

**A STUDY ON FAMILY AND CAREGIVER SUPPORT TO
PSYCHIATRIC PATIENTS IN KATUTURA:
A PSYCHIATRIC SOCIAL WORK PERSPECTIVE**

by

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DEDICATION

This work is dedicated to the following:

My parents, **Mr. BASILIUS** and **Mrs. ANGELIKA LUKAS**, for their love, encouragement and support throughout my entire life.

DECLARATION

I declare that **A STUDY ON FAMILY AND CAREGIVER SUPPORT TO PSYCHIATRIC PATIENTS IN KATUTURA: A PSYCHIATRIC SOCIAL WORK PERSPECTIVE** is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete reference.

I did not made use of this research project for the obtaining of any degree.

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ABSTRACT

De-institutionalization brought with it a shift in the care taking of psychiatric patients from institutional care to community care. As a result, people with mental illnesses have to rely on families for support and care. Existing literature in the field of psychiatry tend to over concentrate on the well-being of the mentally ill, while the experiences of caregivers are understudied. This exploratory study was designed to investigate family and caregivers support to psychiatric patients.

The objectives of this study were to determine the nature and extent of family support which psychiatric patients receive, investigated the need for family and caregivers support amongst psychiatric patients, and also searched for options to improve family and caregiver support.

The purposive sample method was employed to select forty- five family caregiver of psychiatric patients who lives in Katutura. The hospital files of all the psychiatric patients whose families formed part of the sample was studied, contact details of the family caregivers as well as some background information of the ill person was recorded. A structured interview schedule consisting of both closed and open-ended questions was used as an instrument for data collection, and in-depth interviews took place with family caregivers. Other methods of data

collection were focus group discussions as well as discussions with key informants. A pilot study was undertaken before the actual data collection with the sample population. The data were processed manually and are presented in tables, graphs and charts.

The findings indicate that families provide in the basic needs of the mentally ill person, such as shelter, food and clothing. Families were less likely to provide in emotional support to the mentally ill. The study also found that family caregivers do not have much contact with mental health professionals, and they lack knowledge on mental illness.

The results suggest that the relationship between mental health professionals and family caregivers need to be strengthened in order to address the needs of family caregivers. Effective intervention by mental health professionals should focus on both the family and the mentally ill, and should be based on a positive attitude towards the family caregivers of psychiatric patient. Education campaigns to people with mental illnesses, family caregivers and the community at large need to be embarked upon. Further studies on family and caregiver support need to investigate the family caregivers of mentally ill patients who have been diagnosed with a specific mental illness.

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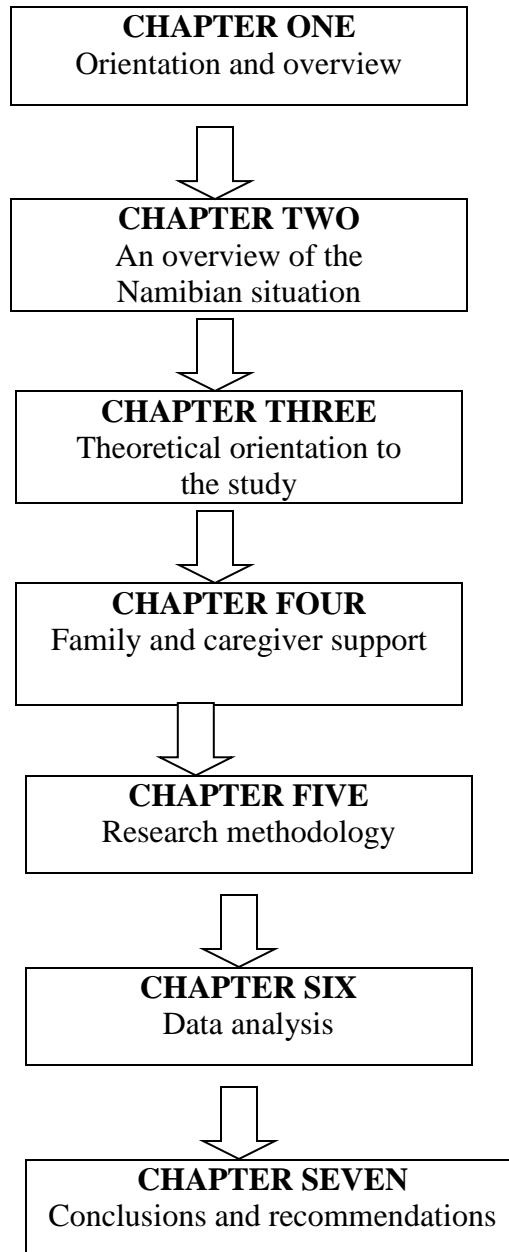
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CHAPTER 1 INTRODUCTION AND OVERVIEW

1.1 Introduction

Not much social science research has been undertaken in the field of psychiatry in Namibia, as compared to other social sciences areas. At present, no reliable data exists on the nature and magnitude of mental health problems in Namibia. No epidemiological survey has ever been done on mental illness. A rough estimate by the National Housing & Population Census in 1991 reveals that there are 7362 mentally disabled people in Namibia and the majority of the mentally disabled lives in the Khomas and Karas region (See *National Planning Commission* 1994:67). The high concentration of mentally disabled people in the Khomas and Karas regions can be ascribed to factors such as urbanization who brings with it unemployment, alcohol and substance abuse and other social problems that is characterized in urban areas.

The 8th meeting of the global coordinating group for the mental health programme revealed that more than 300 million people in the world suffers from mental illness or it's consequences (World Health Organization 1987:7).

According to Dartnall, Modiba, Porteus & Viljoen (1998:74) mental

illness has a great impact on many members of our society and represents one of the most serious contemporary public health issues.

At a panel discussion on 10 October 1997 for the observation of World Mental Health Day, Dr. Shaun Whittaker, a clinical psychologist pointed out that one in five people world-wide are experiencing a mental health problem. Two-thirds of these people go untreated, which may result into social problems such as suicide and alcohol abuse (Whittaker 1997:25).

A draft guideline for the development of a National Policy on Mental Health for Namibia was developed in 1999 (*Programme Policy Document* 1999: 5).

The Unit for Mental Health within the Directorate Primary Health Care of the Ministry of Health and Social Services conducted a National Needs Assessment on mental health services during 1996. Data was gathered through interviews with health and social workers, community leaders and psychiatric patients. The needs assessment survey only reflected on the awareness in health workers, social workers and community leaders from the various regions in Namibia about psychiatric conditions (*Ministry of Health and Social Services* 1996:1).

According to the mental health action plan of Botswana the magnitude of mental disorders has been recognized globally. The burden that mental illness is causing to the individual, the family and the community has serious implications for the socio-economic development. It is essential

that countries adopt strategies for the prevention and treatment of mental illness and for promoting good mental health. (Mental Health Action Plan 1992-1997, Ministry of Health- Botswana:1).

A newsletter from the Psychological Association of Namibia stipulates that the seriousness of mental illness is underestimated in Namibia. This is ascribed to the fact that the occurrence of deaths is valued as more serious than disabilities caused by mental illness. (Psychological Association of Namibia Newsletter, October 1998: 5).

Bland (1998:1) confirms that little attention is paid to the causes of mental disabilities because the leading causes of mental disabilities differ from the leading causes of deaths in society. Most public health efforts prefer to focus on modifying the causes of death.

Whenever somebody is diagnosed as suffering with a mental illness, then the family has no choice but to provide support to their ill relative. The question however is what the nature and extent is of support that family members provide to their ill relative. The care that family caregivers provide to their ill relative can be regarded as promoting the mental health and the prevention of mental illness. The study would therefore like to explore the circumstances of families and their mentally ill relatives.

1.2 Motivation for the study

Researchers have theorized in the past about the importance of social support to mentally ill patients, but little empirical evidence exist to confirm these theories. Studies were usually restricted to specific disciplines (See Kaplan et al in Forrester-Jones & Grant 1997: 6).

Some research studies Antonovski, Cobb, Henderson, Brown & Harris in Forrester- Jones & Grant (1997:9)) states that family relationships play a significant role in the promotion of mental health. Family and social support is viewed as a stress buffer, acting as a cushion against the impact of life stresses, which thereby reduces morbidity. According to scientific and clinical beliefs stress and life changes may be a significant factor in a wide variety of psychiatric and physical disorders. Previous studies have produced evidence that lack of social support to psychiatric patients was associated with increased pessimistic thoughts.

Confiding relationships has been emphasized as the key characteristic of the relationship between the mentally ill patient and its family. Some researchers found that patients who were released to “family dominated, emotionally, supportive, secure networks, had less severe symptoms of the illness than those who returned to larger more socially diverse networks”. Studies by some researchers imply that people with psychiatric disorders

tend to be members of restricted and impoverished social networks and have a less fulfilling social world. (See Foresster-Jones & Grant, 1997: 10).

Other research studies, such as Rook (1992), Eurelings-Bontekoe et al (1995), and Wintersteen et al (1997) suggest that not all support provided by family members should be perceived as being helpful to the recipients from a clinical point of view, because unfavourable aspects of social support needs to be explored. A critique to existing literature is that the beneficial effects of social support are sometimes over –emphasized. It is assumed that an individual's recovery or adaptation after a chronic illness will be negatively affected if there is no family support. However, it is recognized that it could be stressful to have a family member who suffers from a mental illness.

Sometimes psychiatric patients themselves become upset with their family members from which they receive the most assistance. Certain norms and values also hamper people to accept social support, for example when family members might uphold high standards of cleanliness and friendliness and the ill person may not be able to comply to these.

Little research has been done on long -term psychiatric patients who may face chronic indebtedness in their social relations. Research studies still

need to be undertaken on the level and forms of social support (Forrester-Jones & Grant 1997: 12).

The study aims at exploring the circumstances of families and their mentally ill relatives. This study would be of significance to psychiatric patients, their families, mental health professional and policy makers because of the many aspects to be explored.

1.3 Formulation of the research problem

Sarankantos (1993: 111) explains the formulation of the research problem as a way of gathering additional information to clarify the object of study and to organize the research project. To be more specific, this step aims to refine the research question, to make it more specific and to prepare it for investigation and to develop a framework for the research project. It links the research question with the research methods and procedures.

Bless & Higson-Smith (1995:29) defines a research problem as “a general question about the relationship between two or more variables”.

The research problem can be altered into a research hypothesis, which presupposes a relationship between two or more variables (Huysamen 1994:10).

A hypothesis is defined by Weiten (1992:648) as a tentative statement about the relationship between two or more variables.

Ruben & Babbie (1994:120) refers to the hypothesis as a statement that presumes the relationship between the independent and dependent variable. In other words, hypotheses are unconfirmed statements that foresee what one can expect to find about the way variables co-vary together.

Bless & Higson-Smith (1995:37) defines hypotheses as “ tentative, concrete and testable “ answers to problems. A hypothesis has to be empirically tested before it can be accepted and integrated into a theory.

In a relatively new area in exploratory studies, where there are no proven theories and research findings, specific research hypotheses may not be feasible (Huysamen 1994:10).

Little research has been undertaken on the topic under investigation in Namibia, this is also an exploratory study. Thus no hypothesis is necessary.

Social work with mentally ill patients in Namibia disclosed that these patients do not receive the necessary support from their families. Relapses in the mental state of patients, who were released in the care of their

family members, occur regularly. Relapses are serious since the mental state of the patients usually deteriorates with every relapse. This could lead to chronic hospitalization. It is assumed that many families of the mentally ill seem to be indifferent towards the needs of the patients. There might be various reasons that will be investigated through the study. The psychiatric patients, however, need ongoing support to cope through ongoing stresses of daily life, and also need to be continuously monitored to take their medication regularly.

The research question will be formulated as follows;

TO WHAT EXTEND DOES FAMILY OR CAREGIVER SUPPORT
INFLUENCE THE WELLBEING OF THE PSYCHIATRIC PATIENT?

1.4 Research objectives

The objectives of this study are:

- * To determine the nature and extent of family support which psychiatric patients receive.
- * To investigate the needs for family and caregiver support among psychiatric patients.
- * To investigate options for improving family and caregiver support

for psychiatric patients.

* To offer recommendations to policymakers concerning the extension of family and caregiver support with regard to psychiatric patients.

1.5. Research Design

Huysamen (1994:20) refers to a research design as “ the plan, which specifies how participants are going to be obtained and what is going to be done to them with a view to reaching conclusions about the research problem”.

According to Bless & Higson-Smith (1995:63) a research design has two meanings. Research design can be interpreted as the planning or management of any scientific research, and serves as a programme guide to the researcher in collecting, analyzing and interpreting observed facts. The second interpretation of a research design has relevance to the testing of hypotheses.

All decisions that are made about how a research study is conducted are referred by Ruben & Babbie (1993:330) as the research design. Research designs can be classified according to their purpose; hence a differentiation is made between exploratory, descriptive and explanatory designs

The aim of exploratory studies according to Bless & Higson-Smith (1995:42) is to gain insight into a topic of research, which follows in the absence of basic information on an unknown area.

The subject under study is relative unknown in Namibia and need to be explored in order to gain insight, therefore the exploratory approach will be employed.

1.6. Qualitative and quantitative methods

Quantitative methods accentuate the creation of exact and generalizable statistical findings. Quantitative methods are used most probably to confirm whether a cause offers an outcome (Ruben & Babbie 1993:30).

Qualitative methods give prominence to the understanding that attempts to obtain a deeper interpretation of human experiences and intend to produce theoretically richer findings, which cannot easily be reduced into numbers (Ruben & Babbie 1993:30).

The conditions and purpose of a research study would be determining factors whether qualitative or quantitative research methods will be used. In some studies the two types of methods are combined in the same study.

In this study, both qualitative and quantitative methods will be used.

1.7 Variables

Weiten (1992:654) defines a variable as any assessable predicament, event, attribute or behaviour that is controlled or observed in a study.

Huysamen (1994:7) regards a variable as “.... an attribute of individuals, or of conditions to which they are exposed, which are not the same for all persons”.

Bless & Higson-Smith (1995:30) defines a variable as an empirical property that is likely to take two or more values. Bless & Higson-Smith furthermore differentiates between the independent and the dependent variable.

An independent variable is defined by Bless & Higson –Smith (1995:30) as :“.... that factor which is measured, manipulated or selected by the researcher to determine its relationship to an observed phenomenon which constitutes the dependent variable”.

Bless & Higson-Smith (1995:30) defines a dependent variable is “... that factor which is observed and measured to determine the effect in it of the independent variable”.

Key variables in care giving are identified by Harrison, Mark, Dadds &

Smith (1998:918-924) as the following;

1.7.1 The quality of the ill person's symptoms

The more severe the mentally ill person is, the more difficult it is for the family caregivers to cope with their ill relative. The quality and degree of the illness will influence the behaviour, which can be withdrawing from others or demonstrating violent behaviour.

According to the newsletter Primary Health Care in action (1997:24) it is stated that mental disorders are found in different degrees. You may find the not so serious or not so severe mental disorders which does not affect the functioning of the individual that much. Then, you may find the very severely mentally ill individual who's functioning will be very much affected. A mentally ill person's personality may have changed as a result of the illness for example, the person may be overly suspicious, may not want to meet strangers, may be afraid of going out alone or may even act violent or aggressive.

1.7.2 Knowledge of the caregiver on mental illness.

Many people lack knowledge on mental illnesses. This results into family caregivers not understanding the illness and not knowing how to take care of their ill relative, and leads to relapses and hospitalization.

Cunningham (1992:10) states that knowledge that the family can acquire

to cope with a mentally ill member is of utmost importance to mental health care that needs to be considered.

1.8 Possible barriers

One major limitation was related to the research design. This is a cross sectional study, meaning that all the data on family and caregivers support was collected at a particular time. The limitation of this design is that it does not allow any observations over a period of time. Family support was thus investigated at a specific time and can be different over a time period. Many social scientists however prefer this design because of the immediate nature of this design and the collection of data is relatively easy. A possibility for future research projects in family and caregiver support could include a longitudinal design, whereby data collection is distributed over time.

Many family caregivers could have been available for the study. Family caregivers were however either out at their work places and school children was at school; these families would therefore not be included in this study. These families are probably also out of reach of mental health professionals; this could be explained for their non-involvement in the treatment plan of the mentally ill.

Time was a limitation, more time would have allowed for more

exploration. Because of the time restriction the study could only be conducted in one residential area, namely Katutura.

The language barrier was another limitation. Namibia is a diverse population with eleven different indigenous language groups. The interviews took place in either Afrikaans or English because the majority of the participants could express them in either of the two languages. However, there were a few participants who had difficulty expressing themselves in either of the two languages and an interpreter was used. Interpreting makes data complex and at times changes the meaning of a question.

1.9 Operational definitions of key concepts

Certain key concepts might be interpreted in different ways. In order to have a uniformed understanding of concepts, the following clarifications are provided.

1.9.1 Family

The Concise Oxford Dictionary (1995) defines family as “ a set of parents and children, or of relations, living together or not. Families might be related by birth, marriage or adoption. There are different forms of families, the most common type of families that can be found are the

nuclear family, the extended family and the single parent family.

A nuclear family consists of a husband, wife and their children (Gelles 1995:6).

Bassis et al (1991:362) defines the extended family as members of three generations, related by blood or marriage who live together or near one another.

Single parent family refers to a family with only one parent of either sex, and one or more siblings.

For the purpose of this study family will include either one of the three different forms of families, and could consist of one or both parent with children, and it may include three or more generations who are related by blood, or marriage.

1.9.2 Caregiver

The Concise Oxford Dictionary (1995) defines a caregiver as a person who regularly takes care of a child, elderly or disabled person, in the case of this study, the mentally disabled. The caregiver may be a family member or any other person who takes care of the ill person

According to Hirst & Metcalf, as quoted by Jensen & Given (1991:181) a family caregiver is “ one who attempts to meet the physiological and psychological needs of the individual”.

1.9.3 Mental Illness

It is difficult to have a universal concept of mental illness because cultural factors have a great influence on such a definition. Townsend (1993:18) characterizes mental illness as maladaptive responses to stressors from internal and external environment, which is manifested by thoughts, feelings and behaviours that are congruent with the local and cultural norms, and interferes with the individual's social, occupational and physical functioning.

“A condition which causes serious abnormality or disorder in a persons behavior or thinking capacity, irrespective of intelligence; a disorder of the mind.” The Concise Oxford Dictionary (1995). The term psychiatric illness is sometimes used when referring to mental illnesses, because they have exactly the same meaning.

1.9.4 Psychiatric patient

“A Patient suffering from mental illness “. The Concise Oxford Dictionary (1995).

For the purpose of this study when referring to a psychiatric or mental patient, it will be referring to any person who has been diagnosed as suffering of a mental illness, and who is receiving treatment from the psychiatric hospital.

1.9.5 Support

“To strengthen the position of a person or community by ones assistance, countenance or adherence” The Oxford English Dictionary, Volume X (1979).

1.9.6 Social Support

Forrester-Jones & Grant (1997:109) identified seven types of social support, which are the following household, personal, confiding, companionship, material, decision- making and feedback.

1.9.7 Relapse

The Concise Oxford Dictionary (1995) defines relapse as “a deterioration in a patient’s condition defines relapse after a partial recovery.”

1.10 Summary

In this chapter, an effort was made to present an introduction and overview with regard to the problem being investigated. The motivation for the study was briefly discussed and the research problem was formulated.

The chapter also looked at the research objectives, the research design and the variables to the study. The chapter further pointed out possible barriers to be encountered to the study.

An overview of the Namibian situation with regard to psychiatry will be addressed in the following chapter.

CHAPTER 2

AN OVERVIEW OF THE NAMIBIAN SITUATION

2.1 Introduction

This chapter will be an overview on the Namibian situation. First of all, the chapter will focus on the background of Namibia, and then it will state the statistics on mental illness. The current state of psychiatric services will then be discussed. The chapter will conclude with the aspects of the family and the community.

2.2 Background of Namibia

Namibia is a vast country of 824 295 square kilometers. It is sparsely populated, 1 646 000 estimated from the 1998 census. The majority of the population, 63 % are found in the northern part of the country. The population growth rate is 3 % per annum. There is a drift of the population to the urban areas; rural -urban migration has serious health and social consequences. Namibia has an average per capita income of US\$1065 one of the highest in Sub Saharan Africa. However, there exists gross regional and social class disparities, 47 % of households are poor. Poverty and unemployment pose serious consequences to mental health.

Namibia is a very young country, which gained its independence nine years ago, on 21 March 1991 after being under colonial rule of the White

South African Government for almost a century. The consequences of the apartheid colonial system, long struggle to independence and the related psychological problems and stresses had mental health implications. This led to the majority of Namibians from the previously disadvantaged communities, being marginalized in all aspects because of oppression (*Draft Programme Development Policy on Mental Health in Namibia*: 1999: 7).

Matlala (1995: 30) noted that the South African apartheid regime led to economic exploitation that caused poor living conditions, work alienation, race and sexual discrimination which are all harmful to mental health.

The mental well being of Namibians is threatened by various factors. Alcoholism and dependence on other substances is a growing problem in Namibia and problems related to alcohol consumption include various serious mental illnesses. Domestic and sexual violence against women and children is increasing. There is a lack of personal safety especially in the squatter community. There is an increase in the crime rate, and a very high unemployment rate. Namibia has become one of the countries with the highest HIV infection rate in the world, HIV/AIDS brings additional mental health problems. There is a significant increase in the number of people who commit suicide in Namibia, which is an indication of the high

stress levels that the Namibian community is going through. (*Draft Social Welfare Policy in Namibia*: 1997: 87).

Rapid socio- cultural, technological and political changes, overcrowding, unemployment, rural - urban migration, together with lack of modern health facilities make mental health a major health problem. The process of adjustment and adaptation has serious mental health consequences.

Mental health problems may present in various ways such as physical complaints, criminal offences, suicide, and absenteeism from work; school dropouts, and delinquency. While these problems are serious enough in themselves, they also cause suffering to the family (*Draft Programme Development Policy on Mental Health in Namibia*: 1999: 7).

