

**THE EXPERIENCES OF FAMILY MEMBERS OF A PERSON WITH A HEAD INJURY**

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2010**

## DECLARATION

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Maria Tegelela Iyambo

## **DEDICATION**

I dedicate this dissertation to the memory of my dearest late parents,

Sakaria Kambogo Nangula and Aina Gweendama; my husband Daniel;

Daughters: Natangwe, Ndapandula, Ndagwedhwa and Ndapanda;

Grand-daughter: Tuyakula and sister: Ndesheetelwa.

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## **LIST OF ABBREVIATIONS**

ABI	:	Acquired Brain Injury
GCS	:	Glasgow Scale
ICU	:	Intensive Care Unit
MCHI	:	Mild Closed Head Injury
MOHSS	:	Ministry of Health and Social Services
MVA	:	Motor Vehicle Accident
OIH	:	Oshakati Intermediate Hospital
OPD	:	Out Patient Department
PCS	:	Post-concussive Syndrome
TBI	:	Traumatic Brain Injury
USA	:	United States of America
WHO	:	World Health Organization

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## **ABSTRACT**

The study on the experiences of family members of a person with a head injury took place in the three of the Northern Regions of Namibia, namely: Oshana, Omusati and Ohangwena.

The purpose of this study was to make an effort to understand what the family members of a person with a head injury go through during the pre-hospitalization, hospitalization and rehabilitation time went through. The objectives set for this study were, to: explore and describe the experiences of family members of a person with a head injury, and to develop guidelines for family members on how to cope and support a person diagnosed with a head injury.

A purposive sample was selected from the records of the Intensive Care Unit at the Intermediate Hospital Oshakati where the addresses of the head injury patients were identified. An explorative, descriptive, contextual study was conducted utilizing a qualitative design utilizing a purposive individual in-depth face-to-face interview to gather data from family members of a person with a head injury. Data was analyzed using Tech's method for content analysis.

The results showed that family members of a person with head injury had varied and different experiences varying from different feelings, challenges and support to them.

Guidelines for family members of a person with head injury were developed. Recommendations were made for both health care providers and family members of a person with a head injury. Family members need to take an active role in acquiring relevant information on head injury from health care providers and to utilize resources that are available in their communities to support a person with a head injury.

## **CHAPTER 1**

### **INTRODUCTION**

#### **1.1 BACKGROUND TO THE PROBLEM**

Head injuries are common occurrences world-wide and can have debilitating effects on a person and family units as well. *Head injury* is defined as any injury causing brain illness. This is usually referred to as traumatic brain injury (TBI). The causes of head injury vary in developing and developed countries. Sometimes injury results from a blow to the head that may be suffered in a motor vehicle accident such as when a person

is swung through the wind screen, from a fall, causing a closed head injury, or from a gunshot causing an open wound. According to answers to questions by members of head injury patients, Hutchison and Hutchison (2009) pointed out that head injury may also occur as a result of lack of oxygen, such as during drowning, or as a result of lack of blood supply to the brain, such as following a cardiac arrest. Tidy (2007) cites that head injury is usually referred to as traumatic brain injury (TBI) or acquired brain injury (ABI) which occurs when a sudden trauma causes damage to the brain. Head injury may also be as a result of a concussion (when the brain is shaken) or a contusion (bruise on the brain).

Direct trauma to the head may cause a closed head injury (mild or diffuse), that occurs when the integrity of the skull is not compromised by the trauma. Although there is so far not a consensus on the exact definition of a mild closed head injury (MCHI), Foulis (1999) in her paper on Predicting the outcome of Mild Closed Head Injury, states that it is “a non-penetrating cranial injury, resulting in a loss of consciousness of 20 minutes or less. The Glasgow Scale (GCS) evaluation shortly after the incident is 13 to 15, and hospitalization (due to head injury, not concomitant injury) does not exceed 48 hours”. MCHI is sometimes followed by a range of symptoms that is called post-concussive syndrome (PCS) which can be as high as 80%. According to Bond, Rae Lee Draeger, Mandleco and Donnelly (2003), about 10%, of head injury patients sustain moderate traumatic brain injury (GCS score 9 – 13), and may be admitted to an Intensive Care Unit (ICU) for observation, while 10% who have severe traumatic brain injury (GCS score 3 – 8), require rapid intervention and stabilization in an ICU.

Direct head injury may also cause open wounds to the head that is mostly fatal or cause severe head injury with a poor prognosis. The brain is inelastic and has a jelly-like consistency. When an adequate force is administered to the head, millions of nerve fibres twist and stretch or may cause the shearing and death of some neurons. This may result in physical, emotional, psychological or behavioural complications (Foulis, 1999).

Indirect injury may be caused by movement of the brain within the skull leading to contusions (haematoma) on the opposite side of the head from the impact, or disruptive

injuries to axons or blood vessels from shearing (causing a haemorrhage) or rotational forces as the head is accelerated and decelerated after the impact (Concise Colour Medical Dictionary,2007).

Furthermore, traumatic brain injury may be categorized as primary (damage occurring at time of impact), which could be mild or diffuse; or secondary injury as a result of neuro- physiological and anatomical changes minutes to days following primary insult, e.g.

from cerebral oedema, haematoma or increased intracranial pressure (Tidy, 2007).

Secondary brain injury may also be mild or diffuse and may give rise to severe complications (Headway, 2009).

In developed countries head injuries are a major medical and social problem and is the leading cause of mortality and morbidity especially in the under 5 and 15-24 age groups. These causes challenge not only for the Government to establish and maintain rehabilitation services for patients and other medical costs, but also for the patients themselves and their family members (Tidy, 2007); (Elbaum & Benson, 2007).

Blast injuries from incendiary devices can also cause head trauma that primarily affects soldiers and secondarily civilians because of explosions where energy from blasts can directly impact the cranium and be transferred to the brain. Based on existing data, veterans' advocates in the United States believe that between 10% and 20% of Iraq veterans, or 150,000 and 300,000 people have some level of TBI. Among wounded

troops, the rate of TBI rises to 33% (Brain Trauma Foundation, 2007). Turner (2007) quoted Kaye (1991) who reported that in Australia 3.5% of all deaths have been attributed to head injuries. According to the Saskatchewan Brain Injury Association in Canada, it is estimated that 55 000 Canadians incur head injuries each year and 2500 occur in Saskatchewan alone (i.e. 5 persons injured per day), of which the majority are the youths and young adults (The Saskatchewan Brain Injury Association, 2001).

In the UK, according to a study by Sinnakaruppan, Downey and Morrison(2005) it is estimated that 5.2 people out of every 10 000 suffer serious head injury each year; whereby an estimated number of  $\pm 20\%$  of head injury individuals die prior to admission to hospital. The authors further pointed out that it is family carers who undertake the responsibility for the life-long care of their relatives with head injuries. Such a caring role has adverse effects that make family members to suffer high levels of anxiety, depression and distress and a family unit may become dysfunctional.

Mokhosi and Grieve (2004) indicated that like in many developing countries, it is estimated that the incidence of TBI in the Republic of South Africa is higher than the worldwide average and a figure of 316 per 100 000 a year for the Johannesburg area has been reported. They further highlighted that TBI could have both negative and positive effects on both a person with head injury and family functioning.

Namibia is a developing country, thus its socio-economic spheres are under-developed and home and road accidents are of common occurrence. Motor vehicle accidents (MVA) and home accidents, like falls, especially under children, are a cause of morbidity and mortality especially in the under 10 years age groups and amongst older people of 70 years and above. The Intensive Care Unit (ICU) in Intermediate Hospital Oshakati (IHO) recorded 42 head injury related admissions between June 2009 and May 2010 of which 14 were fatal (MOHSS statistics, 2010). Common causes of these injuries are motor vehicle accidents, falls and common assaults.

Head injuries might cause minimal or severe structural changes (changes in appearance) and physiological (behavioural and functional) impairments that may be temporary or permanent. A victim has small or extensive wounds on the head and physiologic functions may be mildly lost or severely altered (Ursano, Caughey and Fullerton, 1994); and sometimes there is no evidence of any trauma on the scalp (e.g. in cases of shaken baby syndrome). The effects depend on the area(s) of the brain damaged and the extent of the injury. When damage is done to the brain, its effects may be irreversible, or the brain requires time, dedication and a lot of patience, even from medical professionals, to recover (Anon, The Saskatchewan Brain Injury Association, 2001). When particular portions of the cortex are injured, the special functions controlled here are likely to be lost or at least depressed.

Head injuries are not only challenges to victims alone, but also to family members and the Health Services. Nearly US\$100 billion is spent annually on hospitalization and lost productivity because of trauma in the United States (USA) alone (Thelan, Lough, Urden, & Stacy, 2006). Although the costs spend on head injuries in Namibia are not known, these cannot be less than the costs in developed countries like the USA, because of her under developed services. Family members spend lots of money on hospital bills, transport to and from hospitals and other hidden costs on a hospitalized member, and sometimes have to foot bills for funerals resulting from such injuries. Family members also suffer not only physically, but also psychologically during the time of hospitalisation, bereavement or rehabilitation as they are trying to come to terms with new and difficult changed situations.

They may also not fully understand explanations or intentions of health professionals regarding the extent of the injury, because their perceptions of accidents, or head injury in particular, may differ from those of health professionals and may also be distorted by senses of guilt, regret, anxiety, disbelief, hopelessness, loneliness or frustration as situational support might be inadequate or non-existent. Family members may not think rationally because an expected death or possible disability confronts them. Their distorted thoughts and emotions may further be aggravated by disfigured and swollen heads of loved ones who might be lying motionless in a coma or under the influence of sedatives during the first days of hospitalization. The environment of the ICU itself is a

strange place. It may be perceived as hostile, formidable, stressful and frightening with its alarming machines (Thelan et al, 2006).

Family members' lives, caring roles and sometimes even their employment are negatively affected as a result of consequences of injuries or the time period required for rehabilitating the victim. Some head injuries are mild, requiring little medical attention and a short period of time to recover, but for major and severe cases the recovery period is long, difficult and filled with uncertainty leading to frustrations, sometimes even with distress, both for the patient self and family members.

Admissions of patients to hospital, especially to the ICU, are stressful for family members of any patient, and a sudden unexpected onset of a traumatic head injury makes them more vulnerable. This is caused by the unstable nature of the injury and a strong possibility of death. Family members go through the “the vigilance” as expressed by Johnson(1998) and want to be with the loved one 24 hours. Many thoughts go through their heads when thinking about the fate of a loved one and what they might have to face.

Under such circumstances, health professionals, especially nurses, who many at times have to deal with family members of head injury patients, need to have an understanding of diverse behaviours, which may even be irrational or unacceptable according to

hospital rules, and need to exercise a lot of patience to maintain calmness, offer support and keep order in the units.

## **1.2 PROBLEM STATEMENT**

Any stressful unexpected event, of whatever nature, may threaten lives of family members and may destabilise the homeostasis of a family unit. The experiences of each member might differ during such stressful life events and if there are inadequate support to enable them to cope with it, distress or even ill health might result. In the case of a crisis because of a head injury, each member might experience it in a unique way. Thus, the experience of a spouse will differ from that of siblings and from that of children. For this study, the researcher investigated how family members experience difficult times of having a family member who sustained a head injury, either during hospitalization or after discharge. Furthermore, as far as the researcher is aware, currently no formal structured guidelines or equivalent measures are in place, especially in Namibia's Government health facilities, to prepare care givers (family members) to live and care for a person with a head injury and to support him/her including:

- The promotion of the well-being of the head injured patient and his/her family members;
- The reduction of impairment and suffering of the person with a head injury, and/or

- Understanding the continuation of rehabilitation aspects as this may be long and slow requiring courage, patience and endurance from both the head injury person himself and the family members.

With this in mind the researcher explored and describes the experiences of family members of a person with a head injury and hints at developing guidelines for family members to enable them to cope and to support the patient. The question for the study therefore was: What are the experiences of family members of a person with a head injury?

### **1.3 AIM OF THE STUDY**

The aim of this study was to explore and describe experiences of family members of a person with a head injury.

### **1.4 SPECIFIC OBJECTIVES**

The objectives set for this study were, to

- explore and describe the experiences of family members of a person with a head injury, and
- develop guidelines for family members on how to cope and support a person diagnosed with a head injury.

## 1.5 PARADIGMATIC PERSPECTIVE

Paradigms are lenses that help us to sharpen our focus on a phenomenon (Polit and Hungler, 2001). In this study, the researcher's focus was on the experiences of family members of a person with a head injury.

Assumptions are statements taken for granted or considered true, even though they have not been scientifically tested. In research, assumptions are embedded in the philosophical base of the framework, study design and interpretations of the findings (Burns and Grove, 2005).

This study utilized a phenomenological-interpretivist method with a qualitative or naturalistic inquiry approach. Phenomenology is premised on a world that is „constructed“ – people are creative agents in building a social world; and „inter-subjective“ - experience the world with and through others. Individuals are therefore central to the conduct of phenomenological studies (O'Leary, 2004). For the naturalistic inquirer, reality exists within a context, and many constructs are possible (Polit and Hungler, 2001). The researcher holds the same view. Thus, the family members of a person with a head injury are central in this study who „construct“ their own world through lived experiences.

### **1.5.1 Ontology**

The ontological assumption asks the question „what is the nature of reality?“ According to the naturalistic paradigm reality is multiple and subjective, mentally constructed by individuals (Polit and Hungler, 2001). For the naturalistic inquirer, reality is not a fixed entity but rather a construction of the individuals participating in the research. Reality exists within a context, and many constructions are possible (Polit and Hungler2001). In this study, reality is mentally constructed by each family member of a person with a head injury and is subjectively experienced. The researcher is trying to understand this reality as experienced by each family member in multiple life worlds.

### **1.5.2 Axiology**

Axiology is a study of human beings and influences how people view themselves in their relationships with others. In this regard values play an important role (Polit and Hungler, 2001). Nurse practitioners as well as family members bring their own values with them and these values are the fundamental core around which interpersonal relationships develop. It is important that this be taken into consideration when patients are admitted to hospitals. Furthermore, a patient who is diagnosed with a head injury is usually critically ill and thus admitted in an Intensive Care Unit. Such a situation makes family members very vulnerable. Therefore, there should be an understanding and

commitment of health care providers to assist and support affected family members as far as possible.

### **1.5.3 Epistemology**

Epistemology has to do with how a researcher understands knowledge and comes to acquire knowledge (McNiff, Whitehead & Lomax, 2003). In this study the researcher does not have knowledge on the experiences of family members of a patient diagnosed with a head injury. Therefore in-depth interviews were conducted to get answers. As truth lies in constructed reality, it can thus be generated from family members' and other stakeholders' experiences (McNiff, Lomax & Whitehead, 2003).

Knowledge is also maximised when the distance between the researcher and the participants is minimized. The voices and interpretations of participants are the key to understanding the phenomenon in this study – namely the experiences of family members when a person is diagnosed with a head injury (Polit & Hungler, 2001).

## **1.6 SIGNIFICANCE OF THE STUDY**

This study will provide knowledge about the experiences of family members of a person with a head injury. This information will assist family members of a person with head injury to understand, assist and support this person diagnosed with a head injury. The development of the guidelines enlightens family members to acquire knowledge on the

phenomenon of head injury, what possible complications might arise from the injury, how they are expected to handle the head injury patient during transportation, hospitalization and what they need to observe and how to support the head injury person.

The findings of the study may also be useful to researchers who want to conduct a study on the topic so as to generalise the findings and add to the understanding of the phenomenon.

Community involvement and empowerment play a role in health care provision, thus the study may also be useful in the formation of a support group of family members of a person with a head injury.

Furthermore, the findings of the study may be applied in nursing education and training to better prepare nurses to care, support and understand family members of persons with head injuries.

## **1.7 CONCEPTUALIZATION**

The concepts in this study to be clarified are family members, experiences and head injury patient.

