45
Chronological order: 29 29 31 32 33 35 38 40 42 42 43 45 46 48 49 50 50 52 52 53 57 58 60 60 61 63 67 67 68.
Age range: 29 to 68
Mean: 48
Median: 49
Mode: 29, 42, 50, 60, 67. All these ages appear twice in the sample.

- Frequency Distribution of relatives’ ages.

Table 1: Shows the number ages of relatives visiting, together with the frequency of their visits.

<table>
<thead>
<tr>
<th>AGE RANGES</th>
<th>NO. OF RELATIVES</th>
<th>NO. OF VISITS IN ONE MONTH</th>
<th>FREQUENCY OF VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 - 40</td>
<td>8 (28%)</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>41 - 59</td>
<td>14 (48%)</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>60 and above</td>
<td>7 (24%)</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>29</td>
<td>19</td>
<td>10</td>
</tr>
</tbody>
</table>
Out of the 19 visits in the category 1 – 3, the middle aged relatives have 8 visits (42%), the highest percentage of visits, followed by the adults with 6 (32%) visits, and the old aged with the lowest visits of 5 or (26%). Out of 10 visits in 4 – 5 category (more frequent), the middle aged visitors are the most visiting with 6 (60%), followed by the adults and the old aged with equal visits (20%) each. According to total of visits, all ages visit more in 1 – 3 times category, and a few visits in 4 – 5 times a month. The most visiting age group encountered by the researcher during the period of the study irrespective of frequency is the middle aged family members.

**Figure 2:** Frequency Distribution of relatives’ ages in graphical presentation.
Key: X axis has three columns, number of relatives, less frequent visits (1 -3) and more frequent visits (4 – 5) times in a month. Y axis is the measurement in numbers.

Figure 2, shows the graphical presentation of family ages and their number and frequency of visits to their mentally ill members in an institution, by use of a bar graph. Adults are coded blue, middle aged family, red and the old aged with green colour. According to No. of relatives column in the graph, the middle aged families are the most visiting with 14 visits, followed by adults with 8 visits, and the old aged with 7 visits. In frequency of visits (1 – 3), middle aged families have highest visits of 8, followed by adults with 6 visits and the old aged with 5 visits. In more frequent visits (4 – 5), middle aged are still leading, followed by the adults and the old aged with the same number of 2 visits.
4.3.3 GENDER OF VISITED PATIENTS

Table 2: Showing percentage of visited patients, by looking at their gender during data collection time

<table>
<thead>
<tr>
<th>GENDER</th>
<th>NUMBER</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALES</td>
<td>18</td>
<td>62</td>
</tr>
<tr>
<td>FEMALES</td>
<td>11</td>
<td>38</td>
</tr>
</tbody>
</table>

TOTAL 29 100

Table 2 shows the gender of patients which are visited most by the researcher during data collection. Out of the 29 mentally ill members visited, 62% were males, and 38% were females. Males are therefore, more visited than females, with a difference of 24%.

Figure 3: A graphical presentation of families that visited their mentally ill members during the time the researcher was collecting data, looking at their gender.
Figure 3 illustrates graphically the number of visiting family members according to gender. As clearly indicated in the pie graph, females, which are labeled red in the graph, constitute more space than the male (blue) patients. Females are the most visiting gender than males.

4.3.4 RELATIONSHIPS

Figure 4 is the graphical presentation of number of visits of families to their mentally ill members according to family attachments or closeness of family relations. It is clearly indicated in the pie graph with different colour codes and percentages presenting attachments of families to patients.