In South Africa it was documented that 63% of schizophrenic patients from the Baragwanath psychiatric out patient clinic are unemployed (Matlala 1995: 30). Matlala further confirmed the important causes of emotional disorders among black people in South Africa are overcrowding, low educational level, unemployment, poverty, low self-esteem and hopelessness. Namibia and South Africa have many similarities therefore the statement by Matlala applies to the Namibian situation.

2.3 Statistics

There is no reliable data on the nature and magnitude of mental health problems in Namibia. There has never been any epidemiological survey done in the country. The National Population and Housing Census of 1991 found that the disability rate is 3,1% of which 7360 (15%) were registered to have a mental disorder.

An intelligent estimate of the magnitude of mental health problems can be made from studies that were undertaken in other countries with similar socio- economic development. The World Health Organization (WHO: Geneva, *Technical Report Series* 564, 1974) states that well conducted epidemiological studies in several parts of the world have shown no fundamental differences in the range of mental disorders that occur or in the prevalence of seriously incapacitating mental illness. These studies indicate that such disorders are likely to affect at least 1 % of any population at any time and at least 10% at some time in their life. A conservative estimate of the number of serious mental health problems in Namibia is as follows;

Adults with serious mental health problems: 10 000 to 15 000 (1 - 1,5% of the adult population)

Children with serious mental health problems: 3 300 to 6 600 (0,5 - 1 % of children below the age of 15 years.

Children with learning or behavioural problems are a total of 6 600.

2.4 Psychiatric Services

Psychiatric services for White and Black Namibian were segregated, as was the case with all other sectors in the country. White people received better services than black people were. With the end of the apartheid era, after independence exclusive services for certain groups was terminated and people were treated equally. The infrastructure of psychiatric services where black people were treated before was of sub standards. New modern buildings were then constructed.

Mental health care in Namibia had a curative approach in the past. Services were characterized by a lack of follow up to discharged patients and an absence of sufficiently skilled mental health professionals. Combined with the community perception that mental health problems are an individual and family problem rather than a societal one have resulted in the high relapse rate (*Draft Programme Development Policy on Mental Health in Namibia*: 1999:8).

High numbers of psychiatric patients from the Baragwanath psychiatric unit in Soweto are discharged while the patients are not well enough to cope into the community because of an increase in the number of psychiatric patients and a lack of larger facilities (Matlala 1995:30).

Recent literature reports that institutional care of psychiatric patients is still emphasized. Masilela & Macleod (1998: 11) noted that the adequate provision of mental health care in South Africa is hampered because of an over emphasize on institutional or hospital based care. There are minimal levels of preventative, promotive and rehabilitative care. Services extend mostly to the hospitalization of severe cases and monthly clinic visits to collect medication for long-term out- patients.

Windhoek and Oshakati Mental hospitals serve as central referral, tertiary treatment and, training centers. These psychiatric hospitals receive patients from all over Namibia.

There is, however, a lack of trained mental health professionals, there is only one psychiatrist in the Government services. The few psychologists are private practitioners, which is inaccessible to the majority of the Namibians. The Nursing profession is the most dominant in the psychiatric services and provides services to both admitted patients as well as known out patients. There is only one social worker and one occupational therapist that have to serve a very big patient population. Due to limited manpower, mental health professionals are focussing more on the treatment of diagnosed patients and are less involved in educational campaigns (*Draft Policy Programme Development on Mental Health in Namibia: 1999:8*).

Maslovski (1996: 17), Psychiatrist and former Head of the Mental Health Unit in Namibia, cited that a community service approach has been adopted with regard to mentally ill patients. Traditional psychiatric institutions remained as academic institutions, training and consulting centres or treatment facilities for violent behavior or when patients are in the acute phase of a mental disorder.

Until recently, there was no forensic psychiatric services and patients declared not responsible for their criminal offences used to be sent to forensic psychiatric wards in South Africa. Maslovski further stated that the provision of psychiatric services has improved to such an extent in Namibia that a forensic psychiatric complex and accommodation for observation, evaluation and treatment was officially launched in 1997. Services in psychiatric related sub specialties such as Geriatric, Child, Alcohol and Drug Rehabilitation and Sexology will be provided in the near future.

Maslovski further confirmed that successful treatment depends upon a change of public image on the nature and treatment of mental disorders.

Maslovski stated that annual Mental Health workshop forms an integral part of the training of Mental Health professionals. The provision of

mental health services has improved but there lies still a long road ahead in achieving the goal of efficient, effective and accessible mental health care for all Namibians.

There is still no mental health policy in Namibia, a key factor in setting out general as well as specific goals. No adequate services are available for private psychiatric patients; private hospitals are also not equipped to cater for the needs of psychiatric patients. Private patients are therefore forced to use the same facilities as state patients.

At the time the study was conducted, two social workers were employed at the Psychiatric hospital, and strive to provide treatment, rehabilitation as well as preventative services to psychiatric patients, their families and the entire community. There is a need for more social workers in the field of psychiatry due to the magnitude of psychiatric illnesses.

2.5 Families

Psychiatry depends a lot on families of patients. African communities are characterized as caring for each other and live as extended families. Western influences lead to the change from extended families to nuclear families in Namibia. In the rural areas, extended families still exist, but in urban areas life is too expensive and has forced families to adopt the nuclear family system. Female -headed households characterize the

majority of Namibian communities, because of historical and socio – economic factors. Families are the ones to take care of their sick relatives.

The majority of people with mental health problems avail themselves to the services of traditional healers and religious forms of treatment. While lack of mental health services is a contributing factor, the most important factor is the similarity of the belief system of the people and the traditional healers in the causes of mental illnesses. These believes are that mental illness is caused due to acts omitted or sins committed and to supernatural factors like spirits of the ancestors, witchcraft, misfortunes and other familial factors. (*Draft Policy Programme Development on Mental Health in Namibia*: 1999:7).

Only a small percentage of those who could have benefited from modern mental health services are at present getting help. The few patients who are brought to the Windhoek state hospital or to the Oshakati psychiatric wards do so after all attempts have been tried and failed and after the family has exhausted all their resources and run out of hope. Outcome of treatment in mental health depends on early detection and intervention. That could be achieved if treatment is available as close to the community as possible (*Draft Policy Programme Development on Mental Health in Namibia*: 1999:7).

2.6 Community

Community initiatives to provide a service to the mentally ill persons are almost non-existent. There are no community houses, available to psychiatric patients in Namibia. The “ Hephata” Day Care and Rehabilitation Center in Wanaheda, Katutura, is the only community initiative that offers services to psychiatric patients. These initiatives cannot expand because of a lack of resources.

The general public seems to have very limited information regarding mental illness. The public is also not too tolerant towards the mentally ill.

2.7 Summary

This chapter dealt with some background information on the Namibian situation, estimated statistics on mental health, psychiatric services, as well as the family and community. What was evident was that a lot needs to be explored within the Namibian situation, and this is what the study aims to achieve.

CHAPTER 3

THEORETICAL ORIENTATION TO THE STUDY

3.1 Introduction

In this chapter, psychiatric conditions most commonly found in Namibia will be highlighted. The conceptualization of support will be focussed upon as well as the historical perspective of the care taking of the mentally ill. A theoretical framework for this study is the family systems model.

3.2 Common Psychiatric Disorders

In order to understand the psychiatric ill person, it is important to know about the various psychiatric illnesses. The most common psychiatric disorders that can be found in Namibia are discussed as follows:

3.2.1 Anxiety disorders

Anxiety disorders are the most prevalent mental illness in society. Carlson & Arnolds (1996:693) refers to anxiety as a diffuse response to a vague threat, and to fear, as an acute response to a clear-cut external threat. There are four levels of anxiety ranging from mild to severe. Anxiety can be treated with medication and behavioural therapy. Support and encouragement are helpful too.

Frude (1998: 34) points out that anxiety disorders are marked by substantial emotional distress, high levels of anxiety, frequent fears and persistent worries. More men than women suffer from anxiety disorders,

and the prevalence is higher amongst those aged less than 45 years. Individuals suffering from anxiety disorders recover quickly, but if the individual is sick for longer than six months without treatment, it might take at least two years. The success rate of the treatment of anxiety disorders is high when appropriate help is provided.

There are different types of anxiety disorders, which will be listed as follows;

3.2.1.1 Generalized anxiety disorder

The persistent excessive worrying and feelings of anxiety, which are not restricted to a limited range of situations or issues. Genetic factors are usually a pre-dispositioning factor. Soukop (1995:33) states that families might be able to cope if they understand the illness and encourage the mentally ill to obtain treatment.

3.2.1.2 Posttraumatic stress disorder

It follows the experience of an exceptionally traumatic event. Onset is often delayed and marked by a persistent state of physiological arousal with accompanying intrusive and disturbing thoughts and images. Depression, nightmares and feelings of guilt are common, especially guilt about having survived the trauma when others have perished. Exposure to memories of the event is an effective form of treatment (Frude 1998: 73).

3.2.1.3 Panic disorder

It is characterized by the presence of unexplained panic attacks. Carlson & Arnolds (1996: 697) define a panic attack as a specific period of intense fear or discomfort. Panic attacks are caused by an underlying chemical imbalance. The tendency to experience panic attacks can be inherited, but can be treated successfully.

The condition is be complicated by the presence of depression and substance abuse (see Soukop 1995: 34).

3.2.1.4 Obsessive-compulsive disorder

Obsessions are persistent, intrusive and disturbing thoughts, images and impulses. Compulsions mean voluntary but disagreeable repetitive motor or cognitive actions. Obsessional thoughts have a direct relevance to the performance of compulsive and ritualized actions. Biological, psychological and environmental factors are determining. Cognitive treatment that involves repeated response prevention is effective (Frude 1998: 73).

Carlson & Arnolds (1996: 703) cite that symptoms begin during adolescence or young adulthood. Obsessive -compulsive disorders are caused by a chemical imbalance in the brain. Treatment with medicine, as well as behavioural and cognitive therapy is helpful.

3.2.2 Major depression

According to Carlson & Arnolds (1996:34) depression is caused by a chemical imbalance in the brain. Medication and support services can correct these imbalances. The criteria for a major depression are either a depressed mood or loss of interest, which is different from how the individual has functioned before. An episode can be classified as a major depression, if it has lasted for at least two weeks. Psychotic features might be present such as delusions of guilt, inadequacy, disease, or death. Major depression may be chronic, when lasting for more than two executive years.

Sufferers of depression may deny that they feel depressed or that they have lost interest, but family members usually notices that the individual is withdrawn and has an attitude of disinterest.

Depression affects people differently; the individual might have a loss of appetite or an increase in food consumption. Some sufferers complain of insomnia while others have a tendency to oversleep. Some might have a high energy level while others a low energy level.

Soukop (1995:75-82) add that the reasoning, judgement and problem solving abilities of the individual might be impaired. The sufferer finds it difficult to make decisions. The sufferer might experience physical

symptoms and have feelings of hopelessness and despair. The person will be preoccupied with death and the risk of suicide is high.

Psychological stresses may be the cause of depression, and it may recur. Depression sometimes occurs during specific seasons in the year. Depression may last six months or more if the person stays without treatment. The impact of depression is different on the various family members; it can however be severe because of the sufferer's inability to take care of him/herself.

3.2.3 Bipolar Disorder (Manic Depression)

Bipolar disorder is commonly known as manic depression and includes a manic episode. Depressed and manic states may follow one another immediately and may be separated by periods of normal functioning (Frude 1998: 123).

This disorder is especially disturbing to family members because the judgement, reasoning and reality testing of the individual are impaired. There is a high risk that the financial position of the family might be jeopardized and the individual might injure him or others. The behavior of the individual is based on psychotic and delusional thinking, and does not make sense to others.

Episodes can appear suddenly and unrelated to a stress, but stresses can also precipitate an episode. There appears to be a genetic disposition for bipolar disorders in families. It is also hypothesised that the disorder is one of a chemical imbalance.

Episodes may last from a few days to months if the ill person stays without treatment and often ends abruptly. The individual does not realize that they are ill, and might resist attempts for treatment. The disorder can be successfully treated with medicine and psychotherapy. Individuals sometimes are demotivated to take treatment because they like to be hypomanic and energized. Individuals also complain that side effects as a result of the medicine are disturbing and annoying to them, side effects however decrease over a period of time (Soukop 1995: 83 - 87).

3.2.4 Schizophrenia

Schizophrenia is one of the most crippling mental illnesses because of the dysfunctional, bizarre, inappropriate and disorganized behaviours that manifest during an episode. The disorder has its onset during adolescence or early adulthood. In order to make a diagnosis of schizophrenia; there must be at least two psychotic symptoms that are related to schizophrenia present and the impairment in the functional areas such as work, social relations and self - care.

Schizophrenia is classified under various types, such as paranoid, disorganized, catatonic, simple, undifferentiated and residual schizophrenia.

The behavior of the individual might not be related to a particular stress, this creates anxiety in the family. Some theorists believe that vigilance and anxiety in the family may trigger episodes. Schizophrenics often resist taking anti-psychotic medicine because of the side effects. Side effects are intolerable and unpleasant, but last only a short time. Schizophrenia is treated successfully with a combination of medicine and psychotherapy. In some cases the mentally ill may develop resistance to treatment and medical compliance, the disorder might become chronic see Soukop (1995: 125-130).

3.2.5 Personality disorder

Personality disorders are long -lasting behaviours or characteristics that result in the significant deterioration in the social or occupational functioning or to subjective distress. Symptoms are usually recognized during adolescence and become more intense and fixed during adulthood. The behaviours and characteristics of the individual could be disturbing, disruptive and dysfunctional. The individual might be incapable to keep a job because of an inability to get along with others. Individuals suffering

of personality disorder do not usually seek treatment (Soukop 1995: 149-154).

3.2.6 Delusional Paranoid Disorder

People suffering from delusional disorder experience constant ordinary misbeliefs or delusions. Paranoid thoughts might follow as a result of schizophrenia, the use of cannabis or cocaine intoxication. Individuals might have various thoughts; the ill person might believe that someone of a higher social status is in love with him / her, or would express delusions of grandiosity or jealousy. An individual who suffers of paranoid delusions tends to be angry and annoyed, and could turn into violent behaviour. Delusions should have existed for at least one month in order to classify a person suffering of a delusional paranoid disorder. Onset takes place in middle or late adulthood. The individual could function occupationally, but may be impaired socially and within relationships.

Individuals who suffer of paranoid delusions tend to develop problems with dependency and intimacy. Paranoid individuals could be preoccupied with detail and find fault in the significant. Medication is not always effective because delusions or beliefs are not psychotic in nature. Individuals with the disorder often deny that they have a problem and resist treatment and change (Soukop 1995: 115 - 118).

3.2.7 Organic Disorder

According to Frude (1998: 290), organic disorder entails damages to the brain tissue as a result of either of the following: severe head injuries, cerebro-vascular accidents, tumours, infections or tissue de-generations. The effect of the brain damage largely depends on the site and nature of the damages. Specific syndromes related to organic disorder include Alzheimer disease, epilepsy and HIV/AIDS related disorders.

3.2.8 Substance Abuse

Frude (1998: 218) consider substance abuse as a social and psychological phenomenon. It is not a disease, although the constant and heavy use of most of the drugs may eventually lead to physical and psychological disorders. Most people reach a point at which they wish to stop using drugs. Many are able to abstain with little effort, while others find it difficult or impossible and have a prolonged struggle to overcome problems alone or without professional help.

3.3 Conceptualization of support

Landman (1992: 8-9) differentiates between various forms or categories of support. Support can take the form of emotional, material, social, tangible, or it can be informational.

Emotional support refers to the sharing of condolences, having someone to share feelings with, the provision of empathy, care, love and trust.

Material support involves the provision of loans, subsidies, bursaries, subsidized accommodation, and subsidized transport.

Tangible support involves assisting with baby-sitting, household help, practical assistance, and provision of services.

Informational support has to do with advice - giving or sharing of information.

Social support involves providing friendship, kin - relationships, being part of a sport, religious or cultural group, feeling accepted, hobbies or other activities outside the home.

Forrester - Jones & Grant (1997: 175) cite that the nature of the support is the key factor. Confiding, decision-making, feedback and surveillance are perceived as relevant dimensions for psychological wellbeing.

In this study support to psychiatric patients will refer to providing of shelter, food and clothing. Support will also include love, communication and companion to the ill person. Practical support such as child care,

supervising of the medicine intake and support in cases of hospitalization of the mentally ill.

Masilela & Macleod (1998: 11) note that social support could be conceptualized as being functional or structural. Functional support provides the following: material aid, emotional support, affirmative acknowledgement, informational guidance, and companionship. Structural support concerns the networks of relationships in which a person is involved, and can be analyzed in terms of size and type. In this study structural support will make reference to the family and other social networks, while functional support has to do with the different forms of support that will be provided.

A differentiation is also made between “ objective” or enacted support and “ subjective” or perceived support. This differentiation is of great importance because social interactions between the ill person and significant others might be classified by an outsider as supportive but are in fact negative or destructive.

Masilela & Macleod (1998: 13) state that social support could be related with adaptation in early adolescence, psychological wellbeing in older women with a chronic illness, depressive symptoms and adjustment in elementary school children, in research circles.

Masilela & Macleod (1998: 13) distinguish between a direct protective or main effect of support and a buffering effect of support. The direct protective effect refers to support that has an effect without regarding the level of stress. These authors suggest that under low or high levels of stress, those with good social support will be less prone to developing symptoms of distress than those with poor social support. The buffering effect refers to support that only reduces the potentially harmful effects of stress. In the absence of stress, social support has no effect.

Landman (1992: 9) listed the various advantages or functions of support as follows;

- * It is a buffer against stress.
- * It maintains physical health.
- * It decreases psychological distress.

3.4 Historical perspective on the care taking of the mentally ill

Carlson & Arnolds (1996: 14) imply that throughout history, the mentally ill have been cared for in a variety of settings that ranged from prisons to almshouses, to asylums and eventually to private and public mental health hospitals. Many abuses of the mentally ill were recorded everywhere because of the unscientific attitudes towards the mentally ill. During the 1960s the process of moving individuals from the public mental hospitals to the community was undertaken. Through de-institutionalization the

number of patients in the hospitals was drastically reduced; however, there were only few successful transitions.

Morris & Goldman (1984: 34) report that after care studies were rare in the 1960s, and those in the 1970s did not document any solution to the problem of care for the severely mentally ill.

Hatfield (1987:221) observe that the family became the prominent caregiver for the mentally ill. In the 1980's and 1990's families and consumers of mental health services started to advocate about mental health and for needed support.

The aspect of de-institutionalization was supported by some scientist but rejected by others. Toomey, First, Rife & Belcher (1989: 21) note that a lot of criticism has been directed to the concept and the implementation of de-institutionalization, but limited evaluation of community care is available.

Landman (1992: 9) cite that facilities in the community such as day centres, day hospitals and hostels enable chronic patients to get treatment and support without being excluded from all aspects of ordinary life.

Connolly, Marks, Lawrence, McNamee & Muijen (1996:3) note that many countries have closed down large psychiatric hospitals to resettle the

patients in the community. When a comparison was made between hospital care and community care, the last mentioned was found to be more favourable and also less cost effective. People with serious mental illnesses are more in need of a daily support network. A comprehensive service could include a 24- hour crisis line, out patient clinics; day care facilities, short and long term hospital care, and specialized living and working arrangements. Serious mentally ill patients need regular contacts with regard to housing, work, finance, socializing, hygiene, physical health and medication. Follow- ups are essential to prevent relapses. A daily programme of activities would also be useful.

Wolff, Pathare, Craig & Leff (1996: 69) undertook a study on the community's perception of community care for the mentally ill. Many respondents had a negative view of psychiatric hospitals, which was described as "terrible" and "horrible". Other people viewed the system as abusive and that people were being filled with drugs and beaten up. Black people especially viewed the system as being racist. Even people who were positive had some reservations since they viewed psychiatric medicine as primitive and experimental. The study further found that the provision of education to communities had mix results, some authors discovered that education was ineffective while others found education to be effective. The education campaign needs however to be scientifically evaluated.

Cooney, Dean, Muijen, & Sheppard, (1996: 448 - 456) conducted a comparative study on the quality of care and the quality of life of residents in the hospital and the community in London. Twenty community homes and five rehabilitation wards in the psychiatric hospital were selected randomly. Means of data collection took place by holding several meetings and by direct observation. The result of the study was that the severely mentally ill live in the hospital under poorer conditions than in residential homes. Hospital residents were found to be more dissatisfied with their living conditions than the mentally ill at residential homes. The study concluded that attention should be paid to the most severely mentally disabled patients that remain in the hospital under poor living conditions. Hospital staff needs to be properly trained and they should practice quality services in order to improve quality of care to patients in the hospitals.

Barry & Crosby (1996:215) released the findings of a qualitative study that proved that the movement to the community had a considerable positive impact on clients who reported positive changes in their outlook and perceived their lives as having improved dramatically.

Mak & Gow (1996: 761) cite that de-institutionalization of the mentally ill brought with it various social problems, which can only be solved by adequate community resources and after care.

Most of the literature that was reviewed was supporting the idea of de-institutionalization. However, there was one critique from Whitehead (1996: 257) that the shift from institutional care to community care only applies to psychiatric services and not the rest of medicine. Mental patients are as a result singled out and discriminated against through this practice.

Freeman (1999: 4) cites that health services should not only look at caring for psychiatric patients but also attend to the need of family caregivers. Mental health services also need to be integrated into primary health care and the community.

3.5 Theoretical framework to the study

Kendell & Hamman (1995: 55-60) cite that different perspectives have different ideas about how families contribute to psychiatric illnesses.

Behaviourists emphasized the environment as a controlling and contributing factor in human behaviour and view the family as one of the most important environments.

In this study, the family systems model will be used. The family system model suggests that an individual is disordered as a result of disturbed family systems. This means that the family system approach places the disorder within the family system instead of the individual. Since the family is the primary social network, the interaction patterns within the family are seen as dysfunctional.

Behaviourists view the learning paradigms within the family.

3.6 Summary

This chapter deals with the different theoretical aspects of mental illnesses. First of all, the most common psychiatric illnesses that can be found were listed. Thereafter, the conceptualization of support was discussed followed by a discussion of the historical perspective on the care taking of the mentally ill. Finally, the theoretical framework of the study was explained.