**Family members:** Family members are people who are related to each other through a biological or legal bond. A person is a combination of different variables and behaves to forces inside and outside him/her as such no one can exist in isolation. She/he always

belongs to one or another group, like a family, recreation group or any other social grouping. This gives her/him a sense of belonging where she/he functions effectively. Her existence and that of others contribute to the existence of such a group. When a member is taken from a group through illness or because of any other reason, other members may feel threatened and this may cause drastic reactions. S/he is in constant change, depending on events and influences in his/her environment, moving towards a dynamic state of system stability or toward illness of varying degrees (George, 2002).

For this study family members are individuals who are biologically or legally related to a head injury patient who had been treated in the Intermediate Hospital Oshakati during the period under study.

**Experiences:** Experience is defined as the things that have happened to you that influence the way you think and behave (Oxford Advanced Learner's Dictionary, 2006). Behaviours are the result of a person's feelings and perceptions in a particular situation. Experiences mould a person to maturity and make him to accept and adapt to circumstances in which he finds himself. This can also make him adopt and adapt to new roles, functions and responsibilities in life or may even change his life completely. For this study experiences are those things that happened in the lives of family members as specified by the aforesaid definition.

**Head injury patient/person with a head injury:** Head injury is defined as any alteration in mental or physical functioning related to a blow to the head. Loss of consciousness does not need to occur (Oslo, 2010). For this study a head injury patient is one who meets the aforesaid definition and has been treated in the ICU at the Intermediate Hospital Oshakati during the period of study.

## **1.8 SUMMARY**

In this chapter the overview of the study, problem statement, purpose of the study, significance of the study and conceptualisation has been discussed. The research design and methodology will be described in detail in Chapter 2.

## **CHAPTER 2**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **2.1 INTRODUCTION**

In this chapter the design and methods employed in conducting the research are discussed in more detail. Data was collected by means of in-depth face-to-face interviews with caregivers and family members of head injury patients. Data gathered was grouped into themes and concepts for analysis. Broad guidelines are constructed to facilitate family members in coping with and supporting a person with a head injury.

#### **2.2 RESEARCH DESIGN**

A research design is a blueprint to conduct a study and instructions to be followed in addressing the research problem (De Vos, Strydom, Fouche and Delport, 2009 and Burns and Grove 2005). The design of a project is a journey planner or itinerary with a set of guidelines and instructions on how to reach the goal that one has set for oneself that precedes the actual research process. A research design is a plan and structure of a research project in which the eventual validity of the research findings is maximized without sacrificing the validity of the study (Mouton, 2000).

The researcher adopted a qualitative, explorative, descriptive and contextual study design based on the phenomenological approach to data gathering.

### **2.2.1 Qualitative Research**

Qualitative research is an investigation into a phenomenon, typical in an in-depth and holistic fashion, through the collection of rich narrative materials using a reflexive design (Polit and Hungler, 2001). Qualitative research uses an inductive approach, reasoning from the specific to the general (Creswell, 2003). Qualitative research is a systematic, participative approach used to describe life experiences, giving them meaning (Burns & Grove 2001).

Creswell (2003) cited some characteristics as follows:

- Qualitative research takes place in natural settings which enables the researcher to develop a level of detail about a participant and a place and to be highly involved in the actual experiences of the participants.
- Qualitative research utilizes multiple methods that are interactive and humanistic as they involve active participation by participants and sensitivity towards them. This is achieved through involving the participants in data collection and seeking to build rapport and credibility with the participants in the study.
- Qualitative research is emergent rather than tightly prefigured, as a researcher may change and can refine research questions as he/she learns what to ask from whom.
- Qualitative research is fundamentally interpretive. This enables the researcher to interpret data; thus developing a description of an individual or setting, analyzing data for themes and sub-themes, and making an interpretation or drawing

conclusions about its meaning personally and theoretically, stating lessons learned, and offering further questions to be asked.

- The qualitative researcher looks at social phenomena holistically. This explains why qualitative research studies appear as broad, panoramic views rather than micro-analyses.
- Qualitative research enables the researcher to systematically carry out an introspection and acknowledgement of biases, values and interests (or reflexivity).
- The qualitative researcher utilizes complex reasoning that is multi-faceted, iterative, and simultaneous.
- Qualitative research uses inductive reasoning that is also iterative, with a cycling back and forth from data collection and analysis to problem reformulation and back. Added to this are the simultaneous activities of collecting, analyzing, and writing up the data.
- The qualitative researcher adopts and uses one or more strategies of inquiry as a guide for the procedures in the qualitative study.

The researcher therefore utilized this research design to gain an in-depth understanding of the experiences of the family members of persons diagnosed with head injuries. The data obtained provided a wealth of information in understanding the aforementioned experiences of family members. The latter information received, assisted the researcher in constructing guidelines that could facilitate family members coping and giving support to a person diagnosed with a head injury.

### **2.2.2 Exploratory Research**

The aims of an exploratory study are to establish the facts, explore topics which are relatively unknown, formulate a problem, and develop a hypothesis for further study (Babbie& Mouton2001, p. 79). These authors further state that exploratory studies are done for the following reasons:

- to satisfy the researcher's curiosity and desire for better understanding of a topic,
- to test the feasibility of undertaking a more extensive study,
- to develop methods to be employed in any subsequent study,
- to explicate central concepts and constructs of a study,
- to determine priorities for further research, and
- to develop new hypotheses about an existing phenomenon.

The researcher therefore selected this design because she intended to explore and describe the lived experiences of family members of a person diagnosed with a head injury which provided insights into and understanding of their experiences with regard to how they coped and supported persons diagnosed with head injury.

### **2.2.3 Descriptive Research**

Descriptive research is the description of a phenomenon in a real life situation. It provides an accurate account of characteristics of particular individuals, situations and/or groups. Through descriptive studies researchers discover new meanings, determine what exists, determine the frequency with which something occurs and categorize information. Thus, its purpose is to provide a picture of a situation as it naturally occurs

(Burns & Grove, 2001). A descriptive research design was selected so that the researcher could give a rich description of the research findings.

#### **2.2.4 Contextual study**

According to Holloway and Wheeler (2002) contextual research describes the space and environment of interaction. This includes cultural and historical implications which are important for understanding the phenomenon being studied (Burns & Grove, 2001). The researcher gives a description of the reality, typical of a specific context in which a target phenomenon occurs. The total context of the participants' lives will affect the findings of the study (Holloway & Wheeler, 2002). The context involves situating the object of the study or phenomenon of study within its immediate setting (Creswell, 1994).

In this study a contextual design is used to describe the experiences of family members of persons diagnosed with a head injury. This study was conducted in three of the northern regions of Namibia i.e. Oshana, Omusati and Ohangwena.

#### **2.2.5 Phenomenological Approach**

This study is grounded in a phenomenological approach to inquiry, which is aimed at understanding and interpreting the meaning that the participants give to their everyday lives (De Vos, Strydom, Fouche & Delpont, 2009). The understanding and interpretation was achieved by following a naturalistic method of study and analyzing the

conversations and interactions between the researcher and the participants. Data is systematically collected and meanings, themes and general descriptions of experiences were analyzed within a specific context (De Vos et al, 2009). In attempting to describe the lived experiences of family members of a person diagnosed with a head injury the researcher focused on what was happening in their lives and how they were treated at the hospitals.

The success of this research was thus dependent on having a phenomenological approach throughout the study. Through this approach the researcher aimed to bring the „human side“ of the participants to the fore.

## **2.3 RESEARCH METHOD**

The research method, which involves data collection and data analysis, was divided into two phases, which are:

### **2.3.1 Phase One: Exploration and description of the experiences of family members of a person with a head injury.**

This phase comprises the research population, sampling method, data-collection method and data analysis and literature control. Each of these will now be discussed.

### **2.3.1.1 Research population**

A research population is the entire aggregation of cases that meet a designated set of criteria (Stanhope & Lancaster, 2004). It is the larger pool from which the sampling elements are drawn and to which findings are generalized – thus theoretically the population encompasses all the elements that make up the unit of analysis (Blanche, Durrheim & Painter, 2006). The research population for this study comprised of family members of persons with head injuries who have been treated in the intensive care unit at the Intermediate Hospital Oshakati.

### **2.3.1.2 Sample and sampling technique**

Criterion-based, purposive sampling was used in the recruitment and preparation of research participants. For the in-depth face-to-face interviews, participants were selected so as to maximize the richness of information obtained pertinent to the research questions. Brink, Van der Walt & Van Rensburg (2006) and Polit & Hungler (2001) describe purposive sampling as a sampling method based on the researcher's judgment about subjects that are typical or representative of the phenomenon being studied in cases where the researcher is particularly knowledgeable about the problem. In such cases the researcher intentionally selected the participants who met the set criteria and requested them to participate. The advantage of purposive sampling is that it allows the researcher to select the sample on the basis of their knowledge of the phenomenon being studied.

A sample is a sub-set of measurements drawn from a population in which the researcher is interested. A sample is not an end in itself, but rather as a means for helping the researcher to explain some facet of the population. The sample is the element of the population considered for actual inclusion in the study a portion of the population from which data is collected and represents the population (de Vos, 2009).

In this study the researcher utilized a purposive sampling to collect data as the researcher consciously selected participants purposefully or according to the judgment that the sample would provide the needed information to address the research question. The sample for this study consisted of family members of persons diagnosed with a head injury and who had been treated at the intensive care unit in Intermediate Hospital Oshakati (IHO) between 1 June 2001 and 31 May 2002. The researcher got the names and addresses of the head injury patients from the admission records of the intensive care unit (ICU) at the Intermediate Hospital Oshakati and looked up the family members of these head injury patients guided by the addresses provided.

Ten family members were interviewed, 6 mothers, 1 grandparent and 3 siblings. All ten participants were Oshiwambo speaking people from typical African cultures with extended families. From these participants three mothers and two siblings lived in separate settlement areas and were full-time employees; while the other five lived in a rural set-up and were unemployed. Eight of the participants had a secondary or a tertiary

education background and two were uneducated; and were from different religious denominations.

Some family members of a head injury patient were excluded from the study because of one or more of the following reasons:

- Some family members were difficult to reach as it would be costly for the researcher to travel to distant places including Angola;
- Some could not be traced because they had been admitted as “unknown”;
- Some family members could not be found by the researcher because they no longer lived at the given addresses and their new addresses were unknown;
- Some places were difficult to access and the researcher could not afford to trace family members because of limited resources.

### **2.3.1.3 Data-collection method**

The researcher made use of the phenomenological, in-depth face-to-face interviews as a means of data collection. The in-depth interviews lasted between 40 – 50 minutes. In-depth interviews have become the most common form of data collection in qualitative research (Holloway & Wheeler (2002). It is used to elicit information in order to achieve understanding of the participant’s point of view or situation (De Vos et al 2009).It provides access to the subjective perceptions of individuals by which they give meaning to their experiences (Saks & Allsop 2007) and allows the participant to the freedom to express him/herself (O’Leary, 2004). It is an interactive situation where a conversation

with a purpose takes place between the researcher and the participant. The participant has an opportunity to describe his/her experiences in his/her own words and enables the researcher to explore complex issues in detail by utilizing probing and prompting questions for clarification purposes (De Vos et al, 2009). These interviews are personal and intimate, with an emphasis on depth, detail, vividness (intensity) and nuance (subtle difference and meaning). Unstructured interviews start with a general question in the broad area of the study (Holloway & Wheeler 2002).

The following question was posed to each participant:

“Please tell me about your experiences when your family member was diagnosed with a head injury”.

Probing and follow-up questions were also used for the participants to shed more light on what the researcher wanted, or to enable them to express themselves more clearly. Interviewing continued until sufficient data was gathered.

Face-to-face interviews were conducted at the homes of the participants or places of their choice with little or no disturbances and in their own language, Oshiwambo. The researcher speaks the vernacular being a native of the region where the research was conducted. As such there was no need for an interpreter. The researcher made appointments with the majority of the participants and for some interviews were conducted on the same day the researcher went to look for the family members in rural

areas. Going in person to lookup family members was the easiest available option to the researcher, because it was otherwise difficult to reach them through other means such as the telephone as a result of a no or scanty network coverage. At the respective family homes, the researcher approached the head of the family and introduced herself and explained the purpose of her visit. The researcher then showed her identity document and the university student card, the permission letter from the study supervisor, the letter of permission from the health director, and the letter of permission from the traditional leader and the regional governor. Where the head of the family could not read another family member who could read verified what the researcher was explaining. The researcher was led to a separate room that was quiet where the interview was conducted. At the majority of homes the room was quiet, but at some there was occasional interruptions and noise of the blowing wind as building structures were made of straw/grass and at some homesteads rooms were constructed of corrugated iron.

As a preamble to conducting the interview the researcher re-introduced herself, as an entry point to building rapport and explained the purpose of the research and the process, stressing that participation was voluntary and confidential. The participants' consent form was signed and permission was granted to use the tape-recorder to record the interview proceedings. The aforementioned was necessary to enable the researcher to record the exact words of the interview, including the questions. The interviews were audio-taped by the researcher, using a tape recorder. At the same time, the researcher took field notes. During the interview the participant led the researcher through his/her

experiences as from the time the news broke that a family member had been injured, the time when the head injury patient was admitted to a health facility and treated, discharged and life after hospitalization. The tape was checked immediately before and after the interview to ensure the function ability thereof and also in case the researcher had to re-do the interview. In most cases the participants requested to listen to the tape to listen to what was said and to verify whether the researcher has really recorded as was explained prior to the interview session. The tape was dated and labelled. The interviews were transcribed and translated into English.

#### **2.3.1.4 Field notes**

Field notes are written accounts of the things the researcher hears, sees, experiences and thinks about in the course of the interview and should include empirical interpretations. They help supplement recorded interviews in that the physical setting and impressions made on the researcher by the participants are included in the field notes (De Vos et al (2009) and Polit & Hungler (2001)). Comprehensive, descriptive field notes were made after collecting information to make sense out of what had been observed.

Field notes in this study serve as a detailed description of what the researcher heard and saw in specific terms and as an exact record of particular words, phrases or reactions. The researcher wrote verbatim statements with double quotation marks to distinguish them from paraphrases and also recorded dialogue accessories like non-verbal communication, props, tone, speed, volume and gestures. These are recorded as direct

observation and described in detail and not as a summary (Neuman, 2006) and (Welman et al, 2005).

In this study several types of field notes were made during and shortly after the interviews for cross-referencing with recorded interviews (Morse & Field, 1996). Field notes deepen the insight of the researcher into the life-world of the participants. Gestures and facial expressions were noted. Once the participants repeated the same or similar information without giving new information, interviews were stopped because data was assumed to have become saturated (Streubert & Carpenter, 1995). A separate journal was kept by the researcher for documenting insights, reactions, questions and impressions during the interview sessions (Welman, Kruger & Mitchell, 2005). After the interview, field notes about the interview sessions were written and the researcher's impression documented. Different types of field notes made by the researcher are described in the following paragraphs:

- **Theoretical notes**

This term refers to the theories that emerge in the field during data collection and are clarified by the researcher during reviewing of the data. The researcher made suggestions that would link ideas and proposals and also record and develop new concepts out of the data or observation (Neuman, 2006).

- **Personal notes**

The researcher kept a section of the notes in a personal diary that recorded personal life events and feelings. The researcher kept separate all these personal notes to be used after the data was collected. Personal notes served three purposes:

- As an outlet for the researcher, helping her to cope with the stress;
- As a source of data about personal reactions; and
- As a way to evaluate direct observations or inferences made when the data is re-read later after the interviews (Neuman, 2006).

- **Direct observation notes**

In this study the researcher utilized direct observational notes immediately after leaving the field. These notes were written in a chronological manner with the date, time and place on each entry.

- **Jotted notes**

In the field the researcher jotted down short temporary memory-triggering words and phrases on a notepad. These were incorporated later in the discrete observational notes.

- **Methodological notes**

In this study the researcher also kept methodological ideas in analytical notes to record plans, tactics, ethical and procedural decisions and self-criticism of tactics. In this study

these methodological notes serves as a guide during the researcher's recording of field notes (Neuman, 2006).

