Strengths of families to limit relapse in mentally ill family members

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DEDICATION

I would like to dedicate this study to my late father Mr. Marcus Marekwa Mototo who passed away while I was busy analyzing data. He was a source of inspiration, may his soul rest in peace.

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I thank God Almighty who gave me life and restored my health when I was very ill. He is the source of strength and I trust Him so much because He has shown His love and mercy throughout the years.

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SUMMARY

Studies have indicated that relapse is noted as a major problem facing mental health services both nationally and internationally whereby family members caring for mental health care users experience a serious burden. Factors commonly associated with relapse include poor adherence to treatment, substance abuse, co-morbid psychiatric illness, a co-morbid medical and or surgical condition, stressful life events and the treatment setting. Relapse prevention strategies have been identified and they include, empowering people with mental illness to recognize early warning signs of relapse in order to develop appropriate response plans as well as communication and understanding between the mentally ill person, their family, and specialist mental health system and community support services.

The researcher was prompted by the problem of relapse faced by mental health services to explore and describe the strengths of families in assisting mental health care users to limit relapse and to formulate guidelines for psychiatric nurses to empower family members caring for mental health care users to limit relapse.

A phenomenological design was used in this study and a purposive sampling technique was used to select participants who met the selection criteria. In-depth individual interviews were conducted with 15 family members. All interviews were recorded with an audio recorder after participants gave consent. Data saturation was achieved after 13 participants were interviewed and further two interviews confirmed data saturation. Field notes were written immediately after each interview. Data analysis was done according to Tesch as quoted by Creswell (2007:187) and the researcher and co-analyzer reached consensus on the themes in a meeting.

The findings of research resulted in four main categories namely, accepting the condition of a mentally ill family member, having faith in God, involving a mentally ill family member in daily activities and being aware of what aggravates the mentally ill family member.
The conclusion that can be made is that “acceptance through education” assisted family members in developing a positive attitude and acceptance of their feelings as well as the condition of their mentally ill family members. A strong spiritual base provides family members with strength and hope in times of adversity and teaches them how to have healthy relationships within the family unit and with others. It is also evident that sharing activities, as the things that all members of the family do together, reinforce and strengthen their togetherness and that if family members can be aware of what aggravates mentally ill family members by communicating well with them, that can bring harmony in families and ultimately limit relapse.

Recommendations in this research are made for nursing education, nursing research and psychiatric nursing practice with guidelines for psychiatric nurses to empower families caring for mentally ill family members to use their strengths and contribute to limiting relapse.

[Key concepts: Family strengths, relapse, mentally ill family member, family members caring for mentally ill]
OPSOMMING

Navorsing het aangetoon dat terugval of insinking aangeteken is as 'n major probleem in geestesgesondheidsdienste, nasionale sowel as internasionale, waardeur gesinslede wat na 'n geestesgesondheidsorggebruiker omsien 'n ernstige las beleef. Fakte wat algemeen van toepassing is rondom terugval is: 'n lae vlak van meegaandheid met behandeling, substansmisbruik, komorbiditeit geestesongesteldheid, komorbiditeit mediese of sjirurgiese toestand, stres en lewensdruk, en die omgewing waar behandeling verkry word. Terugvalvoorkomingstrategieë is geïdentifiseer en sluit in: bemagtig geestesongestelde persone om vroeë simptome en tekens wat aanleiding gee tot insinking te herken om toepaslike voorkomingsmaatreëls in werking te stel; sowel as kommunikasie en begrip tussen die betrokke pasiënt, familielede en die spesialis geestesgesondheidsisteem en gemeenskapsondersteunende dienste.

Die probleem van terugval soos beleef deur geestesgesondheidsdienste het die navorser aangespoor om die sterktes van gesinne om geestesgesondheidsorggebruikers by te staan om terugval te beperk te verken en beskryf; en om riglyne vir psigiatriese verpleegkundiges te formuleer om gesinslede wat geestesgesondheidsorggebruikers versorg te bemagtig om terugval te voorkom.

'N Fenomenologiese ontwerp is gebruik in hierdie studie en 'n doelgerigte steekproeftegniek was gebruik om deelnemers wat aan die keuringskriteria voldoen het, te kies. In-diepte individuele onderhoud is met 15 gesinslede gevoer. Alle onderhoud is opgeneem met 'n klankopnemer nadat deelnemers toestemming verleen het. Dataversadiging is bereik nadat onderhoud met 13 deelnemers gevoer is, en 'n verdere twee onderhoud het dataversadiging bevestig. Veldnotas is onmiddellik na elke onderhoud geneem. Data analyse is volgens Tesch (soos aangehaal deur Creswell, 2007:187) gedoen. Die navorser en die mede-kodeerder het gedurende 'n gesprek konsensus bereik rondom die temas.

Die bevinding van die navorsing het tot vier hoof kategorieë geleë: aanvaar die toestand van die geestesongestelde gesinslid, geloof in God, betrek die
geestesongestelde gesinslid in daaglikse aktiwiteite en om bewus te wees van dit wat die geestesongestelde gesinslid ontstel.

Die gevolgtrekking is dat “aanvaarding deur opvoeding” familielede gehelp het om ‘n positiewe houding te ontwikkel en om hulle gevoelens, sowel as die toestand van die geestesongestelde gesinslid, te aanvaar. ‘n Sterk geestelike fondasie voorsien gesinne van sterkte en hoop in moeilike tye en leer hul hoe om gesonde verhoudings binne die gesinseenheid en met andere te behou. Dit was ook duidelijk dat gesamentlike aktiwiteite die gesin se samesyn versterk, en dat indien gesinslede bewus is van wat die geestesongestelde gesinslid ontstel deur middel van goeie kommunikasie, dit harmonie kan meebring en uiteindelik terugval beperk.

Aanbevelings in hierdie navorsing word gemaak vir verpleegonderrig, verpleegnavorsing en psigiatriese verpleegpraktyk met riglyne vir psigiatriese verpleegkundiges om gesinne wat geestesongestelde gesinslede versorg te bemagtig om hul sterktes te benut en by te dra tot die beperking van terugval.

[Sleutelkonsepte: Gesinsterktes, terugval of insinking, geestesongestelde gesinslid, gesinslede wat ‘n geestesongestelde gesinslid versorg]
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CHAPTER 1: OVERVIEW OF THE RESEARCH

1.1. INTRODUCTION AND PROBLEM STATEMENT

The World Health Organization (WHO) defines mental health as a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2001:1). WHO further defines mental illness as an impairment of an individual’s normal cognitive, emotional or behavioral functioning which can be caused by social, psychological, biochemical, genetic or other factors such as infection or head trauma. The World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview (WMH-CIDI) has been used since 1990 to measure the prevalence of mental illness internationally. The WMH-CIDI was developed by the WHO with the aim of obtaining valid information about the prevalence and correlation of mental disorders, treatment adequacy among patients for mental disorders and the societal burden of mental disorders (Kessler & Ustun, 2000:93).

The survey, conducted in six developing countries and eight developed countries, revealed that the prevalence of mental disorders during the previous year varied widely from low rates of 4.3% in China and 4.6% in Nigeria to the highest rate of 26.4% in the United States of America. The results also indicated that 35.5 – 50.3% of serious cases of mental disorders in developed countries and 76.3 – 85.4% in less developed countries received no treatment in the 12 months prior to the survey (WHO World Mental Health Survey Consortium, 2004:2581). The survey conducted in South Africa revealed that the lifetime prevalence for any disorder was 30.3%; 11.2% of respondents had two or more lifetime disorders and 3.5% had three or more lifetime disorders. The most prevalent class of lifetime disorders was identified as anxiety disorders (15.8%), followed by substance use disorders (13.3%) and mood disorders (9.8%). The most
prevalent individual lifetime disorders were alcohol abuse (11.4%), major depressive disorder (9.8%) and agoraphobia without panic (9.8%) (Herman et al., 2009:340).

The prevalence of mental illness as indicated in the survey raises a very serious challenge to mental health services. In order to ensure optimal mental health services, these services should be regulated (WHO World Mental Health Survey Consortium, 2004:2581). Mental health services in South Africa are regulated by the Mental Health Care Act (17/2002) (SA, 2002). Chapter IV of the Mental Health Care Act (17/2002) explains clearly how mental health care users should be admitted in a health establishment. Families of mental health care users play an important role in terms of the admission procedure in a health establishment. Application for assisted or involuntary care, treatment and rehabilitation of mental health care users may only be made by the spouse, next of kin, partner, associate, parent or guardian (SA, 2002). Following an application by a family member, a mental health care user will then be assessed by health care practitioners who will determine whether such mental health care user should receive care, treatment and rehabilitation as an inpatient or outpatient in a health establishment. After receiving care, treatment and rehabilitation as an inpatient, the mental health care user will either be given leave of absence, transferred from inpatient to outpatient or be discharged. Families of mental health care users play an important role by taking care of them at home after being discharged from health establishment (SA, 2002). According to Berglund et al. (2003:119), caring for mental health care users can be a burden to the family, while lack of support by families can lead to their relapse. Relapse is noted as a major problem facing mental health services both nationally and internationally (Kazadi et al., 2008:52). There are early signs of relapse which carers of mental health care users should recognize. According to Burton (2012:1) the early signs and symptoms of relapse may differ from one person to another and from mental disorder to another and they may include the following:

- Losing your sense of humour.
- Becoming tense, irritable, or agitated.
- Finding it difficult to concentrate.
- Retreating from social situations and neglecting outside activities and social relationships.
- Saying or doing irrational or inappropriate things.
- Developing ideas that other people find unusual, strange, or unbelievable.
- Neglecting one’s personal care.
- Neglecting to take one’s medication.
- Dressing in unusual clothes or unusual combinations of clothes.
- Sleeping excessively or hardly at all.
- Eating excessively or hardly at all.
- Becoming increasingly suspicious or hostile.
- Becoming especially sensitive to noise or light.
- Hearing voices or seeing things that other people cannot see or hear.

Factors commonly associated with relapse include poor adherence to treatment, substance abuse, co-morbid psychiatric illness, a co-morbid medical and or surgical condition, stressful life events and the treatment setting (Kazadi et al., 2008:52). The most common factor associated with relapse is poor adherence to treatment. Factors associated with poor adherence to treatment were found to be medication side effects and lack of insight. Poor insight contributed to a 5.2 times increase in the risk of relapse (Kazadi et al., 2008:58).