CHAPTER 4

FAMILY AND CAREGIVER'S SUPPORT

4.1 Introduction

In this chapter, the characteristics and functions of a family as a social institution will be discussed. Mental illness has a considerable impact on families and this will be highlighted. The chapter will further address the nature and extent of family support and will explore the need for family caregiver support. The rights of the family as opposed to the rights of the patient will be considered. The three models of care giving that are identified are the burden on family caregivers, expressed emotions and family functioning.

The intervention strategies with regard to psychiatric illnesses that will be discussed are education, treatment, counseling and support. The chapter will conclude with a review of some major perceptions of families and mental illness.

4.2 Characteristics of the family as a social institution

The family as a social institution has been going through a lot of changes. Patterns and characteristics of families also differ from one another. In order for families to optimally take care of their ill relative, they must have the following characteristics: the displaying of love and acceptance to one another, open communication with the expression of both negative and positive feelings. Family members should be able to enjoy spending time

together. Families should also be able to cope effectively with problems and they should be mutually supportive of one another (Berns 1993:125-126).

To understand the significant role of the family in the life of the mentally ill, it is important to understand the functions of the family. Family functions may vary. Berns (1993: 126) listed the functions as; reproduction, socialization and education, economic support such as shelter, nourishment and protection, as well as emotional support. Since families take different forms, they also fulfill different functions.

According to the National Advisory Mental Health Council (1996:626) lifelong mental bonds have become less common in America and more varied family structures are emerging. Many people are members of more than one family and are linked biologically and emotionally to people who do not share their household. It is a challenge to describe and understand the effects of the varied paths people take in forming and dissolving unions and emotional ties and in establishing new households.

4.3 The impact of mental illness on the family

According to Soukop (1995: 9 - 14) mental illness affects each family differently because of the differences in family systems. Emotional illness however tends to cause emotional responses such as anxiety, anger, co-

dependence, shame and dysfunction from family members. These responses are now discussed in more detail.

Families would try to keep the mental illness as a secret from the community, relatives and friends. Family would often make excuses for the mentally ill individual and would sometimes avoid social engagements on purpose. Family members tend to use denial, minimizing and rationalization as defense mechanism against emotional illness in the family and this often causes families to delay treatment.

The family's social life and the practical abilities of other family members are directed by the behaviours of the mentally ill person. Family members may be exposed to recurrent episodes, and lives in a suspended state of anxiety with the fear that the episode will occur.

Chronic mental illness creates anxiety in the family as well and tends to be more prevalent. Spouses and parents may develop a form of de-personalization.

Sometimes anger is unexpressed where families will ask the question why this has happened to them. Families sometimes do not express their anger because of fear of an episodic response or because past expressions of anger have not improved conditions. Unresolved anger usually results in increased tension and anxiety.

Co - dependence is another response of family members. Co-dependence refers to the attempt by the family to completely provide for the needs of the mentally ill. This is usually offered out of love. Results are often disastrous for both parties because it is impossible to provide completely for the need of another person. The family or caregiver could perceive him or herself a failure, while the mentally ill person might be annoyed. Co - dependence is therefore unappreciated, and no one's needs are met.

Family roles often become unhealthy and dysfunctional as a result of the mental illness. Families might develop practices to hide the shame of mental illness. Relationships are often based on anxiety and anger. Needs are not met because the individual tends to focus on the needs and demands of the ill family member who is depressed, anxious, inadequate or dysfunctional.

Distant relatives are often consulted and confided in, or would assist with care taking responsibilities. Extended families can be utilized in the development of a support system.

Masilela & Macleod (1998: 11) conducted a need assessment in the Bushbuckridge district in the North- Eastern Transvaal in South Africa to study the patterns of social support. In- depth interviews were made with identified psychiatric clients, primary caregivers and a community survey

was presented. The study found that the first level of support for clients was the family who carries the largest burden. Support from employers was short-lived and only towards the clients, while support from friends was found to be in the minority. Emotional and advisory support seemed to be non-existent because the majority of caregivers lacked information concerning the client's condition.

Mental illness unlike other illnesses sometimes takes a long and stressful course. This reduces or even causes failure in the family to help reducing the danger or outcome of the illness and leads to difficulty for family members to cope with it (Ngubane 1991: 10).

Cultural values and beliefs influence the family's attitudes and behaviours towards the mentally ill person. People with strong family ties might be more sympathetic towards a mentally ill person (Weisman & Lopez 1996: 228).

Goldstein, Miklowitz, Nuechterlein, Richards & Simoneau, (1996: 830) noted that the understanding of the emotional climate between families and patients during hospitalization and at discharge is of significant practical and prognostic importance.

4.4 The nature and extent of family support

Cohen & Thomas (1996: 131) state that informal caregivers are left with the burden of taking care of psychiatric patients after there has been a shift from institutional to community care. Little research is however carried out on the needs of caregivers or means to improve their effectiveness. The only available literature on caregivers of psychiatric patients shows that caregivers bear a great psychological and emotional burden, suffer a great deal of economic losses, have various needs and are not provided with satisfactory information from mental health professionals on the condition and management of the mentally ill.

A study was conducted by Cohen & Thomas (1996: 131 - 132) to determine the extent to which the needs of caregivers of psychiatric patients are being met, how caregivers viewed the services they received and what additional input were required to meet their needs. First contacting outpatients in Glamorgan and with their consent to approach their caregivers, the sample were collected. Questionnaires and interviews were used as a method of data gathering. The sample consisted of 36 questionnaires while 13 interviews were done. The questions and interviews supported the findings of previous research. The study concluded that improved professional services to the mentally ill appear to be the most effective way of meeting the needs of caregivers. Although

community care is a good idea, the concept will only work in practice if enough support is provided to caregivers.

Social support often has emotional costs for those who give and receive it. If, for example, attempts to help the mentally ill failed, the relatives might start to avoid the mentally ill. If the relatives offer more support and receive less, they might despise it when their own needs are disregarded. Women share the biggest responsibility with the provision of social support in many cultures, and might feel more personally responsible to provide support. It can sometimes be overwhelming to women; this could make them prone to develop depressive or physical distress. Effective support should be provided to caregivers to enhance their capability in caring for the mentally ill (*Report - Basic Behavior Science Research for Mental Health* 1996: 629).

According to Benson, Bloch, Colussa, Hermann, & Schmukler (1995: 416 - 418) family members often have an intense need to share their experiences of taking care of the mentally ill person when they are given the chance to do so. They often would describe incidences and would provide more detailed stories. Family members often feel a sense of loss and grief over the changed relative who might never be the same person as before, due to mental illness. Family members sometimes feel inadequate and helpless, and could be concerned for not doing enough. Parents sometimes

experience feelings of guilt and that they are to be blamed because of their genes, inadequate parenting, or both.

On the subject of coping, family members are often not sure whether they would be able to manage the situation. Some family members might be undecided as to whether the ill person's behavior is because of the effect of the illness or the personality. Caregivers further might feel troubled how to meet the patient's dependency needs and might feel deprived of any life of their own. Caregivers may also feel concerned that their ways of coping would hinder the patient's adjustment. Many caregivers expressed their dissatisfaction with the help offered by mental health service providers. Some communities who could manifest other negative attitudes as well are stigmatizing both caregivers and the mentally ill.

Benson, Iyabo & Seyi (1996:56) compared the mental health of caregivers of handicapped children with caregivers of children with minor ailments in Ibadan, Nigeria. The study found that caregivers of handicapped children experienced more stress. This could contribute to psychiatric morbidity. Caregivers have to be assessed regularly and psychological disturbances need to be addressed.

4.5 The need for family or caregiver support

Stigma still exists in the community, and the family seems to be of significant importance as the primary support system to psychiatric patients. Re-admission of the mentally ill to the psychiatric hospital may be associated with feelings of intolerable burden experienced by family members. It may also be related to inappropriate interpersonal perceptions of patients and their families or caregivers. Family caregivers need assistance from their own social networks as well as from mental health professional in order to improve adaptation and stress to the illness (Ngubane 1991: 6,12).

A report by the Basic Behavioural Science Task Force of the National Advisory Mental Health Council (1996:622) argues that families shape the quality of lives. Family influences could be positive or negative. Family relationships sometimes lead to pain and conflict instead of support and harmony because of ineffective interactions.

Simoneau et al (1996: 84) cite that psychiatric patients are always return to their families for support after hospitalization and rely on their families for social, emotional and financial support.

Lack of social support might lead to an increased risk of becoming mentally ill and hospitalized according to Bridges, Huxley, Mohamad & Olivier (1996: 94).

Recent research findings from Finland showed that children from parents with schizophrenia who lived in dysfunctional adoptive families were more likely to develop a mental disorder than children from schizophrenic parents who lived with supportive families. This could be attributed to genetic and social influences. (*Report by the National Advisory Mental Health Council* (1996:623).

Hatfield et al (1996:327) state that community support services structured in the form of home based care, day facilities and crisis accommodation are widely identified as needs for psychiatric patients and their families.

Gasque-Carter & Curlee (1999:520-524) cite that there is a positive relationship between family support and medicine compliance and leads to the reduction in hospital readmission. The family, however, requires support and education in order to reduce family stressors and to strengthen the vital role that the family plays in rehabilitation. There is a lot of information available on the needs of families caring for the seriously mentally ill. In two studies conducted in 1983 and 1991 it was found that professionals do not actively involve family caregivers in the treatment of

the ill person, and that caregivers receive little attention from professionals in the care taking of themselves and other family members. Family caregivers in these studies indicate that they want to be more involved with mental health professionals and ranked communication with mental health professionals as their greatest need. Efforts by mental health professionals to provide supportive services to family caregivers are limited and infrequent. Mental health professionals have to communicate with families in order to obtain important information for effective treatment.

4.6 The right of the family versus the right of the mentally ill

Mental illness has an effect on family interaction, family routine, leisure opportunities, work/employment, the mental physical health of caregivers, children and others outside the family. Family finances are also affected. Furthermore, there is a demand on caregivers to help with a variety of daily living skills. Caregivers further experience distress, stigma, worry, shame and guilt. Sometimes family members have problems of their own, which makes it difficult to provide emotional support to the mentally ill. Some patients also do not have contacts with their families long before they become psychotic (Ngubane 1991: 10).

There is a need to balance patients' rights, families, community rights and the right to the ill person to freedom in relation to the rights to receive or reject treatment (*Issues in Mental Health* 1991: 19).

Barker & Baldwin (1995: 122) suggest that caregivers should respect the wishes and be concerned for the welfare of the mentally ill. The question is what rights and obligations do caregivers have, if these rights are in conflict with the rights of the patients and what happen if they do conflict?

According to Barker & Baldwin (1995:123) caregivers must acknowledge that to care optimally means they must be fit mentally, emotionally and physically. A patient's rights should always take precedence, but the right of the caregiver should also not be ignored. Caregivers have the right to protection from their ill relative especially when they act dangerous and violent. The difficulty to deal and live with some very disruptive ill relatives must be acknowledged. There are as many as 6 million people in Britain caring for mentally ill relatives, but it was suggested that more help should be given to care for their family members, little attention is paid to their rights in any moral sense.

Szmukler (1996: 449) state that literature tends to concentrate on the well being of psychiatric patients and in that way has marginalized the position of caregivers. Literature has rarely looked at relatives in their own right.

There is, however, evidence that their distress and morbidity are substantial. Relatives believed that patients should be the beneficiaries of care and only started to ask for help recently. Many families have been dissatisfied with treatment and mental health services. Relatives were not involved in care planning, while it is expected from them to provide care. The perception that families are to be blamed for a patient's mental illness leads to misunderstandings. Work on expressed emotions also has the same perception that relatives are responsible for the illness or for the poor outcome. The question needs to be raised whether the needs of patients and caregivers are not in conflict.

Simoneau et al (1996:85) cites that rights of relatives are often in opposition to the rights of patients, causing problems for the professionals involved. Relatives need to be treated, as clients in their own right, and to provide them with professional services of their own, information and education, advice and support.

4.7 Models of care giving

Scmukler (1996: 450) highlight three frameworks as models of care giving, which are identified as issues in care giving; they are burden, expressed emotions, and family functioning.

Burden is the first approach and has been observed in a theoretical vacuum. Not much relationship was found between burden and caregiver or patient characteristics except for greater burden being expressed by the caregiver about the patient's symptoms and behavioural disturbances. Caregivers regard stresses as the patient's illness, as well as behaviours associated with the mentally ill. The caregiver's coping strategies would determine whether or not they could suffer from psychological morbidity such as depression. Social support and treatment are other factors that would play a contribution towards the caregiver's psychological wellbeing.

Caregivers' expressed emotions are a second approach. Caregivers with high expressed emotions experience greater distress and have more unmet needs than caregivers with low expressed emotions.

The third approach studies care giving with reference to the content of family functioning, in terms of patterns of relationships, roles, rules and systems of maintenance.

Interventions to reduce care - giving distress are identified as educational ones to improve caregivers' understanding of the patient's illness and lead to positive attitude change. Long -term programmes involve broader and

more intensive psychological intervention and could lead to significant changes in coping and care giving distress (Scmukler 1996:450).

The three models of care giving will now be discussed in more detail.

4.7.1 Burden on the family / caregivers

Scmukler (1996: 449 - 450) state that the problems of caregivers are framed in terms “burden”. Burden can be divided into subjective and objective burden. Objective burden is defined in terms of the disruption to family / household life due to the patient’s illness, which is verifiable and observable. Subjective burden is viewed in terms of difficult behavior or disruption by the ill person, as well as how distressed the caregivers feel because of the patient’s illness. Distress arising from non-objective aspects such as grief over the loss of the person the patient once was, is however excluded.

Scmukler et al (1996:450) further cite that the term "burden" is viewed as damaging by some people. It is pejorative, connoting a passive "load" borne by carers, one easily seen as unchangeable. Where patients are encouraged to participate actively in their own care, the term can be offensive too.

The term "burden" furthermore restricts the reactions of caregivers to the negative. Rewarding aspects of care giving and valued aspects of the

relationship with the patient are excluded even though carers, if asked, commonly report them.

A more appropriate term is "care giving". It is a neutral tone, allows for both negative and positive aspects, and has no built-in preconceived ideas. Negative aspects of care giving could be termed "care giving distress" and the positive aspects, "care giving rewards". It is however difficult to abandon the term "burden", because it is now in common use. It perhaps expresses negative stereotypes of mental disorders, which are hard to relinquish, and it trips nicely off the tongue. If we seek to further our understanding and to help both caregivers and patients, we need to examine the hidden assumptions underlying the words we use.

Cunningham (1992:10) argues that an increased level of stress and the lack of appropriate coping skills may heighten the burden for families facing the crisis of having a mentally ill member.

Webster (1992: 309 - 329) investigated the experiences of children of schizophrenic mothers in Britain. The children and families of 28 schizophrenic women were interviewed to assess the amount of burden that family members experience as a result of the schizophrenic member. The study found that family members learnt to cope, depending on the role

of the father and the developmental stages of the children as well as the adverse effects on the family.

Benson, Bloch, Collussa, Hermann, & Schmukler (1995: 413 - 414) cite that the impact of caring for a mentally ill person on the physical and mental health of family members is substantial. Experiences of caregivers are under studied and little attention is given to caregivers on coping mechanisms.

Bridges, Huxley, Mohamad & Olivier (1996: 96 - 97) recognize the troubles and worries over whether the patient would be a danger to themselves or others, disturbed nights, aggressive and embarrassing behavior, elaborate psychotic incidents, social withdrawal and isolation and improper self - care.

Benson, Iyabo & Seyi (1996: 56) cite that caregivers of chronically disabled patients are exposed to many burdens and disappointments that may limit their quality of life. Parents of chronically ill children experience more marital stress, are more prone to depression, mood liability and feel more tired than parents of healthy children. Some of the stress outcomes reported in a group of caregivers from two urban communities in the United States of America were heart attacks, stroke, alcoholism, increased smoking and depression and anxiety. Adverse health

consequences include insomnia, back and stomach pain, hypertension and arthritis. Care giving may negatively affect the physical health and economic circumstances and may as well be an emotional strain.

According to the Information Education and Communication Unit from the Ministry of Health and Social Services in Namibia (1997:22) the burden of mental illness is a heavy one for the patient and for his or her family. Mental illness is a source of great distress to the sufferer and his family because of the disruption that the illness causes, the fear it induces and the stigma it attracts from the community. When knowledge of mental illness is lacking, feelings of hopelessness and panic are aroused, even amongst health workers.

Freeman, Lee, & Vivian (1999: 316) cite that the policy of caring for the psychiatric patient in the community affects the service providers, the patients as well as the family and the community at large. De-institutionalization involves a transfer of care and support from institutions to the family. The attitudes of family members to community care, the support they receive from the health services and the level of burden placed on them will determine the success of a community orientated psychiatric programme. It has been found globally that relatives experience significant difficulties. Issues that are problematic for families include effects on relationships; within the family and with regard to the

community, financial difficulties; which includes expenditure on the relative's behalf and the loss of earning a salary.

Freeman, Lee & Vivian (1999: 316 - 318) evaluated mental health services in the Free State, South Africa. The objectives of the study were to assess the burden of community care on family members, the level of support they receive from the mental health services and their care preference. Semi structured interviews were administered to 62 family members who were attending clinics and 24 family members of patients who defaulted from the services. The result of the study was that the majority of the psychiatric patients live with their families, and that the burden is substantial both socially and financially. Black people appeared to have a greater burden than white people do. The study concluded that there is a need to address the burden placed on the families of psychiatric patients.

4.7.2. Expressed Emotions

Previous studies show some relation in expressed emotion and the high relapse rate of psychiatric patients. Scientists also studied the relationship between expressed emotions and compliance of medicine and found that patients, who are resistant to use medicine regularly and from families with high expressed emotions, had a higher relapse rate. On the other

hand, patients who are medicine compliant and from families with low expressed emotions had a low relapse rate (Ndlovu 1991: 9).

Ndlovu (1991: 1 - 32) conducted a study on the expressed emotions in families of Black psychiatric out patients. The objective of the study was to identify the level of expressed emotions in families of black psychiatric out patients. The sample consisted of families of out patients who were attending psychiatric clinics in Caluza and Imbalehle in Natal. Twenty families from Imbalehle clinic and ten from Caluza clinic were selected through purposive sampling. During the pilot study, the Camberwell Family Interview schedule by Brown and Rutter was used to test reliability and validity. The study concluded that patients do not receive any support from their families. Thirty percent of families were negative towards their sick relatives. This de-motivates patients to take their medication, which causes relapses and re-admissions.

The study further found that married female psychiatric patients experienced the highest degree of hostility from their families. Family members expected from their mentally ill relatives to acquire employment or to be self-employed, and could not understand that mental illness affects the functional level of individuals in all spheres.

Families who are regarded as showing high expressed emotions in a critical form towards the patient display high levels of critical statements

towards the patients. Patients would then also show high expressed emotion towards their relatives in return. Families with high expressed emotions are more prone to escalate negative behavior. High expressed emotions are negative, conflict prone and inflexible. In relation to depressed patients and their spouses, high expressed emotion spouses are both verbally and non-verbally more negative than positive. Patients on the contrary are not negative towards their high expressed emotion spouses (Wuerker 1994: 390 - 391).

Families who recognize the reality of a mental illness, and who know that people with mental illnesses have a limited ability to control their behavior, would be less likely to control their offspring's behavior. Anxious families are more likely to use expressed emotions as a coping behavior. Expressed emotions like suggestions, nagging, threatening, and criticisms are stressful to patients, especially if the ill person is unable and/or unwilling to accept the condition (Wuerker 1994: 191).

Evidence from several investigations imply that some families of psychiatric ill patients who are expressing highly critical emotions and with over-involved attitudes, contribute to the high relapse rate over a 9 to 12 months period after discharge from the hospital. Researchers have found that difficulties and concerns between patients and their relatives influence the expressions of expressed emotions. Several studies found

that relatives with high expressed emotions expressed more critical direct statements when they are in direct interaction with the patient. It is also discovered that families with high expressed emotions and negative affective style relatives have patients who adopted negative coping style patterns when interacting with their relatives (Friedman & Goldstein 1994: 378).

Goldstein, Miklowitz, Nuechterlein, Richards & Simoneau (1996:83) stated that the understanding of the emotional climate between families and patients during hospitalization and at discharge is of significant practical and prognostic importance.

Simoneau et al (1996: 85) adds that critical, hostile and/or over emotionally involved attitudes maintained by relatives during hospitalizations of patients and negative verbal interactive behavior between the ill person and their families or caregivers, are associated with high relapse rates of psychiatric patients.

The relationship between expressed emotions and care taking of psychiatric patients were studied by a number of researchers and found that relatives who were criticizing a lot were associated with high levels of burdens. Furthermore, relatives with high expressed emotions reported more about the disturbed behaviours of patients, complained more about

their subjective burdens, and viewed themselves as coping less effectively than low expressed emotions relatives (Scazufca & Kuipers 1996: 580).

Scazufca & Kuipers (1996: 580 - 587) conducted a study on the links between expressed emotions and burden of care in relatives of patients with schizophrenia. The study aimed at examining what extent expressed emotion levels are related to the relative's burden of care and their perceptions of the patient's deficits in social role performance. Fifty patients who were recently admitted in the hospital and fifty relatives who were in close contact with the patients formed part of the sample, and were interviewed to assess expressed emotions and burden of care. The result of the study was that high expressed emotion relatives experienced a higher burden than low expressed relatives and perceived more deficits in patients functioning than low expressed emotion relatives. Relatives who were unemployed experienced a higher expressed emotional level than unemployed relatives were. The study concluded that the link between expressed emotion and burden of care depends on the relative's judgement of the patient's condition than on the patient's actual insufficiencies.

International studies concerning expressed emotions show that mentally ill people experience relapses more frequently when they are returning home where relatives talk to and about them in a critical and hostile manner, compared with patients where no negative attitudes are expressed. Family

caregivers that are highly critical and hostile and who express negative attitudes contribute to the poor mental state of psychiatric patients. Family members who viewed mental illness as controllable expressed more negative emotions towards the mentally ill than relatives who viewed the illness as beyond their control. Less industrialized societies such as India have less high expressed emotion rates than more industrialized countries such as England and the United States (Weisman & Lopez 1996: 227-228).