#### **2.3.1.5 Role of the researcher**

A qualitative researcher is the primary instrument of data collection and analysis, and implies openness on his/her part with regard to examining new ideas (Creswell, 2003). The research interview is an interpersonal situation, a conversation between two partners about a phenomenon of mutual interest, a specific form of human interaction in which knowledge evolves through a dialogue. The interaction is neither anonymous nor neutral as when a participant responds to a survey questionnaire, nor is it as personal and emotional as a therapeutic interview (Burns & Grove, 2001).

The role of the researcher is to utilize bracketing (Burns & Grove, in De Vos et al., 2009) by placing her knowledge and preconceived ideas about the phenomenon between brackets, focusing her awareness and energy on the experiences being studied to achieve an open context and to facilitate "seeing" all facets of the phenomenon. Intuiting, which is the process of actually "looking at" the phenomenon and developing insight into it, requires concentration and complete absorption in the experience being studied (De Vos et al., 2009). In order to achieve meaningful bracketing and intuiting, continual self-evaluation was a prerequisite for the researcher in order to avoid bias related to preconceived ideas and notions.

### **2.3.1.6 Data analysis**

The recorded interviews were transcribed by the researcher with assistance from two independent persons and translated to English. A clean set of the translated interviews and instructions (see Annexure II) was given to an independent coder, experienced in the field of qualitative research. The researcher and the independent coder analyzed the data independently, together with the field notes, to develop themes and sub-themes. Coding was done according to Tesch to reduce the data into themes and sub-themes (Creswell, 2003). Coding is the process of organizing the material into “chunks” before bringing meaning to those “chunks” (Creswell 2003, p. 192). This method consists of the following steps:

- Get a sense of the whole. Read all the transcriptions carefully and make short notes.
- Pick one document at a time, go through it to try to determine the meaning of its contents and write notes in the margin.
- When this action has been completed for several documents, make a list of all topics. Cluster similar ones together and form them into columns that can be arranged as major topics, unique topics and leftovers.
- Take the list and go back to the data. Abbreviate the topics as codes and write the codes next to the appropriate segments of the text to see whether new categories and codes emerge.
- Find the most descriptive wording for the topics and turn them into categories. Reduce the total list of categories by grouping topics that relate to each other. Lines could be drawn between themes to show interrelationships.

- Make final decision on the abbreviation for each theme and arrange these themes alphabetically.
- Assemble the data material belonging to each category in one place and perform a preliminary analysis.
- Re-code existing data if necessary.

On completion of the coding, the researcher and the co-coder communicated to discuss themes and sub-themes in order to reach consensus. Both the researcher and the independent coder agreed that the data saturation had been reached. Thereafter the researcher discussed themes and sub-themes with the research supervisor and co-supervisor and an agreement was reached. The themes and sub-themes portrayed the storyline in a meaningful and descriptive way.

#### **2.3.1.7 Pilot Study**

In qualitative research the pilot study is usually informal and consists of the researcher determining whether the relevant data can be obtained from the participants. By testing the nature of the questions in a pilot interview, the researcher is able to make modifications with a view to quality interviewing during the main study (De Vos et al., 2009).

In this study two pilot interviews were conducted by the researcher that enabled her to identify the need to rephrase or to indirectly ask the research question to enable participants to share their experiences in a meaningful way. It also served as an

assessment tool for the researcher with regard to the technique of interviewing. The second pilot interview was used in the final ten interviews.

#### **2.3.1.8 Literature control**

After the data had been analyzed a review of applicable literature was done. The purpose of literature control is to place the findings within the context of what is already known about the topic and verify the themes and sub-themes (Streubert & Carpenter, 1995). The literature control was done in order to illustrate the summary of the main ideas from previous studies and some of the findings and contra-indications found and how they related to the findings of this study. The literature control was only done after data analysis had been completed in order to avoid the researcher developing pre-conceived ideas about the problem under review. If no literature had been found to support statements, the researcher highlighted it during the discussion of results in chapter three of this study.

#### **2.3.2 Phase two: Developing guidelines for family members of a person with a head injury**

Within this phase information obtained from the data analysis and literature control was utilized to construct guidelines for family members that could enable them to cope and to support people diagnosed with head injuries. The guidelines are discussed in chapter four of this study.

## **2.4 MEASURES TO ENSURE TRUSTWORTHINESS**

The authenticity of any study is measured by its trustworthiness and its validity. This is possible when strategies used are appropriate for the true reporting of the participants' ideas, when the study is fair and when it helps participants and similar groups to understand their world and improve it (Holloway & Wheeler (2002). Trustworthiness in qualitative research means methodological soundness and adequacy. Authenticity is achieved by the researcher when he/she is fair to participants and by gaining their acceptance throughout the study. The researcher made judgment of the possibility of trustworthiness through developing credibility, transferability, dependability and conformability. Forth study to be trustworthy the "trust value" needs to be established as De Vos et al (2009) cited.

### **2.4.1 Credibility**

Credibility of scientific research addresses the concepts of internal validity and reliability. Validity is the extent to which an account accurately represents a phenomenon to which it refers; while reliability is the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Silverman 2003). Credibility is having the goal to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject was accurately identified and described (De Vos et al 2009). In this study credibility was ensured by peer review and an independent coder.

The following strategies to ensure credibility were utilized by the researcher to meet the criteria that are used to evaluate qualitative studies (Silverman 2003, p. 220):

- The researcher is a trained ICU nurse and has identified the need to research the subject based on her observations of family members of head injury patients;
- The researcher drew up criteria to be met by participants to be interviewed for the study;
- The researcher made use of individual in-depth face-to-face interviews and field notes for data collection, and wrote down the responses and observations of participants during the interviews;
- The researcher used a tape recorder to record what each participant was telling the researcher about her experiences;
- The data was analyzed systematically;
- Qualitative, explorative, descriptive and contextual design was employed since data was to be obtained from the participants themselves; and
- The researcher did a literature control with the aim to compare what is written about the subject studied and the findings of the study.

#### **2.4.2 Transferability**

The findings of this research can be transferred to similar situations or participants. The knowledge acquired in this study is relevant in another, so those who carry out the research in another context are able to apply some concepts originally developed in this

study. In this study use was made of a dense description of the research process to ensure transferability of findings (Holloway & Wheeler, 2002).

### **2.4.3 Dependability**

If the findings of a study are to be dependable, they should be consistent and accurate (Trochim, 2006). The idea of dependability, on the other hand, emphasizes the need for the researcher to account for the ever-changing context within which research occurs. Dependability refers to the degree to which the researcher convinces the reader that the findings did occur as is said they did (Terre Blanche, Durrheim & Painter, 2008).

The context of this research is described in detail in order to account for any changes in the design created by an increased understanding of the phenomenon.

### **2.4.4 Confirmability**

In this study, readers are able to follow the path of the researcher and the way the constructs, themes and their interpretation were reached at. An independent coder and reflexivity were used to ensure trustworthiness (Lincoln & Guba, 1985 in De Vos et al., 2009).

## **2.5 ETHICAL CONSIDERATION**

Ethical considerations have to be considered throughout the study to protect the participants from any harm. The health professions recognize that human life is very fragile and realize that those entrusted with the responsibility of rendering care need a guideline for actions (Searle, 2008). Ethical codes for professions set parameters of the responsibilities the nurse owes to her patients. Professional ethics are moral dimensions of attitude and behavior based on values, judgment, responsibility and accountability that the practitioner takes into account when weighing up the consequences of his/her professional actions (Searle, 2008). Any researcher must be sensitive towards participants and must ensure that ethical principles are adhered to during the whole study. The following principles with their subsections, as set out by Polit & Hungler (2001), were utilized as a guide throughout the research in order to protect the participants from any harm.

### **2.5.1 The principle of Beneficence**

Beneficence is one of the most fundamental principles in research which encompasses above all, *do no harm* (Crosby, DiClemente & Salazar, 2006). Beneficence consists of the following subsections:

- **Freedom from harm**

An ethical researcher must be prepared, at any time during the research, to terminate the research if there is reason to suspect that continuation would result in undue stress to a participant. Participants were assured that they could withdraw at any time if it became too emotionally distressing for them. It was thus important to develop good rapport with the participants so that they would be encouraged to continue in the research study. All attempts were made to prevent any physical or emotional harm to the participants while sharing their experiences (Polit, Beck & Hungler, 2001). The researcher was sensitive to the delicate issues experienced by the participants.

- **Freedom from exploitation**

Involvement in the research study did not place participants at a disadvantage or expose them to situations for which they had not been explicitly prepared (Polit & Hungler, 2001). Once the whole research process had been explained to the participants they were no longer hesitant to share even their negative feelings of varied emotions they experienced. The researcher assured the participants that the information they gave would not be used against them in any way and would not be divulged. The researcher applied the principle of freedom from harm to all the interviews conducted.

### **2.5.2 The principle of human dignity**

According to Polit & Hungler (2001) human beings should be treated as autonomous agents, capable of controlling their own activities and destinies. The principle of human dignity consists of the following subsections:

- **Right to self-determination**

The principle of self-determination was adhered to throughout the study. This meant that the prospective participants had the right to decide voluntarily whether to participate in the study without a risk of incurring any penalty or prejudicial treatment. It also meant that the participants had the right to decide at any point to terminate their participation, to refuse to give information or to ask clarification about the purpose of the study or specific questions (Polit & Hungler, 2001).

- **Right to full disclosure**

The researcher ensured the right to full disclosure by fully describing the nature of the study, likely risks and benefits and also allowing the participants' right to refuse participation (Polit & Hungler, 2001).

- **Informed consent**

Informed consent was obtained from each participant in this research study. Informed consent refers to the consent of participants to participate voluntarily in the research or to decline participation, on the basis that they have adequate information regarding the

research, are capable of comprehending the information and have the power of freedom of choice. The researcher documented the informed consent process by having participants sign a consent form. This form includes information about the status of the participants, the study purpose, specific expectations regarding participation and contact information of the researcher (Polit & Hungler, 2001).

In addition to consent that must be obtained from the family members of a person diagnosed with a head injury, Brink et al (2006) states that the consent of a research ethics committees within health services is also necessary so that the researcher and the participants are protected. The researcher obtained written permission to conduct the study from the following departments and offices to ensure that the relevant authorities were fully aware of the nature and purpose of the study:

- At the National level: permission was granted by the Permanent Secretary of the Ministry of Health and Social Services (MOHSS) (see Annexure IV);
- At the Directorate level: permission was granted by the Regional Director of the then North-west Health Directorate (see Annexure V);
- From the political arena: permission was granted by the Regional Governors of Oshana Region (Annexure VI), Omusati Region (Annexure VII) and Ohangwena Region (Annexure VIII); and
- At the local level: permission was granted by the chief headman of Uukwambi Traditional Authority (Annexure IX).

### **2.5.3 The Principle of Justice**

The principle of justice includes the following:

- **Right to fair treatment**

Participants have the right to fair and equitable treatment before, during and after their participation in the study. The fair treatment of participants in this study included the following aspects (Polit&Hungler1999, p. 138):

- The fair and non-discriminatory selection of participants. In this study participants were selected by purposive criterion-based sampling strategy.
- Non-prejudicial treatment was implemented to those participants who declined to participate. No participant withdrew from the study after agreeing to participate.
- All agreements made between the researcher and the participants as indicated in the participant consent form were honoured.
- Debriefing was offered to share any information withheld before the study or to clarify issues that arose during the study.
- Sensitivity and respect for beliefs, habits and lifestyle was upheld.
- Participants were treated courteously and tactfully at all times (Polit & Hungler, 2001).

- **Right to privacy**

According to Brink et al (2006), privacy is the freedom an individual has to determine the extent to which, and general circumstances under which, private information will be

shared with, or withheld from others. Participants who agree to participate in research have the right to expect that the information collected from them will remain private.

This can occur by:

- **Anonymity**

Anonymity refers to the act of keeping individuals nameless in relation to their participation in the research. Although anonymity cannot completely be guaranteed in qualitative research, as it involves direct face-to-face contact with each participant the researcher kept the audiotapes in a safe place and these would be destroyed after the research. Privacy was be ensured through confidentiality.

- **Confidentiality**

Confidentiality refers to the researcher's responsibility to protect all gathered data within the scope of the project from being divulged or made available to any other person. This means that the research data should never be shared with outsiders. The participants were told before they gave consent to participate that the researcher intended to publish the results but would not use their names. A breach of confidentiality may occur when a researcher allows an unauthorized person to gain access to the raw data of a study or when a researcher accidentally or otherwise reveals the participants' identities in reporting the results (Brink et al, 2006).

## **2.6 SUMMARY**

Chapter two described the research design, research method, trustworthiness and ethical considerations in detail. The research consisted of two phases. During phase one individual in-depth interviews within a phenomenological approach were described as well as the data-collecting method. Data analysis followed, describing how themes were created and consensus sessions with an independent coder held afterwards. After data analysis, a literature control was implemented to compare findings from data with existing literature. The first objective of the study is to explore and describe the experiences of family members of a person with a head injury. This objective was reached through completion of phase one. Phase two consisted of constructing guidelines for family members of a person with a head injury on how to cope and support a person diagnosed with a head injury (to be developed in chapter four).

In the next chapter the researcher will discuss the identified themes and sub-themes and provide relevant back-up with literature control.

## **CHAPTER 3**

### **ANALYSIS OF DATA AND LITERATURE CONTROL**

#### **3.1 INTRODUCTION**

This chapter will concentrate on the discussion of the results that emerged from the data analysis and a literature control will be incorporated. The data were collected through interviews. For analysis purposes, the data were organized, coded and grouped together into themes and categories.

#### **3.2 RESULTS**

Three themes emerged from the data analysis. The themes and categories that have been identified are shown below in table 3.1. Each theme will be discussed, verified with the necessary direct quotations from the interviews with the participants and relevant literature control will be cited to back up the findings from this study.

**Table 3.1 Themes and sub-themes of the study**

<b>THEMES</b>	<b>SUB-THEMES</b>
<p>1. Feelings of varied emotions experienced by family members of a person with a head injury</p>	<p>1.1 Negative feelings experienced by family members of a person with a head injury.</p> <ul style="list-style-type: none"> <li>▪ Psychological shock because of the news/sight of a family member with a head injury.</li> <li>▪ Fear and uncertainty because of the appearance and possible impending death of the person with head injury.</li> <li>▪ Hopelessness and powerlessness because of the condition of a family member with a head injury.</li> <li>▪ Disbelief, loss and grief because of the death of the person with a head injury.</li> </ul> <p>1.2 Positive feelings experienced by family members of a person with head injury.</p> <ul style="list-style-type: none"> <li>▪ Relief because of the improvement in the condition of the person with a head injury.</li> </ul>

<p>2. Challenges experienced by family members of a person with head injury.</p>	<p>2.1 Limited transport for the family members to go to and from the hospital.</p> <p>2.2 Ineffective interpersonal communication between the nurses and family members of a person with a head injury.</p> <ul style="list-style-type: none"> <li>▪ Lack of information regarding the condition of the person with head injury, the extent and possible outcome of a head injury.</li> <li>▪ Ineffective coping by family members of a person with a head injury.</li> </ul>
<p>3. Varied degrees of support experienced by family members of a person with head injury.</p>	<p>3.1 Effective social support provided to family members of a person with head injury by relatives and friends.</p> <p>3.2 Lack of support through counseling of family members of a person with head injury.</p>

### **3.3 DISCUSSION OF THE FINDINGS**

#### **3.3.1 Theme 1: Feelings of varied emotions experienced by family members of a person with head injury.**

The Oxford Advanced Learner's Dictionary (2006) defines emotions as "strong feeling such as love, fear or anger; the part of a person's character that consists of feelings" (Oxford Advanced Learner's Dictionary 2006, p. 394). McFerran(2008) also defines emotions as "a state of arousal that can be experienced as pleasant or unpleasant" (McFerran 2008, p. 156). Feelings are subjectively experienced that evoke several physical and/or psychological effects on an individual and may be pleasant (positive) or unpleasant (negative).

In an African culture, family has a wider circle of members than the word suggests in „Western“ traditions. Within this context the family includes children, parents, grandparents, uncles, aunts, cousins, nephews, nieces, and significant others who are tied to each other by some sort of blood or marital bond as described by Mokhosi and Grieve (2004) and Du Toit and van Staden (2005) – being referred to as the extended family.