Different studies have been conducted in South Africa and internationally to investigate ways to reduce relapse rates. These studies indicate that relapse rate can be reduced if families are supported by mental health care practitioners, either in the form of prompt implementation of behavioral family treatment during the period of hospital care (Berglund et al., 2003:120) or psycho-educational family interventions (Magliano et al., 2006:1790). Hogarty et al. (2004:146-157) have shown that personal therapy had a positive effect among patients who lived with their family, while patients living independent of family had an increased rate
of relapse. According to Rickwood (2005:15), relapse prevention involves empowering people with mental illness to recognize early warning signs of relapse in order to develop appropriate response plans. Another strategy to prevent relapse with is communication and understanding between the mentally ill person, their family or carers, the specialist mental health system and community support services. Relapse prevention is found to be important because it reduces the negative impact of mental illness on individuals, families and communities, and it improves quality of life of people with mental illness, enabling them to participate more fully in their work, leisure and relationships (Rickwood, 2005:15).

In addition, Sittner et al. (2007:353) indicate that with a family strengths approach, nurses' help families define their visions and hopes for the future instead of looking at what factors contribute to family problems. Another study conducted by Sousa et al. (2006:64) indicate that incorporation of a strengths centered approach into the practitioner's intervention improved the lives of families with multiple problems such as caring for mental health care users. According to Mace (cited by Defrain and Stinnet, 2003), family strengths are those relationship qualities that contribute to the emotional health and well-being of the family. Family strength qualities are regarded as commitment, appreciation and affection, positive communication, time together, a sense of spiritual well-being and the ability to cope with stress and crisis (Sittner et al., 2007:353). Silliman (1995:3) reported that every family has some strengths or positive attitudes and skills for meeting daily challenges. Traits that build such family strengths include the following:

- **Commitment** – Working towards shared goals through self-sacrifice, persistence and loyalty to other family members, cultivating an environment of trust and dependability.
Connectedness – Receiving support from and contributing to extended family, neighborhood and community, resulting in a sense of belongingness as well as accountability to others.

Coherence – Maintaining family identity and togetherness, balancing family priorities with support for member esteem and achievement, producing strong family bonds and freedom for individual self-expression.

Adaptability - Coping with change, balancing stable roles and traditions with flexibility to change rules and share decisions, with the consequence that challenges stimulate growth and health.

Communication – Engaging in clear, open, affirming speaking consistent empathic listening, resulting in constructive conflict management and problem solving.

Spirituality – Believing in high power and acting on a value system beyond self-interest, affecting a sense of purpose and divine support in everyday and difficult events.

Time together – Creating daily routines as well as special traditions and celebrations that affirm members, connect them to family roots and add creativity and humor to ordinary events.

Asay and De Frain (2012:4) indicate that over the past three decades, researchers looking at couples and families from a strengths perspective have developed a number of propositions derived from their work around the world and they are as follows:

“Families, in all their remarkable diversity, are the basic foundation of human cultures. Strong families are critical to the development of strong
communities, and strong communities promote and nurture strong families”.

- “All families have strengths, challenges and areas of potential growth. If one looks only for problems in a family, one will see only problems. If one also looks for strengths, one will find strengths”.

- “Strong marriages are the centre of many strong families. The couple relationship is an important source of strength in many families with children who are doing well”.

- “Strong families tend to produce great children; and a good place to look for great children is in strong families”.

- “If you grew up in a strong family as a child, your chances of having a strong family of your own are greater, however, you can also have a strong family if you didn’t see that model”.

- “Strengths are often developed in response to challenges. A couple and family’s strengths are tested by life’s everyday stressors and as well as significant crises”.

- “Strong families don’t tend to think much about their strengths, they just live them. However, it is useful to examine a family’s strengths and discuss precisely how family members use them to great advantage”.

- “Strong families, like people, are not perfect. Even in the strongest of families conflict exists. A strong family is a piece of art continually in progress, always in the process of growing and changing”.

- “When seeking to unite groups of people, communities, and even nations, uniting around the cause of strengthening families can be a powerful strategy. Families are the foundation for all our groups, and the strengths of families that are remarkably similar from group to group, gives us powerful common ground for working together”.

- “Human beings have the right and responsibility to feel safe, comfortable, happy and loved”.

Studies on family strengths have been conducted as indicated above but little has been done on strengths of families to help limit relapse in mental health care users. Relapse in mental health care users has been noted as a major problem both nationally and internationally (Kazadi et al., 2008:52). The problem of relapse is also evident in the practical setting where the researcher works. The relapse rate in the hospital where research was conducted ranges between 35% and 50% for the year 2011 (Admission register in the mental health unit). This poses a very serious burden on families who provide care for such mental health care users. Families caring for mental health care users need support from health care practitioners to assist them to cope. One approach, as explained, is to explore family strengths to improve the family’s life as well as that of the mental health care user. Family strengths should thus be looked into in order to explore how families can be assisted to care for mental health care users and to limit relapse. This research forms part of the RISE project (Koen & Du Plessis, 2011), which focuses on strengthening the resilience of health caregivers and risk groups, such as mental health care users and their families, by means of a multifaceted approach. Research on the strengths of families in caring for such a family member in order to limit relapse will contribute to the RISE project because family members caring for mentally ill family members are regarded as a risk group. Family members participate in the study to identify strengths that assist them to limit relapse in mentally ill family members. The following research questions are thus formulated:

- What are the strengths of families in assisting mental health care users to limit relapse?
- What guidelines can be formulated that can be used by psychiatric nurses to empower families caring for mental health care users to limit relapse?
1.2. RESEARCH PURPOSE

The purpose of this research is to explore and describe the strengths of families in assisting mental health care users to limit relapse and to formulate guidelines that will be used by psychiatric nurses to empower family members caring for mental health care users to limit relapse.

1.3. PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this study includes the meta-theoretical assumptions, theoretical assumptions and methodological assumptions.

1.3.1. Meta-theoretical assumptions

The meta-theoretical assumptions of this study are grounded on the researcher’s own philosophy that respects the uniqueness of every person’s dignity, beliefs, value systems as well as culture. These assumptions are in line with Newman’s theory of health as expanding consciousness, as it is a holistic approach to health care, is person-centered and it describes that the community and family consists of psychological, physical, social, cultural and spiritual aspects (Newman, 1990:37). Newman’s theory also proposes that there are positive and negative external and internal factors that affect a human being. This paradigm is relevant in this study as the factor that negatively affects the family is the relapse of mental health care users, whilst their strengths to cope with this were explored.

1.3.1.1. Person

The researcher believes that a person is a biological, physical, spiritual and social being. Every person is unique in the manner that they react to stimuli within their environment, based on the way they think as well as their beliefs and values. Persons react to the environment based on their previous experiences.
Every person is therefore, in constant interaction with their environment which may be internal or external. In this research, person refers to family members taking care of mental health care users.

1.3.1.2. Environment

The environment is internal as well as external and comprises all those forces that influence a person at any given time of a lifetime. All these forces influence the person either positively or negatively. When the environmental forces are positive, an individual’s reaction becomes positive and when they are negative, the individual’s reaction may be negative. Strengths of families in this research are positive internal forces that can assist them to be positive in order to take care of mental health care users to limit relapse.

1.3.1.3. Health

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 2001:1). Mental health is an integral part of health and is intimately connected with physical health and behavior. Every individual is responsible for their own health. When an individual fails to maintain his or her own health, he or she may seek the intervention of the health professionals. In the context of this research, families caring for mental health care users seek professional intervention to assist them to cope with the burden of caring for such patents to limit relapse and maintain mental health.

1.3.1.4. Illness / Mental illness

Illness is a state of poor health. An impairment of an individual’s normal cognitive, emotional or behavioral functioning which can be caused by social, psychological, biochemical, genetic or other factors such as infection or head trauma is therefore regarded as mental illness (The American Heritage Dictionary...
of the English Language, 2011:520). This research focuses on individuals with mental illness and how their families take care of them to limit relapse.

1.3.1.5. Nursing

The main goal of nursing is to assist people to attain and maintain stability by assessing their environment, and planning and developing strategies to restore stability (Stanhope & Lancaster, 2000:208). This study focuses on how psychiatric nurses can empower families caring for mental health care users to limit relapse.

1.3.1.6. Nurses

The Nursing Act (33 of 2005) defines a nurse as a person registered in a category of professional nurse, midwife, staff nurse, auxiliary nurse or auxiliary midwife in order to practice nursing or midwifery. Nurses in this research are psychiatric nurses who are specially trained to care for mental health care users. Psychiatric nurses in this research will be focusing on family members taking care of mental health care users to assist them to cope with the burden of disease and limit relapse.

1.3.2. Theoretical assumptions

The theoretical assumptions comprise the central theoretical argument and conceptual definitions.

1.3.2.1. Central theoretical argument

The focus of this study is on the strengths of families to help limit relapse in mental health care users. In-depth exploring and describing of these strengths will lead to a better understanding of how families caring for mental health care
users can be assisted to cope and limit relapse. This insight can facilitate the researcher to formulate guidelines for psychiatric nurses to empower family members in limiting relapse of mental health care users.

1.3.2.2. Conceptual definitions

The following concepts were defined in the study: family strengths, relapse, and mental health care users.

1.3.2.2.1. Family strengths

According to Mace (cited by Defrain and Stinnet, 2003), family strengths are those relationship qualities that contribute to the emotional health and well-being of the family. Family strength qualities are therefore regarded as aspects such as commitment, appreciation and affection, positive communication, time together, a sense of spiritual well-being and the ability to cope with stress and crisis (Sittner et al., 2007:353). In this study, family strengths as ways to assist them to care for mental health care users to limit relapse, were explored.

1.3.2.2.2. Relapse

Relapse is defined as recurrence of symptoms of mental illness similar to those that have previously been experienced (Rickwood, 2005:14). Relapse in mental health care users has been noted as a major problem both nationally and internationally (Kazadi et al., 2008:52). In this research the focus was on mental health care users who have not relapsed in the past two years and who are still treated for mental illness in a health establishment. The reason for focusing on such mental health care users is for their family members to identify strengths that helped them to keep their mentally ill from relapsing in the past two years.
1.3.2.2.3. Mentally ill family member / mental health care users

According to the Mental Health Care Act (17/2002) (SA, 2002), a mental health care user is defined as a person receiving care, treatment and rehabilitation services or using a health service at a health establishment aimed at enhancing the mental status of a user. In this research, mental health care users are cared for by their families after being discharged from health establishments. Families of such users need assistance with regard to caring for them at home to limit relapse. The term mental health care user was used throughout the study as synonym of mentally ill family member.