Weisman & Lopez (1996: 342) conducted a study to test whether family cohesion and religiosity had any effect whether family members would express more favourable or less favourable emotions towards their sick relatives. Sampling consisted of 88 undergraduates from Los Angeles and Guadalajara. The result of the study was that the perception of family unity is an important aspect of reaction towards schizophrenic patients. Religiosity was not found to bring about unfavourable or favourable emotions.

Strong evidence exists on studies about expressed emotions that family conflict or criticism influences psychological wellbeing and psychiatric utilization. The continuous expression of negative emotions leads to a high relapse rate of schizophrenic patients. In a study with a control group with lower levels of expressed emotions, there was a reduction in the

hospitalization of schizophrenic patients. Patients who were treated in their family system had only an average of 12 % relapse rate in comparison to patients who were treated as individuals where the relapse rate was as high as 48 percent (Fiscella, Franks & Shields 1997: 25 - 26).

Environment may employ a significant influence on the progression of schizophrenia. Several studies on expressed emotions prove that patients who return to family environments with high levels of expressed emotions, are three times more likely to relapse than patients who return to families of low expressed emotions; Harrison, Mark, Dadds & Smith (1998:918-924).

Harrison, Mark, Dadds & Smith (1998:918-924) suggest that the phrase “high expressed emotion” is used to describe families clinically. Literature on expressed emotions is however plagued with many queries. It is still not clear what is being measured by the interpretation of expressed emotions, why some families have high levels of expressed emotions and others do not, and by what instrument a high level of expressed emotion would influence the outcome of the patient. Explanations such as expressed emotion should have useful implications for the management and care of people with schizophrenia. An over concentration on the link between expressed emotion and relapse has hampered a thorough investigation of the factors that may influence the level of expressed emotions among family caregivers.

Some studies have concentrated on the differences between caregivers in efforts to explain expressed emotions. People with high levels of expressed emotions might be more socially isolated, less capable in coping, or have little information of mental illness.

A lack of knowledge about mental illness has been presented as a major source of high levels of expressed emotions. Providing information to caregivers about the nature of mental illnesses can improve their effectiveness, lower frustration and lessen their tendency to be critical.

Other researchers suggest that high levels of expressed emotions might be a reaction to the behavior of the patient or could display an interactive process. Many studies have surveyed the relationship between the patient's behavior and caregiver's expressed emotion. These studies ignored the negative symptoms of the disorder and did not report whether patient's disturbances varied across the over-involvement of caregivers versus the critical comments of caregivers. Criticism of caregivers was associated with the long-standing social weakening, while other researchers demonstrated that caregivers find negative symptoms of particular concern. These findings suggest, that in order to understand expressed emotions, the inter relationships amongst patients and caregiver variables must be taken into account. Many writers have theorized that

attributing symptoms to the patient rather than the illness is related to high expressed emotion among caregivers. Other writers suggest that negative symptoms such as apathy, social withdrawal and poor personal hygiene are perceived by caregivers to be more controllable by patients than are positive symptoms like hallucinations and delusions, and are therefore more likely to be criticized by caregivers.

Studies found that when caregivers view the causes of behaviours as personal and controllable by the patient their families would be more likely to be critical. It was also found that critical caregivers are more likely to ascribe negative symptoms to the personality of the patient than caregivers with low expressed emotion or emotionally over-involved caregivers. Caregivers who had less knowledge on mental illness were more likely to link it to internal attributions.

Studies found that emotionally over involved caregivers would make the largest number of external attributions, which are attributions to the illness rather than to the patient. It is further important to understand what expressed emotion are made of, in order to accept the link between expressed emotion and relapse.

The key variables that explain why some caregivers respond negatively to their ill relatives and others do not, are the following:

- * the quality of the patient's symptoms,
- * the knowledge of the caregiver on mental illness, and
- caregiver's attributions.

4.7.3 Family functioning

Lea (1989: 256-261) conducted research to study the nature of the relationship between institutionalized mentally handicapped children and their parents in South Africa. The sample consisted of six families with a mentally handicapped child who maintained good relations compared to four families with poor relationships. The study found that parents who had good relationships with the mentally handicapped had adequate personal resources unlike parents who had a poor relationship with the child. Parents who had good relationships could benefit from sources of social support whereas parents with poor relationships were feeling isolated and alone. Finally, parents who maintained good relationships with their handicapped child could speak to family and friends about the child and find acceptance and understanding for their situation. Parents with poor relationships on the other hand seldom spoke about the handicapped child, and did not come to terms with the emotions that they felt in relation to the child.

Bentley (1990: 111) proposes that the more face-to-face contact there is between the family and the patient (more than 35 hours per week), the higher the stress is experienced.

Some families reject their ill relatives because of the stigma attached to mental illness. Other families are relieved when their ill relatives are admitted in the hospital because they are experience tremendous stress and difficulties prior to admission (Ngubane 1991: 33).

The entire community needs to be educated to reduce the stigma of mental illness as an approach to change the attitude towards mental illness. Patients and families often lose their jobs and housing, and lives are isolated because of stigma. (*Issues in Mental Health* 1991:18).

In the first 5 years after a person has been diagnosed as suffering from a mental illness such as schizophrenia, more noticeable destructive behavior is observed and relatives experience more anguish. After 5 years, schizophrenic patients changed to becoming more withdrawn, neglected and it is more obvious that the person is less active. Adult relatives become enduring to the difficulties after 5 years, while children under the age of 16 years show emotional and physical symptoms or conduct problems. Mentally ill parents, who took care of their children themselves,

were more capable to protect their children from psychological illness (Webster 1992: 311).

In the cases of married mentally ill people, some studies found that a third of couples were positive towards their spouses after a psychotic episode and even willing to renew their commitments. This is uncommon since some spouses would distance themselves from the mentally ill spouse through separation. Mental illness affects the personality, mood, behavior and performance of an individual, a partner would therefore prefer to take custody of children, the younger ones might be at risk of being abused, neglected or are exposed to a hostile environment or bizarre behavior. In cases of a mentally ill mother, very young children are often cared for by the extended family. Older children often take care of themselves see Webster (1992: 310).

Friedman & Goldstein (1994:386) state that many relatives are willing to admit that they are sometimes involved in negative interactions with the mentally ill patient.

Simoneau et al (1996: 85) cite that schizophrenic patients show frequent negative symptoms after a psychotic episode, which could be demonstrated as passivity, avoidance or disconnection in their relationship with relatives. In return, relatives become frustrated and withdrawn if they

would attempt to become involved into discussions with the patient without receiving any response.

Hundreds of studies prove that social support protects people from the negative mental health consequences of stressful life events. Researchers also found a link between social support and how well mental patients are functioning in the community. Psychiatric patients who have larger social networks, more frequent contacts and more interactions have increased independence and better adaptive functioning (*Report- Basic Behavioural Science Research for Mental Health* 1996: 628).

Social support contributes to successful treatment and to helping patients maintain their treatment gains. Higher levels of support are associated with fewer relapses, less frequent hospitalization and success and maintenance in treatment gains. The findings indicated that the provision of social support leads to the prevention of mental illness and the improvement of mental health. (*Report - Basic Behavioural Science Research for Mental Health* 1996: 826).

Researchers shows that access to social networks contribute to the flow of information, material assistance and other resources to the mentally ill. This in turn influenced patient's behaviour. The perceptions of the mentally ill person of receiving support is extremely important to prevent

mental distress, it is even more important than the actual level of support received. (*Report Basic Behavioural Science Research for Mental Health* 1996:628).

Friedman et al (1997: 357) state that psychiatric disorders are increasingly associated with family functioning. Friedman et al further noted that family functioning predicted the course of several psychiatric disorders. Depressed patients are more likely to have relapses after hospital discharge if their families are expressing high levels of criticism and/or show emotional over-involvement.

Previous studies suggest that levels of family functioning were higher in families of psychiatric patients than in families of medically ill members. (Friedman et al 1997: 358).

Friedman, Katner, McDermut, Miller, Ryan, & Solomon (1997:357) conducted a comparative study on family functioning and mental illness with psychiatric and non- - clinical families. The objective of the study was to examine adaptive functioning in families who had patients with psychiatric illnesses. A total number of 353 families who had mentally ill relatives with a variety of diagnoses were selected. The result of the study was that to have a psychiatric ill family member, especially in the acute phase of the disorder, is a risk factor for poor family functioning. The type

of psychiatric illness did not make much difference. Having a family member with a mental illness, is stressful, therefore family intervention was found to be essential whenever a patient requires hospitalization for the onset of acute illness of any psychiatric disorder.

Lefley & Hatfield (1999: 369-375) did a comparative study between mothers of mentally ill adult children and mothers with mentally retarded adult children. Mothers of mentally ill adults have smaller support networks and are more dependent on social support for their psychological wellbeing than are mothers of adults with development disabilities. This is attributed to the fact that families develop a stable coping pattern over the lifetime of children with mental retardation, while mental illness develops later in life, with unexpected challenges and at times unpredictable patterns.

Relatives seem to have high tolerance levels when providing support to patients with problematic behavior. Relatives expect help from the government but receive little and only in times of crises. The marriage of a mentally ill patient usually leads to divorce and separation. It is very difficult and a task without end to cope with mental illnesses; therefore mental health professionals should work in partnership with families to strengthen the coping capabilities of relatives and to reduce relapse rates. Intervention entails addressing the various family needs by helping families to understand the problem that the patient goes through, relatives

should formulate their own problems in coping with the demands and needs of the patients and the utilizing of available resources. The most effective intervention focuses on both the family member and the patient and is based on a positive attitude towards the relatives of psychiatric patients and their valuable contributions towards the management of psychiatric patients. Mental health professionals should also be sensitive towards the specific needs of families.

The relationship between relatives and mental health professionals should be frank and open and there should be mutual willingness to share information, knowledge and ignorance, and setting of realistic goals. Interventions should include education about mental illness, this would increase the understanding, tolerance and empathy. Relatives would obtain cognitive behavioural approach when solving or coping with specific problems or sources of stresses. This will improve the social functioning of the patient within the family setting. Interventions should especially be geared towards relatives who are unwilling to be involved.

4.8 Intervention strategies

Cuipers & Stam (2000:375-379) cite that psychosocial intervention have been developed for families and people with mental illnesses. Some intervention aims at preventing relapses in-patients, by lessening the level of expressed emotions through education, training and therapy.

Interventions are also directed to the supporting of relatives. Supportive intervention became popular after professionals recognized the burden and responsibilities that family caregivers of psychiatric patients bear. Self-help family organizations are pleading for more and better support for relatives and aim to improve the quality of life of relatives by reducing stress and burden.

Intervention involves education, the management of the disease as well as counselling and support. The quality of interventions will be improved if elements of subjective burden, which are closely related to elements of objective burden, are focussed upon.

Intervention strategies will be discussed as follows;

4.8.1 Education

Bentley (1990: 101) states that the education about mental illness and coping skills to psychiatric patients and their relatives reduces family stress and leads to successful community care.

Potential opportunities for prevention in mental illness are the public schools and at workplaces. Knowledge regarding human behaviour can be used to help young people before they drop- out from school or become

involved in other socially destructive behaviour. Employees under stress and about to be lost can be assisted with counselling for themselves and their families. (Thackeray, William & Milton 1994: 140).

Matlala (1995: 30 - 35) investigated the major psychological stresses that are prevalent amongst mentally ill people attending the Zola community psychiatry clinic in South Africa. A questionnaire was used as a method of data gathering with 73 respondents. The study proved that unemployment, poor education, lack of skills and over crowding was common amongst psychiatric patients. The study concluded that health systems should adapt an approach towards the prevention of mental illness and the promotion of mental health.

Wolff et al (1996: 441 - 447) conducted a study to test the effect of public education campaigns on the community attitude towards the mentally ill. An experimental group was introduced to the educational campaigns while the controlled group was not. The study concluded that public education campaigns improved the attitudes of communities and the social integration of patients was enhanced. There was, however, a limited increase in the community's knowledge of mental illness.

Forrester - Jones & Grant (1997: 130) state that public education is essential in overcoming ignorance and prejudice about mental illness. All

sections in the communities, which include public and private organizations, should work closely together.

4.8.2 The treatment of mental illnesses

The management of the psychiatric patient is usually done by mental health professionals, and involves pharmaceutical treatment as well as psychotherapy. The pharmaceutical treatment is most of the time issued on a monthly basis, often, the person with the illness have to take the treatment on a day –to- day basis. This is where the involvement of the family is of utmost importance, to prevent relapses.

With regard to the management of psychiatric patients in South Africa, Ndlovu (1991:1) cite that the treatment strategies for black psychiatric patients in South- Africa, are focussing on medication. Psycho -education and family relations are not a priority. The admission rate is however very high.

Pilgrams & Rogers (1993: 57) also observed different psychiatric treatment for black and white people in some regions. Black people were more likely to receive physical treatment like Electro-convulsive therapy and would receive more tranquilizers. Black people were also more likely to be treated by junior medical staff. Black people were also found to react more violently than white people do, but it is obvious that black people

would react in an aggressive way considering the history of being colonized by a discriminatory regime.

Roos (1992: 352 - 355) cites that the involvement and emotional support of the family and the multi-disciplinary team is an essential component of long term treatment of the schizophrenic patient in the community. The family of the schizophrenic patient is often a valuable and unexploitable source in the treatment and rehabilitation. It is in the best interest of the client that the mental health providers build a strong relationship with the family. Family usually grieves over the loss of their once promising relative, now a different person, and stranger in the family. Support groups for families of these patients could provide support, advice and information regarding schizophrenia.

The value of medication and Electro-convulsive therapy, especially the likely side effects of it, needs more explanation. Counselling or support to individuals with mental health problems, support and advice for the families of such individuals is important. Some female patients encounter practical problems such as transport and childcare, which hinder them to visit the treatment centers for follow-up treatment (Hatfield et al 1996: 325 - 326).

4.8.3 Counselling and support

Rushton (1990: 380) cite that there is a need to capture the complex processes of interaction that are involved in fully developed social work with the mentally disordered person. They are the following, the need to examine more closely the tasks of working with tension and disputes between disordered clients and caregivers; holding the anxiety when a client lives on the very borders of adequate community adjustment.; communicating with people who are thought disordered, the tasks of supporting, encouraging and negotiating in order to maintain people in non - hospital accommodation and creating balanced care packages based on real familiarity with the client group.

The counsellor may need to occupy manifold roles including that as figure of support, tester of reality, sanctioning agent, collaborative problem-solver, educator and so forth. It is important to bear in mind that caregivers are not patients, may have been urged to enter counselling rather than sought it themselves. They are preoccupied not only with their own needs but also with the needs of their ill relative and perhaps with other family members, as well as with the provision of psychiatric services and society's attitude.

The counselling of caregivers of the severely ill entails a particular set of tasks and responsibilities, it is therefore not "low-key" non-specific psychotherapy.

Le Croy & Ashford (1992:14) cite that social workers need more knowledge to identify most likely approaches to produce intended effects.

Support groups have become the latest trend and strength to family caregivers and psychiatric patients. Support groups entails that the members of this group meet regularly and discuss issues related to care giving. However, mentally ill patients might also benefit when they could be part of a homogenous group of patients. Cunningham (1992: 11) stated that support groups are of great importance. Families could receive much support from other people who face the same problem. Support groups meet regularly to share mutual problems. However, mentally ill people also need support from others who understand them. The popularity of support groups is based on increasing evidence that support programmes help family members cope with a loved one's illness.

Dr. Phyllis Solomon, a professor of Social Work and social psychiatry at the University of Pennsylvania, studied 225 family members of persons with serious mental illness. She found that belonging to a support group tends to increase a family member's ability to deal with the illness. The

groups gave family members a sense of community and belonging as well as coping strategies. Her study concluded that mental health professionals should encourage family members to use the support provided by community - based organizations or to form groups if none are available. Furthermore, support groups empower family members and make them better advocates. (Internet: <http://mentalwellness.com/helphope/hopeq2.htm>. 1.12.99).

4.9 Family perceptions on mental illness

Friedman & Goldstein (1994:377) undertook a research study to investigate relatives' perceptions of their interactional behaviour with a schizophrenic family member. The perceptions of 77 relatives were measured through an adjective checklist, and were compared with outside observer's ratings of the relative's affective style and the patient's coping style during a family interaction task.

The results of the study indicated that overall, the relatives in the sample perceived their own interactional behaviour towards the patient, as well as the patient's behaviour towards them, in a way that paralleled their affective behaviour as assessed by outside raters. The relatives rated their relationships with the patient in a fashion that was more predictive of the observed interactional behaviour of both the relatives and the patients than

were the outsider's observer ratings of the relative's expressed emotions measured either at the patient's index hospitalization or during the last discharge.

Barrelet, Ferrero, Giddey, Pellizer & Szigerthy (1999:357-362) studied the expressed emotions of 36 French speaking families in Geneva. Sixty six percent of high expressed emotion households were identified. At a nine-month follow-up, the relapse rate for the high expressed emotion group (33%) was significantly higher than for the low expressed emotion group. The results confirmed the relevance of expressed emotions as a predictor of relapse. In the sample of this study, it appeared that one component of expressed emotions, critical comment, was responsible for the prognostic validity.

Barrowclough & Parle (1997:26-30) studied the appraisal, psychological adjustment and expressed emotions in relatives of schizophrenic patients. It was argued that the coping theory might be useful to understand how relatives adapt to the demands of living with a schizophrenic sufferer. Univariate and multivariate relationships were explored between the appraisal of symptom threat and perceived symptom control, expressed emotions and psychological distress in relatives of schizophrenic patients. The profile of relatives who show sustained distress over time was also investigated.

The results of the study were as follows; appraisal variables were related to concurrent distress, expressed emotions ratings of relatives at the time of the patient's relapse and hospitalization, and when the patient was discharged back home. Relatives who demonstrate sustained distress were likely to show high expressed emotions and had a longer caring relationship. The study concluded that appraisal processes would depend on how relatives react to having a family member with schizophrenia. This has implications to identify those who are at risk of poor adaptation and for understanding strategies that would improve wellbeing.

Bebbing & Kuipers (1994:707-718) did an aggregate analysis to predict the utility of expressed emotions in schizophrenia. Aggregate data from 25 studies that linked expressed emotions and schizophrenia was used, 17 studies provided 1346 cases from around the world. The association of expressed emotion with relapse was overwhelming and was maintained in different geographical locations. Both men and women had the same capacity of expressed emotions. High contact with a high expressed emotion relative increased the risk of a relapse, the opposite was true of low expressed emotion households. Medication and expressed emotions were independently related to relapse.

Dadds, Harrison, Mark & Smith (1998:918-924) undertook a research study in Brisbane, Australia, to investigate the negative comments that

families express towards schizophrenic patients. The objective of the study was to examine the link between negative symptoms, the knowledge of schizophrenia, caregiver's attributions about the cause of symptoms of patients and the response of caregivers to the symptoms. The sample consisted of 84 caregivers of patients who suffer from schizophrenia. Structured interviews were used and measures were designed for the study. The results indicated that 3 variables predicted caregiver's criticism of their ill relatives; a smaller proportion of negative symptoms in the patient's overall symptom patterns, if caregivers have limited information about mental illness and if caregivers ascribe the cause of negative symptoms to the patient's personality than to the illness.

Bishop, Epstein, Keitner, Kohn, Miller & Ryan (1995: 1002-1008) investigated the role of the family in recovery and major depression. The family environment of the depressed patient significantly transforms major depression. The researchers examined changes in the family functioning over a one-year course of major depression in order to explore how family functioning relates to this illness. Subjective and objective assessments of family functioning were accumulated at hospitalization, and 6 to 12 months after discharge for 45 patients who were diagnosed with major depression and their family members. Patterns of family functioning were examined by subjective and objective perspective, initial levels of functioning, and feedback of patients and other family members. The

results indicated that half of the families with a depressed member viewed their family functioning as unhealthy, while professionals rated 70 % of the families as unhealthy. Family functioning had improved from hospitalization until 12 months after discharge, but this did not apply to all families. Patients with good family functioning during hospitalization were found to maintain their healthy functioning and were more likely to recover by 12 months than patients with poor family functioning. The study concluded that there is a clear association between family functioning and recovery from major depression.

Akabawi, Dawla, Okasha, Snyder, Wilson, & Youssef (1994: 1001-1005) did a study to determine the value of families expressed emotion and patient's perceptions of family criticism in predicting relapse in depressed patients in Egypt and to evaluate transcultural differences. The subjects consisted of 32 depressed patients from psychiatric clinics in Cairo and Ismailia, Egypt. The Camberwell Family Interview Schedule was administered to key relatives of depressed patients. A qualified rater performed levels of criticism, hostility, emotional over involvement, warmth and positive remarks. How patients perceived family criticism was also assessed. Patients were followed up after 9 months to assess relapse and medicine compliance. The study found that the relationship between relapse and family criticism was significant. No association was detected between perceived criticism and relapse. The study concluded that

expressed emotions are a factor that should be taken into consideration whenever cultural and interfamilial patterns are assessed. The use of perceived criticism to predict relapses in depression was questioned.

Gasque-Carter & Curlee (1999: 520 - 524) studied the educational needs of families of mentally ill adults in South Carolina, Columbia. The subjects consisted of 80 families who participated in a telephone survey. Families were asked about their information and support needs in 13 areas, where they preferred the location and scheduling of family services should be and what were the barriers that prevented them from taking part in a family programme. According to the results of the study, the respondents identified needs in several areas. More than 75 percent of families identified advocacy in communication with professionals and others as the most frequent need. Twenty nine percent of respondents indicated that they need more contact with the social worker or medical doctor to improve their relationships with their ill relatives. Families were more interested in individualized sessions of family services. Thirty - five percent of families were interested in informal support groups and 29 percent in formal support groups. Families did not had any special preferences with regard to educational and support services, 48 percent indicated the hospital, 46 percent the community, and 48 percent the home. Transport problems and distance were the barriers, which prevented families from taking part in family service. The study concluded that

mental health professionals should continue to involve families, because it will be to the benefit of the patient and the family.