Citing Henslin (1999), Du Toit and van Staden (2005: 143) define a family as "any group of people who consider themselves related by blood, marriage or adoption". Neighbours and friends may even provide, especially physical and emotional support, far better than blood-bond family members.

The participants experienced different feelings that were both positive (pleasant) and negative (unpleasant). These feelings were experienced at different levels and with varied intensity and evoked varied emotions. Negative feelings that the family members experienced included psychological shock, fear, uncertainty and disbelief, hopelessness and powerlessness that lead to desperation and anxiety; while the positive feeling was relief because of the improvement that they observed in the condition of the person with the head injury.

#### **3.3.1.1 Negative feelings experienced by family members of a person with a head injury.**

The negative feelings in family members/carers of a person with a head injury developed after the accident has occurred. Some family members had these feelings because of the nature of the injury, or the manner in which the news was received and the general condition in which the head injury patient was found by family members/carers.

#### **Psychological shock because of the news/sight of a family member with a head injury.**

The results revealed that participants experienced varied emotions due to a stressful event and experienced symptoms such as sensation of heart racing, trembling, rapid breathing and a sense of fear and uncertainty leading to powerlessness and hopelessness. The majority of the participants experienced psychological shock, of different intensities. The shock was intense at the beginning when news had been received or

when they came to the accident scene and eventually got better after sometime as the condition of the person with a head injury improved and they felt relieved.

Psychological shock is a state of sudden disturbance of mental homeostasis or equilibrium in an individual. It is also called acute stress over reaction, acute stress disorder or mental shock which is a psychological condition resulting in response of a terrifying event and should not be confused with the unrelated circulatory condition (Wikipedia, 2009). Dr.Trisha Macnair(2009) argues that psychological shock may be caused by hearing bad news such as the death of a loved one, being involved in a traumatic event like MVA, or being the victim of crime, violence or otherwise.

This is reflected in the following remarks by the participants:

*“I just started crying. I felt very bad”*. [mother]

*“I was crying even before the time I was told what happened by the boys who accompanied him to the clinic”*. [mother]

*“I was shocked to such an extent that I didn’t want to go see him in the hospital”*. [mother].

*“I was so shocked to such an extent that I didn’t know what to do when I came to the accident scene as blood was flowing from his ears and head ... I didn’t know where to touch him...”* [mother].

Such intense reactions are considered as similar to posttraumatic stress disorder (PTSD) when such an extreme or frightening event occurs (Thompson, McFarland, Hirsch and Tucker 2002). The individual exhibits numbing feelings, increased arousal, impairment of functions and general anxiety symptoms lasting for more than a month. Shock may be experienced immediately following a loss and this state may last for several days. Some participants used gestures with the hands to illustrate to the researcher the state of shock they were in and how they were left numb.

Thompson et al (2002) further explained that these reactions are physiologic and are caused by hormonal influences when the sympathetic nervous system, both directly and indirectly, release epinephrine and to a lesser extent nor-epinephrine from the medulla of the adrenal glands. The release of these hormones is triggered by acetylcholine released from pre-ganglionic sympathetic nerves. These are catecholamine hormones that facilitate immediate physical reactions by triggering increased heart rate and breathing, constricting blood vessels in many parts of the body – but not in the involuntary muscles (where there are vasodilatation), brain, lungs and heart – and tightening muscles. An abundance of catecholamine at the neuro-receptor sites facilitates reliance on spontaneous or intuitive behaviours of fight-or flight (combat or escape) ([Wikipedia, 2009](#)).

Because of psychological shocks participants developed feelings of fear and were uncertain as to what might happen to their loved one who had sustained a head injury.

- **Fear and uncertainty because of the appearance and possible impending death of the person with head injury.**

The results revealed that participants experienced moderate to severe feelings of fear and uncertainty. While, some of the participants experienced fear at the accident scene, others experienced fear during the time of hospitalization, because of the ICU environment or because of the changes they had already observed in the person with a head injury and some were uncertain of the future of the person with a head injury or what they could do.

This was manifested by the following comments

*“Blood was flowing from his ears and head and this has frightened me very much”.*  
[mother]

*“I was so afraid and didn’t know where to touch her”.* [grandmother]

*“I was afraid that he may die as his face was very much swollen”.* [mother]

*“When I came to my child it was as if I have never known him. His head was very swollen and his breathing was irregular... As I looked at him I immediately retreated from the room”.* [mother].

*“I was having a heavy heart, because maybe after you left the child dies”.* [mother]

*"... perhaps my child's brain has been crashed as I heard that if a person has been injured in the head and blood has made contact with the brain, it could lead to death..."*

[mother]

Fear is "an emotion or feeling of apprehension aroused by impending or seeming danger, pain, or other perceived threat. The fear may be a response to something that has already occurred, in response to an immediate or current threat, or in response of something the person believes will happen" (Kozier Erb, Bergman & Snyder 2008, p. 1064). Gross (2001) points out that fear may cause or may be caused by shock and may vary in intensity or duration. Fear may be so great and rather inhibiting than facilitating action or behavior. The latter author further argues that "... high level of fear can produce changes in behavior; but in situations of minimal or extreme fear, the message may fail to produce any attitude change, let alone any change in behaviour" (Gross 2001, p. 357). Fear may result in anxiety. Anxiety is an emotion and is subjectively experienced by an individual and is communicated interpersonally and is experienced when the demands of life require capabilities that seem to exceed resources or when people feel the threat of loss and exposure.

The following statements are evident of the numb feelings because of the fear these participants experienced:

*“as a mother looking at my child like that ... [then silence, crossing her fingers with a facial expression of agony] I was having a heavy heart and didn't know what to do ...”.*  
[mother]

*“okwa li hai kakama, shaashi onda ninga nokuli omafiku 7 inaandi popya naye ...”*,  
meaning,

*“I was trembling because I already spent 7 days without talking to him...”* [mother]

The results revealed that participants experienced mild to moderate anxiety as some of the participants could not express their feelings in words as there were bouts of silence and bodily expressions like facial expressions of frowning coupled with lifting up of shoulders in despair. Stuart & Laraia (2005) differentiates fear from anxiety as he states that fear involves intellectual appraisal of a threatening stimulus, while anxiety is the emotional response to that appraisal.

The Intensive Care Unit (ICU) environment itself and previous unpleasant experiences in the ICU evoked fear in the participants because it was foreign and frightening to them. The alarms from the many machines and monitors, or what the participants see, like the underwater drainage bottle with its contents or connecting lines lying over the head injury patient, make them to be more afraid.

Statements as these are evident of that fear:

*“Oh! I felt like running away. I do not know whether it was the machine I was afraid of or ..., as they attached it to the hands as well. They attached so many things to her some were attached here and here, Oh!...”* (demonstrating by showing all over her body with her hands). [mother].

*“I was afraid as I didn’t know what all that means. As I was looking at all those “things” and hear many sounds I was thinking maybe she is not going to be with us any longer”.* [sibling]

*“I felt like that I was not going to go back home with her as I could see that her condition was deteriorating. I was taking care of a sibling in this same ICU and he passed away. The machine with its many lines did not help. When I saw the entrance of the same room to where she was taken, I did not believe that she would come out from that room alive”.* [guardian].

*“... relatives were very afraid as they had previous experiences when some family members died in the ICU after accidents. Initially they thought that the accident will take him to his grave”.* [sibling].

This is also confirmed by Thelan et al (2006) who described the ICU environment as a cause of stress to family members having loved ones being treated there. A lay person with previous bad experiences of the ICU, or who have little or no understanding of the

ICU environment and facilities will interpret all these from a different perspective and it obviously will aggravate his/her fears.

Some participants were uncertain as to what was going on with the person with a head injury during the time of hospitalization in the ICU. Moreover, some participants observed changes in the way the person was behaving towards them, disorientation to the environment or the way the person is talking and was a cause of fear and worry. These changes were observed during the time the person with a head injury was still in the ICU and after discharge.

This is evidenced by the following remarks by participants:

*“... we were feeling a bit worried because she was saying she doesn’t recognize us. In the mean time we were told to go back to the waiting room. First she said she did know us, but now she doesn’t know us any longer”.* [sibling]

*“One could tell when he speaks; you could see that his brain was very much affected as he was talking about things that were not appropriate and confusing. He was asking questions like: “Mom, where am I?”* [mother].

*“We were with her in the ICU, but she (the head injured) couldn’t recognize her. She (the head injured) said it’s for the first time she saw her [the sibling]. The day when we came to her for the first time she was only saying she did know us, but in reality she*

*really didn't recognize us who came to her. Even the next day when others went to visit her, she told them she hasn't seen us". [sibling].*

*"The child never felt better. ... hearing from others, it is a bad thing to get hurt on the head. [mother]*

This uncertainty that results in worries can easily result in anxiety, hopelessness and powerlessness as the person may feel that there is no future to the person with a head injury.

- **Hopelessness and powerlessness because of the condition of a family member with a head injury.**

The results showed that participants felt hopeless and powerless as they were unable to think, understand or able to do anything for their beloved ones, as they felt incapable of doing anything for him/herself. The situation to them was unbearable and did not know what to do. Participants felt hopeless or powerless as there was little or no response from the person with a head injury after the accident at the accident scene, or during the transportation of the person with a head injury to hospital from one hospital to the next one, or during the hospitalization or after discharge from hospital. In the case of the latter, the family members expected the person to be as before the accident.

The following statements are evidence of this:

*“I touched the child, but she was not moving”.* [grandmother at the scene of accident]

*“I lost hope because the nurse who escorted us doubted whether we will reach the hospital ...”* [and] *I could see [that the] condition was deteriorating, therefore I lost hope that I had her no more”.* [guardian].

*“The doctor has given us good advice before departure to Oshakati; however, the nurse who escorted us to Oshakati Hospital has contributed to my loss of hope, anxiety and fearfulness as she felt that [the patient] would not reach Oshakati, as she might die on the way”.*

*“Initially I was thinking that it was just an attempt that was better than nothing as I earlier took care of a sibling in the same ICU and she passed away. The machine with its many catheters did not help; and when I saw the entrance of the room she was taken to, I did not believe that she would come out from that room alive”.* [guardian to a one year old child during admission to the ICU].

*“... he is no longer the same person he was before the accident. He gets very angry easily, he has pain that never stops, and after four to five days he changed”.* [mother, one year after her child was discharged from hospital after sustaining a head injury].

Thompson, et al., (2002) view hopelessness as a subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilize energy on own behalf; and powerlessness is the perception that one's own action will not significantly affect an outcome; a perceived lack of control over a current situation or immediate happening.

Some participants became more powerless as the family life was already having other internal problems to deal with. One participant stated:

*"Hmmmmm, heee? You know, men sometimes do not really care. He doesn't say anything [silence]. Men, ... what can they do? If he comes home and has drunk beer, hmmmmmm. Everything is shifted on your shoulders and you struggle on your own with your child". [mother]*

The feeling of hopelessness and powerlessness may result both in physical and psychological exhaustion and the person may feel angry for no apparent reason and may socially isolate him/herself. Some participants felt hopeless and powerless because of the death of a loved one, before they could visit him in the ICU resulting in disbelief, sense of loss as they grieved his passing on.

The participant's responses indicate the sense of hopelessness and powerlessness, coupled with sadness. Specific beliefs about death are developed during the normal

developmental stages of life and people behave differently when death occurs based on religious values and norms as stated by Kozier et al (2008). Grief is expressed through different reactions that may include crying, anger, denial, despair and feelings of powerlessness. People derive comfort, hope and power from their religious beliefs and spiritual convictions. Any loss is painful, frightening, and it triggers an array of emotional responses like sadness (through crying), depression, loneliness, and questioning of beliefs.

One participant explained her feelings and reactions after finding out about the death of a loved one, by expressing herself as follows:

*“I cried because it was not easy to see with my own eyes and it hurts ... I was feeling bad. I did not have words to say when I looked at him lying there”.*[Sibling].

Perry and Potter (1999) assert that grief is manifested in a variety of ways that are unique to any individual and is based on personal experiences, cultural expectations and spiritual beliefs. In many cultures it is normal to cry after someone who is close and dear to you is no more, and the grief may take few months to years, before one can resume normal life and move on without the person.

In every culture and tradition there are rituals people carry out when they found themselves faced with death. Christians too have rituals they carry out in difficult situations such as praying and singing when a loved one passed away. Mokhosi and

Grieve (2004) also quoted Mbiti (1969) in their study they conducted in a rural set-up in South Africa that African families believe that God is called upon in attempts to explain what is difficult for the human mind to understand and to comfort those affected by bad luck – like losing a loved one to death.

This correlates with the following statement from one of the participants as she states:

*“As I am a Christian I made a sign of the cross on my forehead and prayed for him to God and then realized that it is done and finished”*. [sibling].

The researcher also observed how the participant looked sad as tears appeared in her eyes and she looked up simultaneously on the faces of her mother and brother as if she was hoping to get some comfort or approval from them. These expressions are evident of loss of control, intense yearning and spiritual despair. People grieve in different ways and there is no timeline for bereavement.

Kozier et al (2008) explain grief as the total response to the emotional experience related to loss, and is a process that sometimes does not take any specific sequence. Meyer (2002) states that grief is severe when death of a loved one comes suddenly before its expected time on the social clock and may trigger a year or more of mourning flooded with memories and may subside in mild depression that may take several years. It is influenced by different factors such as human development, psychosocial perspectives of

loss and grief, socioeconomic status, personal relationships with the deceased, nature of the loss, culture and ethnicity and spiritual beliefs, and could take few months to several years.

The results further revealed that some participants started to grieve even long before the worst had taken place as highlighted by Degeneffe (2001) in his article on Family care giving and TBI on the findings of a research he conducted, that families often demonstrate a variety of grief reactions when trying to come to terms with the reality of the injury immediately after such injury. This impending loss may make the person become uncontrollable.

One participant's own words verify this as she states:

*"I was crying bitterly... when I arrived at the relatives' house, where I stayed, I was still crying uncontrollably ..."* [a mother after her child sustained a severe head injury and was admitted to the ICU in a critical condition].

The participants did not only experience negative feelings, but also had positive ones as the condition of the person with head injury showed improvement.

### **3.3.1.2 Positive feelings experienced by family members of a person with head injury.**

As the condition of the person with a head injury improved, negative feelings faded and relief took over. This helped the participants gain hope for recovery of the loved one and were all smiles as the person with a head injury was eventually discharged from the ICU or from the hospital.

#### **Relief because of the improvement in the condition of the person with a head injury.**

The results from this study showed that participants experienced feelings of relief after the person with a head injury showed improvement; either in hospital or when the person had been discharged from the ICU or hospital. This was evident in the following statements:

*“...The more he got better, the less frightened I felt as I began to have an expectation that there is a possibility for him to get out of the ICU”.* [mother]

*“I was feeling better because my spirit has changed as I felt that [he] was getting better”.* [sibling]

*“I felt better as he started speaking very well because initially he was not speaking at all*

*and then ... he was mumbling ...”* [sibling]

*“... eventually I was feeling good when she opened her eyes as she was not breathing very well nor talking ...” [grandmother]*

*“I was really feeling very good and when I came back I found out that the child has been transferred to a ward for children”. [mother]*

*“Oooh!(laughing to herself) I was calling out her name and welcoming her home. I was laughing and my heart was very happy that she could walk on her own. Yes, she was having some bruises on her face and head, but these were just flesh scars, but that was nothing. Oh, I could not believe that she is now well if I have to think about the time when she was brought to Oshakati hospital from Thumb hospital. I thank God that she is well again”.*

Relief is the removal of stress and discomfort, or the feeling that is associated with the removal of stress and discomfort (Kozier et al 2008). It is used synonymous with alleviation, assuagement the feeling that comes when something burdensome is removed or reduced. The family members who were stressed because of a threatening situation, felt relieved when the stress to which they had been exposed was reduced as the person with a head injury showed improvement.

Although the participants were relieved from their stress and fears they experienced several challenges.