1.3.3. Methodological assumptions

Methodological assumptions directed the research because they are based on the researchers’ world-view, values and beliefs concerning the nature and structure of science. Methodological assumptions are concerned with the purpose, methods and criteria for the trustworthiness of research (Polit & Hungler 1997:304). This study follows a functional approach proposed by (Botes 1995:12), which assumes that research findings should be used to advance practice of nursing. Research emanates from three orders that for descriptive purposes may be arranged as follows:

The first order referring to the nursing practice is from time to time confronted by problems which need solutions or improvements. The research problem in this study focuses on the strengths of families which might contribute to limit relapse in mental health care users. Exploring strengths of these families will yield results which will contribute to the practice of mental health nursing.

The second order represents the research methodology to be adopted. A phenomenological design was used in this study because the strengths of families taking care of mental health care users was explored and described.
The third order represents meta-theoretical assumptions which are the researcher’s beliefs as described under section 1.3.1.

1.4. RESEARCH DESIGN

A phenomenological design was used in this study because the strengths of families taking care of mental health care users, as lived by these families, were explored and described. The strengths of families explored and described assisted in the formulation of guidelines for psychiatric nurses that will be used to empower other families to limit relapse in mental health care users. The design as well as the context of this research will be discussed in more detail in Chapter 2.

1.5. RESEARCH METHOD

The research method refers to all the aspects pertaining to population, sampling, data collection and data analysis, which will be discussed in brief manner. An elaboration is provided in Chapter 2.

1.5.1. Sampling

The sampling consists of population, sampling method and sample size and they are discussed as follows:

1.5.1.1. Population

Population refers to the entire set of individuals or elements who meet the sampling criteria (Burns & Grove, 2009:366). The population for this study was all families of mental health care users who are receiving treatment at a particular hospital. A detailed description of the population will be done in Chapter 2.
1.5.1.2. Sampling method

A purposive sampling technique was used because the sample was identified by means of selection criteria developed from the research problem, the purpose and the design. In this research the sample included family members caring for mental health care users who gave consent to participate in the study. Family members were recruited by contacting them telephonically after being identified in the register of the mental health unit where mental health care users were admitted.

1.5.1.3. Sample size

The sample size was determined by data saturation (Burns & Grove, 2009:361).

1.5.2. Data collection

A brief description of data collection follows, including role of the researcher method of data collection and physical environment and. A more detailed discussion will be done in Chapter 2

1.5.2.1. Role of the researcher

The researcher obtained ethical clearance from the North West University’s Ethical Committee (Appendix A and B). Thereafter she obtained permission from the North West Department of Health to conduct the study. The purpose and the importance of the research were explained in the letter of request (Appendix C). Participants were recruited, selected and interviewed after the researcher had received a permission letter from the North West Department of Health (Appendix D).
1.5.2.2. Method of data collection

Data was collected through in-depth interviews with family members using an open-ended question where participants were asked to verbally describe their experiences of a phenomenon (Burns & Grove, 2009:607), in this case specifically their strengths that contribute to limiting relapse. The open-ended question that was asked is: What do you think are your strengths in taking care of your mentally ill family member to limit relapse? A trial run interview was conducted to determine whether the question as formulated focused on the study and was clear to the participants and also determined the interview skills of the researcher. The trial run interviews as well as interviews conducted for the study were all recorded with an audio recorder. Communication techniques as described by Okun et al. (2008:76-77), were used during interviews. Field notes were documented immediately after each interview and they included reflective, descriptive and demographic notes (Creswell, 2009:152)

1.5.2.3. Physical environment

The interviews were conducted in a private room at the hospital to ensure privacy and confidentiality.

1.5.3. Data analysis

According to Parse (quoted by Burns & Grove, 2009:531), the audio recorded dialogue is transcribed to a typed format for the extraction synthesis process. Extraction synthesis is a process of moving the descriptions from the language of the participants up the levels of abstraction to the language of science. The detail of this process is described in Chapter 2. A work protocol was given to the co-analyzer who independently analyzed the data and had a consensus discussion with the researcher thereafter in order to reach consensus on the categories that emerged from the data.
1.5.4. Literature control

The research results were compared with relevant literature and existing research findings as confirmation of the data obtained in this research. New insight gained from this research was also highlighted.

1.6. TRUSTWORTHINESS

The goal of trustworthiness in qualitative research is to accurately represent study participants’ experience (Speziale & Carpenter, 2007:49). Terms that embrace trustworthiness are, credibility, dependability, conformability and transferability. A detailed discussion on trustworthiness follows in Chapter 2.

1.7. ETHICAL CONSIDERATIONS

Ethical approval was obtained from the North-West University’s Ethical Committee, under the RISE project (Ref no NWU-00036-11-S1) (Appendix A and B). Permission to conduct the research was obtained from North West Department of Health (Appendix D). The hospital management allowed the researcher to conduct the study based on the permission letter from North West Department of Health.

Following thorough explanation of the nature of the study, informed consent was obtained from the family members who agreed to participate in the study (Appendix E). The issue of privacy was considered whereby the researcher did not reveal participants’ identities when preparing the final manuscript.

The three primary ethical principles on which standards of ethical conduct in research are based on are: beneficence, respect for human dignity and justice.
(Polit & Beck, 2010:121). Discussions on these principles and the procedures the researcher adopted to comply with these principles, follow in Chapter 2

1.8. CONCLUDING REMARKS

This chapter introduced the research problem, purpose, objectives and significance of the study. It also outlined the paradigmatic perspective of the research as well the research design and method. Measures to ensure trustworthiness and ethical considerations were discussed and the study layout was outlined. The next chapter provides more detail on the design, method, trustworthiness and ethical considerations.

1.9. FURTHER CHAPTER LAYOUT

Chapter 2: Research design and method
Chapter 3: Discussion of research findings and literature control
Chapter 4: Conclusions, limitations and recommendations
CHAPTER 2: RESEARCH DESIGN AND METHOD

2.1. INTRODUCTION

This chapter entails a full exposition of the research design and method that were followed in this study.

2.2. RESEARCH DESIGN

Research design is described as a blueprint for conducting the study that maximizes control over factors that could interfere with the validity of the findings and which guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove, 2009:41). A phenomenological design was used in this study. Phenomenology, rooted in a philosophic tradition developed by Husserl and Heidegger, is an approach to exploring and understanding people’s everyday life experiences (Polit & Beck, 2010:267). Phenomenologists investigate subjective phenomena in the belief that critical truths about reality are grounded in people’s lived experiences which give meaning to each person’s perception of a particular phenomenon (Polit & Beck, 2010:267). In phenomenological study, the main data source typically is in-depth interviews and it involves a small number of participants. In this study, strengths of families taking care of mental health care users were explored and described. In-depth interviews were conducted and 15 participants were involved in the study. The strengths of families explored and described assisted in the formulation of guidelines for psychiatric nurses that will be used to empower other families to limit relapse in mental health care users.
2.3. RESEARCH METHOD

A short description of the research method was given in Chapter 1. A detailed description of sampling, the method of data collection and data analysis follows.

2.3.1. Sampling

Sampling involves selecting a group of people, events, behaviors or other elements with which to conduct a study (Burns & Grove, 2009:343). The population, sampling method and sample size are discussed.

2.3.1.1. Population

Population refers to the entire set of individuals or elements who meet the sampling criteria (Burns & Grove, 2009:366). An accessible population is the portion of the target population to which the researcher has reasonable access. The accessible population for this study was all families of mental health care users who were receiving treatment at a particular hospital. The family members included mothers, fathers, brothers and sisters of mental health care users. Their ages range between 39 and 70 and they stay in the greater Rustenburg area in places such as Boitekong, Phokeng, Tlhabane, Rustenburg East and North. The researcher in this study had reasonable access to the population because she is working in the mental health unit in the hospital where such mental health care users are admitted for treatment and rehabilitation.

2.3.1.2. Sampling method and recruitment

A purposive sampling technique was used in this study. Purposive sampling is referred to as judgmental or selective sampling in which a researcher consciously selects certain participants, elements, events or incidents to include in the study. The researcher selects information-rich cases or those cases that can teach a
great deal about the central focus or purpose of the study (Burns & Grove, 2009:355); in this case, strengths of families to limit relapse in mentally ill family member.

The focus was on the family member taking care of the mental health care user on a daily basis who is directly involved with this family member. Mental health care users were identified from the Admission register where they were recorded and their families were contacted telephonically by the researcher after getting permission from the hospital management. Twenty five family members were contacted telephonically to participate in the study but only fifteen came for interviews. Chapter 3 gives detailed demographic information of each participant and how they are related to their mental health care user. The identification and recruitment focused only on those mental health care users who have been following up at the mental health clinic and have not relapsed in the past two years. The researcher has access to the register because she is the unit manager of a mental health unit where the research was conducted.

For the purpose of this research the selection criteria were:

- Family members of mental health care users who had been attending the mental health clinic and had not relapsed in the past two years.

- Family members who were caring for mental health care users at home and who were:
  - directly involved with the care of mental health care users;
  - consenting to participate;
  - consenting to the use of an audio recorder during an interview; and
  - able to communicate in Setswana or English.
2.3.1.3. Sample size

The sample size was determined by data saturation. Saturation of data occurs when additional data provides no new information, only redundancy of previously collected data is elicited (Burns & Grove, 2009:361). Chapter 3 gives details of how many interviews were conducted before data saturation was reached.

2.3.2. Data collection

Data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of a study (Burns & Grove, 2009:43). The actual steps of collecting data are specific to each study and are dependent on the research design and measurement methods. A description of data collection follows which includes the role of the researcher, method of data collection, and physical environment.

2.3.2.1. Role of the researcher

The researcher received approval as described in Chapter 1. On receiving the approval, the researcher started selecting participants from the register in the mental health unit according to selection criteria. The selected participants were contacted telephonically and when they agreed to participate, the researcher interviewed them after they had signed a consent slip (Appendix E) to participate in the research and had also given permission for the use of the audio recorder during the interview. The researcher explained to each participant the purpose of the research and re-assured them that confidentiality and partial anonymity would be maintained as far as possible.
2.3.2.2. Method of data collection

Data were collected through in-depth interviews. In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of participants to explore their perspectives on a particular idea, programme or situation (Boyce & Neale, 2006:3). In-depth interviews are used when one wants detailed information about a person’s thoughts and behaviors or wants to explore new issues in depth. The researcher asked open-ended questions orally and recorded the participants’ answers verbatim. Interviewing is typically done face-to-face, but can also be done via telephone (Crossman, 2012:12). In this case, face-to-face interview with a family member was conducted. The open-ended question that was asked is: What do you think are your strengths in taking care of your mental ill family member to limit relapse? These verbal data was collected in a relaxed atmosphere with sufficient time allowed to facilitate a complete description by the participants. The interviews were recorded with an audio tape recorder and participants were informed regarding recording of interviews before so that they could give voluntary informed consent.