The figure shows relationships of family to patient, looking at the number of visits in relation to the attachment and/or closeness of relationships between family members and patients. According to the illustration, the most visiting family is the female siblings of patients, with 34% visits, followed by mothers with 24%, brothers with 21%, fathers and grandmothers with 4% each, and lastly the extended family, uncles and nephews with 3% visits each.
4.3.5 EMPLOYMENT

**Table 3:** Shows how the employment/unemployment status of relatives affects their frequency of visits.

<table>
<thead>
<tr>
<th>EMPLOYMENT</th>
<th>NO. OF VISITS / MONTH</th>
<th>NO. OF VISIT / MONTH (4 – 5)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>8 (61%)</td>
<td>5 (39%)</td>
<td>13</td>
</tr>
<tr>
<td>NO</td>
<td>11 (68%)</td>
<td>5 (32%)</td>
<td>16</td>
</tr>
</tbody>
</table>

According to the table, out of 13 employed families, 61% visit less frequently (1 – 3), and 39% visits more frequently (4 – 5). The unemployed families have less frequent visits of 68% and more frequent visits of 32%.

**Figure 5** illustrates the number of visits, in category 1 to 3, by both the employed and unemployed family members.

Figure 5 shows less frequent (1 to 3 category) visits by employed and unemployed families. The unemployed are coloured red, have more space than the employed relatives (blue coloured) in the
pie graph. This is suggestive of the fact that unemployed workers are more visiting, with 11 (68%) visits while the employed constituted 8 (61%) visits. Generally, employment affects the frequency of visits to institutions by families whose members are treated for care, treatment and rehabilitation.

**Figure 6** shows more frequent visits in graphical presentation, using a pie graph. As illustrated in the graph, the unemployed families (red) and the employed families (blue) have equal number of visits.

There is no significant difference shown in this category (4 – 5), since both employed and unemployed families constituted the same number of visits.

4.3.6 FREQUENCY OF VISITS

No of visits according to the studied families : 3, 4, 1, 3, 1, 4, 2, 1, 1, 1, 2, 2, 4, 4, 4, 1, 4, 1, 1, 4, 4, 4, 1, 2, 2, 4.

Frequency Range: 1 to 4

Mean: 2

Median: 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 2, 2, 2, 2, 3, 3, 3, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4. The median is 2

Mode: 1. The number appears eleven (11) times in the sample.
- **Frequency distribution**

Figure 7, is the frequency distribution graph showing comparison between the length of stay in hospital and number of visits by relatives in one month. This is a graphical presentation of period of stay in years, in relation to the number of visits by relatives. The number of patients is indicated with a blue colour in the bar graph, less frequent visits (1 to 3) are red and more frequent visits are green.

![Figure 7](image)

**Measurement (numbers)**

**Length of stay (years)**

The figure shows that patients with less than one year stay in hospital have the highest number of visits by their families, followed by those with 2 to 5 years of institutionalization, 11 and above are the third, the last being those with 6 to 10 years of stay.
Table 4: Percentages of visits viewed in terms of length of stay of patients in hospital

<table>
<thead>
<tr>
<th>LENGTH OF STAY (in years)</th>
<th>NO. OF PATIENTS</th>
<th>NO. OF VISITS/MONTH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 - 3</td>
</tr>
<tr>
<td>Less than one year</td>
<td>11</td>
<td>4 (36%)</td>
</tr>
<tr>
<td>2-5</td>
<td>7</td>
<td>5 (71%)</td>
</tr>
<tr>
<td>6 - 10</td>
<td>5</td>
<td>4 (80%)</td>
</tr>
<tr>
<td>11 and above</td>
<td>6</td>
<td>5 (83%)</td>
</tr>
</tbody>
</table>

The percentages (%) for more frequent (4 to 5) and less frequent (1 to 3) visits are provided in each period of stay. According to the table those patients with very low period of stay are more frequently visited. The more the period of stay the less number of visits, this is clearly indicated in the most frequent (4 to 5) visits column.

4.3.7 NATURE OF RELATIONSHIPS PRIOR AND AFTER THE OCCURANCE OF THE MENTAL ILLNESS

Table 5: Table shows relationship between family and patient before and after the occurrence of the mental illness.