Davis, Goldstein & Nuechterlein (1996: 689-696) investigated the gender differences in family attitudes about schizophrenia. The sample composed of relatives of 110 recent onset schizophrenic patients. The measurement tools that were used were the Camberwell Family Interview, the five-minute Speech Sample Method and a measure of Affective Style. No differences were found by patient's gender, however, males were found to be recipients of more harsh criticism than female patients.

Schene & Wijngaarden (1995: 807-813) conducted a survey at an organization in the Netherlands to families of patients with serious mental illness. Part of the objectives of the survey was to find out about the experiences of families on the course of their relative's illness, to determine what kind of mental health care the patients received and what the opinion of relatives was about this care.

An extended version of the Involvement Evaluation Questionnaire was used to measure the consequences of psychiatric disorders for the relatives of the mentally ill. A random sample of 1000 relatives was selected, and 70 % of them completed the questionnaire. The results of the study show that many respondents were reported to be dissatisfied with the quality of mental health care of their ill relatives. Respondents further reported that

they lack access to treatment professionals and that there was a lack of family involvement in the treatment and planning. Information about mental health was also reported to be limited to relatives. The study concluded that relatives of the mentally ill needed more information and support from mental health professionals. Families in different countries have a lot in common, but the extent of de-institutionalization varied between countries.

Geller, Nicholson & Sweeney (1998: 643-649) conducted a qualitative study to explore the experiences of mothers with mental illnesses regarding their family relationships. Data was gathered through six focus groups of mothers with mental illness and five focus groups of case managers. During the focus groups problems and possible solutions were discussed that are experienced by mothers with mental illness. During the focus group discussions, a range of relationships and attitudes of family members was discussed, as well as ways in which family members contributed positively and negatively to parenting. The study concluded that family involvement in the context of parenting is not entirely positive. Furthermore, mental health professionals should consider the contributions of family members in the context of parenting, in order for mothers with mental illness, to avoid unintentional negative outcomes.

Solomon & Draine (1995: 1156-1160) studied the coping mechanisms among family members of persons with serious mental illness. The sample consisted of 225 family members with a mentally ill relative. Interviews were used as a means of data gathering. The respondents identified the following five factors; the demographic characteristics of the family member, the severity of the relative's illness, the subjective burden and grief of the family members, social support and personal coping resources. The results of the study demonstrated that more adaptive coping was associated with increased social support, when rating the density of the social network, the extent of declaring social support and the participation in social support groups for families. Better coping was associated with a greater sense of the effective dealing with the relative's illness. The study suggested that mental health professionals should encourage family members to utilize support that are provided in support groups or to form such groups if none are available.

Biegel, Milligan & Song (1995: 477-482) conducted a comparative analysis of family caregivers' perceived relationships with mental health professionals. The analysis showed that only a minority of caregivers was dissatisfied with their contacts with mental health professionals. Caregivers ranked more communication with mental health professionals as a great need. The study concluded that partnership between family

caregivers and mental health professionals must be developed and promoted to address caregivers' unmet needs.

Dixon, McNary, & Lehman (1995: 456-458) conducted a study to determine how substance abuse affects family relationships of persons with severe mental illnesses. A comparison was made about how patients perceived their family relationships between 101 mentally ill patients with substance use disorder and 78 subjects with severe mental illness only. The study found that patients with substance use reported lower family satisfaction and expressed greater desire for family therapy. The study concluded that substance abuse is associated with low levels of satisfaction in family relationships among the severely mentally ill. The need of the substance abuser can be met through family intervention.

Cuipers & Stam (2000:375-379) investigated the occurrence of burnout amongst relatives of psychiatric patients who are participants of psycho-educational support groups in the Netherlands. The objective of the study was to examine the relationship between subjective burden and objective burden to caregivers of psychiatric patients. Pre-test data was used from an intervention in which psycho-educational support groups were evaluated. The number of participants was 164 from 19 psycho-educational groups. They completed a Dutch translation of the Maslach Burnout Inventory and the Involvement Evaluation Questionnaire. The study found that burden in

general, as well as emotional exhaustion were aspects of subjective burden that were predicted by objective burden. Two features of objective burden were related to almost all the investigated features of subjective burden. These features are stress on the family relationships with the patient and the ability to cope with the behavior of the patient. Strong evidence was found for the relationship between objective and subjective burden, and the assumption that particular elements of objective burden contribute more to subjective burden than others. The findings suggested that psycho-education should concentrate on assisting relatives to cope with the stress on the relationship with the patient and to improve the abilities of relatives to cope with the patient's behavior.

4.11 Summary

In this chapter, the literature review concentrated on the aspects of family and caregiver support. The characteristics of the family as a social institution was briefly stated, thereafter the impact that mental illness have on the family was discussed. Attention was given to the nature and extent of family and caregiver support and the need for family and caregiver support was outlined.

Attention was also given to the three models of care giving, and to the intervention strategies. Lastly, attention was given to family perceptions on mental illness.

The literature study was followed by an empirical study. The aim of the empirical study was to establish whether information acquired through the literature study is reflected in the reality, and to establish whether the situations is the same in Namibia as in other countries.

CHAPTER 5

RESEARCH METHODOLOGY

5.1 Introduction

This chapter begins with a brief outline of the research design, which is exploratory. This is followed by a discussion of population and sampling, data collection and analysis. In conclusion, the chapter presents the ethical considerations, and discusses the validity and reliability of the study.

5.2 Research Design

In order to achieve the research objectives and answer the research questions, the research design chosen was an exploratory, in-depth study. An exploratory design is employed as the term implies, to explore an unknown field in order to gain new insight into a research problem (Bless & Higson 1995:42). The fact that little research has been undertaken in the field of psychiatry in Namibia justifies the design chosen.

Babbie (1998:36) differentiates between two approaches in social research, the quantitative and qualitative approaches. Both these approaches are useful and legitimate in social research and they are calling for different skills and procedures. Researchers need to match the tools

use with the research questions and conditions face, and may use a qualitative approach for some studies, a qualitative approach in other studies or both approaches combined for still other studies. This study was a combined study, both quantitative and qualitative approaches was pursuit.

5.3 Literature Review

An intensive literature review of existing works was done. Available literature in especially the Southern African region, the entire African continent, as well as globally was emphasized.

5.4 Population and sampling

The study population for the research was caregivers/family members of psychiatric patients in Katutura. The purposive or judgemental sampling method, a subtype of the non-probability sampling technique was employed. This sampling method is based on the judgement of the researcher regarding the characteristics of a representative sample. This method involves selecting units that are believed to be typical of the study population (Bless & Higson 1995: 95).

The Katutura psychiatric hospital is a referral hospital that serves almost the whole Namibian community except for patients in the northwestern

part of the country. The research focussed upon family members or caregivers of psychiatric patients who live in the residential areas of Katutura. The sampling population consisted of families whose relatives were diagnosed as suffering from a mental illness and were attending out patient clinics either at the psychiatric hospital or clinics in the residential area of Katutura.

As part of the activities of the Community Psychiatric Nurses, they visit the various clinics every week to provide follow up treatment to psychiatric patients. The Community Psychiatric Nurses operate on pre-arranged appointments with patients whereby patients receive their follow up medication.

Amongst the population of out patients living in Katutura, forty-five (45) caregivers/ family members of patients made up the research sample and were interviewed by the researcher.

5.5 Methods of data collection

5.5.1 Instruments for data collection

As an instrument for capturing data, the researcher prepared a structured interview schedule consisting of both closed and open- ended questions. The content of the literature study formed a valuable background for the

drafting of the questionnaires. The forty-five (45) family caregivers of psychiatric patients were the main source of information. The interview schedule was prepared in English. However, respondents were able to communicate in either English or Afrikaans. All the interviews that took place in Afrikaans were translated into English.

Another research instrument prepared was the interview guide for the focus group discussions, which was carried out with some family caregivers who did not form part of the same sample of respondents for the individual interviews. The interview guide consisted of open-ended questions only.

In order to make sure that the data collection instruments are clear and understandable, the researcher conducted a pre-test with her supervisor and the necessary adjustments was made.

5.5.2 The Pilot Study

A pilot survey involves the testing of the actual programme on a small sample taken from the community for whom the program is planned and would therefore portray the community's most possible answers to the questions. The pilot study might identify any difficulties with the method or materials and will investigate the accuracy and appropriateness of the research instruments (Bless & Higson – Smith 1995: 50).

According to Bless & Higson-Smith (1995:110), unstructured and semi-structured interviews may be used with the pilot study since this will help the researcher in establishing a list of possible answers or solutions in the constructing of multiple-choice questions. Through the pilot study, questions are reformulated and it allows for the researcher to discover new aspects of the problem by investigating in detail some explanations that are given by the respondents.

A pilot study was carried out with a small sample of family caregivers of five patients who did not form part of the actual sample. The pilot study specifically checked whether all the respondents universally understood the questions and amendments were made. The researcher also tried to establish through the pilot study the average time spent to complete an interview schedule. This was useful since the researcher was able to plan the time needed to spend on an interview. The researcher also discovered that some respondents required more time, especially older caregivers or respondents who just needed someone to talk to.

5.5.3 Documentation Review

The reviewing of existing documents is another method of data gathering. The disadvantage of this method according to Forrester-Jones & Grant (1997:20-21) is that information might sometimes be missing,

contradictory or both. Notes are sometimes written according to the medical practitioners' or nurse's point of view, and not from the patient's point of view.

In order to obtain the names and addresses of the family caregivers of psychiatric patients, the researcher had to consult the hospital files of the patients. In addition to the addresses of patients and families, the researcher searched for more background information on the ill person such as the age, gender, diagnosis and the period of illness of the patient.

5.5.4 Focus group discussions

Focus group discussion is regarded by Babbie (1998:249) as “...an excellent device for generating questionnaire items for a subsequent survey”. Focus group discussions are small group discussions that are guided by a researcher. Participants for the discussions are selected on the relevancy of the topic to be investigated.

Focus group discussions can be useful in circumstances where an area is unknown and needs further exploration, as is the case with this study.

Bless & Higson-Smith (1995:113) states that focus group discussions also enable participants to share thoughts and experiences with one another and to reach some kind of consensus about the topic. It will therefore be

interesting to compare the quality of the data collected through the focus group discussions and the data obtained from the individual interviews.

The participants of the focus group discussions were obtained through the availability sampling method. The most desired place where a collection of family caregivers of psychiatric patients could be found is at the out – patient psychiatric services at the psychiatric hospital. Family caregivers who accompanied their ill relatives to the hospital were approached to participate in the focus group discussions. At the time of the investigation, few family caregivers accompanied their ill relatives to the hospital, as a result only two focus group discussions took place with 5 family caregivers in each group. Thus, a total number of 10 family caregivers took part in the focus group discussions.

The participants for the focus group discussions were from different cultural backgrounds, all of them could communicate in Afrikaans. The discussions therefore took place in Afrikaans and were translated into English.

The researcher explained the purpose of the study, and obtained permission from the participants to take part in the study. Each participant

introduced him/herself and stated what their relationship was to the person with the illness.

Many participants needed help to cope with their life situations while at the same time they were informants to the researcher. The fact that there was no permanently appointed social worker at the psychiatric hospital at the time of the study, made it difficult to refer participants for the necessary services. To a certain degree the researcher had to combine the roles in such a way that it would not jeopardise the research and also not to increase the burdens of the participants.

Observations and findings were recorded everyday in a field note -book and a personal diary.

5.5.5 The Research Interview

The interview is basically verbal questioning. The interview is prepared and also executed in a systematic way. An interview is controlled by the researcher to avoid bias and distortion and is related to a specific research question and a specific purpose (Sarankantos 1993: 177).

The researcher made use of a scheduled structured interview, which was based on structured questionnaires to acquire data from the family

caregivers of psychiatric patients. The interviews were conducted at the homes of the family caregivers. The researcher attempted by all means to interview the primary caregiver of the mentally ill, and would visit some households more than once in order to interview the primary caregiver.

The houses in the Katutura residential areas are very small, in instances where the mentally ill was just in another room, they would be able to hear the conversation. As a result privacy of the interview was not always guaranteed where there will be absolutely nobody to hear the conversation. This might have influenced the respondent's answer, but the researcher had little control over this situation.

Field notes were made immediately after every interview took place on the researcher's observations and personal experiences about each and every interview. The time span for the actual data collection took place over a period of 3 weeks from 7 August 2000 until 26 August 2000.

5.6 Permission for the study

Permission for the study was obtained from the Research Committee at the Ministry of Health and Social Services. Permission was also obtained verbally from the Psychiatrist Dr. Japhet, who was the Head of the Psychiatric Unit.

5.7 Ethical considerations

Informed consent was obtained from the respondents, by the completion of a consent form. Respondents took part voluntarily in the study and were free to withdraw participation in the study. The content of the consent form was explained to respondents who were unable to read and write. In these cases, verbal consent was obtained. All the respondents were assured of anonymity and confidentiality. Permission to conduct the study was obtained by the Research Committee from the Ministry of Health and Social Services.

5.8 Data analysis

The researcher did the analysis of the data manually. Observations and field notes were transcribed. Interviews that took place in Afrikaans were translated into English. The qualitative data was subjected to content analysis and classification, and was interpreted.

5.9. Validity and reliability

Sarankantos describes validity as “.... The ability to produce findings that are in agreement with the theoretical or conceptual values, in other words to produce accurate results and to measure what is supposed to be measured” (Sarankantos 1993: 74-75).

Babbie refers to reliability as “...the likelihood that a given measurement will yield the same description of a given phenomenon if that measurement is repeated” Babbie (1998:136).

Validity and reliability was assured through the conducting of a literature review, which was helpful to develop the instruments for data collection. Preliminary instruments for data collection were submitted to the supervisor of the researcher and the necessary amendments were made. A Social worker and Community psychiatric nurse gave their inputs as well with regard to the changes to the instruments for data collection.

A pilot study was carried out with 5 family caregivers to assess the relevance and comprehension of the instrument, and the necessary adjustments were made as an aid to enhance validity and reliability.

5.10 Summary

This chapter outlined some of the fundamental methodological issues as to how the research was conducted. Attention was paid to the research design, population and sampling, the methods of data collection, some ethical considerations and the validity and reliability of the study.

After gathering the raw data, the researcher analyzed the results. This exercise will be dealt with in the next chapter.

CHAPTER 6 DATA ANALYSIS

6.1 Introduction

The main results following from the data analysis are presented here. A summary on the main points of the results from the focus group discussions will first be presented, thereafter the results obtained from the documentation review will follow. Lastly, the results of the individual interviews will be presented. Descriptive statistics (tables, graphs and charts) will be used to analyze the data from the individual interviews.

6.2 Results from the focus group discussions

Two focus group discussions took place with 5 family caregivers of psychiatric patients, which amounted to a total number of 10 family caregivers.

The focus group discussions took place in the office of the Social Worker at the psychiatric hospital. The participants of the discussion were all accompanying their ill relative to the psychiatric hospital for outpatient follow-up treatment. While they were waiting for services from the multidisciplinary team members, the participants were approached to take part in the discussions. The family caregivers participated and co-operated

out of their own free will. The researcher took notes of the discussions as well as observations.

A summary of the main issues discussed will be highlighted.

6.2.1 Characteristics of the participants

The participants from the focus group discussions are either mothers, children, siblings, spouses and extended family members of psychiatric patients. All the psychiatric patients live with family members, but not necessarily with the participants of the focus group discussions. The majority of the participants indicated that their ill relative is unemployed. Only one of the participants mentioned that their ill relative is employed as a teacher, while another participant indicated that the ill relative do receive a disability pension. This is clear that the majority of participants do not receive a disability pension.

6.2.2 Knowledge base of participants on the causes of mental illness:

Many participants did not know what the cause of mental illness is.

The perceptions that participants had on the causes of mental illness varied according to their experiences as caregivers:

Alcohol and substance abuse was mentioned by many participants as a cause of mental illness.

One participant stated that their ill relative sustained brain injuries after being involved in a fight.

Another participant also perceived malaria as a cause of the mental disorder.

The wife of a mentally ill man stated the following;

“ My husband did not made peace with his past, while he was still young he has seen his mother hanging after she committed suicide, and my husband also has a low self esteem ”

Another participant indicated that a female patient became mentally ill after the birth of her child because she ‘ *het winde gekry*’, a term that is referring to cultural beliefs that a women have to follow certain practices after child birth in order to maintain healthy. Postpartum psychosis is a mental condition, which occurs after childbirth.

The few responses on the causes of mental illness show that family caregivers stated the causes of mental illness as they have experienced and understood it. Participants were however unable to state the exact name of the mental disorder.

6.2.3 Forms of support provided by the family:

Most of the participants provide in the basic needs of their ill relatives, such as food, shelter, clothing and money.

The involvement of the participants in the treatment plan of their ill relatives were as follows; some participants stated that they always accompany their ill relatives to the hospital or clinic for the follow-up treatment. However, from the researcher's observations it was evident that mentally ill patients would attend follow-up hospital or clinic visits without being accompanied by any family member. The researcher also had difficulty to find participants for the focus group discussions due to the fact that few family caregivers were accompanying the mentally ill to the hospital or clinic. The community Psychiatric Nurse, a key informant of this study, stated that family caregivers would only accompany their ill relatives to the hospital or clinic whenever there is a problem at home.

With regard to the medicine intake most of the participants indicated that their ill relatives take their mental treatment themselves.

One participant stated that sometimes their ill relatives have to be reminded to take their medication.

Two participants indicated that they have to force the ill person to take his medication, and that they at times have to place the medication in the drinks and food of the ill person.

Participants responded as follows, with regard to the communication with their mentally ill relatives; most of the participants do not communicate well with the ill person.

Some typical comments from participants were the following;

“The ill person uses swear words towards people”

“ It is sometimes difficult to communicate with the patient because of the illness”

Communication of mentally ill men and their spouses were reported to be the following;

“ The patient would quarrel with his wife and would look for mistakes”

“ The patient would be fighting with his wife, especially when the moon comes up.”

Very few participants reported that they communicate well with their ill relatives. Few participants stated that they would be a companion to their ill relative and made the following comments;

“ We would talk to the sick person, keep him company and ask him how he feels”

“ We will have telephone conversations with the ill person every now and then”

Some of the participants involves their ill relatives in regular family activities while other do not.

The level of mental illness is a determining factor whether participants will spend time with their ill relatives.

One participant had the following comment;

“ When the patient relapses it is difficult to involve him in regular family activities”

A young man who's mother is mentally ill said the following;

“My mother leaves the house early in the morning and returns back home late at night. It is also difficult to communicate with my mother”

Another participant stated that the lack of material resources hinders them to involve the ill person in regular family activities and had the following to say;

“ The ill person does not have shoes anymore because he sold it, we therefore cannot involve the patient in regular family activities”

Another participant stated that their ill relative would become quieter and withdrawn when he becomes ill, and this makes it difficult to involve him in regular family activities.

Some typical comments of participants who do involve their ill relatives in regular family activities were the following;

“We would attend for example church services together with the ill person”

“ We would go together for example to weddings and dances”

6.2.4 Problems experienced with regard to care giving

Most of the family members have financial difficulties. Many of the participants reported that the ill person does not receive a disability pension and that their ill relatives are unable to work. Participants expressed their wishes that their ill relatives should receive a disability pension.

It was also mentioned that some patients does not have the necessary Namibian documents and has difficulty to obtain documents.

One participant who is the son of the mentally ill patient stated the following;

“ It is impossible to wait with my mother in a cue for the application of an identity document, because my mother is not someone that can be kept still

for a long period. I therefore came to the doctors to ask them to write a letter to the Ministry of Home Affairs in order for my mother to obtain these documents.”

With regard to disagreements and conflicts the participants had the following to say; disagreements and conflicts do occur between family caregivers and the mentally ill.

Some of the comments were the following;

“Disagreements and no cooperation occur as a result of the illness”

“We are constantly having disagreements because the ill person is not an easy person to get along with”

“The patient is quarreling a lot with his spouse, and becomes very angry. It is very difficult to stop the patient, I fear that he might even kill his wife”

“We start to quarrel whenever I send the patient somewhere and he refuses to go”

Very few participants do not have disagreements with the mentally ill.

One participant, who is the child of the mentally ill, did not report any negative experiences with regard to living with a mentally ill person and rather made the following comment;

“ I am proud about my mother”

Some participants also reported that their ill relatives were behaving violently while others did not.

A young man who's mother was suffering of mental illness after sustaining brain injuries, had the following to say;

“ My mother is a difficult person to live with”

Another participant explained that aggressive behavior is displayed when the ill person does not want to take his medication and stated as follows;

“ Aggressive behavior is experienced when the ill person has to take the medication, and would fight. We as the family would try to place the medication in the coffee or tea.”

Another participant, who has a spouse that suffers of mental illness had the following to say;

“My husband does not want to listen to anybody at home. When I am trying to talk to him, his behavior becomes worse. The only person to calm down my husband is our daughter”

6.2.5 Impact of care giving:

Participants were psychologically affected as a result of living with a mentally ill.

One participant, a parent living with a mentally ill child said the following;

“ I would feel depressed at times and would walk to some places to cool off”

Another participant, who has a mentally ill husband stated the following;

“I considered to separate from my husband, but was stopped by my children”

Mental illness brings about a lot of changes, not only within the mentally ill individual but within the entire family. When participants were asked about any changes in the family roles as a result of taking care of the mentally ill relatives, many participants confirmed about changes in family roles.

One participant who is the wife of the mentally ill stated the following;

“I had to take over the responsibilities of my husband, and in the end fulfill double roles”

Another participant, who was also a wife of a mentally ill patient and who lives in the Windhoek district had the following to say;

“ My husband was supposed to look after the cattle, but due to his illness, I have to do it”

It is evident that the spouses of mentally ill patients fulfill double roles.

In the case where the participant was the child of the mentally ill patient, it was mentioned that even being an adult man, caring for a mentally ill mother is very difficult.

In order to determine participant's perceptions on their family functioning as a result of the mentally ill relative, they stated the following; most of the participants felt that their family is different from other families who does not live with a mentally ill.