Communication techniques as described by Okun and Kantrowitz (2008:76–77) were used during interviews and they included:

- **Clarifying**: A technique used to clarify unclear statements, e.g. “Is this what you are saying…”

- **Paraphrasing**: by repeating the participant’s words but using synonyms.

- **Probing**: An open-ended question that will encourage the participant to give more information, whereby the interviewer will say “tell me more about that”.  


- Minimal verbal response by the researcher by way of encouraging the participant to continue talking by nodding and saying “Hm, yes or Ee”.

- Reflecting: Verbalizing the concerns and perspectives of the participant to show understanding.

- Summarizing: So that the questions are directed according to the interview schedule and so that it is understood what the participants are saying.

Before the actual data collection took place, a trial run was conducted in order to check if the participants would respond well to the open-ended question. The researcher realized that participants did not immediately understand the open-ended question. The researcher addressed this problem by first focusing on building a trust relationship by obtaining a brief history of the mental health care user from the family member and asks questions such as when the illness had started, how often the mental health care user had been admitted to hospital and when the last admission was. After giving the brief history, the family member could then answer the open-ended question: What do you think your strengths are in taking care of your mental health care user to limit relapse? The data collected during the trial run could be included in the study.

Immediately after the interview, the interviewer recorded field notes once the participant left the room to avoid forgetting some aspects that might affect the research findings and to enhance in the analysis of data (see Appendix G: Field notes). Field notes were taken as described by Creswell (2009:152), as follows:

- Reflective notes: A record of personal thoughts such as a speculation of incidents, feelings, problems encountered during the interview, ideas generated during the process, hunches, impressions and prejudices.
Descriptive notes: These are reports on the portraits or descriptions of participants, physical setting, the interviewer’s account of particular events that occurred and activities that took place during the interview.

Demographic notes: These cover information with regard to the time, place, date and weather conditions that describe the field setting when and where the interview took place.

2.3.2.2. Physical environment

There are three common settings for conducting nursing research namely; natural, partially controlled and highly controlled (Burns & Grove, 2009:362). Natural setting was used for this study because the researcher did not manipulate or change the environment for this study. Participants were contacted concerning their choice regarding a physical setting for the interview, either their homes or the hospital. Most of participants opted to be interviewed at the hospital because they said it is a neutral place for them. A consultation room in the hospital was organized in such a way that it was away from activities in the hospital with no telephone, as well as well ventilated, clean and warm. There was no barrier or object between the interviewer and participants; they sat on the same side of a small table at a comfortable close distance.

2.3.3. Data analysis

Data analyzed included the transcripts and field notes of the interviews conducted with participants. Data were analyzed according to a technique for analysis described by Tesch (as quoted by Creswell, 2007:187) as follows:

Each transcript was divided into three columns with the middle column used for the interviewer’s and the participant’s verbal responses.
The right-hand column was used for the themes that emerged from the responses of the participants and the left-hand column was used to write down the analyzer’s ideas and thoughts that came to mind.

Transcripts were read first to get the sense of the whole experiences as described by the participants in their own words.

One transcript that was most interesting or the shortest was chosen.

This transcript was carefully read through to try and establish what it is about. The ideas that came to mind were jotted down in the left-hand column. The transcript was read again and this time, the themes, words and phrases as stated by participants were underlined.

The underlined themes were written in the right-hand column.

The identified themes were grouped into three categories that were used to analyze data. These categories were grouped as the main categories, the sub-categories and leftovers categories.

This procedure was followed with each transcript.

The main categories and sub-categories were written in a tabular form using the concrete words of the participants. The re-coding was done at this stage.

Finally, the concrete words and phrases were translated in scientific terminology.

A specialist qualitative researcher was appointed as an independent co-analyzer. The work protocol (Appendix F), transcripts (Appendix H), and field notes
(Appendix G) were given to the co-analyzer. The co-analyzer and the researcher independently analyzed the data followed by a discussion meeting in order to reach consensus on the categories that emerged from the data.

2.3.4. Literature control

Available literature, which includes journal articles, research reports, books, dictionaries and the Bible, mostly obtained through electronic databases such as Ebscohost (CINAHL, Medline, PsychLit ), SAePublications, A to Z Journal List and Google Scholar, were reviewed on the themes that emerged from the interviews to provide a scientific basis for the research and highlight new insights gained from it.

2.4. TRUSTWORTHINESS

Trustworthiness includes the strategies of credibility, dependability, confirmability and transferability. The researcher ensured trustworthiness by going through the transcripts line by line to make sure that all the information was captured because interviews conducted in Setswana were translated into English.

2.4.1. Credibility

Credibility refers to confidence in the truth of the data and interpretations of them (Polit & Beck, 2010:492). The credibility criteria involve establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research. The purpose of qualitative research is to describe or understand the phenomena of interest from the participant's eyes; the participants are the only ones who can legitimately judge the credibility of the results. Credibility is ensured by carrying out the study in a way that enhances the believability of the findings and taking steps to demonstrate to external
readers. To ensure credibility, the researcher has employed the following measures:

- All participants were taken through the same main question.
- The researcher had interviewed the participants to the point at which there was data saturation (prolonged engagement). No new information was raised.
- The interviews were audio-recorded and transcriptions were made of each interview (referral adequacy)

2.4.2. Dependability

Dependability refers to the stability of data over time and over conditions (Polit & Beck, 2010:492). The dependability question is: Would the study findings be repeated if the inquiry was replicated with the same participants in the same context? Dependability emphasizes the need for the researcher to account for the ever changing context within which research occurs. The researcher is responsible for describing the changes that occur in the setting and how these changes affected the way the research approached the study. The researcher in this study did clarify to participants who could not understand the open-ended question by collecting brief history of the mentally ill family member to ensure that they provide relevant data. Data was also organised in categories and themes. All interview materials, transcriptions, documents, findings, interpretations and recommendations are kept, and any other material relevant to the study will be made available and accessible to any other researcher, for the purpose of conducting an audit trail.

2.4.3. Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the data’s accuracy, relevance, or
meaning (Polit & Beck, 2010:492). There are a number of strategies for enhancing confirmability. The researcher can document the procedures for checking and rechecking the data throughout the study. After the study, one can also conduct a data audit that examines the data collection and data analysis procedures and makes judgment about the potential for bias or distortion. Confirmability in this study was ensured by writing field notes immediately after every interview and transcribing interviews verbatim. The researcher and the co-analyzer did data analysis independently and agreed on categories and themes in an organized meeting to confirm their findings.

2.4.4. Transferability

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings. The qualitative researcher can enhance transferability by thoroughly describing the research context and the assumptions that were central to the research. A literature control was done wherein similar findings of other research studies were reported. The researcher had provided a dense description of the research methodology, the participants' background, and the research context to enable someone interested in making a transfer, to reach a conclusion about whether transfer can be possible or not.

2.5. ETHICAL CONSIDERATIONS

The three primary ethical principles on which standards of ethical conduct in research are based on are: beneficence, respect for human dignity and justice (Polit & Beck, 2010:121).
2.5.1. Beneficence

Beneficence is a principle that imposes a duty on researchers to minimize harm and to maximize benefits (Polit & Beck, 2010:121). Participants must not be subjected to unnecessary risks of harm or discomfort and their participation in research must be essential to achieving scientifically and societally important aims that could not otherwise be realized. Participants need to be assured that their participation or information they might provide will not be used against them in any way. Beneficence in this research was ensured by setting a conducive physical environment to make participants feel at ease and by explaining how the research will benefit the whole community when guidelines are done for psychiatric nurses to assist other families.

2.5.2. Respect for human dignity

This principle includes the right to self-determination and the right to full disclosure (Polit & Beck, 2010:121). Self-determination means that prospective participants have the right to decide voluntarily whether to participate in a study without risking penalty or prejudicial treatment. It also means that participants have the right to ask questions, to refuse to give information and to withdraw from the study. Full disclosure means that the researcher has fully described the nature of the study, the person’s right to refuse participation and the researcher’s responsibilities. The right to self-determination and the right to full disclosure are the two major elements on which informed consent is based. This principle was ensured in this study because participants were given detailed information on the study before they could sign an informed consent slip (Appendix E).

2.5.3. Justice

The principle of justice includes participants’ right to fair treatment and their right to privacy (Polit & Beck, 2010:121). The right to fair treatment means that the
researcher must treat people who decline to participate in a study or who withdraw from it, in a non-prejudicial manner. They must honor all agreements made with participants, demonstrate sensitivity to the beliefs, habits and lifestyles of people from different background or cultures and afford participants’ courteous and tactful treatment at all times. The right to privacy means that researchers should ensure that their research is not more intrusive than it needs to be and that a participant’s privacy is maintained throughout the study. Interviews in this study were conducted in a private room and participants were interviewed individually. Participants have the right to expect that any data they provide will be kept in strictest confidence. The issue of confidentiality was considered whereby the researcher did not reveal participants’ identities when preparing a final manuscript.

2.6. CONCLUSION

A detailed description of the research design, method, trustworthiness and ethical considerations was given in this chapter. The next chapter deals with the discussion of the research findings and the literature control.
CHAPTER 3: DISCUSSION OF RESEARCH FINDINGS AND LITERATURE CONTROL

3.1. INTRODUCTION

In this chapter the realization of data collection and analysis are discussed, followed by a discussion of the research findings which were compared with and confirmed against existing literature.

3.2. REALISATION OF DATA COLLECTION AND DATA ANALYSIS

The sample for this research was identified via the register used in the mental health unit. The focus was on mental health care users who have been following up at the mental health clinic and who have not relapsed in the past two years. Twenty five family members of such users were contacted telephonically to participate in the study. They were all given a chance to choose whether they want to be interviewed at home or at the hospital and they all chose to come to the hospital. From the twenty five participants contacted telephonically, only fifteen came for interviews and gave voluntary consent.