<table>
<thead>
<tr>
<th>NATURE OF RELATIONSHIPS BEFORE AND AFTER MENTAL ILLNESS</th>
<th>NO. OF RELATIVES</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good to bad</td>
<td>14</td>
<td>48</td>
</tr>
<tr>
<td>Bad to good</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>No change</td>
<td>14</td>
<td>48</td>
</tr>
<tr>
<td>TOTAL</td>
<td>29</td>
<td>100</td>
</tr>
</tbody>
</table>
Figure 8, a pie graph presenting the type of relationships that existed between family members and the mentally ill before and after the mental illness took place.

![Pie chart showing relationships]

Figure 8 illustrates graphically the nature of relationships between family member and the patient before and after the illness. Purple colour presents those who saw no change in relationships, red is for those viewed a change from good relationship before illness to bad relationship after illness. Green is for the opposite, those who saw a change from bad before illness to good after illness, which is viewed as not a true by the researcher.

4.3.8 PERCEPTIONS BY RELATIVES WHETHER PATIENTS ARE A DANGER TO THE COMMUNITY OR NOT

Table 6: Shows perceptions of relatives about their mentally ill members, viewing whether patients are threats to other people’s lives while in the community, or not.

<table>
<thead>
<tr>
<th>PERCEPTION OF RELATIVES ABOUT PATIENTS</th>
<th>NUMBER OF RELATIVES</th>
<th>PERCENTAGE (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threat</td>
<td>12</td>
<td>41</td>
</tr>
<tr>
<td>No threat</td>
<td>17</td>
<td>59</td>
</tr>
</tbody>
</table>
According to the table, those relatives who viewed patients as not threat to the lives of other people have the high percentage of 59%, and those not viewing them as threat, are 41%.

**Figure 9** shows graphical relationships that existed between family members and the mentally ill before and after the mental illness took place.

Figure 9 is a bar graph presenting the number of relatives who view patients as not a threat to the community and those who view them as a threat. The red colour denotes relatives who do not view patients as threat to the community, and blue colour indicates those who view patients as a threat.
4.4 COMPARISON BETWEEN PATIENT AGES AND THE NUMBER OF VISITS

Table 7: Age of patients compared to frequency of visits by their relatives.

<table>
<thead>
<tr>
<th>AGE RANGE (in years)</th>
<th>NO. OF VISITS / MONTH (1 – 3)</th>
<th>NO. OF VISIT / MONTH (4 – 5)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – 34</td>
<td>7 (54%)</td>
<td>6 (36%)</td>
<td>13 (45%)</td>
</tr>
<tr>
<td>35 – 59</td>
<td>10 (71%)</td>
<td>4 (29%)</td>
<td>14 (48%)</td>
</tr>
<tr>
<td>60 and above</td>
<td>2 (100%)</td>
<td>0 (0%)</td>
<td>2 (7%)</td>
</tr>
</tbody>
</table>

In the total column of table 7 it is clearly indicated that, out of 29 patients visited, the most visited age groups of patients are the adults and the middle aged, with 45% and 48% of visits respectively. The old aged patients are the least visited, with only 7% of visits. It is clear that the more aged the patient the less number of visits by the family, can be due to fact that relatives have given up hope that the aged patients can be functioning well again.

4.5 SIGNIFICANCE TESTING

A chi-square test is used to test if the two variables are related or not, namely the perceptions of families regarding patients in relation to the family gender, in other words, to see if gender of the family members affects their perceptions about whether mentally ill members pose a threat to the community or not. Table 6 has showed the numerical values, where the number of visits by both male and female family members are clearly tabulated. Table 6 is modified to the table below, table 8 to indicate the numerical value as required in the chi-square formula, as follows:
Table 8 shows family gender and perceptions of families whether patient are threat to the community or not.