“ Life is different having a mentally ill relative”

Another participant, who's mother is mentally ill expressed their situation as follows;

“ My mother does not even uses alcohol, but she has this difficult personality because of the mental illness”

The spouse of a mentally ill person, who was also a participant, stated the following;

“ My husband is the only one in his family who did not achieve much in life, because of his illness while the rest of his family is successful in life”

A mother with a mentally ill son added;

“ When comparing my child with other children, he started using drugs while he was in grade 10 and became mentally ill. His life would have been different if he did not become mentally ill”

Another participant, who is the son of a mentally ill patient, said that their mother has been mentally stable for years. She is visiting the hospital regularly for her follow up treatment, but no one would ever notice that she is suffering of a mental illness. In that case the participant could not perceive their family as being different from other families.

The researcher wanted to establish whether there are any positive experiences in care giving to a mentally ill person. Most of the participants only recall negative experiences, which occur as a result of lack of

communication and no understanding between the patient and the family, as well as the fights between the family and the ill person.

The only participant who did recall positive experiences was the wife of a mentally ill patient. She said the following;

“ At times my husband is in a very happy mood, he can cook very well and will make breakfast for the family on Saturdays ”

6.2.6 Needs of family caregivers

Participants were asked about their needs as family caregivers. Some participants requested that their ill relative be provided with basic needs such as employment and food.

One participant who is a child of a stable mentally ill patient stated that stated that they do not need help from no one because their mother is healthy and alright.

Participants stated that there are not many resources available outside the family structure. However, the resources that were listed as helpful were the neighbours, the social worker, the employer and the psychiatric hospital. Participants were especially satisfied with the mental health professionals and express their appreciation for their work at the end of the discussion.

It was the first time for most of the participants to meet with other family caregivers who lives with a mentally ill patient. Participants were asked whether they are interested to meet again in such groups. The majority of the participants indicated that they would want to meet with such groups and had the following to say;

“ I would like to be involved in such groups’

“ You can learn something, and will see that you are not alone”

“ This is Nation Building”

The few participants who stated that they are not interested in meeting other family caregivers with mentally ill patients said the following;

“My family is no longer mentally ill, therefor I do not need to attend such meetings”

“ I am not interested”

6.2.7 Conclusion on the focus group discussion.

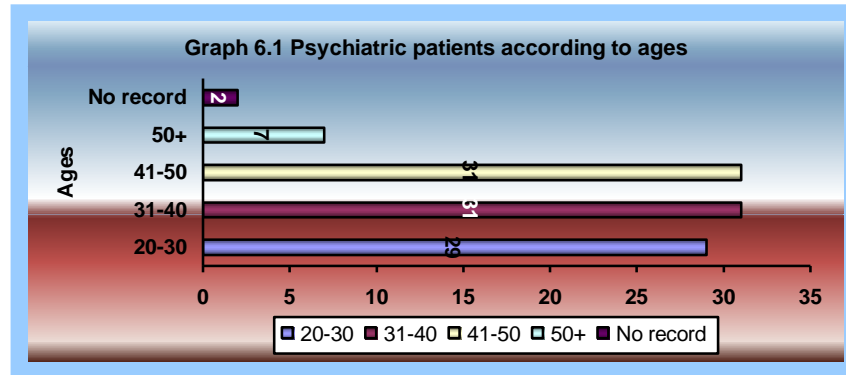
It can be concluded that many family caregivers does not have the necessary knowledge on mental illness. Many family caregivers are also not involved in the treatment plan of the mentally ill, patients are attending follow-up visits alone and are also not assisted with the daily medicine intake.

The most serious problems encountered by family caregivers are financial difficulties, poor communication and violent behaviour. Of course the latter two aspects depends on the degree of the mental illness.

6.3 Results from the documentation review

The population of the research consisted of family caregivers of psychiatric patients. The sampling for the family caregivers was drawn after the researcher obtained access from the hospital files of patients at the psychiatric hospital. All the respondents were family caregivers of the very same patients from whom hospital records were studied. The names and addresses of the family caregivers were obtained as well as some background information on the characteristics of the psychiatric patients.

The classification of different age groups of the psychiatric patients was recorded from the psychiatric hospital record and is presented in the following graph:

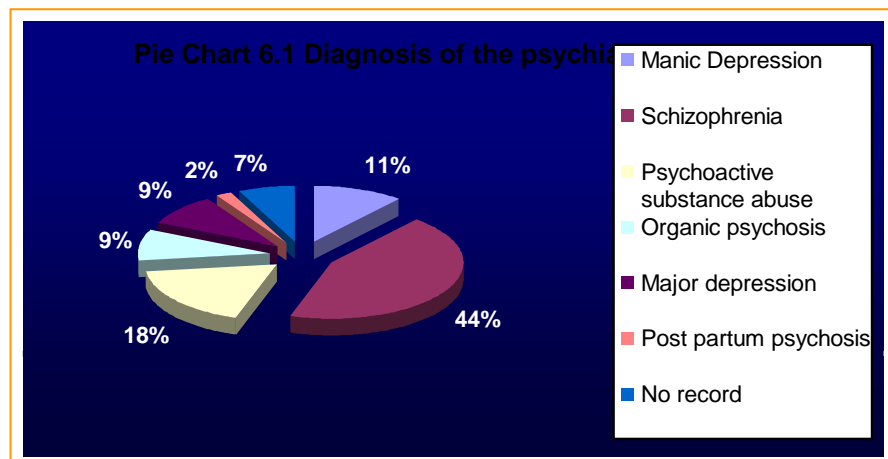
Graph 6.1 Psychiatric patient according to ages

Graph 6.1 displays the age groups of the psychiatric patients. Out of a total number of 45 (100%) patients, an equal number of psychiatric patients to the amount of 31 % (14) were found in the age groups 31 - 40 years and 41- 50 years. Between the age group of 20 to 30 years, 29 % (13) patients were found. Patients above the age of 50 years were 7 % (3). It is evident from the results that the majority of the psychiatric patients in this study were in their early or middle adult life. These results agree with (Carlson & Arnolds 1996:706) who stated that the course of some mental illnesses starts during adolescence or early adulthood.

Table 6.1 Psychiatric patients according to gender

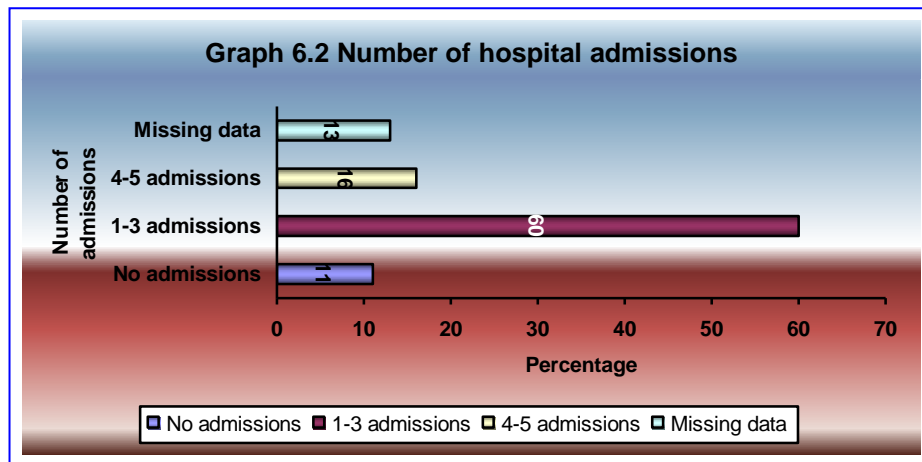
Gender	Number	Percentage
Male	20	44
Female	25	56
TOTAL	45	100

Table 6.1 summarizes the gender of the psychiatric patients. There were almost an equal percentage of male psychiatric patients 44 % (20) in comparison to female 56 % (25).

Pie Chart 6.1 Diagnosis of the psychiatric patients

Pie Chart 6.1 presents the data for the diagnosis of psychiatric patients, which was obtained from the hospital files. Out of a total number of 45 (100%) patients, almost half of the patients 44 % (20) were diagnosed with schizophrenia, while 18 % (8) were diagnosed with psychoactive substance abuse. Patients were also diagnosed with manic-depressive disorder 11% (5), major depression 9 % (4), organic psychosis 11% (4) and post partum psychosis 2 % (1). The results suggest that schizophrenia is one of the most common psychiatric illnesses that were found, it is also regarded as one of the most crippling mental illnesses. The study further suggests that substance abuse is a major cause for mental illnesses.

Graph 6.2 Number of hospital admissions

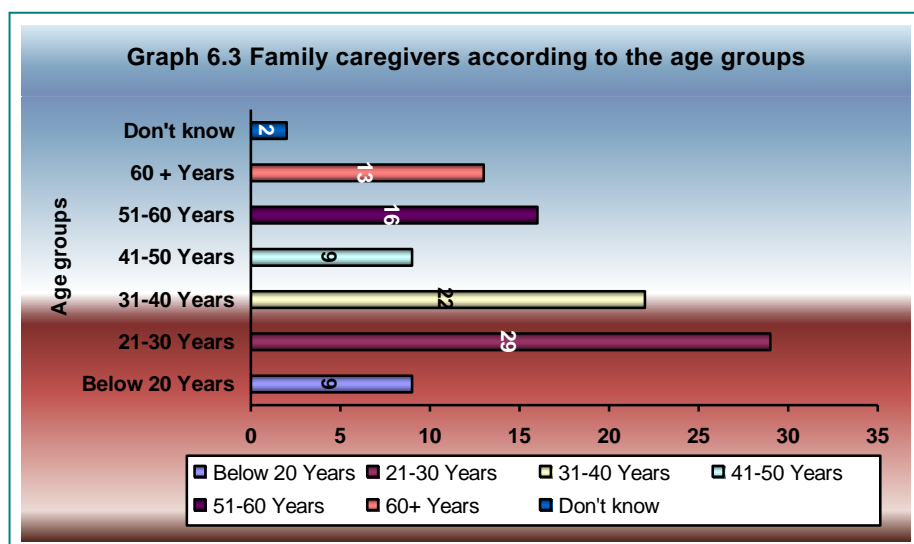


Results on the number of hospitalizations are presented in table 6.2. The data was obtained from the individual hospital file records of psychiatric patients and illustrates the number of admissions that was documented for the past 5 years. The table indicates that the majority of the patients 60 % (27) had been admitted between 1 to 3 times, while 16 % (7) psychiatric patients had been admitted between 4 to 5 times. These figures are very high and seem that psychiatric patients are relapsing often.

6.4 Results from the individual interviews

The sample population and other aspects are already explained in chapter five. A sample of 45 family caregivers of the identified psychiatric patients was extracted, and interviews were conducted. The researcher attempted by all means to interview the primary family caregivers. The data pertaining to the characteristics of the caregivers is presented.

Graph 6.3. Family caregivers according to the age groups



Graph 6.3 summarizes the age groups of the family caregivers. Out of a total number of 45 (100%), the age group 21-30 represented 29 % (13) the highest percentage of family caregivers. There were 22 % (10) of the respondents in the age group 31- 40 years, and 16 % (7) respondents in the age group between 51 to 60 years. Respondents below the age of 20 years were 9 % (4), while respondents above the age of 60 years were 13 % (6). These results suggest that people in different age groups are family caregivers of psychiatric patients.

Table 6.2 Family caregivers classified according to sex

Gender	Number	Percentage
Male	16	36
Female	29	64
TOTAL	45	100

The results of the gender of family caregivers are presented in table 6.2. Out of a total number of 45 (100%) family caregivers, the majority 64 % (29) was female, while only 36% (16) respondents were male. This result is consistent with the report from the *Basic Behavioural Science Research for Mental Health* (1996: 629), which stated that in many cultures women

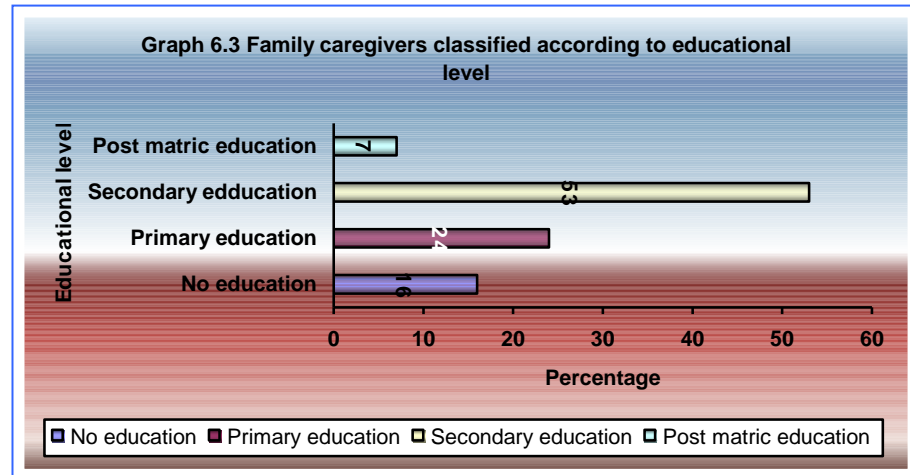
share the biggest responsibility with the provision of social support and might feel more personally responsible to provide support.

Table 6.3 Caregivers classified according to marital status

Marital status	Number	Percentage
Single	27	60
Married	14	31
Widowed	4	9
TOTAL	45	100

Table 6.3 summarizes the marital status of the family caregivers. Out of a total number of 45(100%) family caregivers, 60 % (27) were single, while only 31% (14) were married. This finding is consistent with previous findings on the Namibian society that suggest that single parent families characterize the society. This situation is caused in the Namibia as a result of modernization and industrialization.

Graph 6.4 Family caregivers classified according to educational level



Results of the educational level of family caregivers are presented in Graph 6.4. The results illustrated that out of a total number of 45 (100%) family caregivers, the majority of respondents 53 % (24) have reached secondary education level while 24 % (11) went to school up to primary level only. Respondents who did not have any formal education at all, were 16 % (7) while 7 % (3) only reached tertiary education. It is worth mentioning that one respondent with a mentally ill mother was forced to drop out from school because there was no money to pay school fees. These results shed some light on the educational levels of the family caregivers and may suggest that quite a significant number of family caregivers are illiterate.

Table 6.4 Employment status of the family care givers

Employment status	Number	Percentage
Employed	16	36
Unemployed	29	64
TOTAL	45	100

Table 6.4 summarizes the employment status of the family caregivers. The results indicate that out of a total number of 45 (100%) family caregivers, the majority of the family caregivers 64 % (29) were unemployed, while only 36 % (16) were employed. These results may be explained by the fact that there is a very high unemployment rate in Namibia (*Draft Social Welfare Policy*1997: 1).

Table 6.5 **Number of years family caregivers were unemployed**

Years unemployed	Number	Percentage
Less than 1 year	1	2
1 to5 years	22	49
5 to 10 years	4	9
More than 20 years	2	4
No response	16	36
TOTAL	45	100

Table 6.5 summarizes the number of years that family caregivers were unemployed. The table indicates that almost the majority of the family caregivers 49 % (22) were unemployed for a period of between 1-5 years.

Table 6.6 **Reasons why family caregivers are unemployed**

Reasons	Number	Percentage
Cannot find employment	19	42
Burden due to care taking	5	11
Poor health	5	11
No response	16	36
TOTAL	45	100

Table 6.6 summarizes the reasons why family caregivers are unemployed. More than one third of the family caregivers 42 % (19) were unemployed because they could not find employment, while 11 % (5) were unemployed due to the burden of care taking of the ill relative. Family caregivers who lost their jobs due to poor health conditions were 11 % (5).

Table 6. 7 Total monthly income of households

Total income	Number	Percentage
No income	6	13
Less than 500.00	14	31
1000.00 - 3000.00	15	33
More than 3000.00	5	11
Don't know	5	11
Total	45	100

The total monthly income of the households is summarized in Table 6.7. The table indicates that one third of the respondents 33 % (15) received a monthly income of between N\$1 000.00 to N \$ 3 000.00. A significant number of respondents 31 % (14) received a monthly income of less than N \$ 500.00, while 13 % (6) received no income at all. These results

suggest that the majority of the family care-givers live in extreme poverty.

The majority of the respondents regarded their income as adequate. Many respondents however complained of too high municipality bills for water and electricity. The water and electricity supply has been completely cut off at the house of one respondent because the family was very much in arrears with the payment of the bills. To get an additional income, some families did also rent out rooms inside their houses.

Table 6.8 Employment status of the mentally ill

Employment status	Number	Percentage
Employed	2	4
Unemployed	43	96
TOTAL	45	100

The employment status of the mentally ill relative has been mentioned as an important factor in the care taking of the ill person. The family caregivers were therefore asked what the employment status of their ill relative was. Results on the employment status of the ill person are presented in Table 6.8. The results illustrate that an overwhelming majority 96 % (43) of the mentally ill were unemployed, while only 4 %

(2) of the psychiatric patients were employed. The occupations of these employed mentally ill patients were identified as Welder and Cleaner respectively. The result from this study is consistent with Matlala (1995:25) who found that 63 % of schizophrenic out patients from the Baragwanath hospital in South Africa were unemployed. Soukop (1995:149-150) explains that the mentally ill patients are incapable of keeping a job and cannot find employment due to stigmatization.

Table 6.9 Major source of income for the ill person

Source of income	Number	Percentage
Disability pension	24	53
Partner of patient	3	7
Support from family	16	36
No response	2	4
TOTAL	45	100

Table 6.9 summarizes the major source of income of the mentally ill person. Half of the patients 53 % (24) received a disability pension, while 36 % (16) were mainly supported by their families. There was 7 % (3) who relied on the income from their partners; these partners were the husband, boyfriend or girlfriend.

In addition, some family caregivers commended that the pension applications for their ill relatives were unsuccessful while other family caregivers stated that their ill relatives receive a disability pension but that the pension money is not enough. The misuse of the disability pension by some patients was mentioned.

It is important to note that the Namibian Government allocates a disability pension to the equal amount of the old age pension. Disability pensions are however allocated to a psychiatric ill person depending on the level and degree of the mental illness. This means that not all people diagnosed with mental illness could be entitled to a disability pension.

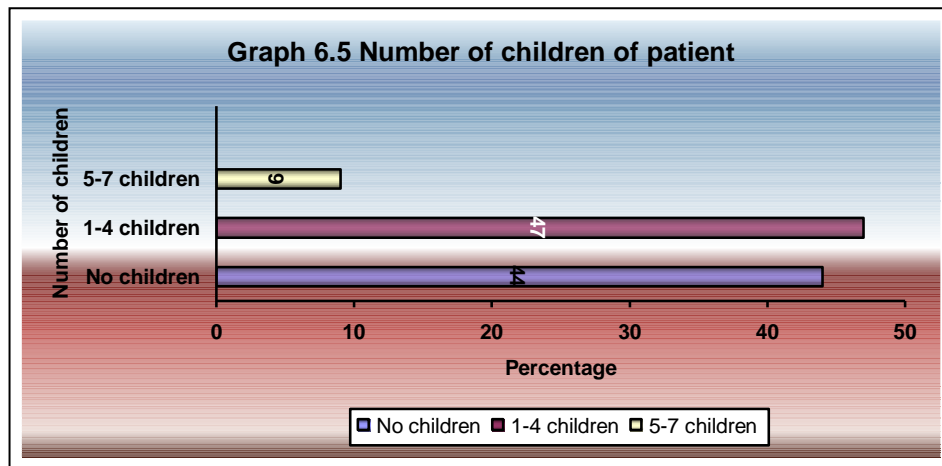
Table 6.10 Forms of family structure

Family structure	Number	Percentage
Nuclear	3	7
Extended	36	80
Single parent family	6	13
TOTAL	45	100

Table 6.10 summarizes the type of households of family caregivers. An overwhelming majority of the respondents 80 % (36) were from extended family households, while 7 % (3) were from nuclear family structures.

Respondents from single parent families were 13 % (6). These results may be justified by the fact that extended forms of families are still dominant in Namibia.

Graph 6.5 Number of children of patient



The respondents were asked what the number of the children of the mentally ill relative was, and the responses are summarized in Graph 6.5. The results illustrated that almost half of the patients 47 % (21) had between 1 to 4 children, while 9 % (4) patients were reported to have between 5 to 7 children. The mentally ill patients without any children were 44 % (20).

It is important to find out who takes care of the children of the mentally ill. The researcher asked the respondents who the caretakers of the children of

the mentally ill were. The answers to this question are illustrated in the following table:

Table 6.11 Care taking of the children of the mentally ill

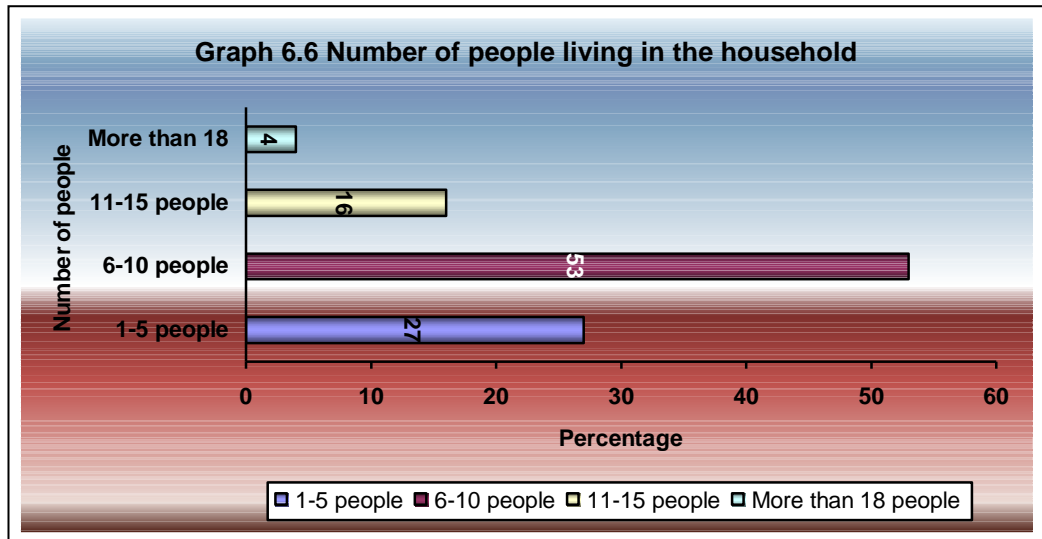
Care taking	Number	Percentage
No response	20	44
Patient self	11	24
Family	7	16
Mother of children	6	13
SOS Children's Home	1	2
TOTAL	45	100

The results of the caretakers of the children of the mentally ill are presented in Table 6.11. The table indicates that 24 % (11) of the mentally ill patients were taking care of their children themselves, while 16 % (7) responded that the family was taking care of the children of their ill relative. In cases of mentally ill fathers, 13 % (6) mothers had been taken care of their children themselves. These results suggest that the children of the mentally ill patient usually remain in the care of their parents. In most of the cases where children were the respondents, these children stated that they were treated badly by other family members and prefer to be cared for by the ill person.