Table 3.1 Demographic information of the participants

<table>
<thead>
<tr>
<th>AGE</th>
<th>GENDER</th>
<th>RELATIONSHIP TO MENTAL HEALTH CARE USER</th>
<th>LANGUAGE USED DURING INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>Female</td>
<td>Mother</td>
<td>Setswana</td>
</tr>
<tr>
<td>62</td>
<td>Female</td>
<td>Mother</td>
<td>Setswana</td>
</tr>
<tr>
<td>52</td>
<td>Male</td>
<td>Father</td>
<td>English</td>
</tr>
<tr>
<td>59</td>
<td>Female</td>
<td>Mother</td>
<td>Setswana</td>
</tr>
<tr>
<td>47</td>
<td>Female</td>
<td>Sister</td>
<td>English</td>
</tr>
<tr>
<td>42</td>
<td>Female</td>
<td>Sister</td>
<td>Setswana</td>
</tr>
<tr>
<td>41</td>
<td>Male</td>
<td>Brother</td>
<td>Setswana</td>
</tr>
<tr>
<td>45</td>
<td>Female</td>
<td>Sister</td>
<td>Setswana</td>
</tr>
<tr>
<td>Age</td>
<td>Gender</td>
<td>Relationship</td>
<td>Language</td>
</tr>
<tr>
<td>-----</td>
<td>--------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>50</td>
<td>Male</td>
<td>Brother</td>
<td>English</td>
</tr>
<tr>
<td>39</td>
<td>Female</td>
<td>Sister</td>
<td>English</td>
</tr>
<tr>
<td>70</td>
<td>Female</td>
<td>Mother</td>
<td>English</td>
</tr>
<tr>
<td>58</td>
<td>Male</td>
<td>Father</td>
<td>English</td>
</tr>
<tr>
<td>40</td>
<td>Female</td>
<td>Sister</td>
<td>English</td>
</tr>
<tr>
<td>60</td>
<td>Female</td>
<td>Mother</td>
<td>Setswana</td>
</tr>
<tr>
<td>62</td>
<td>Male</td>
<td>Father</td>
<td>Setswana</td>
</tr>
</tbody>
</table>

Before each interview, the researcher explained the purpose of the research project and obtained written consent (Appendix E) from each participant. In each interview, as in the trial run, the researcher started by building a trust relationship through collecting a brief history on the mental health care user. The participants were asked questions such as when the illness started, how often the mental health care user was admitted to hospital and when the last admission was. After giving the brief history, an open-ended question was then asked, namely “What do you think are your strengths in taking care of your mental health care user to limit relapse?” The participants understood the question well, especially after giving a brief history of the mentally ill family member. The interviews were conducted and the data was recorded using an audio recorder after obtaining permission from participants. The interviews were conducted in Setswana and English. Eight participants were interviewed in Setswana and seven were interviewed in English. The interviews conducted in Setswana were translated into English by the researcher. The duration of interviews differed but most lasted for 30 to 45 minutes. The interviewer wrote field notes immediately after each interview. Data saturation was reached after thirteen interviews, and a further two interviews confirmed data saturation.

The audio recordings for all the interviews were labeled and each one of them transcribed verbatim. The transcriptions as well as field notes which were subsequently labeled according to the sequence of the interviews were typed. Data analysis was then completed independently by a researcher as well as a
nurse specialist with qualitative research experience who acted as the co-analyzer. The technique for data analysis as described in the protocol (Appendix F) was followed. A meeting for the consensus discussion between the researcher and the co-analyzer was organized after independent coding had occurred. Consensus on the coded data was reached after the discussion. The data was then written up in a scientific language and summarized in a table (See Table 3.2). The detailed description of these findings follows.

3.3. RESEARCH FINDINGS AND LITERATURE CONTROL

The consensus reached between the researcher and the co-analyzer resulted in the identification of four main categories as displayed in Table 3.2. Table 3.2 summarizes four main categories in Columns A, B, C and D of what family members expressed as strengths to help them limit relapse in mentally ill family members.

The categories are divided as follows:

- Accepting the condition of a mentally ill family member (Column A).
- Having faith in God (Column B).
- Involving a mentally ill family member in daily activities (Column C).
- Being aware of what aggravates the mentally ill family member (Column D).

These categories as well as subcategories are discussed in detail with direct relevant quotations from the transcripts to enrich the data. The discussion of the literature follows this and serves to confirm the findings.
Table 3.2: Strengths of families caring for mentally ill family members to limit relapse

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
<th>Column D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accepting the condition of the mentally ill family member</strong></td>
<td><strong>Having faith in God</strong></td>
<td><strong>Involving a mentally ill family member in daily activities</strong></td>
<td><strong>Being aware of what aggravates the mentally ill family member</strong></td>
</tr>
<tr>
<td>➢ Family members expressed how they felt the first time their mentally ill family member became ill</td>
<td>➢ Praying daily</td>
<td>➢ Families expressed how they used to segregate their mentally ill family members</td>
<td>➢ Maintaining a calm attitude towards the mentally ill family member and communicating well</td>
</tr>
<tr>
<td>➢ Being impatient</td>
<td>➢ Going to church</td>
<td>➢ Families are now spending time with their mentally ill family members</td>
<td></td>
</tr>
<tr>
<td>➢ Feeling guilty</td>
<td>➢ Having fellowship with other believers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Feeling shame and embarrassment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Family members explained what helped them to accept the condition of their mentally ill family member</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Educating self on the diagnosis and relevant treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Developing a positive attitude</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Accepting their feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.3.1 Discussion of findings concerning strengths of families to limit relapse in mentally ill family members

3.3.1.1 Accepting the condition of a mentally ill family member.

This category deals with the finding, accepting the condition of a mentally ill family member, as indicated in column A of Table 3.2 which is divided into two subcategories.

Table 3.3: Accepting the condition of a mentally ill family member

- Family members expressed how they felt the first time their mentally ill family member became ill:
  - Being impatient
  - Feeling guilty
  - Feeling shame and embarrassment
- Family members explained what helped them to accept the condition of their mentally ill family member:
  - Educating self on the diagnosis and relevant treatment
  - Developing a positive attitude
  - Accepting their feelings

Family members expressed how they felt the first time their mentally ill family member became ill

From the findings of this research it seems that family members experienced difficulties when their mentally ill family members were diagnosed the first time with mental illness. The following indicates what family members expressed during interviews regarding the feelings they experienced:
• Being impatient

The family members interviewed expressed that they were impatient with their mentally ill family member’s behavior. Most of them indicated that they thought that their mentally ill family members were just acting out when they displayed an unusual behavior. They only realized that their members were ill when they started to become violent, fighting and destroying properties. Following are examples of direct quotations from the transcriptions of interviews:

“I ignored him when he refused to bath and was locking himself in the room”

“I used to shout at him because I thought he is just naughty”

“I once fought with him because I thought he is just stubborn”

Literature confirms that when mental illness strikes, family members may deny that the person has a continuing illness and during the acute episode, family members may be alarmed by what is happening to their loved one (Nichols, 2008:12). Croft (2008:1) also confirms that most people go through a phase of denial when faced with the diagnosis of mental illness and this makes it difficult for them to cope.

• Feeling guilty

The family members interviewed, indicated that they felt guilty because they thought that they contributed to the mental illness of their loved one. One of the family members indicated that he felt he contributed a lot because he was not there for his son, he did not even realize the symptoms when they started. Following are examples of direct quotations from the transcriptions of interviews:

“I remember the days when my son used to lock himself in his room but I just ignored him because I thought it is an adolescent stage”
“My sister used to listen a lot to a very loud music because she said there were people talking to her ears. I took her for granted because I did not understand that those were hallucinations”

These findings are confirmed by Tartakovsky (2011:2) who mentions that feeling guilty is a normal reaction. Some families may worry that they didn’t get their loved one into treatment sooner; others may think they caused the disorder. Another confirmation is that families wonder how the illness developed and they may feel that they might be responsible for their mentally ill family member’s illness (Croft, 2008:1)

- Feelings of shame and embarrassment

It emerged from the interviews that family members expressed the feeling of shame and embarrassment. They indicated how they would not tell their friends about their loved one’s illness because it is common that mental illness is stigmatized. During admissions of their mentally ill family members, they indicated that they would not even tell their colleagues at their work places because they felt embarrassed by the diagnosis. The following quotations confirm these findings:

“My sister was undressing in the street and this was really embarrassing, I could not even walk freely at the mall.”

“I could not tell my fiancé what was wrong with my younger brother because I was embarrassed”

“I changed my work place because everybody at work knew my sister before she became ill. She used to come to my office during school holidays when she was at university”

The feeling of embarrassment is closely related to stigma, which is defined as a sign of disgrace or discredit which sets a person apart from others (Byrne, 2000:65). Self-stigmatization has been described in literature similar to what was found in this research and there are numerous personal accounts of psychiatric illness, where shame overrides even the most extreme of symptoms (Byrne, 2000:65). Families’
attitudes towards mental illness contribute to the feeling of shame and embarrassment and that can be difficult to overcome. They may feel that they cannot tell anyone about the condition of their mentally ill family member (Croft, 2008:1)

- **Families explained what helped them to accept the condition of their mentally ill family member**

Family members expressed how they struggled to accept the condition of their mentally ill family members. They indicated that the more they struggled, their family members were also struggling because they did not get enough support from them and they ended up being admitted to hospital several times because they relapsed. Berglund et al. (2003:119) confirm that lack of support by families can lead to the relapse of mentally ill family member. Families reported how they started to be worried about their loved ones and they then decided to do something about what they were going through. The following indicates what families did to help themselves to accept their mentally ill family member’s conditions:

- **Educating self on the diagnosis and relevant treatment**

The families interviewed mentioned that they decided to seek information on the condition of their loved one in order to understand how to handle them. Most of them indicated that they started asking the doctor who was treating their family member to explain the diagnosis and the treatment in detail. Six family members reported that they obtained the information from the Internet and read about the diagnosis. Following, is one of the direct quotations from the interview conducted with families:

“I had to request leave from work just to come and meet the doctor in order to get information on my brother’s condition”

What was expressed by families about education is confirmed by Tartakovsky, (2011:1), who reported that educating yourself about your loved one’s illness is really the foundation of support. Evidence has shown that if you provide families with education and involve them in the treatment process, patients experience a reduction in symptoms, hospitalization days and relapse (Tartakovsky, 2011:1)
• Developing a positive attitude

It emerged from the findings of this research that family members accepted the conditions of their mentally ill family members when they stopped being negative. They learned to treat their mentally ill family members with respect and not to undermine them. Most of the families explained that they learned a lot from the group sessions they used to attend with a psychologist. That is how their attitude has changed and they are now treating their loved ones well. Following are direct quotations from the interviews:

“I stopped shouting at my sister because I realized that she is really sick, it is not adolescent stage like I thought”

“I realized that my daughter was really sick and I decided to talk to her well and gave her support by ensuring that she takes her medication as prescribed by the doctor”

Nichols, (2008:12) confirms that positive attitudes help families to provide better support for a family member with mental illness.

• Accepting their feelings

Family members expressed how they felt about their mentally ill family members when they were first diagnosed with mental illness. They were in denial, ashamed and embarrassed but they realized that they had to accept their feelings in order to accept their loved one’s conditions. These are direct quotations from interviews which are written in Setswana and translated to English:

“Wa itse ke ne ke sa dumele gore morwa waka o lwala tlhogo. Ke ne ke nagana fela gore o thakatlhakane ka nthla ya stress mme go tla fela e se kgale. Ke ne ke palelwa ke go bolelela tsala yame gore ngwanake wa lwala mme ga jaana re bua ka yone re lokologile ka gore ke amogetse gore morwaake wa lwala”
(You know I did not believe that my son is mentally ill, I thought it was just a confusion caused by stress that will clear up with time. I could not even tell my best friend that my son is sick, but now we can discuss it freely because I have accepted my son’s condition).