### **3.3.2 Theme 2: Challenges experienced by family members of a person with head injury.**

This theme was supported by two categories; firstly, limited transport for the family members to take the person with head injury to hospital, or to go to and from the hospital to visit the person a with head injury; secondly, ineffective interpersonal communication between the nurses and family members of a person with a head injury.

The results pointed to some distinct challenges the family members of a person with head injury met, as from the moment they got the news about the injury till the time after discharge and living with the person with a head injury.

#### **▪ Limited transport to go to and from the hospital**

The results from this study revealed that some of the participants experienced challenges of limited transport to take the injured to the health facility as they had to wait for some time before they could get public transport to get the patient to a hospital or to go and visit the loved one in hospital.

The following comments that were made provide evidence relating to this particular challenge

*“When she got injured I stopped a taxi to take us to the hospital ...”* [grandmother]

*“The day when we were told ... we were not having any transport ...”* [sibling]

These statements indicate that limited transport was a challenge to the participants as they could not go to the hospital immediately, either to take the person with head injury to the hospital or to go and see the person after being injured. Pre-hospital emergency services are not available in the area and this adds another challenge to the already challenging situation.

Besides the limited transport challenge, some participants were faced with the challenge of ineffective interpersonal communication, especially with the health personnel attending the person with head injury.

- **Ineffective interpersonal communication between the nurses and family members of a person with a head injury.**

The results from this study demonstrate ineffective communication between the nurses and family members of a person with a head injury when they provided information.

The results showed that nurses and doctors did not provide any information with regard to the extent of injury, treatment regimen, prognosis, rehabilitation, or possible outcome deficits or what to do or where to go in case any unpleasant/unfavorable outcome deficits were observed.

The following statements are evident of this:

*“I always visited him very early in the morning yet no one has told me the extent of the injury or where he has been injured”.* [mother].

*“The information that I received was that the child is in a better condition”.* [mother].

*“From the hospital staff they used to tell us: “He is getting better, he is getting well”.*

[sibling]

*“Meme okaana okeli nawa, shi taambako ashike. Okaana okeli nawa, ye ina ehama unene” meaning “madam, the child is well, just accept his situation, the child is fine. He is not injured that much”.* [mother]

Nurses may feel that because the family members are worried because of the condition of their relative, they feel that they only need to assure them and calm them down. They forget that the family members are also observing the patient and make their own conclusions which many times are inaccurate or totally wrong as they have little or no medical knowledge on the condition – in this case head injuries.

Another participant stated:

*“... they informed me that she was most injured in the head and they were thinking of transferring her to the Windhoek Hospital”.* [mother]

*“... the child has undergone all the checkups, follow-ups and examinations. We were then referred to the regional health director, and then we went to the lady that took his blood for an HIV-test. I was shocked. They told me that I should not be afraid, as my child will be tested for HIV as a result of the accident. Furthermore, there might be a possibility for him to be transferred to other hospitals, therefore, I must just be patient for the child to be tested for HIV,” they told me. From there on, I was of the opinion that the child was probably on the list to be transferred to other hospitals for further treatment. His current state of health... (Couldn’t finish the sentence and shook her head). No further attempts had been made”.*

Our interpersonal communication skills define our humanity and highlight our personal and professional relationships with other people (Quinn and Hughes, 2007). Nursing is not only concerned with the person who is sick, but also with those who are well and includes the family members of the patients, like the person with head injury. Quinn and Hughes (2007) underscore the importance of giving clear information, using language that is familiar to patients and their families and the need to ensure that the information provided is understood.

Ineffective interpersonal communication undermine the trust relationship that need to be between the nurse, the patient and family members of the patient for effective caring of the whole person as indicated by Mulaudzi, Mokoena and Troski (2000). Lack of proper information provision to family members of a person with a head injury has also been

identified by research conducted by Verhaege, Defloor, van Vuuren, Duijnste, and Grypdonck (2005) on the needs of family members with a family member in the ICU.

Sometimes the information that was provided was dubious, and in the medical terms that is not well understood by participants or was contradictory. Statements like the following are evident:

*“He [the doctor] told those who were present and they told me and explained to me that apparently the child is not well”.* [mother].

*“They told me that the child’s condition was somehow. I don’t know how...”.*

A lay person would hardly make any head or tail (sense) from such communication from a professional nurse. In their study on the needs of family members of patients with severe traumatic brain injury (TBI) Bond et al (2003) cited some of the possible reasons why information was not provided that included time restrictions and shortages of staff, or nurses may consider interaction with patients’ family members a low-order priority. However, the family members of a person with head injury are not totally ignorant. They expect adequate information and proper counseling as it has been described by Sinnakaruppan, Downey & Morrison, (2005) in their study head injuries in a rural setup: challenges and potential solutions carried out in a rural setting in India.

One participant stated the following:

*“Ideally, I wanted one of the staff members to take me to a quiet place to explain what the problem is, whether he could be treated or not and that he was likely to develop complications. This is the kind of assistance I wanted to get from the staff, but to no avail, except when I was told that he is better”.* [mother]

Communication is not only by word of mouth, but occurs also non-verbally, which could be through actions, facial expression, body posture or space between the sender of the message and the receiver thereof.

Another participant stated strongly as follows:

*“I told the nurse that the child was not feeling good at all. The nurse just took a cloth and covers his head, because she could see that I was thinking very badly”.* [mother].

Such actions can be interpreted differently by the said family member and might aggravate fear or provoke anger and despair. According to the MOHSS's Patients Charter of Rights (1999), it is unacceptable and unprofessional to ignore the right to information of the family member who is the parent and guardian to the patient who is a minor or to act in such a rude manner.

Lack of information revealed in this study is contrary to the results in a research study conducted by Watanabe, Shiel, McLellan, Kurihara, Hayashi (2001), where they evaluated the views of families living with TBI patients about the nature of the problems they experienced as a result of TBI in Japan and the United Kingdom (UK). The findings in their study was that the families in the two countries had experienced almost the same problems; but the families in the UK were likely to have more information about TBI, while those in Japan experienced increased social embarrassment in respect of social relations. This contradiction may be attributed to differences in cultural perspectives of these countries and Namibia, being a third world country, might not be at the stage were family members having access to all types of needed information.

Institutional policies were also contributing factors to the lack of information, particularly the policy that do not enable family members to talk to a doctor, at least every day, about the condition and the prognosis of the person with a head injury. Some participants wanted a nurse to explain to them about the care, the unit, the equipment and what they can use for the patient as was evidenced by a study by Verhaege et al (2005). This was evident from the following comment:

*“I then wanted to be around during the doctor’s rounds ... ”*;and added

*“In my opinion, I needed someone to inform me about how far [he] was injured, what they were treating him for, what kind of assistance he needed or how to assist him”.*

A study conducted on the African families' perceptions of TBI by Mokhosi and Grieve in 2004 in South Africa illustrates that there are many factors that influence the way people perceive and understand TBI and one of these factors is the level of education. The better educated the caregiver (which is mostly a family member), the better the understanding (Mokhosi & Grieve, 2004). The majority of the participants interviewed did not get proper information to help them understand the person with a head injury better or to observe him/her for possible head injury deficits.

The results of this study also revealed that nurses did not provide information with regard to reasons why certain actions were not permitted with regard to the head injury patient, like keeping to the minimum stimulation or extensive communication with the head injury patient. This is evidenced by the following statement:

*“On the second day, he opened his eyes and responded. However, the nurses told me not to disturb him as he was injured and that I should just check on him and leave him without going further than that. On the third day, I realized that he recognized me, as he started smiling and crying at the same time when he saw me. At that point in time the nurses informed me not to stay long”.*

As participants lacked information in respect of head injury, this made the family members vulnerable and caused them to cope ineffectively with head injury deficits they observed. Some participants even concluded that nurses were not supportive and kept

information to themselves that made it unacceptable as they needed information from the health care providers.

▪ **Ineffective coping by family members of a person with a head injury**

The results of this study showed that participants had varied challenges to cope with the outcome of head injury at different levels – when in hospital and at home after the person with head injury had been discharged. In hospital the participants expected certain services to assist them to cope with the changed situation. The following remark testifies to this fact:

*“They (nurses) must know and feel that when the parents are around, as sometimes we are frightened and in a state of shock, they must sympathize and counsel us, informing us in an appropriate manner and try to make us to understand the situation fully. If possible, there is a need for counselors in the Intensive Care Unit to counsel the visitors, especially, the parents”.*

Coping is described by Kozier et al (2008) as dealing with change successfully or unsuccessfully; while Feldman explains it as the effort to control, reduce or tolerate the threats that lead to stress (Feldman, 2000). There are different coping strategies one can utilize to respond to a changing environment – either problem-focusing or emotion-focusing. Coping mechanisms or strategies are viewed as an active method of problem

solving developed to meet life's challenges, which could be short term or long term and varied in individuals. Coping with a changed environment may be positive or negative.

The results of this study showed that loss of concentration was experienced by some participants as they were unable to think straight because of the psychological turmoil caused by the head injury of a loved one. One participant put it eloquently as follows:

*"Hmmm! I was not able to do the work every day ... Even when I have to be at home my thoughts were occupied asking myself how she was doing. Sometimes you are not doing anything because of the many thoughts". [grandmother]*

Some participants blame themselves for not seeking enough medical assistance and information, for example, not keeping up to follow-ups or when they identified outcome deficits in the head injury patient.

The following statements are evidence:

*"... I did not go back to the doctors as they might have referred us or they had something in mind".*

*"Oh! [Moving her shoulders up and down]. I am also to be blamed because when we came home I kept quiet and didn't go back again".*

In a study conducted by Mokhosi and Grieve (2004) they identified a pattern of family reaction of denial where most of the family members wanted to believe that their loved ones would recover and return to them with some semblance of their former selves. The authors further points out that denial of family members was prolonged by fantasies that head injury patients would return to their former selves if the right traditional treatment was administered and if appropriate traditional rites were performed (Mokhosi and Grieve, 2004). The results of this study contradict the findings of Mokhosi and Grieve's study as none of the participants mentioned such traditional aspects, although they showed some denial characteristics.

Denial is a coping strategy which any individual can use to cope with a difficult situation. Although none of the participants provided any reason why they did not go back to the hospital when the head injury patient had some unfavourable behavioral outcomes of denial, desperation and frustration or hopelessness and powerlessness could have influenced this decision.

According to information provided by The Brain Injury Association (2009) everyone who has had a head injury can be left with some changes in emotional reaction and behavior, and many family members might deny this or they might not know about this. The results of this study indicated that family members faced challenges due to a lack of information regarding TBI and hence they coped ineffectively.

Bond et al (2003) cited the research findings of Burr's study where she used the Critical Care Family Needs Inventory and qualitative interviews to examine the extreme distress of family members of patients with TBI that the unmet need of knowing was a major contributor to this distress. In a situation where a person is stressed he/she loses concentration on his/her daily activities as he/she finds it difficult to cope with the change.

The results evidenced some of the issues such as the presence of fatigue, short-term memory, poor inter-personal relationships and aggression make the family members unable to cope and understand the head injury patient. This is evidenced by statements from different participants such as the following:

*"... when he came home he was sleeping almost all the time".  
[mother]*

*"He used to complain of having pain in the head as it was injured". [mother]*

*"He used to say that the pain is in the head or he feels as if something is moving in his head or he would say mom, I am tired. For example, if you ask him to get you water with a 5-litre bucket, by the time he will get home he would be breathing heavily, saying:  
"Mom, I am very tired ... Now the problem seems to get worse. When he is doing some work at the same time he may be complaining about something moving in his head. He would say "it is moving here". "...he would say, "Mom, I thought I have finished doing a certain task but I have forgotten about it". [mother]*

*“She has been behaving well. It is only now that we are hearing her saying: “Grandmother I feel in my head something moving around as if there is something that is loose as if it is moving in my brain”. [grandmother]*

*„She still gets angry very easily even, it is only a slight thing done to her, she gets very angry”. [grandmother]*

*“I only used to hear her saying that she doesn’t know what is wrong with her because sometimes she does not understand herself. She is saying sometimes she forgot. She will think about going or doing something or she wanted to say something but she might forget about it”. [sibling]*

The participants are challenged by these head injury outcomes and are worried which could cause distress and despair in respect with their futures and those of their loved ones. This might hamper normal functioning of family units. This was also evident in a research study conducted by Mokhotsi & Grieve (2004) in South Africa and by Kneafsey & Gawthorpe (2004) in the UK, amongst both head injury patients and their care givers.

Some literature reports point out that the healing process is not over with brain injury and this causes ineffective coping with the outcome of head injury. Although family members of a person with a head injury were coping ineffectively, none took drastic

steps to the change the situation, like leaving the family as it was reported by Dalphonse (2007) where a partner moved out after his girlfriend sustained a head injury and was suffering from amnesia.

In an article written on family reaction to TBI in the UK, it is indicted that “families need attention, education, guidance and support if they are to survive, regroup and rebuild their lives. Some families cope better than others, but all have difficulties” (Tidy, 2007). There is no normal way of responding to a head injury. The saying that 'people act abnormally in abnormal situations' is undoubtedly appropriate. The health care professionals have a responsibility to address these aspects.

Although the participants experienced many challenges, they also had some sort of support in one way or another.

### **3.3.3 Theme 3: Varied degrees of support experienced family members of a person with head injury.**

This theme is supported by two categories; namely effective social support provided to family members of a person with head injury by relatives and friends, and lack of professional support for family members of a person with a head injury. These categories will be discussed in the next paragraphs.

## **Effective social support provided to family members of a person with head injury by relatives and friends**

Support means “to sustain (a person, the mind, spirits, courage, etc.) under trial or affliction” (Online Dictionary, 2003). Support to another person may be physical, emotional, social, religious or financial. Social support comes from people around us; being those we live with or outside the house. The results revealed that some participants enjoyed social support from relatives, friends and some professionals.

It is evidenced by the following statements:

*“... the police put the injured one, together with the other neighborhood children, in the police van and took him to the hospital”.*

This indicates professional support that the family members of a person with head injury received.

*“We were with the neighbours who escorted us to the hospital ... ”*[mother]

The neighbours escorted the mother providing emotional support as they left the accident scene when her child sustained a head injury.

*“They really helped us, as they used to visit her in the hospital and they have made efforts to go to [visit her]. Some nurses are relatives of our neighbours and they told me to keep myself busy as they looked after her on my behalf and promised to inform me to come urgently if her condition deteriorated”.* [sibling]

*“On the part of the parents, they hoped and encouraged us to be patient as life is like that”. [sibling]*

*“My sister together with my family at home assisted me. They kept bringing what we needed. There was always someone who used to come and stay with me nearly every time and she brought food for us”. [mother]*

*“...some sent cards; some wrote letters to her quoting Bible scripts and some sent anything they wanted to give. We read all these during the time we were with her and we told her who gave her all these. She also got gifts. Sometime we only saw the gifts when we came to visit her when people had visited her”. [sibling]*

*“When he came home his friends used to visit him and they brought him things like juices”.*

These are evidence of effective and strong social support systems the participants enjoyed from the accident scene, during hospitalization of the person with head injury and even at home as friends came to visit.

In rural areas many families are poor and anything that is provided to them for which they could have bought with the scarce financial resources, like juice or any other food or other commodities, will be highly appreciated.

The results of this study show that the participants enjoyed and appreciated such support. Other support that was cited by the participants was financial support. When illness or an accident strikes unexpectedly, family members might be struggling to meet the needs, especially when it comes to finances.

As one participant commented:

*“The person that did something was our lastborn sister who gave us some money to buy food for the child”.* [mother]

In the Owambo culture, family has the responsibility to assist each other in many aspects depending on the need. Where one is unemployed or having a low income, others who have financial means or who are better off are expected to assist when the need arises. This was evidenced also in this study.

- **Lack of support through counseling of family members of a person with head injury**

The results of the study revealed that there was lack of support through counselling by health professionals like doctors and nurses to family members of the head injury patient.