<table>
<thead>
<tr>
<th>PATIENTS ARE A THREAT TO THE COMMUNITY</th>
<th>MALES</th>
<th>FEMALES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>5</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>NO</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11</td>
<td>18</td>
<td>29</td>
</tr>
</tbody>
</table>

The researcher calculated the chi square test using the numerical values in table. For a 2 x 2 contingency table the Chi Square($X^2$) statistic is calculated by the formula:

\[
X^2 = \frac{(5 \times 11) - (6 \times 7))^2 \times 29}{(11 \times 18 \times X12 \times X17)}
\]

\[
= (55 - 42)^2 \times 29 \div 40392
\]

\[
= 4901 \div 40392
\]

\[
= 0.121
\]

Before we can proceed we need to know how many degrees of freedom (Df) we have. Degree of freedom is equal (number of columns minus one) x (number of rows minus one) not counting the totals for rows or columns. For this data it gives (2-1) x (2-1) = 1, therefore, Df = 1. Chi-square tests produce a p value. If the p value is less than the predetermined alpha level of significance (0.05) or 5%, it means there is a small probability that the difference in the results has occurred by chance, and they are real, if large they are by chance and unreal. A chi-square distribution table is used to read the actual p value. Table 9, chi-square distribution table.

(Probability alpha)

<table>
<thead>
<tr>
<th>Df</th>
<th>0.5</th>
<th>0.10</th>
<th>0.05</th>
<th>0.02</th>
<th>0.01</th>
<th>0.001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0.455</td>
<td>2.706</td>
<td>3.841</td>
<td>5.412</td>
<td>6.635</td>
<td>10.827</td>
</tr>
<tr>
<td>2</td>
<td>1.386</td>
<td>4.605</td>
<td>5.991</td>
<td>7.824</td>
<td>9.210</td>
<td>13.815</td>
</tr>
</tbody>
</table>
By entering the Chi square distribution table with 1 degree of freedom and reading along the row we find our value of $x^2 (0.121)$ lies at 2.706. The p value is therefore 2.706. This is above the conventionally accepted significance level of 0.05 or 5%, so the null hypothesis that the two distributions are the same is not verified. In other words, there is no statistical significance difference between the perceptions of families about their mentally ill members and their gender. In other words the perceptions of families about the mentally ill are not related or associated with their own gender.

4.6 CONCLUSION
Data has been already analysed, sample and variables discussed. The interrelation between some of the variables is discussed. The significance testing was done using the chi-square test. The chi-square showed that the perceptions of families about their mentally ill members have nothing to do with their gender. The information has been gathered and further discussion and recommendations needs to be made with the information, hence the following chapter.
CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

5.1 INTRODUCTION
The sample meant to be studied was 30 participants but only 29 questionnaires returned the other one decided to withdraw from the study for unspecified reasons. Out of 29 families 18 were females and 11 were males, and the patients that were visited were 18 males and 11 females.

This is the final chapter, where results are discussed, comparison between literature reviewed and the findings of the study will be linked to see if there is similarity or difference existing. Recommendations if available will be made in the chapter. The discussion of the results is aligned with the research objectives. Results will also be checked if they accommodate answers posed by the research questions.

5.2 DISCUSSION OF RESEARCH RESULTS
The researcher investigated by reading documents of records of family visits at the institution where the study was conducted. The records at the time of the study showed a total of 74 patients including both males and females, where only 50 patients had regular visits from relatives. 24 patients were not visited by their relatives. That is 67% are visited and 23% of in-patients are not visited.

Therefore 23% of in-patients are neglected by their relatives.