“Ke ne ke tlhabiwa ke ditlhong ga batho ba mpotsa ka bolwetse ba nnake. Ka gale ke ne ke ba ikgatholosa, mare gompieno ga ba mpotsa ke tlhalosa bolwetse ba nnake e kete ke bame”

(I was always feeling ashamed when people asked me about my sister’s condition. I used to ignore them, but currently when they ask me I explain my sister’s condition as though it is mine).

Nichols, (2008:12) confirms that people may find themselves denying the warning signs, worrying what other people will think due to stigma or wonder what caused their family members to become sick, but they should accept that these feelings are normal and common among others. According to Geggie et al. (2000:38), who conducted a family strengths research project, acceptance is one of eight family strengths identified. Acceptance is defined as showing respect, appreciation and understanding for the other family member’s individuality (Geggie et al., 2000:38).

3.3.1.2 Having faith in God

Column B of Table 3.2 deals with families having faith in God as strength that contributes to limiting relapse. This category is further divided into three subcategories indicated as follows (Table 3.4):

**Table 3.4: Having faith in God**

- Praying together
- Going to church
- Fellowship with other believers
Praying together

Family members interviewed, indicated that they are strengthened by having faith in God. They expressed that praying together in their families assist them to carry on providing support to their mentally ill family member. They further indicated how prayer kept them going irrespective of the challenges they experienced with their mentally ill family member. The following are some of the direct quotations from the transcripts:

“You know sister, I have a strong relationship with God and that always give me courage to go on with life because God is a source of my strength”

“I am always strengthened by prayer especially when I pray with my prayer partners”

“Prayer bring me very close to God because when I am burdened I communicate with my God and I receive power to carry on with life”

“God is my a source of strength and that helps me to carry on with life and to support my son”

From a Christian viewpoint, the book of James 5 verse 13 confirms that anyone in trouble should pray. Another scripture in the book of Mark 11 verse 24 confirms that whatever is asked in prayer, one should believe and it shall be done for them (The Holy Bible, New International Version, 1996:1015). In addition, Tepper et al. (2001:663) reported that specific religious coping strategies such as prayer or meditation are more common among families caring for a mentally ill relative. Rammohan et al. (2002:105) also confirm that religious beliefs and practices are important resources for family members involved in caring for a mentally ill relative. It continues to say that a strong belief in God helps family members to reduce their distress.
Going to church

From the interviews it emerged that going to church assists families to have a strong spiritual base because they receive encouraging words from the pastors. The following are direct quotations from interviews:

“Ke rata go ya kerekeng ka gore moruti o phela a rera message o nthotlhoetsang thata. Le fa ausi a ne a le kwa sepetlele, moruti o ne a mo etela”

(I always go to church because the pastor preaches messages of encouragement. Even when my sister was admitted at the hospital, the pastor visited her).

“Ga nke ke rata go fetwa ke sermon go tswa go moruti wa rona ka gore ke kereya matla go tsawa mo melaetseng e a e rerang”

(I don’t want to miss any sermon from our pastor because I always receive strength from his messages).

“Ke phela ke tsholetsegile mo moeng ga ke boa ko kerekeng ka gore moruti o rera ka matla”

(My spirit is always uplifted when I come back from church because of the powerful preaching I receive from our pastor).

A strong spiritual base gives families a sense of belonging and acceptance by a higher being. It gives meaning and purpose to families that provide strength and hope in times of adversity (Thames & Thomason, 2000:2).

Fellowship with other believers

Families indicated that they have a good relationship with fellow believers and such believers give them a lot of support. They expressed that they sometimes feel down and that they are always encouraged by fellow believers. Following are direct quotations from interviews:
“I always meet with a group of ladies in our church and they always give me a lot of support especially when my son is not well”

“Every Wednesday I meet with my prayer partners and that gives me strength to go on even during tough times”

“During men’s fellowship, I always get encouragement because we discuss our problems and we pray together for different problems”

According to the Biblical scripture in the book of Hebrews 10 verse 25, believers should not give up meeting together, as some are in the habit of doing it, but they should encourage one another (The Holy Bible, New International Version, 1996:1015). Furthermore, according to Thames and Thomason (2000:2), believing in high power and acting on a value system beyond self-interest is defined as spirituality. Spirituality offers a belief system that teaches how to have healthy relationships within the family unit and with others.

3.3.1.3 Involving a mentally ill family member in daily activities.

Column C of Table 3.2 deals with the category of involving a family member in daily activities. This category is divided into two subcategories and they are as follows:

Table 3.5: Involving a mentally ill family member in daily activities

| ➢ Families expressed how they used to segregate their mentally ill family members |
| ➢ Families are now spending time with their mentally ill family members |

Family members indicated that they were not comfortable in involving their loved ones in daily activities the first time they were diagnosed with mental illness. They thought that they will make mistakes because they thought mental illness is a
permanent disability whereby one will not be able to do anything. Most of them reported that they did not allow them to do any household chores because they thought they will destroy their properties. The following quotations are directly from the interviews conducted:

“I did not want to allow him to touch anything in the kitchen because I thought he will break all my glasses because he broke some before he was admitted in hospital”

“I stopped her from doing the washing because I was scared that she will flood the house like it happened in the past”

“I left him in the house when I went for shopping because I was scared that he will cause a scene at the mall like he did before he was admitted to hospital”

Nichols, (2008:2) confirms that families behave negatively towards their mentally ill family members as a result of the negative associations that mental illness carry in our society. It is therefore imperative that families should break through the stigma in order to give the family member the help they need.

➢ **Families are now spending time with their mentally ill family members**

It was indicated by most of the family members interviewed that they changed their approach after receiving more information on the condition of their mentally ill family member. Some reported that after meeting the doctors and nurses treating their family members, their attitude towards their loved ones changed a lot. They started involving them in activities such as household chores and they realized that they did them well. Another thing the family members indicated was that their mentally ill family members were isolating themselves because they also felt neglected by families. The findings of this research indicate that when families share activities with their mentally ill family members, there might be a lot of improvement noted. Their mentally ill family members are now responsible even for their own health because they sometimes go alone to the hospital for their follow-up appointments. Following are some of the quotations from the direct interviews:
“My daughter used to spend time in her bedroom, she would eat and do everything in her room, but now she sits with us in the dining room for meals and she is able to watch TV with us.”

“My son enjoy helping in the kitchen with cooking and washing of dishes because I allow him to cook for us. He is the best cook.”

“I like to do shopping with my son because he helps me a lot especially when I want to buy new clothes. He has a very good eye when it comes to fashion”

The Family Strength Research Project confirms that sharing activities, as the things that all members of the family do together, reinforce and strengthen their togetherness (Geggie et al., 2000:32).

3.3.1.4. Being aware of what aggravates the mentally ill family member

Column D of Table 3.2 deals with the category of being aware of what aggravates the mentally ill family member. The sub-category under this is as follows:

Table 3.6: Being aware of what aggravates the mentally ill family member

- Maintaining a calm attitude towards the mentally ill family member and communicating well

- Maintaining a calm attitude towards mentally ill family member and communicating well

Family members expressed during the interviews how they used to have a negative attitude towards their mentally ill family members. They indicated that when their family members became agitated, they would shout at them and some would even fight them. They realized that when they treated them like that, mentally ill family members will be more agitated and they would sometimes end up destroying properties or injuring someone in the house. Most of the families interviewed indicated that they changed their attitude towards their mentally ill family members through the help of professionals in the hospital. They attended group sessions and
they learned from such sessions that when their mentally ill family member becomes agitated or angry, they should stay calm at all times to avoid aggravating their mentally ill family member. They also learned how to communicate with their mentally ill family members in order to avoid agitating them. The following are some of the quotations from the interviews:

“I used to shout at him when he was agitated, but now when he start I move out of the room to give him space and I stay calm”

“I knew that my sister was mentally ill but I thought she is also stubborn and want to control us at home. I would shout at her and even fight with her and she ultimately injured me on the arm, here is the scar. Now lately when she start becoming angry, I avoid her as much as possible and concentrate in doing something else until she is calm”

The findings of this research are confirmed by Swink (2010:1) who reported that when someone communicates with a mentally ill, they should show respect because when someone feels respected and heard they are more likely to return respect and consider what you have to say. The Family Strength Research Project identified communication as one of the family strengths and it is defined as interacting with each other in a predominately open, positive, honest and frequent manner (Geggie et al., 2000:26).

3.4. CONCLUSION

The realisation of data collection and data analysis on strengths of families to limit relapse in mentally ill family member was discussed in this chapter. The findings of this research included four main categories which included, accepting the condition of a mentally ill family member, having faith in God, involving a mentally ill family member in daily activities and avoid upsetting the mentally ill family member. These findings were enriched with direct quotations from the transcriptions as verbalised during interviews which were also compared to the available relevant literature for confirmation. In the next chapter, conclusions, limitations and recommendations will be discussed.
CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

In this chapter the conclusions and limitations of the research are discussed. Recommendations are made for psychiatric nursing practice, nursing education and nursing research with reference to the formulation of guidelines for psychiatric nurses to empower family members caring for mental health care users to limit relapse.

4.2. CONCLUSIONS ABOUT STRENGTHS OF FAMILIES TO LIMIT RELAPSE IN MENTALLY ILL FAMILY MEMBERS

Conclusions from the findings of this research as well as from the confirming literature and field notes about the strengths of families to limit relapse of mental health care users are discussed.

4.2.1. General conclusion

Reflecting on the information gained from the family members which literature confirmed, the family members went through the process of initially not accepting their mentally ill family members due to emotional disturbance and negative attitudes but through education from health professionals they ended up accepting their mentally ill family members. They discovered their strengths and started applying them to limit relapse in their mentally ill family members. From the findings it seems that there is a need that family members caring for mentally ill family members should be involved from the beginning, immediately when their member is diagnosed with mental illness, and that they should be guided through a process of acceptance.

4.2.2. Acceptance through education

One of the strengths family members stressed to limit relapse in mentally ill family members is “acceptance through education”. Family members initially experienced difficulties when their mentally ill family members were diagnosed for the first time.
with mental illness, such as being impatient, feeling guilty and feeling shame and embarrassment. They indicated that their reactions affected their mentally ill family members to an extend that they did not receive enough support from them and most of them ended up relapsing and being admitted several times in hospital. Most family members indicated that they requested the doctors to give them information regarding the diagnosis and treatment of their mentally ill family members and others obtained information from the internet. This assisted them in developing a positive attitude and acceptance of their feelings as well as the condition of their mentally ill family members. Acceptance through education helped them to give their mentally ill family members the support they needed and hence they have not relapsed in the past two years.