The following statements provide evidence of this concern:

*“They (nurses) must know and feel that when the parents are around, as sometimes we are frightened and in a state of shock, they must sympathize and counsel us, informing us in an appropriate manner and try to make us to understand the situation fully. If possible, there is a need for counselors in the Intensive Care Unit to counsel the visitors, especially, the parents”.* [mother]

*“During visiting times one comes and stays in a certain room first. They could see that I was always afraid so they use to crack some jokes with me to lessen my fear. I took it as if they were not serious with me because the child was looking lifeless”.*

Searle (2008, p. 261) pointed out that “too often the nurse forgets that the patient’s family is concerned for his welfare and may express their fears rather forcibly, or make a so-called “ „nuisance”” of themselves”. When family members are drawn in the therapeutic environment through supporting them, the nurse-patient relationship is strengthened and the patient will receive all the necessary support especially from the primary group (the family) to which he/she belongs.

It further emerged that sometimes nurses take it very lightly when family members expose fear and uneasiness as they visit a loved one in the ICU. The family members may interpret these jokes as a mockery and can negatively affect the building and maintenance of a trusting relationship. Some research findings indicated that some nurses considered interaction with the patient's family members a low-priority (Bond et al, 2003).

The nurse on the other hand has a co-coordinating function and must serve as a bridge between the family members of a head injury patient and other health care professionals. Head injury patients experience irritability very easily, especially if a multi-disciplinary health care provision is followed. The nurse needs to prepare the family members to, for example minimize stimulation of the head injury patient during visits as they may interpret the irritability wrongly.

It further emerged that Sinnakaruppan et al (2005) found that it is the unpaid family carers who undertake the responsibility for the life-long care of the relative with head injury. They need thus all the professional support they need to be able to fulfill this function on their own and to have confidence to come back when professional advice is needed.

Lack of professional support through counseling gives a negative image of the nursing profession in the community and the goals of nursing services will not be accomplished.

PHC aims also at community participation and this will be achieved if family members are to be involved in the care and support of a person with a head injury, even during the time of hospitalization. The study revealed that participants felt bad as they did not receive the professional counseling needed in this stressful situation.

### **3.4 SUMMARY**

This chapter has presented themes and sub-themes that have emerged from the data analysis of the interviews with family members of a head injury patient. Relevant literature, as control to the research findings, was also included in the discussion. The next chapter will deal with conclusions, guidelines, limitations and recommendations.

## **CHAPTER 4**

### **CONCLUSIONS, GUIDELINES, RECOMMENDATIONS AND LIMITATIONS**

#### **4.1 INTRODUCTION**

In the previous chapter the results were analyzed and themes and sub-themes that have emerged from the analysis were discussed and a literature control was done. In this chapter, conclusions drawn from this study, the guidelines and limitations are discussed. The recommendations will then finally be suggested.

#### **4.2 CONCLUSIONS**

The conclusions of this study are drawn from the findings and are discussed below per objective.

##### **4.2.1 Objective 1: Exploration and description of the experiences of family members of a person with head injury**

The researcher met this objective through face-to-face interviews with family members of a person with a head injury. It was concluded that participants experienced positive and negative feelings which lead to emotional turmoil – a state of great commotion or disturbance. Negative feelings that were experienced include psychological shock, fear and uncertainty and disbelief, loss and grief, hopelessness and powerlessness; and the

positive feeling was relief. The relief feelings were experienced because of the improvement in the condition of the person with a head injury and by encouragement from relatives, friends and a few nurses. The relief feelings for some family members were of short duration, as some cognitive and behavioural changes were observed in the person with a head injury while still being treated in the ICU. This resulted in confusion and worry of the family members as they had no knowledge of potential head injury outcome deficits.

The different feelings the family members of a person with head injury experienced was a result of the whole situation that occurred unexpectedly and evoked distress and turmoil or disquietude. These feelings did last for quite a time especially the time when the person with head injury was treated in the ICU.

The family members faced a stressful situation that was ill-timed and needed some sort of information related to the whole phenomenon of head injury and some counseling to be able to understand and adapt to the situation that was a reality (Degeneffe 2001, Agrawal et al 2008 and Elbaum and Benson 2007). It was also concluded that counseling was not only needed during hospitalization, but also long after discharge to understand that the rehabilitation and well-being of the person with head injury needs patience and that it might take long to recover completely. It is also important to understand what roles family members ought to play in the whole process of recovery (Bond et al 2003).

Moreover family members experienced several challenges such as limited transport, ineffective interpersonal communication, lack of information and explanations, lack of counseling by health professionals and ineffective coping. In general, some participants received support from relatives, parents, neighbors, the police, a few nurses and well-wishers; while others did not receive any support – not even from their spouses.

Further conclusions made were that some family members of a person with head injury experienced support of transporting the person with head injury to a health facility. Several other types of social support from family members were experienced and were instrumental to satisfying the needs of the person with a head injury. These included, assistance with a problem; tangible support such as donation of goods, information support such as giving advice; and support of an emotional nature such as giving reassurance by praying together with relatives and/or friends and notifying close family members about the accident. This indicated cohesion amongst the family members and that of the community at large as it is typical in many rural communities. The study further concluded that some family members of a person with a head injury did not have sufficient support even from some nurses and doctors who were treating the person with a head injury or other health care professionals, – for example, social workers, neuropsychologists, pastors, physiotherapists, and speech therapists. It further emerged that some family members of a person with a head injury were left on their own as they struggled with many unanswered questions that caused emotional turmoil, frustration, uncertainty, anxiety and self-blaming.

Support by health care providers, especially nurses, do not only ensure continuity and flow of information in both directions (from and to the family members), but it also strengthens a trusting relationship between family members and nurses. Trust forms the key to this relationship and is strengthened when nurses apply the „prudent man principle“ or the diligence paterfamilias that shows humanness from their side. Additionally, trust is the key to the relationship between health care consumers and health care professionals (Searle, 2008), and this is only possible if the communication between them all is effective. Communication is not just „being nice“ but produce a more effective interaction. Furthermore, effective communication significantly improves accuracy, effectiveness and supportiveness; health outcomes for the patient; satisfaction for both the patient and health providers, and the therapeutic relationship, because it bridges the gap between health care providers and patients and their family members (Silverman, Kurtz & Draper, 2008) and (Townsend, 1996).

#### **4.2.2 Objective 2: Develop broad guidelines for family members on how to cope and how to support the person with head injury**

Guidelines are defined as “rules or instructions that are given by an official organization telling you how to do something; or something that can be used to help you make a decision or form an opinion” (Oxford Advanced Learner’s Dictionary 2006, p. 663).

Broad Guidelines were developed. See the description below.

## **4.3 A DESCRIPTION OF THE GUIDELINES FOR FAMILY MEMBERS ON HOW TO COPE AND SUPPORT A PERSON WITH A HEAD INJURY**

### **GUIDELINE I:**

#### **FACILITATING THE UNDERSTANDING OF THE PHENOMENON HEAD INJURY TO FAMILY MEMBERS**

The goal of this guideline is to facilitate the understanding of the phenomenon head injury. The rationale is for the family members of a person with a head injury to acquire the knowledge about the whole phenomenon of head injury and how to live with a person with head injury.

Family members have to:

- request from nurses/doctors relevant information so as to understand the phenomenon of head injury;
- actively participate in interventions related to the physical and emotional care of a person with a head injury with the guidance from health care providers;
- observe the person with a head injury for any physical, social, psychological and behavioral deficits and to report early to the health care providers;
- learn to understand and physically and emotionally support the person with a head injury; and

- understand and effectively play their role during the rehabilitation period of a person with a head injury.

## **GUIDELINE 2:**

### **FACILITATING SUPPORTING MECHANISMS BY FAMILY MEMBERS OF A PERSON WITH A HEAD INJURY**

The rationale is that family members need to identify and develop their own short and long term supporting mechanisms. One support mechanism is the need to develop a positive attitude towards the person with a head injury and towards the condition itself. Attitudes influence our thinking and behavior and develop over time through socialization. Attitudes are influenced by a personal or social philosophy and determine the person's willingness to care, support or assist another person (Kozier et al 2008). Another supporting mechanism is to manage to tolerate the behaviors of the person with a head injury that might be non-responsive, slow-responsive, aggressive or inappropriate. Family members need to know and understand that recovery from a head injury takes long and needs patience and tolerance – thus patience is an important virtue.

Family members have to:

- ask information from intensive care nurses, religious leaders or community volunteers to put them into contact with persons or support groups of family members of a person with a head injury to assist and support them in the new life facing them of caring for a person with a head injury;

- ask intensive care nurses to bring them into contact with a skillful person, like a psychiatric nurse, in order for them to discover their personal belief systems and why/how they are going to take care, maybe for a very long time, for the person with a head injury;
- ask the intensive care nurse to bring them into contact with a social worker or psychiatric nurse or psychologist for a sensitivity session so that they can express all their doubts, fears, misgivings and then, with professional help, try to figure out solutions;
- identify, utilize and appreciate available social support systems for the care and support of a person with a head injury; and
- learn and develop tolerance and understanding of the responsibilities in the caring and support of a person with a head injury from an expert for example a psychiatric nurse, of support group.

### **GUIDELINE 3**

#### **FACILITATING COPING MECHANISMS RELATED TO THE EMOTIONAL TURMOIL AFFECTING FAMILY MEMBERS OF A PERSON WITH A HEAD INJURY**

When a person experiences a stressful situation that is difficult to understand or adapt to, he/she experiences emotional turmoil because of the many and varied feelings and emotions arising from such a situation. Family members undergo such emotional turmoil as the injury to a loved one strikes unexpectedly and threatens effective family

functioning. Therefore, the rationale is that family members need to learn how to cope with such a patient.

Family members have to:

- verbalize their needs to each other and to professional health care providers, like social workers, spiritual leaders, nurses and doctors;
- critically reflect on and utilize different coping skills they might have and learn and practice new ones, both short term and long term ones. These coping skills must be based along two dimensions: problem management,(that are directed at changing the stressful situation) and emotional regulation, (including the seeking of social support, venting of feelings, avoidance and denial) (Glanz, Rimer, & Lewis, 2002).
- learn and practice positive thinking and living with a person with a head injury; and
- identify and utilize counseling services available either in health facilities or in their communities.

#### **GUIDELINE 4**

##### **FACILITATING INTERVENTIONS RELATING TO CHALLENGES FACING FAMILY MEMBERS OF A PERSON WITH HEAD INJURY**

Family members are faced with many challenges when an accident occurred, especially when there is a head injury, which could be originating from the external environment or

from within. A head injury may cause physical, cognitive, behavioral or social deficits in a person which could pose challenges to family members and they need to carry out certain activities that the person with a head injury can no longer perform or may perform poorly. The family members may not understand the change in knowledge the person with a head injury previously had, or changed behavior or social interaction, and may thus be powerless or even embarrassed by the person's communication or interactions.

Family members have to:

- ask for assistance to learn how to recognize complications that could occur in the patient and report that to the relevant health care provider;
- ask intensive care nurses to bring them into contact with a skillful person, like a psychiatric nurse, in order for them to discover their personal belief systems and why/how they are going to take care, maybe for a very long time, for the person with a head injury;
- ask intensive care nurse to bring them into contact with a social worker or psychiatric nurse or psychologist for a sensitivity session so that they can express all their doubts, fears, misgivings and then, with professional help, try to figure out solutions;
- identify, utilize and appreciate available social support systems for the care and support of a person with a head injury; and

- learn and develop tolerance and understanding of the responsibilities in the caring and support of a person with a head injury from an expert for example a psychiatric nurse, and/or a support group.

## **GUIDELINE 5**

### **FACILITATING CONSTRUCTIVE INTERPERSONAL RELATIONSHIPS AND EFFECTIVE COMMUNICATION BETWEEN FAMILY MEMBERS AND HEALTH CARE PROVIDERS.**

Communication forms the basis of all human relationships and forms the bond of humanness especially in the health care system (Searle, 2008). The rationale is that family members need to communicate all aspects concerning the patient they care for.

Family members have to:

- initiate and strengthen healthy interpersonal skills because these are crucial for the establishment of therapeutic nurse-family members relationship;
- develop interest in, and sensitivity towards the health care providers;
- be genuine, real, honest and authentic towards themselves, health care providers and the person with head injury;
- recognize and correctly interpret non-verbal communication between themselves, health care providers and the person with head injury;;
- cultivate sensitivity towards challenges to the communication process;
- establish, promote and maintain effective inter-personal communication between themselves, the multi-disciplinary team and the person with head injury; and

- actively participate in information sharing programs and support group activities.

#### **4.4 RECOMMENDATIONS**

With reference to the findings of this study recommendations are made for ICU health care providers, family members of a person with a head injury and on aspects for further research.

##### **❖ Recommendations for health care providers in practice**

Recommendations for health care providers are as follows:

- Since family members experience varied feelings that cause distress, a multi-professional approach to address the plight of the family members of a person with head injury is recommended. Nurses and doctors need to hold a daily briefing meeting with the family members to tell them on any progress observed in the patient or to assure them of all efforts implemented if there is any deterioration. Social workers, counselors or religious leaders needs than to be called in to provide further emotional support/assistance to enable family members of a patient with a head injury to cope with the difficult situation.
- Nurses, doctors, social workers, counselors, religious leaders, psychologists, speech therapists, etc. are needed to provide the necessary care, support and assistance to the family members of a person with head injury. Nurses can alleviate the stress of family members of a person with head injury by providing them with information and ways for the family members to be involved in the

care of the person with head injury (Bond et al., 2003). This might be providing information leaflets or flyers on head injury and possible questions that they may ask in respect with the head injury patient. Family members might also be involved, where possible, in the basic care of the patient like washing, feeding or turning the patient to make them feel they form part of the caring of the loved one.

- A Critical Care Family Assistance Program (CCFAP) need to be developed and instituted to enable a systematic and logical way of flow of information to and from both the family members of a person with a head injury and health care providers. Within such a program family meetings and information sharing sessions will be utilized to provide information to the family members of a person with a head injury with regard to treatment regimen, extent of injury, possible head injury outcome deficits and other related information on head injury in leaflet or flyers formats. The leaflets and flyers must be in a simple straightforward language which the family members can understand very easily. During family meetings/information sharing sessions, nurses need to assess the needs of family members and for signs of extreme or abnormal behaviors and empower them or refer them to personnel who are trained in crisis intervention and counseling.

The CCFAP can also serve as an effective therapeutic tool that can formalize a powerful collaborative relationship between the family members and health care

providers that can maximize the family members' adjustment in a traumatic life-altering situation (Klonoff, Koberstein, Talley & Dawson, 2008).

- In-service training: Nursing services management in health facilities with a unit dealing with persons with head injuries need to implement an in-service program that enlighten and improve nurses' knowledge regarding assisting and supporting family members of a person with head injury (during hospitalization and during the rehabilitation period). These in-service sessions must also deal with issues like group dynamics to cover aspects such as communication, group norms, group cohesion and group leadership (Du Toit & van Staden, 2005). In turn this will enable nurses to better understand the importance of their coordination functions in the provision of nursing care from the PHC approach that are incorporated in training programs; and need to be sensitized on legal foundations of nursing in the practicing of the nursing profession. Additionally, issues in the Constitution of the Republic of Namibia (such as Basic Human Rights), the Nursing Act of 2004 (Act No 8 of 2004), Government Notices of January 1999 No 10 and 13 and the provisions in the Patient's Charter of Rights need also to be addressed so as to provide an ethical and legal based care and support to the family members of a person with head injury.

Health facilities, especially ICUs, need to have inventories for families with a person with a head injury to be able to refer new members of a person with a head injury for support and/or assistance with adaptation; or to track them with the idea to set-up support groups.

- The Health Facilities should provide critical care nurses and physiotherapists with printed booklets, flyers, leaflets or posters that cover aspects to fulfill basic needs like hygiene, mobility and feeding of a person with a head injury.
- Nurses need to demonstrate to family members during the bed-wash sessions, or during daily multi-disciplinary information sharing sessions or during visiting times on how to meet these basic needs when the condition of the patient allows.

The Patient Charter of Rights, as published by the MOHSS, requires health care providers to share information with patients and their family members regarding aspects of the patient's condition and about the Ministry's health facilities (MOHSS, 1999). Perry & Potter (1999) cited that written information are useful supplementary material because the person can refer back to points that were unclear or that may have been forgotten. These informational materials should be available well in advance (Perry & Potter, 2002) so as to enable chances of questions in case of clarity that may be needed. It is therefore strongly recommended that family members of a person with head injury be provided with all the necessary information they need on how to cope and how to support a person with head injury. Thus, a problem shared is halfway solved.