Table 1 show the frequency of visits which are categorised from one to three visits, and four to five visits in one month. The study results showed that only 34% of high frequency visits and a 66% of low frequency visits. This s suggestive of poor relationships hence only a 34% of relatives that are visiting more frequently, and a larger portion of 66% that has a difference of 32% is unwilling to visit, according to the results. A breakdown in family relationships is evident in this case where the number of unwilling families nearly doubled up that of those willing to visit. It means nearly half of the sample, if not, counting the questionnaire that was not returned or the participant that withdrew from the study, broke their relationship with their families due to mental illness or stigma attached to the. This is confirmed in the Malaysian study by where relatives feel embarrassed about their mentally ill and end up detaching themselves from social activities with friends, fearing the stigmatization of their families.
The nature of relationships existed before and after the onset of the mental illness is showed clearly in table 5 and figure 8 which shows 48% relatives voted for a good to bad, 4% for the opposite, that is, bad to good, and another 48% who experienced no change. Again if we were to gain that one vote it should have been very clear that bad relationships existed between families and their mentally ill members. If those who voted neutrally were ignored it will be clear that the researcher’s hypothesis that mental illness causes breakdown in family relationships, is confirmed by the findings. If the neutral voters can be interpreted as not responded to the question, it should have been 86% of relatives who have been brave enough to divulge their true feelings about their relationships with the mentally ill members. The researcher in this instance suspected that most families felt the question as sensitive though did not want to say so, thinking that they will disown their mentally ill should they say they are not satisfied with their relationship despite the researcher and the team’s continued support. The scholarly reviewed confirmed the researcher’s findings. A study where perceptions of families regarding relocation of patients to community based care were sought, 53% of families were against the relocation worrying about the emotional and financial burden that will be put on them after the relocation. Results from a study by Francell et al (2002) where eighty-six care givers were interviewed regarding their perceptions of burden care for chronic mentally ill relatives also confirms the researcher’s findings.

The research questions posed are accommodated in the results, which requested views of families with mentally ill members regarding the effects of mental illness on their relationships, and the nature of relationships that existed before and after the onset of the mental illness are also mentioned by the results of the study.

According to a study on family coping with the mentally ill by William Doll, where 125 families were studied to determine the effect of the current movement (de-institutionalization) toward returning mental patients to their homes, confirms the need for enhanced family relationships with patients will facilitate the process and keeps patients in the community with their families. From interviews with and attitudinal tests of those families, he reports that they will generally care for the former patient in their home, often with little shame or embarrassment, and usually without re-hospitalizing him. But the former patient's presence, especially when severe psychotic symptoms persist, often puts heavy emotional and social strains on the families. He warns that although
families accept the physical presence of the patients, the accompanying social rejection could have serious consequences for the community mental health movement. Researchers and clinicians have noted that although personal relationships are important to women with mental illness, they often have difficulty establishing support networks and maintaining family relationships. Relationships can be both a buffer against stress and a source of competence, especially if women are able to give to others in return. Ritsher and colleagues reported that women with mental illness maintained some mutual relationships despite the negative impact of their illness on their ability to participate fully in these relationships. Fifty-five percent of the women in their study had at least one family member who was supportive, and 61 percent felt that they were a fully accepted member of their family (Nicholson, Sweeney & Geller, 2009). The studies confirm the importance of family relationships when families are having a mentally ill member as the most supportive care giver. Without family, patient will experience difficulty in getting along with the entire community members. A need to mobilize families in caring for the mentally ill members is vital especially when de-institutionalization is in process.

5.3 RECOMMENDATIONS
Recommendations include involvement of families in the care, treatment and rehabilitation of their mentally ill members, mobilizing families to engage themselves in local self-help and/or support groups to gain relevant knowledge they seek about mental illness. Families are advised to follow the guidelines or coping strategies mentioned in the first chapter of the thesis. Results will be disseminated to policymakers in mental health institution so that they can encourage community involvement in mental health activities and/or programmes. Tertiary learning institutions such as universities and colleges will be provided with the results for learning purposes. Data will also be stored in university libraries to enable further research in the same or similar future studies.

5.4 CONCLUSION
Mental health disorders are a common occurrence in Mdantsane, and affect people of all ages, gender and socio-economic status. Mental health problems and illnesses can have a considerable effect on families and relationships, with issues such as a lack of diagnosis, treatment use and efficacy, chronicity and propensity all impacting on a family’s experience of mental illness. Likewise, relationship and family problems can have a significant impact on mental health. Both
living with and/or caring for someone under these circumstances not only impacts on the well being of the person with the illness, but on those around them.