4.2.3. Having faith in God

Another strength employed by family members is “having faith in God”. Family members are strengthened by having faith in God. They are able to provide support to their mentally ill family members irrespective of the challenges they experience because they are strengthened by prayer. They also have a strong spiritual base by going to church where they receive encouraging words from the pastors. Fellowship with other believers also helps them a lot because they receive support during difficult times. A strong spiritual base gives family members a sense of belonging and acceptance by a higher being. It also provides strength and hope in times of adversity and teaches them how to have healthy relationships within the family unit and with others.

4.2.4. Involving the family member in daily activities

A third strength used by families is to involve a mentally ill family member in daily activities. Families initially experienced difficulties in involving their mentally ill family member in daily activities the first time they were diagnosed with mental illness, because they thought mental illness is a permanent disability. Most of them reported that they did not allow their mentally ill family members to do any household chores because they thought they will destroy their properties. Mentally ill family members would on the other hand isolate themselves because they felt neglected by families.
After searching for and receiving information from health professionals, they started spending time with their mentally ill family members and thus involving them in daily activities. Some family members have indicated that they even do shopping with their mentally ill family members because they have learned to involve them in daily activities. Involving mentally ill family members in daily activities helped them to take responsibility over their lives and for their own mental health. This was evident when some mentally ill family members attended their monthly follow up appointments alone at the hospital. It is therefore imperative that family members should break through the stigma in order to give the mentally ill family member the help they need. It is also evident that sharing activities, as the things that all members of the family do together, reinforce and strengthen their togetherness.

4.2.5. Maintaining a calm attitude and using communication skills

Families also use the strengths of maintaining a calm attitude, and using communication skills, to limit relapse in mentally ill family members. Families used to have negative attitude towards their mentally ill family members and that contributed to their agitation. Mentally ill family members would end up destroying properties or injuring someone when they became agitated. Families changed their attitude after receiving professional help through group sessions and they learned how to handle their mentally ill family members when they are agitated and that they should stay calm at all times to avoid aggravating them. They then became aware of what aggravates them, started communicating well and that brought harmony in families. Communication as one of the family strengths is defined as interacting with each other in a predominately open, positive, honest and frequent manner

4.3. LIMITATIONS

The study was restricted to the clinical area of one hospital and 25 family members caring for mental health care users who attend their follow ups at the hospital were contacted to participate in the study. Only 15 family members responded and participated in the study. The findings of the study therefore cannot be generalized to the whole province or to other areas of the country. Nevertheless, the guidelines formulated for psychiatric nurses can be used elsewhere.
Participants who agreed to come for interviews did not understand an open-ended question, especially those who were interviewed in Setswana. The researcher had to collect brief history on the concerned mentally ill family member before the participant could understand the question and that took more time compared to participants who were interviewed in English. The researcher suspected that some information was held back because of lack of understanding of the open-ended question. The researcher addressed this limitation by ensuring that data saturation was reached.

4.4. RECOMMENDATIONS FOR NURSING EDUCATION, NURSING RESEARCH AND PSYCHIATRIC NURSING PRACTICE

Recommendations for psychiatric nursing practice, nursing education and nursing research will be made in this section, with reference to the findings of this research, the literature as well as the conclusions that were made.

4.4.1. Recommendations for psychiatric nursing practice

Recommendations for psychiatric nursing practice are formulated as guidelines. Guidelines for empowerment of families caring for mentally ill family members in Bojanala district in the North West Province have been proposed. These guidelines were developed from conclusions drawn by the researcher, based on the experiences of participating families caring for mentally ill family members. The guidelines are meant to be implemented by psychiatric nurses working at the clinics and hospitals as well as the mental health coordinators in sub districts and they must be used in conjunction with the existing policies and protocols within the framework of the Mental Health Care Act 17 of 2002. Guidelines are as follows:

- Psychiatric nurses helping family members who care for mentally ill family members should assist them identify feelings which disturb them to accept the conditions of their mentally ill family members. This will be achieved through psycho-education. When family members have dealt with their feelings such as guilt, shame and embarrassment, they will be able to move towards
acceptance, which in turn will empower them to assist and support their mentally ill family member. The following issues should be addressed:

- Education to family members in order to give detailed information on the diagnosis, treatment and follow-ups of the mentally ill family member. Family members can also be encouraged to look for more information on the diagnosis of their mentally ill family member by reading books or searching for information from the internet. This will assist them to accept the condition of the mentally ill family member and give necessary support to comply with treatment, thus limiting relapse.
- The family should be able to be aware of what aggravates the mentally ill family member. This will assist them to maintain a calm attitude using effective communication skills and maintaining harmony in the family.
- The spiritual base of family members may be explored with the family as strength to limit relapse. Examples of how this strength may be facilitated are through prayer and fellowship with other believers who serve as a support system for these family members.

Psychiatric nurse should facilitate the strengths of the family members to discover their strengths and implement these strengths in limiting relapse of their mentally ill family members. The process of this facilitation follows:

- Building a trusting relationship with the family member caring for a mentally ill family member by spending more time with them.
- Exploring family strengths together with the family, that include acceptance, faith in God, involving a mentally ill family member in daily activities and maintaining a calm attitude and using communication skills, and how they can use these strengths to limit relapse in their mentally ill family members
- Evaluating if the family strengths explored assisted in limiting relapse of mentally ill family member.
Psychiatric nurses working at the clinics and mental health coordinators should do home visits. The mental health coordinator in each sub district should coordinate the programme with all the clinics in the area. During home visits, the family strengths explored will be evaluated and any other support that the family needs will be implemented.

It would also be helpful if psychiatric nurses can mobilize family support groups that will assist families having newly diagnosed mentally ill family members. This could be met by identifying and recruiting families caring for mentally ill family members in this area and who are interested in joining the support group. The support group can start with small numbers of the family members, and the steps or principles of establishing a support group can be followed.

4.4.2. Recommendations for nursing education

Recommendations for nursing education should be aimed at assisting psychiatric nurses under training in the development of skills that will enable them to guide families to discover and implement their strengths to limit relapse in mentally ill family members. The following are the recommendations based on the conclusions made for this study:

The findings of this research and the guidelines for psychiatric nursing practice will be valuable when included in the curricula of the four year programme within the psychiatric nursing curriculum and the one year diploma in psychiatric nursing, where students learn to deal with the support of families caring for mentally ill family members.

To include both findings and guidelines in in-service programs for qualified nurses and working in the community for them to give support to families caring for mentally ill family members.

4.4.3. Recommendations for nursing research

From the findings of this research, follow-up research is recommended as follows:
To explore and describe experiences of families who have been empowered by psychiatric nurses using the guidelines.

- Explore the process the families undergo towards acceptance and discovering their strengths.
- The role of the faith based organization in supporting families with mentally ill family members

5. CONCLUDING REMARKS

The objective of this research namely, to explore and describe the strengths of families in assisting them to limit relapse of a mentally ill family member, with the aim of developing guidelines to psychiatric nurses to assist families to limit relapse of mentally ill family members, have been achieved.

Interviews using open-ended questions were conducted with family members to collect data on strengths of families to limit relapse of mentally ill family member. After data collection, data was analysed by the researcher and co-analyser. Existing literature from electronic databases and library catalogues were used to confirm the findings of this research. The findings of this research about strengths of families to limit relapse in mentally ill family member were identified as acceptance through education, having faith in God, involving a mentally ill family member in daily activities and maintaining a calm attitude and using communication skills.

The conclusion that can be made is that acceptance through education assisted family members in developing a positive attitude and acceptance of their feelings as well as the condition of their mentally ill family members. A strong spiritual base provides family members with strength and hope in times of adversity and teaches them how to have healthy relationships within the family unit and with others. It is also evident that sharing activities, as the things that all members of the family do together, reinforce and strengthen their togetherness and that if family members can avoid aggravating mentally ill family members by communicating well with them, that can bring harmony in families.
Recommendations in this research are made for nursing education, nursing research and psychiatric nursing practice with guidelines for psychiatric nurses to empower families caring for mentally ill family members to use their strengths and contribute to limiting relapse.
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APPENDIX A

ETHICAL APPROVAL FROM THE NORTH-WEST UNIVERSITY’S ETHICS COMMITTEE

ETHICS APPLICATION: NWU-00036-11-S1 (M.P. KOEN & E. DU PLESSIS)

The applicants responded in a satisfactorily way to the comments made by the panel members.

Ethical approval is recommended.

Yours sincerely

[Signature]

Prof. H.H. Vorster
APPENDIX B

A LETTER THAT INDICATES THAT THIS STUDY FORMS PART OF THE RISE PROJECT

Dear NWU Ethics Committee

AMENDMENT - ETHICAL APPROVAL OF RESEARCH PROGRAMME: STRENGTHENING THE RESILIENCE OF HEALTH CAREGIVERS AND RISK GROUPS

The amendment requested, relates to the research project, entitled: *Strengthening the resilience of health caregivers and risk groups*, with ethical clearance from the Ethics Committee of the North-West University (Ref no NWU-00036-11-S1). The co-investigators are Prof MP Koen and Dr E du Plessis.

The co-investigators identified the problem that the resilience of health caregivers as well as risk groups should be strengthened by means of a comprehensive, multi-faceted approach and that research should be conducted on how resilience of health caregivers and risk groups can be strengthened by means of such an approach. The purpose of the overarching research is thus to develop a comprehensive, multi-faceted approach to strengthen the resilience of health caregivers as well as risk groups. We intend to reach this purpose through the following objectives:

- To explore and describe the resilience of health caregivers and risk groups
- To implement and validate strategies developed by Koen, Van Eeden and Wissing (2010c) to strengthen resilience of professional nurses and other health caregivers and risk groups
- To explore and describe faith community nursing as intervention to strengthen the resilience of health caregivers and risk groups
- To explore and describe sensory stimulation as intervention to strengthen the resilience of health caregivers and risk groups

To achieve these objectives, it is necessary to explore and describe various health caregivers and risk groups. Within this overarching research project, Mrs. TT Tlhowe (Student number: 16202783), intends to focus on exploring and describing the strengths of families in assisting mentally ill family member to limit relapse. The results of this sub-study will contribute to reaching the objectives of the overarching project, namely by formulating
guidelines for psychiatric nurses to empower families of mental health care users to limit relapse. The methodology and ethical aspects of Mrs. Tlhowe study is congruent with the methodology and ethical aspects of the approved overall study.