#### ❖ **Recommendations for family members of a person with head injury**

Recommendations for family members of a person with head injury are as follows:

- Family members of a person with a head injury should be trained on how to fulfill basic needs of these persons and they need to request such training. They too have

the responsibility to maintain their own health and that of their family members, including a person with head injury as part of the provision of Primary Health Care.

The training can be done by means of:

- Demonstrations during the bed-wash sessions, visiting times or at discharge of patients by critical care nurses or by multi-disciplinary team members;
- Booklets, flyers or posters that clearly shows how specific activities can be performed, for example turning, feeding or washing of a bed-ridden patient at home need also to be printed and given to family
- Family members must see the importance of self-care training where they learn stress and anger management skills, meditation skills and other health awareness issues individually or in company of members of support groups identified in their communities

#### ❖ **Recommendations for nursing education**

It is recommended that nursing education need to strengthen training of nurses, especially critical care nurses, in the following aspects:

- communication and inter-personal relations;
- legal and ethical foundations of nursing, that specifically addresses aspects of trauma management with special emphasis on professionalism;
- rehabilitation of patients diagnosed with head injury.

### ❖ **Recommendations for further research studies**

The following recommendations for further research studies are made:

- Research studies targeted at coping strategies utilized by family members of a person with head injury during hospitalization of such a person.
- Studies to determine challenges experienced by nurses when caring a person with a head injury in hospitals in Namibia.
- Studies on the experiences of a person with a head injury post hospitalization.
- Needs of family members of a person with a head injury during and post hospitalization.
- The influence of post traumatic head injury outcome deficits on family life.

### **4.5 LIMITATIONS**

Although this study is one of its kinds, limitations were present. Limitations are explained by Burns and Grove (2001) and Nieswiadomy (2002) that it can be theoretical and methodological and are uncontrolled variables that restrict or decrease the generalizability of the findings of any study, which may affect study results.

### **Limitation applicable to this study**

#### **Data collection and data analysis:**

Data were collected using an in-depth face-to-face interview and participant observation at the same time, and this makes data analysis time consuming and difficult (LoBiondo-Wood and Haber, 2006). Since the interviews were conducted in the local language, Oshiwambo, and afterwards translated into English, the possibility of losing some of original expressions of the participants during the translation process cannot be ignored. Furthermore, at some homes of the participants there were occasional interruptions from other family members and noise of the blowing wind as building structures were made of straw/grass and at some homesteads rooms were constructed from corrugated iron. This might have caused losing some of the data as flow of thoughts might have been disturbed or the participant might forgot some of the information needed by the researcher.

#### **Participants' effects:**

The researcher assumed that the participants have shared their experiences with her openly as far as possible. Participants might have done so in a manner they perceived as being polite, and not really as what they had experienced. This effect may skew the results and is referred to as the Hawthorne effect (Polit et al., 2001).

#### **4.6 FINAL CONCLUSION**

TBI is of concern in both developed and developing countries, not only to persons with head injury and health care services, but also to family members. A sudden unexpected admission to the ICU is stressful and the severity thereof may place demands on family members beyond their ability to cope and to live with a person who had a head injury (Bond et al 2003).

This study indicates that family members of a person with a head injury experienced varied feelings and challenges causing them to develop anxiety as they identified head injury outcome deficits and were afraid of the untimely death of the loved one. Some participants had some support from other family members, relatives, friends and a few professionals that enabled them to cope with the stressful situation. Some family members did not have relatives near them to support them or stand by them and had other problems on the table that was threatening family functioning. Nurses can alleviate the stress of the family members of a person with a head injury by providing information in respect of coping strategies, extent of head injury and possible head injury outcome deficits, initiating or referral to available support services and how to live with a person with a head injury.

Recommendations were drawn to assist or support family members of a person with head injury. The researcher hopes that the findings of this research will guide ICU health

care providers to identify their responsibilities with regard to family members of a person with head injury so as to enable them to provide holistic care to the person with head injury.

The researcher hope that this study will make a modest contribution to understanding this challenging and demanding field that needs to be explored and promoted for the improvement in the development of health services to our people and country.

## 5. LIST OF REFERENCES

Agrawal, A., Johrapurkar, S.R., Golhar, K.B., Shahapurkar, V.V., Dwivedi, S and Abhuday, M. (2008). *Head Injuries in a rural setup: Challenges and Potential Solutions*. Journal of Emergencies, Trauma and Shock: Volume 1 (2); July – December 2008. Retrieved on the 17 September 2009 from <http://www.pubmedcentral.nih.gov/fprender.fcgi>.

Anon. (2001). *Brain Injury*. Saskatchewan: Saskatchewan Brain Injury Association Press.

Anon. (2007). Denial's Ugly Head. Brain Injury Resource Center Publication. Retrieved on the 20 July 2009, from [www.headinjury.com/denial.htm](http://www.headinjury.com/denial.htm).

Anon. (2009). About Brain Injury. Retrieved on the 19 September 2009 from <http://www.Headway.org.uk/sitePages>.

Anon. (2009). *Family reaction to TBI*. Retrieved on the September 19, 2009 from <http://www.headway.org.uk.sitePages>.

Anon. (2009). NINDS Traumatic Brain Injury Information Page. Retrieved on the 19 September 2009 from <http://www.ninds.nih.gov/research/tbi/index.htm>.

Babbie, E. & Mouton, J. (2001). *The Practice of Social Research*. Cape Town: Oxford University Press Southern Africa.

Blanche, M. T., Durrheim, K & Painter, D. (2006). *Research in Practice – Applied Methods for Social Sciences*. (2<sup>nd</sup> ed.). Cape Town: Juta

Brink, H., Van der Walt, C. & Van Rensburg, G. (2006). *Fundamentals of Research Methodology for Health Care Professionals*. (2nd ed.). Cape Town: Juta

Bond, E., Rae Lee Draeger, C., Mandleco, B. and Donnelly, M. (2003). *American Association of Critical-Care Nurses: Volume 23* Published on line retrieved on July 21, 2009 from <http://ccn.aacnjournals.org/cgc/content/full>.

Browndyke, J. N. (2002). *Telepsychology Solutions* retrieved on the 19 September, 2009 from [www.neuropsychologycentral.com](http://www.neuropsychologycentral.com).

Burns, N. & Grove, S.K. (2005). *The Practice of Nursing Research: conduct, critique and utilization*. (4<sup>th</sup> ed.). Philadelphia: W. B. Saunders Company.

Concise Colour Medical Dictionary. (2007). (4<sup>th</sup> ed.). Oxford: Oxford University Press.

Creswell, J. W. (1994). *Research Design*. (1<sup>st</sup> ed.). Thousand Oaks: Sage Publications.

Creswell, J. W. (2003). *Research Design. Qualitative, Quantitative, and Mixed methods Approaches*. (2<sup>nd</sup> ed.). Thousand Oaks: Sage Publications.

Crosby, R. A., DiClemente, R. J. & Salazar, L. F. (2006). *Research Methods in Health Promotion*. (1<sup>st</sup> ed.). San Francisco: Jossey-Bass.

Dalphonse, S. (2007). *Experiences by Others*. Retrieved on the 19 September 2009 from <http://www.google.com>.

De Vos, A. S., Strydom, H., Fouche, C. B. & Delpport, S. C. L. (2009). *Research at Grass Roots for The Social Sciences and Human Service Professions*. (3<sup>rd</sup> ed.). Pretoria: Van Schaik.

Degeneffe, C. E. (2001). *Family Care giving and Traumatic Brain Injury*. Health & Social Work Volume 26, Number 4, Published Online: 5 March 2001 retrieved on 29 July 2009 from <http://www.naswpress.org>.

Du Toit, D.A. & van Staden, S.J. 2005. *Nursing Sociology*. (3<sup>rd</sup> ed). Pretoria: Van Schaik Publishers.

Elbaum, J. & Benson, D. M. (2007). *Acquired Brain Injury Challenges and Interventions*. Retrieved from <http://www.springerlink.com/content/> on the 28 November 2009.

Feldman, R. S. 2000. *POWER Learning – Strategies for success in College and Life*. Massachusetts: McGraw-Hill Companies.

Frisch, C. N. & Frisch, L.E. (2002). *Psychiatric Mental Health Nursing*. Albany: Delmar Publishers.

Foulis, E. (1999). *Head Injury*. Retrieved on the 11 August 2009 from <http://www.unisa.ac.za/contents/public>

George, J.B. (2002). *Nursing. The Base for Theories Professional Practice*. East Norwalk: Appleton & Lange.

Glanz, K., Rimer, B. K. & Lewis, F. M. (2002). *Health Behavior and Health Education: Theory, Research and Practice*. (3<sup>rd</sup> ed). San Francisco: Jossey-Bass.

Government Gazette of the Republic of Namibia No. 3249. (2004). *Nursing Act No. 8 of 2004*. Windhoek: Namprint

Gross, R. (2001). *Psychology: The Science of Mind and Behaviour*. London: Hodder Headline plc.

Holloway, I. & Wheeler, S. (2002). *Qualitative Research for Nurses*. (2<sup>nd</sup> ed.). Oxford: Blackwell Publishers

Hutchison, R., Hutchison, M.S. (2009). Frequently Asked Questions about Head Injury. Retrieved on July 20, 2009 from <http://hosting.texoma.net/business/biotech/thia-faq.htm>.

Johnson, G. (1998). *Traumatic Brain Injury Survival Guide*. Retrieved on the August 27, 2008 from <http://www.tbiguide.com>.

Klonoff, P. S., Koberstein, E., Talley, M. C. & Dawson, L. K. (2008). A Family experiential model of recovery after Brain Injury. *Journal of Brain Injury*, Volume 72, No. 2. Retrieved on September 29, 2009 from <http://www.google.com>.

Kneafsey, R. & Gawthorpe, D. (2004). Journal of Clinical Nursing Volume 13 Issue 5, Pages 601 – 608, Published Online. Retrieved on the 20 July 2009 from <http://www.chestjournal.org/content/>.

Kozier, B, Erb, G, Bergman, A & Snyder, S. (2008). *Fundamentals of Nursing. Concepts, process, and practice*. Pearson: Prentice Hall.

LoBiondo-Wood, G.& Haber, J. (2006). *Nursing Research. Methods and Critical Appraisal for Evidence-Based Practice.*(6<sup>th</sup> ed.) Elsevier: Mosby.

Macnair, T. (2009). *What is shock?* Retrieved on the 10 October 2009 from <http://www.bbc.co.uk/health/conditions/shock1.shtml/> .

McFerran, T. A. (2008). *Oxford Dictionary for Nursing.* (5<sup>th</sup> ed.). Oxford: Oxford University Press.

McNiff, J., Lomax, P. & Whitehead, J. (2003). *You and Your Action Research Project.* London: RontledgeFalmar.

Meyer, D. (2002). *Exploring Psychology.* Michigan: Worth Publishers.

Ministry of Health and Social Services. (2010). *Annual Health Statistics.* Windhoek: Government Printers.

MOHSS (1999). *The Patient Charter of Namibia.* Windhoek: Namib Graphics.

Mokhosi, M. T. & Grieve, K. W. (2004). *African families'' perceptions of traumatic brain injury.* South African Journal of Psychology 2004, 34 (2), pp. 301 – 317. Retrieved on the 19 September 2009 from <http://www.google.com>.

Mouton, J. (2000). *Understanding Social Research*. Pretoria: Van Schaik.

Morse, J. M. & Field, P. A. (1996). *Nursing Research: the application of Qualitative Approaches*. (2<sup>nd</sup> ed.). London: Chapman & Hall.

Mulaudzi, F. M., Mokoena, J. & Troski, R. (2000). *Basic Nursing Ethics in Practice*. Sandown: Heinemann Publishers (PTY) Ltd.

National Institutes of Health; Brain Injury Resource Center. (1998). Traumatic Brain Injury Rehabilitation Consensus Statement. Retrieved on the 20 July 2009 from <http://www.headinjury.com/denial.htm>.

Neuman, W. L. 2006. *Social Research Methods: Qualitative and Quantitative Approaches*. (6<sup>th</sup> ed.). Boston: Allyn and Bacon.

Nieswiadomy, R. M. (2002). *Foundations of Nursing Research*. (4<sup>th</sup> ed.) New Jersey: Prentice Hall.

O'Leary, Z. (2004). *The Essential Guide to Doing Research*. (1<sup>st</sup> ed.). London: SAGE Publications.

On-line Dictionary. (2003). Retrieved on the 19 November 2009 from <http://www.google.com>

Oslo, D. A. (2010). Head Injury. Retrieved on the 15th September 2010 from <http://emedicine.medscape.com/article/1163653-overview>.

*Oxford Advanced Learner's Dictionary*. (2006). (7<sup>th</sup> ed.). Oxford: University Press.

Perry, A. G., & Potter, P. A. (1999). *Basic Nursing. A Critical Thinking Approach*. (4<sup>th</sup> ed.). London: Mosby.

Perry, A. G., & Potter, P. A. (2002). *Clinical Nursing Skills and Techniques*. (5<sup>th</sup> ed.). London: Mosby.

Polit, D. F., Deck, C. T. & Hungler, B. P. (2001). *Essentials of Nursing Research- Methods, Appraisal and Utilization*. (5<sup>th</sup> ed.). Philadelphia: Lippincott.

Polit, D. F. & Hungler, B. P. (1999). *Nursing Research – Principles and Methods*. (6<sup>th</sup> ed.). Philadelphia: Lippincott.

Polit, D. F. & Hungler, B. P. (2001). *Nursing Research – Principles and Methods*. (7<sup>th</sup> ed.). Philadelphia: Lippincott.

Quinn, F. M. & Hughes, S. J. (2007). *Quinn's Principles and Practice of Nurse Educator*. (5<sup>th</sup> ed.). Cheltenham: Nelson Thornes Ltd.

Sacks, M. & Allsop, J. (2007). *Researching Health: qualitative, quantitative and mixed methods*. Los Angeles: SAGE Publications.

Searle, C. (2008). *Professional Practice – A Southern African Nursing Perspective*. (4<sup>th</sup> ed.). Pietermaritzburg: Butterworth Publishers (Pty) Ltd.

Silverman, D. (2003). *Interpreting Qualitative Data*. (2<sup>nd</sup> ed.). London: Sage Publications.

Silverman, J., Kurtz, S. & Draper, J. (2008). *Skills for Communicating with Patients*. (2<sup>nd</sup> ed.). Oxon: Radcliffe Publishing.

Sinnakaruppan, I., Downey, B & Morrison, S. (2005). *Brain Injury*, April 2005; 19 (4): 283 – 308). Retrieved August 11, 2009 from [www.google.com](http://www.google.com)

Stanhope, M & Lancaster, J. (2004). *Public Health Nursing Population Centered Health Care*. (7<sup>th</sup> ed.). St. Louis: Mosby.

Streubert, H. J. & Carpenter, D. R. (1995). *Qualitative Research in Nursing. Advancing the Humanistic Imperative*. Philadelphia: Lippincott.

Stuart, G. W. and Laraia, M.T. (2005). *Principles and Practice of Psychiatric Nursing*. St. Luis: Mosby.

Terre Blanche, M., Durrheim, K. & Painter, D. (2008). *Research in Practice*. Cape Town: University of Cape Town Press.

Thelan, L.A., Lough, M.E., Urden, L.D. & Stacy, K.M. (2006). *Critical Care Nursing. Diagnosis and Management*. St. Louis: Mosby.

Thompson, J. M., McFarland, G. K., Hirsch, J. E. & Tucker, S. M. (2002). *Clinical Nursing*. (5<sup>th</sup> ed.). St. Louis: Mosby.

Tidy, C. (2007). Comprehensive Information to patients on Head Injury. *On line PatientPlus Newspaper*, UK. Retrieved September 19, 2009 from <http://www.google.com/>.

Townsend, M. C. (1996). *Psychiatric Mental Health Nursing – Concepts of Care*. (2<sup>nd</sup> ed). Philadelphia: FA Davis Company.