Table 6.12 Ownership of property

Ownership	Number	Percentage
Own house	42	93
Rented house	2	4
Shack	1	2
TOTAL	45	99

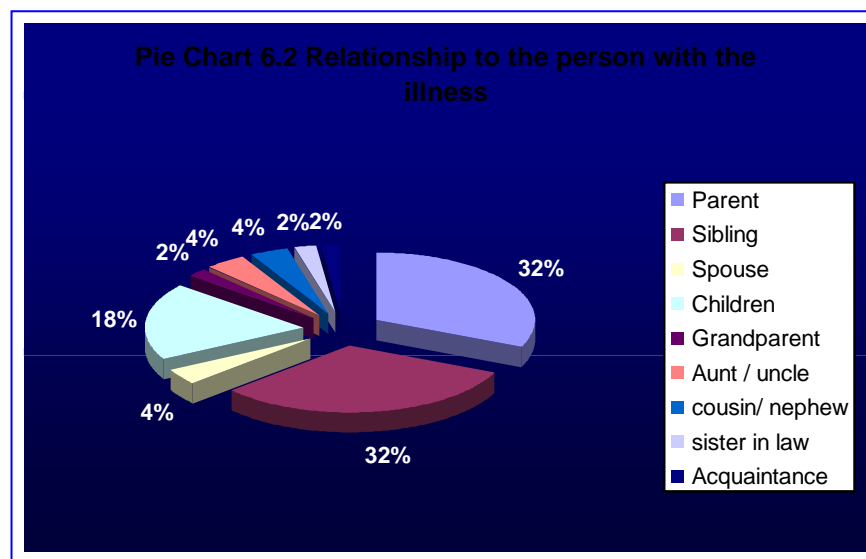
Table 6.12 summarizes the question whether the respondents are owners of their houses. The table indicates that an overwhelming majority of respondents 93 % (42) are the owners of their houses.

Graph 6.6 Number of people living in the household

Respondents were asked what the total number of people was that lived in their households. Results on the total number of people living in a

household is presented in Graph 6.6. The results indicated that more than half of the respondents 53 % (24) lived with between six to ten people in the house, while 27 % (12) of he respondents lived with between one to five people. A significant number of respondents, 4 % (2) lived in extreme overcrowded circumstances of more than 18 people in their households. These results may suggest that respondents are from big families and may live in overcrowded circumstances.

Pie Chart 6.2 Relationship to the person with the illness



Pie Chart 6. 2 summarize the results on the relationship of the respondents to the mentally ill person. The figure illustrates that 32 % (14) respondents were parents and 32 % (14) were siblings of the mentally ill person. Almost a fifth of the respondents 18 % (8) were children of the mentally

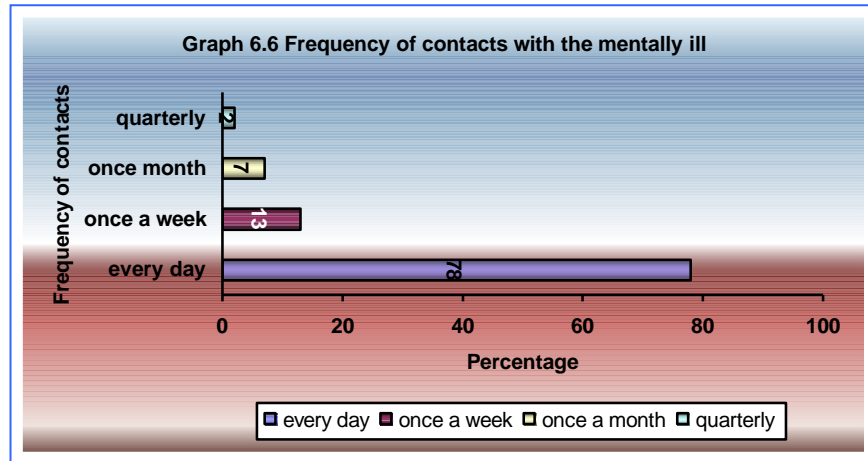
ill patients. The relationship of the rest of the respondents to the ill person was as follows; spouse 4 % (2), aunt / uncle 4 % (2), cousin /nephew 4 % (2) and 2 % (1). There was one respondent who was an acquaintance to the ill person had been living with the patient for many years and could provide valuable information on care-giving. In some Namibia families, people are referring to nieces and nephews as brothers and sisters.

Table 6.13 Whether the mentally ill live with respondent

Response	Number	Percentage
Yes	35	78
No	10	22
TOTAL	45	100

The family caregivers were asked whether their ill relatives live with them. The results to this question are presented in Table 6.13. The results illustrate that out of a total number of 45 (100%), an overwhelming majority of respondents 78 % (35) lived with their mentally ill relatives, while only 22 % (10) did not live with their ill relative.

Graph 6.7 **Frequency of contacts with the mentally ill**



Graph 6.7 summarizes the results on the contact that family caregivers have with their mentally ill relatives. The results illustrated that out of 45 (100 %), 78 % (35) of the family caregivers had contact with the mentally ill relative every day, whereas 13 % (6) family caregivers had contact with their ill relative once a week. A significant number of respondents maintained irregular contact with their ill relative, one stated that their ill relative is presently in prison for the past year after being involved in a criminal offence. The other respondent stated that they are not living in the same town as the ill person.

Table 6.14 Where family caregivers get help

Response	Number	Percentage
Hospital / clinic	36	80
Police	4	9
Church	1	2
No help	4	9
TOTAL	45	100

Respondents were asked where they usually get help with regard to their mentally ill relative, and the results are presented in Table 6.14. The results illustrate that out of a total number of 45 (100%) respondents, an overwhelming majority of 80 % (36) received help from the hospital, while 9 % (4) indicated that they did not received any help.

Many respondents indicated that they were grateful with the help from the hospital, while others were not that satisfied. These results are consistent with those of Benson et al (1995:125) who found that caregivers expressed dissatisfaction with the help offered by mental health professionals. The reason for their dissatisfaction was that the hospital staff does not want to admit their ill relative in the hospital, and that patients are admitted for not long enough periods.

On the issue of the police, family caregivers usually contacted the police when the patient becomes difficult to control. Some family caregivers do not like to call the police for help when the patient becomes difficult because whenever a police van is parked in front of a house, it attracts a lot of spectators.

Few respondents do not need help because their relative does not look or behave like someone that is sick. Here, it is clear that it depends on the degree and the specific diagnosis of mental illness whether the respondents would ask for help.

Table 6. 15 Hospitalization

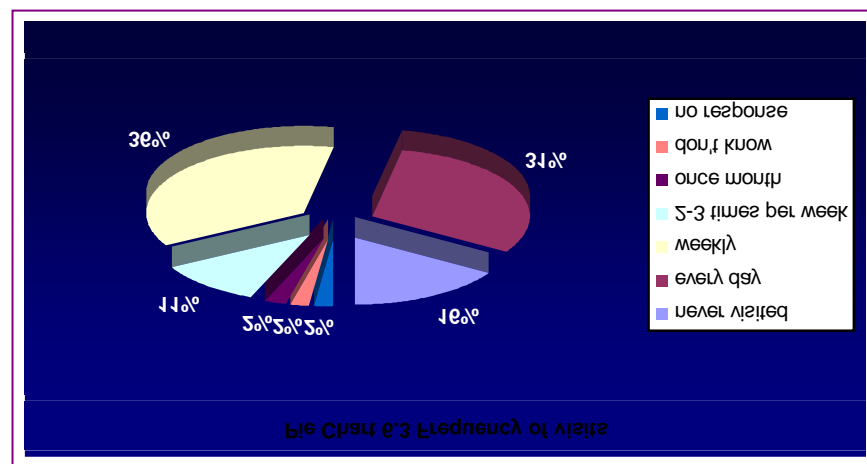
Response	Number	Percentage
Yes	40	89
No	5	11
TOTAL	45	100

Almost all the patients were out patients who live in the community with their families. The family caregivers were asked whether their ill relatives were ever hospitalized. Table 6.15 summarizes the results on the

hospitalization of psychiatric patients. The data illustrate that out of a total number of 45 (100 %) respondents, an overwhelming majority of 89 % (40) has been hospitalized before, while 11 % (5) respondents has never been hospitalized. At the time of the study, three mentally ill patients were admitted in the hospital.

Some families disliked it whenever their mentally ill relatives are admitted in the hospital. Other families feel relieved whenever the ill person is admitted in the hospital because of the difficult behaviour of the ill person. There were a number of complaints from family caregivers that patients are absconding from the hospital, while they are not completely healed.

Pie Chart 6.3 Frequency of visits to the hospital



The respondents were asked how often they could visit their ill relative in the hospital. Pie chart 6.3 summarizes the results on how often family caregivers can visit their mentally ill relatives in the hospital. The figure indicated that out of a total of 45 (100%) respondents, 36 % (16) could only visit their ill relative once a week, while 31 % (14) family caregivers could visit their ill relative every day. Eleven percent (5) respondents indicated that they visited their ill relative 2 to 3 times a week, whereas 16 % (7) family caregivers never visited their ill relatives in the hospital.

Respondents have provided various reasons why they could not visit their ill relative regularly in the hospital. Some family caregivers claimed that the ill relative would want to go home, and were advised by the mental health professionals not to visit the patient every day. Other family caregivers had no time to visit their ill relative because they were all employed. Respondents also claimed that they do not have transport to visit their ill relative, and that they were physically ill. It is a fact that the psychiatric hospital is somehow isolated from public roads and people have to walk distances especially if they make use of public transport.

The family caregivers who visited their ill relatives in the hospital regularly also brought along food to the ill relative, were a companion to

the ill person, and could even request that the patient be released from the hospital to go home during some weekends.

Table 6.16 Contact with traditional or spiritual healers

Response	Number	Percentage
Yes	13	29
No	31	69
Don't know	1	2
Total	45	100

Total 6.16 summarizes the results on the question whether the family caregivers contacted traditional or spiritual healers for the illness of their relative. The table illustrates that out of a total number of 45 (100%) respondents, the majority 69 % (31) mentally ill patients did not have contact with traditional or spiritual healers, while a significant number of 29 % (13) were in contact with spiritual or traditional healers. This is consistent with earlier findings suggesting that African families often contact traditional or spiritual leaders.

Family caregivers regarded the Universal Church and the Oruano Church as examples of spiritual healers. Herbal treatment, communicating with ancestors and visiting the " Holy Fire" were some aspects of the traditional

treatment. The "Holy Fire" is a traditional belief practiced by Herero speaking Namibians. The results are consistent with the Programme Policy Document on Psychiatry from the Ministry of Health and Social Services, 1999, which stipulated that many people with mental health problems avail themselves to the services of the traditional healers and religious forms of treatment.

Table 6.17 Whether traditional healer was helpful

Response	Number	Percentage
Yes	5	11
No	11	24
No response	29	64
TOTAL	45	100

The respondents who had contact with traditional or spiritual treatment were asked whether the treatment was helpful. Results are presented in Table 6.17. Among the 45 (100 %) family caregivers in the entire study, 11 % (5) respondents stated that traditional treatment was helpful, while 24 % (11) stated that traditional treatment was not helpful.

The respondents who usually sought spiritual help claimed that they were born again Christians who worked with God. Some patients however

refused to go to the Universal Church or patients did not know how to pray. Mention was made of a woman who heals through prayers without asking any kind of payment.

Herbal treatment was reported to improve the poor communication of the patient.

The majority of the respondents indicated that traditional treatment was not helpful. Traditional healers were reported to charge too much money. Traditional treatment was also perceived as worsening the mental condition of the patient and making the patient more confused. Some patients refused to be taken to the traditional healers and families could not take them to traditional healers against their will.

Some family caregivers were scolded in the streets by mentally ill patients about the visits to traditional healers.

Table 6.18 Whether patients should be locked up in hospital

Response	Number	Percentage
Agree	1	2
Disagree	44	98
TOTAL	45	100

Table 6.18 summarizes the results on the statement whether mentally ill patients should be locked up in psychiatric hospitals. Respondents were provided with a statement and had to agree or disagree with this statement. The results illustrate that out of a total number of 45 (100%) of respondents, an overwhelming majority 98 % (44) of the family caregivers disagrees that the mentally ill patient be kept in the hospital.

Many respondents commended that family members prefer to take care of their ill relative. Family caregivers further mentioned that they would feel bad if their ill relatives were kept in the hospital for long periods while other family caregivers commended that patients should be discharged when healthy. Respondents also believed that they would be able to give more attention to the patient when the ill person is at home.

Respondents were also concerned that the ill person might copy negative behaviour from other patients if hospitalized.

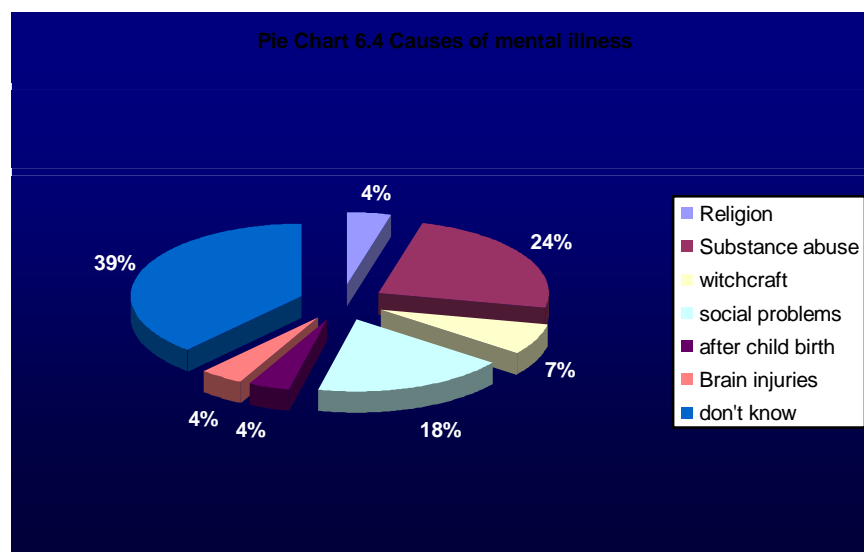
Other family caregivers commended that their ill relatives did not need to be admitted in the hospital because they were stable.

One patient is declared a State President patient after being involved in a criminal offence. The patient is at present in the Windhoek Central Prison

with other State President patients because the psychiatric hospital does not have the necessary resources. The family is dissatisfied and would prefer the patient to be kept in hospital rather than in prison.

On the other hand, there were families who supported the statement that patients are locked up in the hospital because they will be better able to cope with negative thoughts. Families who experienced that it is intolerable to stay with the ill person were also of the opinion that patients are kept in the hospital. These results are consistent with Ngubane (1991:33) who confirmed that families feel relieved when their ill relatives are admitted in the hospital because they are experiencing tremendous stress and difficulties prior to admission.

Pie Chart 6.4 Opinion on the causes of mental illness



Pie chart 6.4 summarizes the results on the knowledge of caregivers with regard to the causes of mental illness. The family caregivers were asked what they thought the causes of mental illness were. The results illustrated that 38 % (17) of the respondents did not know what the causes of the illness of their ill relatives was, while 24 % (11) said that the mental illness of their ill relative was caused by substance abuse. Believing too much in religion was mentioned by 4 % (2) of the respondents as a cause of their relative's illness; 7 % (3) of the respondents claimed that witchcraft was the cause of the mental illness. Brain injuries were also identified as a cause of mental illness by 4 % (2) respondents. These results suggest that family caregivers do not have sufficient information on the causes of mental illness.

The family caregivers explained the religious effect that these patients only wanted to read the Bible every day, went to church services, and would be fasting for too long periods. The results confirm the statement made in the Programme Policy Document on Psychiatry (1999:7) which stated that some people believe that mental illness is caused by acts omitted or sins committed and to supernatural forces like spirits from the ancestors, witchcraft, misfortunes and other familial factors.

On the issue of the witchcraft, the family caregivers explained that the patient was an intelligent boy. When the patient was still in Grade 12 other learners became jealous about the fact that the patient was intelligent in class and bewitched him. Another family member described another

incident of witchcraft when the patient picked up one piece of women underwear during the night while on the farm in the bushes.

Many psychiatric patients have a lot of worries about their children and partners. This causes them to become mentally ill.

Table 6.19 Opinion on the treatment of psychiatric patients

Response	Number	Percentage
Yes, it is treatable	34	76
No, is it not treatable	2	4
Mental treatment is harmful	2	4
Patient without treatment and well	1	2
Treatment does not bring improvements	4	9
Don't know	2	4
Total	45	100

An open question was posed to family caregivers about their opinion on the treatment of mental illness, the results on this question are summarized in Table 6.19. The results illustrate that the majority of the family caregivers 76 % (34) are of the opinion that mental illness can be treated.

There were 4 % (2) family caregivers that saw no improvement even when their ill relative was on treatment, while 4 % (2) of the family caregivers responded that treatment was harmful. These results imply that family caregivers may have a negative attitude towards psychiatric treatment. This may be a great concern for the mental health professionals, because the treatment plan of the patients will be negatively affected.

A few respondents did not have a positive attitude with regard to treatment. One respondent claimed that psychiatric treatment is a drug, which the patient might become addicted to. Another respondent mentioned that the ill person would only take the treatment for 2 to 3 months and would stop the treatment completely.

Some respondents mentioned the fact that the ill person was taking the treatment, but no improvement was taking place, while another patient might stay without treatment but would be mentally stable.

Other families reported that they could observe the difference of patients becoming mentally ill whenever the treatment was stopped.

Respondents mentioned the alcohol abuse of some psychiatric patients, which worsened the condition.

Two family caregivers were dissatisfied with the premature discharge of patients who were not yet mentally stable. These results are consistent with results from Schmukler (1996:449) who found that many families were dissatisfied with treatment and mental health services. Families were not involved in planning, while it is expected from them to provide care. Matlala (1995:26) also found that a high a high number of psychiatric patients are discharged while not well enough to integrate into the community.

Table 6.20 Things family do to help patient

Responses	Number	Percentage
Provide accommodation	30	67
Provide in material needs	31	69
Attend to tangible support	24	53
Companion	12	27
Give information & advice	2	4
Spiritual (prayers)	1	2
Nothing	4	9
TOTAL	104	251

Family caregivers were asked what sorts of things they do in order to help the ill person. They could mention as many things that they were doing towards the ill person. A summary of the results is presented in Table 6.20. The respondents indicated that 67 % (30)) provided a place to stay for their ill relative. The number of respondents who attended to the material needs of the patient was 69 % (31). The material needs that families attended to were providing of food and clothing and to give money to the ill person. One family caregiver who owned his own company provided employment to the ill person.

Respondents who provided tangible support to the mentally ill person were 53 % (24). Tangible support involved cooking, washing of clothes, collecting of medicine for the ill person, and reminding the ill person to take a bath. Some of the patients would be running around, might undress themselves or not dress up properly. Respondents mentioned that they are involved in catching the patient and to dress the patient properly. In difficult cases, respondents usually accompany the patient to the hospital. Some family caregivers expected from their ill relatives to do small households chores or to do their own washing, just to be busy.

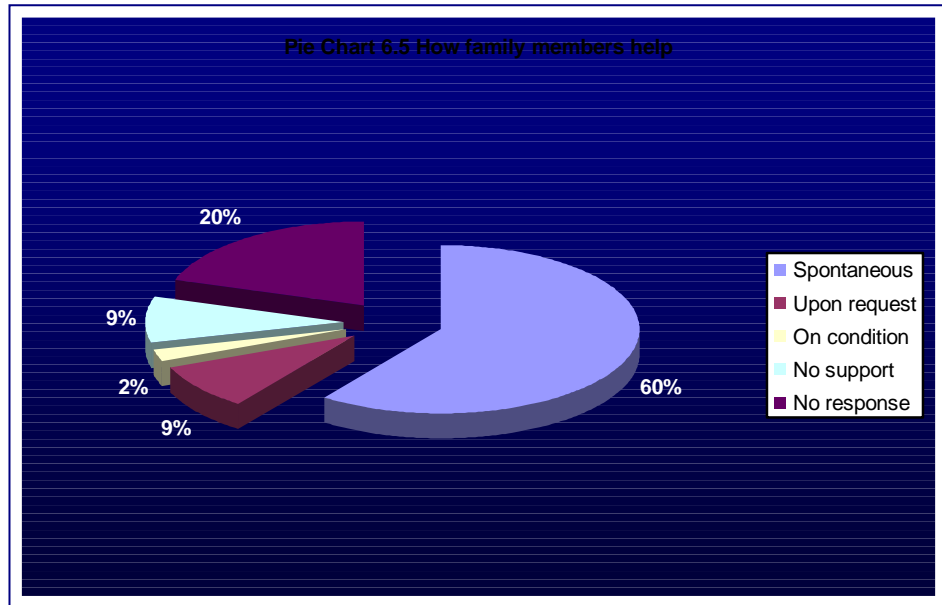
A significant number of respondents stated that they did not do anything to help their ill relative. Some argued that the patient did not need help, while others argued that they did not know how to help their ill family.

Respondents did not mention any emotional support that they provided to the ill person. This is consistent with a similar study, which was conducted in South Africa by Masilela & Mcleod (1998:11) that found that emotional and advisory support was non-existent because caregivers lacked information on the ill person's condition.

Table 6.21 Whether other family members are helping too

Response	Number	Percentage
Yes	30	67
No	13	29
No response	2	4
TOTAL	45	100

Family caregivers were asked whether other family members helped them with the care taking of their ill relative too. The results are presented in Table 6.21. The results illustrate that 67 % (30) of the respondents received help from other family members, while 29 % (13) did not receive any help at all. The 4 % (2) respondents who did not respond stated their ill relative could take care of themselves. These results are consistent with Ndlovu (1991:1) who found that family caregivers needed assistance from their own networks.