From the results of the data and relevant literature reviewed, it is evident that mental illness is the cause of the observed breakdown of relationships between families and their mentally ill members. In order to ensure that relationships between families and the mentally ill are enhanced, the involvement of families in the care, treatment and rehabilitation process of the mentally ill needs to be maintained at all times. In their response to the current study, approximately 100% of families needed assistance to care for their mentally ill members in their homes and communities. The fact that families, as in Spain, are the primary care givers for seriously mentally ill family members cannot be escaped.

As mentioned earlier in the study, tremendous tasks by mental health professionals to establish family contacts for the inpatients who are not visited for an extended period of time, is halted by relatives who do not provide support in the caring of the mentally ill whilst with them. This is due to lack of knowledge about mental health and ill health. According to the results, Mdantsane residents apart from poverty struck, they have additional burden of mental health problems in their families. The area needs more health intervention strategies to mobilize families, make them aware of mental health and ill health. Health institutions need to involve community members in mental health awareness programmes, and encourage their active participation. Self-help groups, such as Schizophrenia Anonymous, local National Alliance for the Mentally Ill (NAMI) and others should be made available and operate involving community members. The reason for their forced existence and their importance should be clearly understood by the community.
LIST OF REFERENCES


JOURNAL ARTICLES


**WEB RESOURCES**


Mdantsane Renewal Programme Overview” [article selected on line] Retrieved November 10, 2009 from World Wide Web: http://www.google.co.za/


National Schizophrenic Company, Rethink Relationship [Article selected on line]. Accessed April, 28, 2009 from World Wide Web: http://www.google.co.uk/

http://www.psychservices.psychiatryonline.org/cgi/content/abstract/49/5/643


APPENDIX A: QUESTIONNAIRE

QUESTIONNAIRE

PATIENT PARTICULARS

AGE (in years)
GENDER
LENGTH OF STAY

1. State your age in years below.

2. What is your gender? Tick relevant box below

   MALE  FEMALE

3. Do you need assistance in relating with the mentally ill?

   YES  NO

4. LIVING CONDITIONS

   4.1 Do you live in the same household with the mentally ill member?

       YES  NO

   4.2 If NO state location of your place of residence. Tick relevant area below.

       Within local area  Outside local area  Another province

   4.3 What are the reasons for not staying with the mentally ill?

       ……………………………………………………………………………………………

   5. State your relationship with the mentally ill member. Tick relevant box below.

       SPOUSE  PARENT  SIBLING  GRAND-PARENTS

       Other (specify)……………………………………………………………………
6. EMPLOYMENT
6.1 Are you currently employed?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

6.2 If YES and working afar, do you have enough off duty time to visit the patient?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

6.3 Explain……………………………………………………………………………………………………………………

7. How often do you visit the patient in one month? Tick the relevant number of days.

<table>
<thead>
<tr>
<th>Once</th>
<th>Twice</th>
<th>Three times</th>
<th>Four times</th>
<th>Five times</th>
<th>Other</th>
</tr>
</thead>
</table>

OTHER (specify)………………………………………………………………………………………………………………

8. When you request leave of absence, for how long do you prefer the patient to stay at home? Tick relevant box below.

<table>
<thead>
<tr>
<th>2 weeks</th>
<th>One month</th>
<th>Three months</th>
</tr>
</thead>
</table>

OTHER (specify)………………………………………………………………………………………………………………

9. Briefly describe your relationship with the person before he/she became mentally unwell?

…………………………………………………………………………………………………………………………………………

10. Do other family members accept patient in the family despite illness?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

OTHER (specify)………………………………………………………………………………………………………………

11. SAFETY
11.1 Do you think the patient is a danger to any member of your family or the
community?

YES  NO

State briefly the reason(s) why you respond to the above

…………………………………………………………………………………………
………………………………………………………………………………………

12. You are alone with the patient at home following an authorized leave of absence. Without any cause the patient shouts at you, uses abusive language and eventually threatens to beat you up. How will you react in this scenario?