Trochim, W.M.K. (2006). Social Research Methods Knowledge Base. Retrieved October 20, 2006 from <http://www.socialresearchmethods.net/kb/qualval.php>.

Turner, K. (2009). *On line article on Nursing a patient with a severe head injury: a case study*. Retrieved on August 13, 2009 from <http://www.google.com/>.

Ursano, R.J., McCaughey, B.G. & Fullerton, C.S. (1994). *Individual and Community Responses to Trauma and Disaster*. Cambridge: Cambridge University Press.

Verhaeghe, S., Defloor, T., Van Vuuren, F., Duijnste, M & Grypdonck, M. (2005). *Stress and Coping among families of Patients with Traumatic Brain Injury*. Journal of Clinical Nursing, Volume 14, Number 4, April 2005, pp 501 – 509(9): Blackwell Publishing. Retrieved on the 19 September 2009 from <http://www.ingentaconnect.com/content/bsc/jcn/2005>.

Watanabe, Y., Shiel, A., McLellan, D. L., Kurihara, M. & Hayashi, K. (2001). The impact of traumatic brain injury on family members living with patients: a preliminary study in Japan and the UK. *Disability & Rehabilitation* 2001, Vol. 23, No. 9, Pages 370-378. Retrieved on the 19 September 2009 from <http://www.informahealthcare.com/>

Welman, Kruger & Mitchell. (2005). *Research Methodology*. (3<sup>rd</sup> ed). Cape Town: Oxford University Press.

Wikipedia, the free Encyclopaedia. (2009). Acute Stress. Retrieved on the 9 November 2009.

## **6. ANNEXURES**

### **ANNEXURE I: Interview Guide**

**Title: The experiences of family members of a person with head injury.**

Items required:

- Research proposal
- Tape recorder with new batteries and extra batteries
- Writing pad
- Pens (blue/black)

Introduction

- Greet the participant by name
  - Introduce myself (name and surname)
  - My work place
  - Explain the aim of the interview and that it will be type recorded.
  - Explain ethical aspects
    - Autonomy – participation is voluntary and can withdraw at any time
    - Anonymity
    - Privacy and confidentiality
      - Explain to the participant that the results will only be used for the stated purposes.
1. Sit at a quiet place chosen by the participant.

2. Switch type recorder on and ask the question

Please tell me about your experiences when your family member was diagnosed with a head injury.

Possible probing questions are:

- What do you mean?
- Can you tell me more about that?
- What does that mean?
- etc.

3. At the end of the interview thank the participant

## **ANNEXURE II: THE INTERVIEW**

Key words:

I: Interviewer

R: Respondent (participant)

**I:** Good morning once again madam.

**R:** Good morning meme (means madam).

**I:** Please tell me about your experiences when your family member was diagnosed with head injury.

**R:** The day that my son was in an accident, I was very much shocked. Yes, (holding her hands together and looking upwards). It was in the evening, a little bit late. To my surprise, I was told: “Meme, ... had a car accident”. When I came to my child I did not know where to touch him! Blood flowed from his ears and head, and this has frightened me very much ...

- **While talking she looks up and holds hands together.**
- **Feeling sad – tears welling up in her eyes, and**
- **Looks down (getting emotional)**

**I:** Can you elaborate more?

**R:** I said that I was very much shocked as a result of seeing my child after the accident. I was shocked to such an extent that I did not know what to do. Luckily, there were so many assistants that could take the child to the hospital.

**I:** Can you explain more?

**R:** My feelings were that I was very much shocked to an extent that I did not know where I was when I looked at my child having been involved in a very major accident.

**I:** Mmmh!

**R:** I took my youngest child that was at home. In the meantime, the police put the injured one, together with the other neighborhood children in the police van and took him to the hospital. As a mother, when I looked at my injured child, all I could do was to pray for my child to be alive.

**I:** When you arrived at the hospital could you tell me about your experience.

**R:** Ooh! (Feeling sad and tears welling up in the eyes) the nurses were very hard at work, as I have seen that they received us very well. They were very fast in covering his head with bandages. Yes, he received first aid but they were very quick. If this were not the case, I wouldn't have sent this child again. They tried to put him on the drip while they kept checking inside his feet, checking if he is in a good condition. They then inserted a metal tool in his mouth, placed him on a small bed and took him to a ward called an Intensive Care Unit.

**I:** And when you went to the Intensive Care Unit?

**R:** I was told that one must follow them, but you cannot enter the Intensive Care Unit.

**I:** Where exactly have you been waiting?

**R:** In one of the rooms.

**I:** Mh!

**R:** We were with the neighbors that escorted us to the hospital and also the driver of the car

**I:** Yes?

**R:** We waited for a little longer, probably due to the treatment he was receiving. I then asked if I could see him and if it is possible for me to stay at his bedside because I felt that my child was in a critical condition. Well, as a mother with an injured child you might have thoughts that the child is in pain or he might die. They told me that the child's condition was somehow and it was not possible for me to sleep there as there was a visiting time from 6 in the morning. They kept checking his condition.

**I:** What else can you tell me?

**R:** I just looked on his face, as the child was not aware of where he was. Meanwhile, they told me and showed me why the machine was making sound, hence, indicating his condition. This meant that the child was in a condition that was a little bit better.

**I:** How did you feel?

**R:** I was trembling as I spent already seven days without talking to him.

**I:** What else could you tell me?

**R:** There was nothing else unless I have forgotten. The only thing they told me is that he has been injured.

**I:** Were you informed by the doctor as to how he was treated or where he was injured?

**R:** Certainly not (shaking her head), but at least I have made an attempt when they discharged him from the unit. I have a bad feeling that, ah my child was injured this much. I always visited him very early in the morning yet no one has told me the extend of the injury or where he has been injured. It got to me that I should not keep quiet, perhaps my child's brain has been crashed as I heard that if a person has been injured in the head and blood has made contact with the brain, it could lead to death as it was his head that fell to the ground. Nonetheless, the nurses did not tell me about the type of injury that my child has sustained. Despite that, one day I have decided to ask a certain nurse if I could look at his X-rays but the nurse told me that it was not possible for her to show me unless I contact the doctor who was treating him. This made it difficult for me, as I could not get hold of him until such a time when he was discharged.

**I:** When the nurse said that unless you see the doctor, did she tell you or explain to you with regard to how you could get hold of the doctor?

**R:** Not really. She just said that I should look for the doctor at the Out Patient Department (OPD) and at the office where he could be found. This has made it difficult for me, as the doctor is not an Oshiwambo speaking which is the

language that I speak. I kept quiet and found out that I should keep quiet. I was only informed on how to take care of him.

**I:** How did you feel about the visiting times?

**R:** Do you mean visiting hours?

**I:** Yes?

**R:** I feel that the duration for the visiting times are enough because this is a hospital regulation. I feel that it is enough although my spirit was forcing to stay in order to see the child's face, to see to it that he opened his eyes and if he was in good condition.

**I:** Could you tell me how your family members and relatives felt when he was hospitalized?

**R:** They were very much shocked by the accident. The person that did something was my lastborn sister who gave us some money to buy food for the child.

**I:** Apart from the assistance given by neighbors on the day of the accident, what other assistance did they give you during the time when he was in the Intensive Care Unit?

**R:** There was nothing else. I was the only one that looked after my child as the whole problem was on my shoulders. In addition, on the part of those that caused the accident, they used to visit in the beginning at times as it suits them, as they were worried that the child might not be well. They did not give me any other assistance.

**I:** You said that you used to have a heavy heart, could you explain more?

**R:** When the person has been injured, you might be crying, worried whether the child would be healthy again as the child was not healthy at all.

**I:** How did this affect your day-to-day work or responsibilities during the time that he was hospitalized?

**R:** Instead of concentrating on my work, I start getting worried about my child. Hence, this has delayed my work.

**I:** What did you do or what have you done on the first day when you visited him in the hospital?

**R:** The first thing that I used to do was to pray to my God for my child to be alive even if it means that he would be disabled. Upon entering the Intensive Care Unit, we use to be given white aprons. I then asked the nurses to give me a face

cloth to clean the child as I was worried that I may find him dirty but they have informed me to buy one and soap. Fortunately, the nurses clean him and each time I visited I found him cleaned. I am very thankful to the nurses because my job was to wake him up, greet him and to pray for him to be alive.

**I:** When you used to call his name, did he respond?

**R:** The day after the accident he did not respond at all. On the second day, he opened his eyes and responded. However, the nurses told me not to disturb him as he was injured and that I should just check on him and leave him without going further than that. On the third day, I realized that he recognized me, as he started smiling and crying at the same time when he saw me. At that point in time the nurses informed me not to stay long.

**I:** What kind of feelings did you have when he did not look at you on the first day?

**R:** I was feeling very bad.

**I:** How did you feel when he responded?

**R:** Very good and I was thankful to God that my child might be alive again. What makes me feel bad is that if the person was injured in the head, his brain might be affected as I believe that the brain is the driving force behind the person's soul. I was hurt despite the fact that he was able to open his eyes yet he was not mobile in the Intensive Care Unit.

**I:** You said that he recognized you, smiled and cried, what did you do?

**R:** I told him not to cry as he would get well. I then asked him if he was feeling well and he said yes.

- I:** How many days did he spend in the Intensive Care Unit?
- R:** Three days and then was transferred to Ward Three on the fourth day.
- I:** Could you tell me what you have experienced during the time when he was transferred from the Intensive Care Unit. Were you present or did you find him already transferred to Ward 3?
- R:** I found him already transferred to Ward 3.
- I:** How did they inform you when you came to the Intensive Care Unit? In what way did they give you the information and how do you feel about it?
- R:** I felt good about it as they did not respond badly although I was scared at first when I went through the entrance I realized that the child was not on his bed, they said to me: "Is this ... mother? He has been transferred to Ward 3.
- I:** Could you tell me about the time when he was in Ward 3?
- R:** He used to complain of having pain in the head as it was injured. One could tell when he speaks, you could see that his brain was very much affected as he was talking about things that were not appropriate and confusing. He was asking questions like: "Mom, where am I"? I answered: "You are in the hospital, my child". When he saw me he said: "Mom, I want to go home". I said to him: "My son, you must stay in the hospital for a while in order to get treatment. You will get well soon and we will then go home. He used to agree.
- I:** During the time that he was in Ward 3, did you get any explanations regarding his injury or during the time when they discharged him from the hospital?
- R:** Do you mean from the nurse that treated him/

**I:** Yes.

**R:** They did not explain to me anything regarding that.

**I:** What difference did you notice after he came home?

**R:** I have noticed some difference in him as he is no longer the same person he was before the accident. He gets very angry easily, he has pain that never stop, and after four to five days he changed.

**I:** Where is the pain?

**R:** He used to say that the pain is in the head or he feels as if something is moving in his head or he would say mom, I am tired. For example, if you ask him to get you water with a 5-litre bucket, by the time he will get home he would be breathing heavily, saying: "Mom, I am very tired". When he was on medication he was a little bit better. Now the problem seems to get worse. When he is doing some work at the same time he may be complaining about something moving in his head. "He would say it is moving here", showing with his hand on top of his head. It was probably the top of his head that hit the ground when he was involved in the accident. In the same way, he would say: "Mom, I feel as if my body is burning whilst feeling cold and experiencing stomach ache".

I do not know exactly what it is. I am thinking of going back to the doctors to discuss the child's illness. I recognize the fact that my child is alive but it is disappointing to realize that my child is handicapped for the rest of his life.

**I:** What sort of assistance did you get from relatives, neighbors or from the hospital apart from the things that you have mentioned already?

**R:** Certainly nothing. I did not get assistance from anywhere.

**I:** When the child was discharged, were you given a follow-up to take him back to the doctors?

**R:** Yes!

**I:** What date was that?

**R:** I didn't take cognizance of the exact date as it has been some time now, however, what I know is that the child has undergone all the checkups, follow-ups and examinations. We were then referred to Doctor... (the regional health director), and then we went to the lady that took his blood for an HIV-test. I was shocked. They told me that I should not be afraid, as my child will be tested for HIV as a result of the accident. Furthermore, "there might be a possibility for him to be transferred to other hospitals, therefore, I must just be patient for the child to be tested for HIV," they told me. By luckily the test showed that the child's HIV status is negative and he is well. From there on, I was of the opinion that the child was probably on the list to be transferred to other hospitals for further treatment. His current state of health... (Couldn't finish the sentence and shook her head). No further attempts had been made. This is so probably because I did not go back to the doctors as they might have referred us or they had something in mind. Perhaps, who knows where the children had been? There should be some sort of records about the patient's profile comprising of the parents details, type of accident and extent of injury.

**I:** Have you made follow up by asking the nurses or perhaps you have gone back to ask for further explanations that the child was involved in a certain kind of accident, what you were told, and what are the current state of affairs on the side of the nurses?

**R:** Not really. I acknowledge that I did not go back. The child never feels better. I have not gone back yet as I am still thinking of going back to the nurses because the child is not yet well.

**I:** Do you think that you need assistance from the hospital?

**R:** Very, very much madam. (Holding her hands together and waving these up and down). I will be thankful if something is done.

**I:** Do you have other experiences with...[name of head injury person] what you want to tell me.

**R:** I am saying (silence) perhaps (a bit of silence)... you know, hearing from others, it is a bad thing to get hurt in the head. Henceforth, if possible, I would like our government to assist us. Indeed, this person has been injured in the brain and he is definitely affected forever. He should be regarded as a disabled person. I mean, that I should be seen as someone having a disabled person, as he could not do any work. His brain is not ready for school, however, he is somehow as he is a gifted person. One could see that when he thinks too hard, he starts to get sick. One is having a disable person as a result. The government should look carefully into this matter. If possible, it should regard children who had been injured in

accidents like him, as children with disabilities. (silence) He thinks too hard and goes numb at times. For instance, he would say, "Mom, I thought I have finished doing a certain task but I have forgotten about it". One could see that he is not himself; there is something wrong with him.

**I:** What about his father, how does he feel?

**R:** Hmmmmm, he? You know men sometimes do not really care. He does say anything (silence). Men took it what can they do? If he comes home and has drank beer, hmmmmm. Everything is shifted on your shoulders and your struggle on your own with your child (a silence).

**I:** Thank you very much for your time.

**R:** O.K. Thank you too.

### **ANNEXURE III:THE PROTOCOL OF THE CO-CODER**

**To:** The co-coder  
Faculty of Medical and Health sciences  
University of Namibia  
Oshakati Campus

**From:** MT Iyambo  
UNAM Northern Campus  
Oshakati

**Date:** 10 August 2009

Dear Colleague,

I am sending the transcriptions from the 10 respondents interviewed. Please follow the steps below to analyse the data from the interviews on: **“The experiences of family members of a head injury patient”**

- Read through all the data carefully to get a sense of a whole of the experiences of the family members
- Group words and ideas arising out of them

- List all those that have a common association, they will fit together easily
- Try to identify themes
- The themes identified can be written alongside the original data to enable the extracting of quotes when interpreting the data
- Underline unit of meaning related to the themes
- Identify the themes and sub-themes
- Identify the interrelationships between the themes and sub-themes

Thanking you very much in advance for your assistance.

MT Iyambo

Master Degree student

**ANNEXURE IV – PERMISSION FROM THE PERMANENT SECRETARY OF  
THE MINISTRY OF HEALTH AND SOCIAL SERVICES (MOHSS)**

**ANNEXURE V - PERMISSION FROM THE HEALTH DIRECTOR OF THE  
NORTHWEST HEALTH REGION**

**ANNEXURE VI – PERMISSION FROM THE GONERNOR – OSHANA  
REGION**

**ANNEXURE VII – PERMISSION FROM THE GOVERNOR – OMUSATI  
REGION**



**ANNEXURE VIII -PERMISSION FROM THE GOVERNOR – OHANGWENA  
REGION**



**ANNEXURE IX – PERMISSION FROM THE UUKWAMBI TRADITIONAL  
AUTHORITY**

**7 TABLES**

**TABLE 3.1 THEMES AND SUB-THEMES OF THE STUDY**