Short summary of student’s study, with objectives:

Relapse in psychiatric patients has been noted as a major problem both nationally and internationally (Kazadi et al., 2008:52). The problem of relapse is also evident in the practical setting where the researcher works. The relapse rate in the hospital where research will be conducted for the year 2009 ranges between 30% and 50% (Admission register in the mental health unit). This poses a very serious burden on families who provide care for such patients. Families caring for mentally ill family members need support from health care practitioners to assist them to cope. One approach is to explore family strengths to improve the family’s life as well as that of the patient. Family strengths will be looked into in this study in order to explore how families can be assisted to care for mentally ill family members. Studies on family strengths have been conducted but there is no specific study that focused on family strengths that will assist families to care for a mentally ill family member in order to limit relapse.

The purpose of this research is to explore and describe the strengths of families in assisting mental health care users to limit relapse and to formulate guidelines that will be used by psychiatric nurses to empower family members caring for mental health care users to limit relapse.

Yours sincerely,

Dr. E. du Plessis (Supervisor)

Prof. M.P. Koen (Co-supervisor)
APPENDIX C

REQUEST FOR PERMISSION TO CONDUCT RESEARCH IN THE HOSPITAL SITUATED IN THE BOJANALA DISTRICT

I am currently registered for the degree Magister Curationis in Psychiatric Nursing Science at the Potchefstroom campus of the North West University. One of the requirements of this course is that I have to conduct a research project.

I hereby request permission to conduct this research with the following title:
Strengths of families to limit relapse in mentally ill family members.

The objectives of the research are:

- To explore and describe the strengths of families in assisting mental health care users to limit relapse
- To develop recommendations for mental health care practitioners to assist families in limiting relapses of mental health care user.

I trust that this research will contribute to the realization of the above mentioned objectives. The research will be conducted under the supervision of experts in Psychiatric Nursing as well as Nursing Research at the School of Nursing Science.

Enclosed please find the research proposal that has been approved by the North West University’s Ethical Committee. This proposal gives an outline of what the research entails.

Positive response to this request will be appreciated.

Yours sincerely

T.T. Tlhowe (Researcher)

Dr. E. du Plessis (Supervisor)

Prof. M.P. Koen (Co-supervisor)
Appendix D

Permission to Conduct Research

Policy, Planning, Research, Monitoring and Evaluation

To: Ms T. T Tshowe

From: Policy, Planning, Research, Monitoring & Evaluation

Subject: Research Approval – Strengths of families to limit relapse in mentally ill family members.

Purpose

To inform Ms T. T Tshowe that permission to undertake the above mentioned study has been granted by the North West Department of Health. The researcher is expected to issue this letter as proof that the Department has granted approval to the districts or health facilities that form part of the study.

Arrangements in advance with managers at district level or facilities shall be facilitated by the researcher and the department expects to receive the final research report upon completion.

Kindest regards

Director: Policy, Planning, Research, Monitoring & Evaluation
Mr B Redlinghys

24/01/2012

Date
APPENDIX E

WRITTEN INFORMED CONSENT TO PARTICIPATE IN THE RESEARCH PROJECT (Also available in Setswana for the participants)

I…………………………………………………………………………………………hereby give consent to participate in the research project titled: Strengths of families to limit relapse in mentally ill family member.

The information pertaining to the research project has been explained to me and I understand the implications thereof.

……………………………….                                    …………………
Signature: Participant                                            Date

……………………………….                                    ……………………………
Signature: Researcher                                           Date
APPENDIX F

WORK PROTOCOL

Dear colleague

Thank you for your willingness and agreement to participate in this research as a co-analyzer of the research titled: Strengths of families to limit relapse in mentally ill family member.

The objectives of this research are:

- To explore and describe the strengths of families in assisting mental health care users to limit relapse
- To develop recommendations for mental health care practitioners to assist families in limiting relapses of mental health care user.

Data to be analyzed include the transcripts and field notes of the interviews conducted with participants. Please analyze the transcripts and field notes as follows:

Each transcript will be divided into three columns with the middle column used for the interviewer’s and the participant’s verbal responses.

The right column will be used for the themes that emerge from the responses of the participants and the left column will be used to write down the analyzer’s ideas and thought that come to mind.

Read through all the transcripts first to get the sense of the whole experiences as described by the participants in their own words.

Choose one transcript that is most interesting or the shortest.
Carefully read through this transcript to try and establish what it is about. The ideas that come to mind will be jotted down on the left column.

Read again through this particular transcript this time underlining the themes, words and phrases as stated by participants.

The underlined themes will be written in the right column.

The identified themes will be grouped into three categories that will be used to analyze data. These categories will be grouped as the main categories, the sub-categories and leftovers categories.

This procedure will be followed with each transcript.

The main categories and sub-categories will be written in a tabular form using the concrete words of the participants. The re-coding will be done at this stage.

Finally the concrete words and phrases will be translated in scientific terminology.

A consensus meeting will be arranged as per agreement on the date and time that suits you.

Your participation as a co analyzer in this research is highly appreciated. Feel free to contact me if you need further details at the following number:

014- 5905201

Yours sincerely

T.T.Tlhowe
APPENDIX G

FIELD NOTES

Interview 1

Descriptive notes

The interviewee was a 65 year old woman who stays with her husband. They have two children. The first one is married and has got three children and they are staying in Pretoria. The second one is the mental health care user who has been sick for 35 years who stays with them.

Reflective notes

She was a bit reluctant to speak when the interview started but she was flowing well as time went by. She indicated how she used to struggle with her emotions when her son relapsed before. They could not stay with him in the house and he was staying in the back room. That affected their relationship a lot because he was always feeling left out. They are currently staying with him in the house because his condition is now controlled.

Demographic notes

The interview was held in the room arranged in the hospital. It was cloudy outside and the wind was blowing. The interview lasted for 45 minutes.

Interview 2

Descriptive notes

The interviewee was a 58 year old woman who was staying with her husband and her two children. The other child is married and stays in Johannesburg with her husband and two children. She explained that she stays home to take care of her
son who has been mentally ill for five years now. She did not understand the open ended question well until she was asked to give brief history of the mental health care user.

Reflective notes

The interviewee found it difficult to give detailed answers. She only responded through probing. She indicated that they were always impatient with their mentally ill family member but they realized that it makes him worse. They have now accepted his condition and that is why he is able to come to hospital alone.

Demographic notes

The interview was held in the room arranged in the hospital. It was 10h00 in the morning and the sun was shining. The interview lasted for 40 minutes.

Interview 3

Descriptive notes

The interviewee was a 30 year old lady who was well dressed. She is the elder sister at home and both her parents have passed away. She has a son and now taking care of her younger brother who has been mentally ill for six years now.

Reflective notes

She indicated how they used to fight with her brother because she could not understand that he is mentally ill. She realized that her brother is really sick when he was admitted in hospital for the whole month. She was called for a family conference and that is where she got an explanation of her brother’s condition. She has now accepted her brother’s condition.
Demographic notes

The interview was conducted in the hospital. It was 11h00 in the morning and it was raining. It lasted for 45 minutes.

Interview 4

Descriptive notes

The interviewee was a 52 year old man who stays with his mentally ill wife. They have two children, the first one is at the college doing her final year and the last one is doing matric. He is doing part time job at the municipality and the wife is on incapacity leave because she was a teacher. The wife has been sick for 5 years now.

Reflective notes

The interviewee indicated how difficult it was the first time his wife was diagnosed with mental illness. He explained that he thought that his wife was just having stress and he did not take her serious until she broke windows at home. He also indicated that he was always embarrassed to disclose his wife’s condition even to his in laws but he was helped by one psychologist who offered him therapy.

Demographic notes

The interview was held in room prepared at the hospital. It was a bit noisy outside because the gardeners were using a lawn mower. They were requested to stop for a while and they cooperated well. The interview lasted for 45 minutes.
## APPENDIX H

### TRANSCRIPT OF AN INTERVIEW

<table>
<thead>
<tr>
<th>Interviewer</th>
<th>Good morning Mrs. R and how are you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewee</td>
<td>Good morning Sister, I am ok, can’t complain</td>
</tr>
<tr>
<td>Interviewer</td>
<td>How is your son doing?</td>
</tr>
<tr>
<td>Interviewee</td>
<td>My son has improved a lot. He is at least controllable even though he still has got a tendency of pacing up and down, but he can sit still with us when we eat or watch TV.</td>
</tr>
<tr>
<td>Interviewer</td>
<td>That’s good news. By the way when was your son diagnosed with mental illness?</td>
</tr>
<tr>
<td>Interviewee</td>
<td>Sister, my son was diagnosed with schizophrenia when he was 15 years old. He was admitted in Weskoppies for 4 months.</td>
</tr>
<tr>
<td>Interviewer</td>
<td>You say your son was diagnosed when he was 15 years old, does that mean that he has been mentally ill for 30 years now?</td>
</tr>
<tr>
<td>Interviewee</td>
<td>That’s true sister.</td>
</tr>
<tr>
<td>Interviewer</td>
<td>In the 30 years of his illness, how many times was he admitted in hospital and when was the last time?</td>
</tr>
<tr>
<td>Interviewee</td>
<td>He was only admitted three times and the last admission was in 2009</td>
</tr>
<tr>
<td>Interviewer</td>
<td>What do you think are your strengths in taking care of your son to limit relapse?</td>
</tr>
<tr>
<td>Interviewee</td>
<td>Oh sister, I believe in God and my faith helps me a lot to carry on taking care of my son. One other thing that helps me a lot is that I have accepted my son's condition and I allow him to do some chores in the house. We also allow him to sit with us in our bedroom especially when we watch TV because we like watching TV in our bedroom</td>
</tr>
</tbody>
</table>
| Interviewer | You have talked about your faith, the fact that you have
accepted your son and that you allow him to do some chores. Is there anything else?

**Interviewee**
I always avoid making him angry. When I see that he is a bit agitated, I always remain calm. I also make sure that he takes his medication daily as ordered by the Doctor.

**Interviewer**
Is there anything else madam?

**Interviewee**
Sister, I always talk to my son about his future after I have died. I have made preparations already for him to stay in Spesbona after I have passed away and we always talk about it to hear how he feels about it.

**Interviewer**
You have indicated that you always talk to him about the future, is there anything else madam that you regard as a strength that help you to care for your son to limit relapse?

**Interviewee**
There is a woman in our church who encourages me every time I meet with her either in our place or hers. She is such a blessing to me; she has been there for us as a family during difficult times when my son was admitted in hospital. Another thing is that I don’t miss any church service because our pastor is always preaching encouraging sermons. I think those are the things that strengthen me to carry on taking care of my son.