Would you talk nicely to patient and try to find the cause of the behavior?

YES  NO

OTHER (specify)………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

13. INTERACTION

13.1 Are there other things that are too difficult to talk about with the patient?

YES  NO

13.2 If YES, give a short description.

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

14. Is there anything more you want to say about this topic? Explain

………………………………………………………………………………………………
………………………………………………………………………………………………
………………………………………………………………………………………………

15. How would you rate the overall quality of your relationship with the patient after the occurrence of the mental illness? Would you say it is?

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>Fair</td>
</tr>
</tbody>
</table>

OTHER (specify)………………………………………………………………………………
…………………………………………………………………………………………

THANK YOU FOR ANSWERING MY QUESTIONS
APPENDIX B: REQUEST FOR PARTICIPANTS

Telephone 0437224372
Cell no 0726722273

Department of Health Sciences
Nursing Department
University of Fort Hare
East London Branch
14 May 2009

To Whom It May Concern

A LETTER REQUESTING PARTICIPANTS IN A STUDY

I am Mfanisi Welcome Magadla from the University of Fort Hare, and I am looking for volunteers to participate in a study about the effects of mental illness on relationships amongst families with the mentally ill members within.

I am responsible for the study. The purpose is to improve social relationships between families and their mentally ill members, to prevent a break-up in couples with the mentally ill partners, and to help families and the community gain positive knowledge about mental illness and the mentally ill individuals. The study will take place in Cecilia Makiwane Hospital specifically on the wards treating the mentally ill patients.

The study will be conducted with the use of questionnaires and it will take not more than thirty (30) minutes to complete. After my study has been completed the data will be stored permanently in a less frequently used medium in a computer system for research and teaching purposes. The names of the participants will not be mentioned in research reports. Data containing identifiers will be stored at an archive which imposes strict condition on the reuse of the data. No potential risk anticipated with the project. Any interested individual is free to participate. As a participant you have the right to abstain from participating in the research if you encounter any discomforts caused by the study.

You also have the right to terminate your participation at any time during the research process. Those volunteering will be provided with the consent form in addition to this letter to sign. Time will be allowed for the volunteers to take the material home and discuss participation, if desired, with family or friends. If after this process, the person remains willing to participate he/she must sign the informed consent. Any queries regarding the study please contact me with details above. Your participation in this regard will be highly appreciated.

Yours truly,

…………......
Magadla M.W. (Mr.)
CONSENT TO PARTICIPATE IN THE STUDY ON THE EFFECTS OF MENTAL ILLNESS ON RELATIONSHIPS AMONG FAMILIES WITH THE MENTALLY ILL MEMBERS

You are invited to participate in a research study conducted by Mr. M.W. Magadla, from the University of Fort Hare [Department of Health Sciences]. I hope to learn whether mental illness is the cause of the breakdown in relationships between families and their mentally ill members, or not.

You were selected as a possible participant in this study because you came visiting the wards at the same time when the researcher was visiting the wards looking for participants at the right place where the study is conducted.

If you decide to participate you will be provided with a questionnaire to complete as truthfully as you can. The purpose of the study is to improve social relationships between families and their mentally ill members, and also to help the family to cope, understand and handle their mentally ill members in an acceptable way. It will take thirty (30minutes) and less to complete the straightforward questions. This is not a sensitive topic and therefore no possible risks are anticipated with the study. However I cannot guarantee that you personally will receive any benefits from this research.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential. It will be disclosed only on your permission or as required by law. Subject identities will be kept confidential, by using codes instead of names, anything that can link the codes to the names will be removed, and the codes will be separated from the names of participants. Pseudonyms will be used in cases where needed instead of subject names.

Your participation is voluntary. Your decision whether or not to participate will not affect your relationship with me, or the university. If you agree to participate, you are free to withdraw your consent and discontinue participation at any time without penalty. If you have any question about the study, please feel free to contact my supervisor, Mrs. NIN Magadla at 0437224372, University of Fort Hare. If you have questions regarding your rights as a research subject, please contact the International Review Board in this e-mail address (IRB at up.edu). You will be offered a copy of this form to keep.

Your signature indicates that you have read and that you understand the information given above, that you willingly agree to participate, that you may withdraw your consent at any time and discontinue participation without penalty, that you will receive a copy of this form, and that you are not waiving any legal claims.

SIGNATURE DATE

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APPENDIX D: REQUEST FOR PERMISSION FROM D.O.H.

University of Fort Hare
Department of Health Sciences
East London
5200
14 May 2009

The Directorate for Research and Epidemiology
Department of Health
Bhisho

Dear Sir/Madam

APPLICATION FOR PERMISSION TO CONDUCT A STUDY

I, Mfanisi Welcome Magadla, student no. 9330941, hereby request permission to conduct a study on the effects of mental illness on relationships amongst families with the mentally ill members at Cecilia Makiwane Hospital in the units that treat mentally unstable individuals.

I am employed by the department of health as a professional nurse at East London Hospital Complex (Frere Hospital). I am doing post-graduate studies towards a Master’s Degree (Advanced Psychiatry) at the University of Fort Hare, East London Branch. This study is a requirement for completion of my studies.

Please find attached to this letter a copy of my research proposal, questionnaire, and the consent form.

Yours truly,

…………….
Magadla M.W (Mr.)
APPENDIX E: REQUEST PERMISSION FROM INSTITUTION

31131 St. Marry Location
Newlands
East London
5201
05 August 2009

The Chief Executive Officer
Frere Hospital
Amalinda

Dear Sir

RE: Masters student research project

I, Mfanisi Welcome Magadla, am a post graduate Mcur student of the University of Fort Hare. As part of the requirements for the degree, I have to complete a research project.

The title of the study is, ‘Effects of mental illness on relationships amongst family members’

The study will be done in Cecilia Makiwane Hospital specifically on the wards treating mentally ill patients.

The aim of the study is to improve social relationships between families and their mentally ill members, prevent a break-up in couples with the mentally ill partners, and to help families and the community gain positive knowledge about mental illness and the mentally ill individuals.

The study protocol has been forwarded to the Epidemiological Research & Surveillance Management office in Bhisho for approval. Attached is the original copy of the Eastern Cape Department of Health letter giving me permission to conduct the study.

Would you kindly give permission to this study at the above-mentioned hospital wards?

Thank you,

Yours sincerely

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Magadla M. W. (Mr.)
Application for clearance from the University of Fort Hare's Ethics Committee

Project Title: Effects of Mental illness on relationships among families with the mentally ill members.

Chief Researcher: Mr. Mfanisi Welcome Magadla
Supervisor/co-supervisor: Mrs. NIN Magadla/ Dr Tshotsho
Date of application: 29 May 2009

Having consulted the Dean of Research, I hereby grant permission to conduct the research.

[Signature]

Professor J R Midgley
Deputy Vice-Chancellor
Chairperson of the interim Ethics Committee

30 August, 2009
30 March 2010

Mr MW Magadla
East London Health Complex
East London
5200

Dear Mr Magadla

RE: Research Proposal in preparation of a research project with the following proposed detail: Effects of mental illness on relationships amongst family members.

We acknowledge receipt of the above mentioned proposal.

Having gone through your proposal, the committee has no ethical problems noted.

Please be advised that the committee has granted you the consent to do the research.

Yours sincerely

[Signature]

Dr P Alexander – Chairman Region C Ethics Committee
Ophthalmologist EL Hospital Complex