Pie chart 6.5 How family members help

Respondents were asked how other family members help with the care taking of the ill relative. The results of the data are presented in Pie chart 6.5. The results illustrate that 60 % (27) respondents were helped spontaneously by other family members, while 9 % (4) received help only upon request. One (2 %) was only offered on conditions of receiving something back.

Table 6.22 Changes in the family in terms of what each one does

Response	Number	Percentage
Yes	15	33
No	30	67
Total	45	100

Table 6.22 summarizes the results on the role changes in the family as a result of care taking of the mentally ill relative. The results illustrate that there were changes with one third of families 33 % (15) in terms of what each one does, while 67 % (30) respondents indicated that there were no changes.

On the question as to what the changes are; some respondents reported that they had been absent from work often because of accompanying the patient to the hospital and others respondents were forced to stop working completely.

Other respondents reported that they had to take care of their ill relative, who is already an adult as if still a small child. In the cases where patients had children, it was an additional responsibility to take care of the children too. Benson et al (1995:417) emphasized this point on families being deprived of any life of their own. Few respondents mentioned that they have more than one mentally ill relative and was it regarded as an additional burden.

In the cases where the respondent was the child of the mentally ill, they reported that they learned to act responsibly towards their ill parent and to take over many of the household's chores especially when the patient

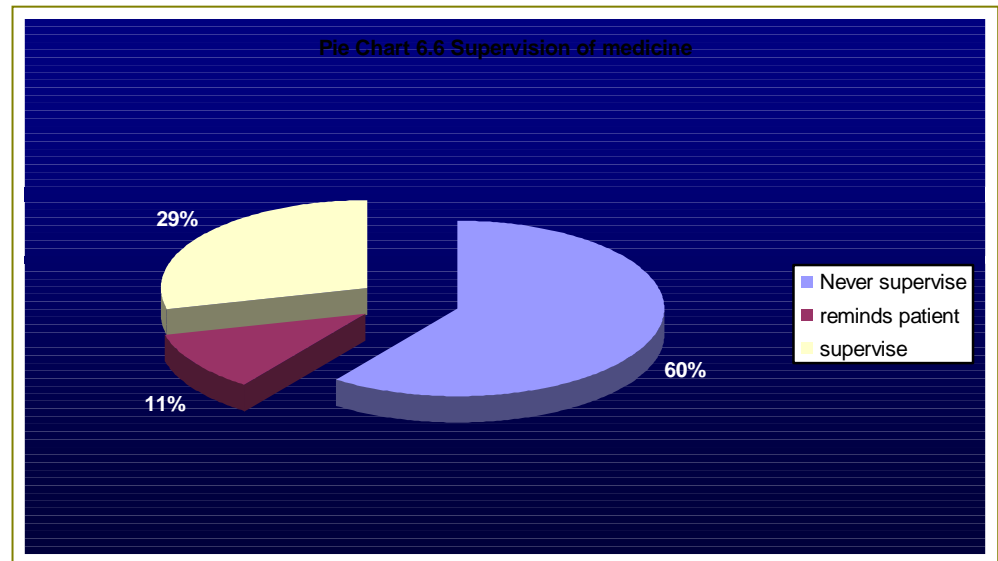
became ill. Another respondent mentioned that they learnt to become independent.

Some family caregivers reported no changes because some patients do take care of themselves while others would stay away from home all day long and only come home in the evenings. Respondents do not feel their presence.

Table 6.23 Adjusting to changes

Response	Number	Percentage
Adjusted well	10	22
Adjusted with difficulty	3	7
Only trusted in God	1	2
No response	31	69
TOTAL	45	100

Table 6.23 summarizes the results on the question of how family caregivers adjust to role changes in the community. The results, 22 % (10) indicated that they adjusted well to the changes while 7 % (3) indicated that they are adjusting with difficulty. One respondent (2 %) indicated that he/she only trusted in God.

Pie chart 6.6 Supervising patient with the daily intake of medicine

The daily intake of medicine forms an essential part of the treatment plan of psychiatric patients. Family caregivers were asked about the supervision of the medicine intake of their ill relatives. Results are shown in Pie Chart 6.6. Results indicated that 60 % (27) never supervised their ill relative with the daily intake of medicine, while only 29 % (13) respondents supervised the patient with the daily intake of medicine. Few respondents 11 % (5) reminded their ill relative to take their medication. Many family caregivers reported that they only supervised the medicine intake of their ill relative at the onset of the illness, but eventually let the patients manage the medicine intake themselves after being taught how it should be done.

Many family caregivers were uncertain whether the patients who were not supervised in fact took their medication, patients need to be supervised because they may take an overdose of the medication. Soukop (1995:87) supported this statement that some mental patients are de-motivated to take treatment because side effects are annoying to them. Gasque- Carter & Curlee (1999:520-524) brought in the relationship between family support and medicine compliance which leads to hospitalization.

The issue of bewitchment is dominant in some cultures; some patients are even accusing their family caregivers of bewitching them, and refuse to be helped with the medicine intake.

As the researcher observed, out-patients who visited the clinic and hospital for their follow up treatment, it was interesting to note that some patients knew the pharmaceutical names of the medication and what effect the medication had on their bodies. Patients reportedly preferred injections to taking tablets because the injections are only issued once a month while tablets have to be taken daily.

A major concern that was raised by the majority of the family caregivers was that many patients are refusing to take their medication.

Table 6.24 Accompanying ill relative to the hospital or clinic

Response	Number	Percentage
Yes	26	58
No	19	42
TOTAL	45	100

Table 6.24 displays the results on the aspect of family caregivers accompanying the mentally ill to the hospital or clinic. The majority of family caregivers 58 % (26) accompanied their ill relative to the hospital or clinic, while 42 % (19) did not accompany their ill relative to the hospital.

Many family caregivers reported that they used to accompany their ill relative only when the illness started, but do not see it necessary to accompany their ill relatives anymore. The researcher observed that follow-up treatment is issued by the Community Psychiatric Nurses at all the local clinics in Katutura. Family caregivers responded that with the fact that follow up treatment was brought nearer to their homes made it not necessary to accompany their ill relative. Some family caregivers reported that when they experience problems at home then they would usually accompany their ill relatives to the hospital. An interview with the

Community Psychiatric Nurse confirmed the data that families only take their ill relatives to the hospital whenever they experience problems in the house.

Table 6.25 Difficulties

Response	Number	Percentage
Yes	29	64
No	16	36
TOTAL	45	100

Family caregivers were asked whether they are experiencing any difficulties with regard to the care taking of their ill relatives. Results to this question are presented in Table 6.25. The results showed that 64 % (29) respondents reported that they experienced difficulties in the care taking of their ill relative, while 36 % (16) did not experience any difficulties at all.

An open question was posed to family caregivers on what the difficulties were with regard to the care taking of their ill relatives. One major concern was that family caregivers have no money to provide the material needs of their ill relative, including money to pay for the follow up treatment. Cohen & Thomas (1996:131) state that family caregivers bear great

psychological and emotional burden and suffer a great deal of economic losses. One patient having no identity document could not apply for a disability pension.

Another major concern was the alcohol and dagga abuse of the psychiatric patients. The researcher observed at a few houses that the family was selling liquor, the ill relatives at these houses were reported to be drinking problematically, however, these respondents mentioned that they did not sell or offer alcohol to the patient. Many patients were drinking a home made brew called " kaal gat". Patients would also stay away from the house until late at night. Families will be concerned about the safety of their ill relatives. Patients reportedly also use abusive language and swear words towards others.

Some psychiatric patients are withdrawing and isolating themselves. Families mentioned this as a difficulty because they were concerned about what the patient was thinking about. Other patients are difficult to control; undressing themselves, tearing off their clothes and would bring dirty things into the house.

The violent and aggressive behaviour of some psychiatric patients towards the family and other members within the community was also mentioned

by families caregivers, they would usually call the police who, at times, do not respond promptly or would be unwilling to help. These results were confirmed by Soukop (1995:9-10) about families living in fear because of the violent behaviour of the ill person. An interview with the Community Psychiatric Nurse revealed that the law stipulates that the police should assist whenever a mentally ill person becomes a danger to himself or to the community.

Some psychiatric patients refuse to eat, bath or to take medication.

Some family caregivers have difficulty geared towards the psychiatric services. Family caregivers complain that patients are not admitted while they are mentally unstable, other family caregivers claimed that their ill relatives were discharged while still mentally unstable. A few patients are absconding from the hospital especially if the family caregivers made a lot of efforts to let the patient be admitted.

One family caregiver reported being referred back and forth between the Katutura hospital and the Psychiatric hospital whenever they wanted to take the patient to the hospital after hours or during weekends. In addition to this, the psychiatric hospital is isolated, between the two hospitals, and public transport (taxis) are not allowed to drive on the hospital roads.

Family caregivers who use public transport have to walk quite a distance to reach the hospital.

A family caregiver regarded mental treatment as a drug and that the ill person may become addicted to, the family caregiver further mentioned that the ill person behaves as if they are under the influence of drugs.

Table 6.26 Experiences of feeling frustrated

Response	Number	Percentage
Yes	21	47
No	24	53
TOTAL	45	100

Table 6.26 summarizes the results on the feelings of frustration that family caregivers might have. A little less than half of the respondents 47 % (21) were experiencing feelings of frustration, while 53 % (24) did not experience any feelings of frustrations. These results may suggest that it can be frustrating for family caregivers to take care of a mentally ill relative. These results are consistent with the findings from previous research as was stated in the literature review.

Family caregivers were asked what the causes are for the feelings of frustration.

The behaviour of the ill person was one of the main causes for these frustrations. This behaviour did not apply to all patients due to the nature of the different kinds of mental illnesses. Some patients were behaving violently and were damaging the property of the family. Other patients were doing things improperly, for example, placing valuable articles in the dustbin. Some patients were described as stubborn, while others do not take their family caregivers seriously. Mental treatment was perceived by one family caregiver as a drug that the patient might become addicted to. Respondents also believed that the ill person behaves inappropriate deliberately.

The lack of finances was another cause of frustration. Many family caregivers cannot find employment as is shown in Table 6.4. The general Namibian population shares this concern. Family caregivers also had to take care of more than one mentally or physically ill person, which was an additional burden.

The alcohol and drug abuse of psychiatric patients also causes feelings of frustration in family caregivers. Some respondents admitted that they were using alcohol, but no one mentioned whether their drinking had any effect on the ill person. Interviews with two psychiatric patients revealed that the

alcohol abuse by the family caregivers is also a disturbance to the patient.

Alcohol and drug abuse is a major problem in the Namibian society.

Family caregivers that were parents expressed their frustration when they compared their mentally ill children with mentally healthy children who are independent and taking care of themselves. Compared to the mentally ill children whose future hopes and aspirations are shattered causes feelings of frustration with family caregivers. These results were confirmed by Roos (1992: 352-255) who found that families usually grieve over the loss of a once promising relative; who became a different person as a result of the mental illness. Benson et al (1995:417) confirmed these results.

Respondents were asked what they regarded as the most serious problem that they faced with regard to the care taking of their mentally ill relative. The responses were the financial difficulties that the family was facing, and the fact that there was no food in the household. Some patients were begging for food and clothing in the streets because of financial problems.

There are patients that are smoke and are constantly asking for cigarettes and tobacco. Another patient had lost the identity document and would apply for a pension application without this document. Other respondents

were only relying on the pension, which was not enough. One of the worst financial difficulties at one specific household who faced already overcrowded situations was that the municipality had cut off the water supply because the family owed too much money. This family reportedly coped by asking water from the neighbours.

One respondent mentioned the fact that their ill relative could not find employment while other mentally ill people who were employed were regarded a serious problem and had also seen that the patient was bad luck. The thinking of this sector can be understood from one of them who said " Why is it only my child (patient) who cannot find employment, while other mentally ill patients are working as nurses or doing other clerical work?"

The alcohol abuse of the ill relatives " kaal gat" and the fact that the patients have more than one sexual partner. One respondent mentioned that one of their ill relatives was already infected with HIV, but still has many sexual partners. Another respondent mentioned that their ill relative was smoking dagga and was very difficult to handle.

Other respondents regarded just the mere fact that their relative was mentally ill and had to be taken care of as a serious problem.

Few respondents mentioned the poor communication between family and patient as a serious problem.

The refusal of the mentally ill to take their medication or refusing to be taken to the hospital and the stubbornness of the patient was regarded as more problems that family caregivers were facing.

Two respondents reported that the ill person lives under too much control and needs more freedom.

Some patients need psychological help because they are experiencing relapses because of worries.

One respondent mentioned that they have a number of small children at home. Their ill relative dislike small children, therefore they fear that the patient might harm these small children.

The family caregivers were asked what motivates them to take care of their ill relative. Most of them stated that the fact that they are the family of the ill person motivates them to take care of the ill. One respondent was not motivated at all to take care of the mentally ill despite the fact of being related to the ill person.

Table 6.27 Whether patients are violent or aggressive at times

Response	Number	Percentage
Yes	16	36
No	29	64
TOTAL	45	100

Table 6.27 presents data on the question whether patients display violent or aggressive behaviour. The results illustrate that almost a third 36 % (16) of the respondents stated that their ill relatives behaved violently or aggressively at times, while 64 % (29) patients did not become violent. The results are confirmed by Soukop (1995:115) that mentally ill patients who were suffering from paranoid disorders tend to become annoyed and might behave violently.

The violent behaviour that the patient displayed ranged from threatening people, using swear words and abusive language towards others, the damaging of property and physical violence against family members and people in the community. Some families have reported cases where their ill relatives were also vulnerable to violence from other people in the community.

Table 6.28 How family caregivers deal with violent behaviour

Response	Number	Percentage
Family help one another	2	4
Fight patient back	1	2
Takes patient to hospital	5	11
Talk to patient	2	4
Call the police	3	7
Don't know	3	7
No response	29	64
TOTAL	45	100

Table 6.28 summarizes the results on how family caregivers deal with the violent behaviour of their ill relative. The table indicates that 4 % (2) of the respondents were supporting one another when the patient behaved violently, while another 4 % (2) of the respondents talked to their ill relative to calm down. More ways of how respondents dealt with the violent behaviour of the ill person was taking the patient to the hospital 11% (5), fighting back the patient 2 % (1), and calling the police 7 % (3). Respondents complained that the police were not always helpful. A small number of respondents 7 % (3) did not know how to deal with violent behaviour.

Table 6.29 Consultations with mental health professionals

Response	Number	Percentage
Yes	9	20
No	36	80
TOTAL	45	100

The study also examined whether family caregivers had consultations with a mental health professional. According to Table 6.29, only 20 % (9) respondents had consultations with mental health professionals, while 80 % (36) did not. Respondents would often be in contact with the professional nurses, the medical doctors and the Social Worker. These results are evident that the ill person usually has regular contact with mental health professionals while it is not the case with family caregivers. This trend is indicated in previous studies. Family caregivers usually will have contact with mental health professionals in cases when they are difficulties at home, as was mentioned by the Community Psychiatric Nurse.

Roos (1992:352-255) established that it is in the best interest of the mentally ill that mental health professionals should build a string relationship with the family. Gasque-Carter & Curlee 1999:520-524) also

found that efforts by mental health professionals to provide supportive services to the family caregivers, was limited and infrequent. In that same study, family caregivers ranked communication with mental health professionals as their greatest need.

At the time of the study, there was no Social Worker employed in the General Psychiatric unit, which meant that social services were non-existent. Contact with Social Workers was associated with applications for disability pensions. This is a general observation that Social Workers were consulted with pension related inquiries. This might be the case because that poverty is one of the major problems most family caregivers are facing.

The research also sought to establish what information levels of family caregivers are with regard to psychiatric illnesses. The following table gives the findings.

Table 6.30 Information about mental illness

Response	Number	Percentage
Yes	2	4
No	43	96
TOTAL	45	100

Family caregivers were asked whether they had any knowledge of the illness of their relative. Table 6.30 presents the findings. The results illustrate that respondents, an overwhelming majority of 96 % (43) of the respondents did not have enough information on mental illness, while only 4 % (2) of the respondents had enough information on mental illness. It seems reasonable to presume that family members lack information on mental illness.

Table 6.31 Where family caregivers learnt about mental illness

Response	Number	Percentage
The doctor	2	4
No response	43	96
TOTAL	45	100

Table 6.31 summarizes the results on where family caregivers learnt about mental illness. The results illustrate that 4 % (2) of the respondents gained their information from the medical doctor. The respondents knew the most basic information on mental illness, one respondent knew that the illness was caused by alcohol abuse, while the other respondent knew that their ill relative was suffering from depression diagnosis.

The family caregivers were asked whether they would like to learn more about mental illness and all the respondents indicated positively that they would like to learn more.

Table 6.32 General health condition of family caregivers

Response	Number	Percentage
Poor health	16	36
Good health	29	64
TOTAL	45	100

The researcher wanted to establish what the health condition of family caregivers was, the results on this question are presented in Table 6.32. The results illustrate that 64 % (29) of the respondents enjoyed good health while 36 % (16) respondents were in a poor health condition. The

poor health condition may be as a result of the care taking role or due to other reasons.

Table 6.33 Type of health problem

Response	Number	Percentage
Physical illness	11	24
Psychological illness (depression)	5	11
No response	29	64
TOTAL	45	100

Table 6.33 presents data on the type of health problem that family caregivers experienced. The results illustrate that 24 % (11) of the respondents suffered from a physical illness, while 11 % (5) respondents suffered of a psychological illness. These results may suggest that the care taking of psychiatric patients can have an effect on the physical and psychological conditions of family caregivers.

These results confirmed by Benson et al (1996:56) stated that parents of chronically disabled children were prone to depression, mood liability, and felt more tired than parents of healthy children.

Table 6.34 Whether the ill person can be left at home alone at times

Response	Number	Percentage
Yes	34	76
No	11	24
TOTAL	45	100

Table 6.34 summarizes the data on the issue of whether the ill person can be left alone at home at times. The table indicated that 76 % (34) of the respondents would leave their mentally ill relatives alone in the house at times, while 24 % (11) of the respondents stated that they could not leave their ill relative alone.

In support of their statements, respondents mentioned that some of the patients could not be left alone when they had a relapse, but could stay all by themselves when they stabilized. Other patients were reliable and could even clean the house properly or do other household chores.

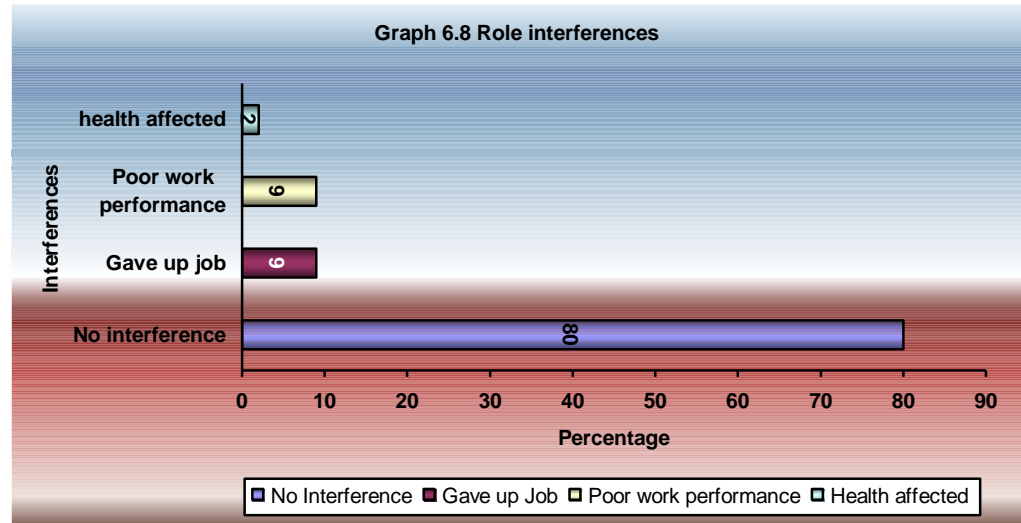
One patient was even left with the responsibility of caring for a small baby. A few patients were reportedly already taking care of themselves.

Some psychiatric patients were living outside the family house in their own "kaya" built with corrugated iron at the back of the house. Some family members locked their homes even if the ill person was at home. It appears that the patient stayed alone but that family caregivers were concerned about their property.

Table 6.35 Reasons why patients cannot be left alone

Response	Number	Percentage
Property not safe	10	22
Violent behaviour might occur	9	20
No response	26	58
TOTAL	45	100

Table 6.35 presents data on the reasons why the ill person cannot be left alone. The results illustrate that 22 % (10) of the respondents were concerned about the safety of their property, while 20 % (9) fear that violent behaviour might break out.

Graph 6.8 Interference between caregiver role and social role

Graph 6.8 presents the data on whether there is any interference between the caregiver role and the social role. The results illustrate that an overwhelming majority 80 % (36) of the respondents did not experience any interference at all with their social life. The same number of respondents, 9% (4) respectively, had to give up their jobs and performed below the acceptable standard of work in their jobs as a result of care giving. One of the respondents 2 % indicated that her health was affected because of the caregiver role.

Family caregivers were asked whether they would like to receive any help with regard to their ill relative. Respondents could choose more than one answer, the results are presented in the table below.

Table 6.36 What services family caregivers would want to receive

Response	Number	Percentage
Home visits from mental health professionals	20	44
Help in emergencies	5	11
Help in knowing how to take care of ill relative	5	11
Day care facilities	1	2
Corrugated iron for building of room	1	2
Material help	4	9
Admit and keep patient in the hospital	2	4
Employment	1	2
Counselling	4	9
Preventing patients from absconding	1	2
No help	4	9
No response	5	11
TOTAL	53	116

The results in table 6.36 illustrate that 44 % (20) family caregivers wanted to be visited by mental health professionals. The same number of respondents 11 % (5) wanted more help in emergency cases, as well as more knowledge on the care taking of a mentally ill person. A significant number of respondents 9 % (4) indicated that they wanted to receive counselling because some of them were struggling with issues like bereavement, communication, and relationships. Families who wanted material help were 9 % (4). There were 9 % (4) respondents who indicated that they did not need any help at all.

The researcher observed during the interviews that some respondents would spontaneously share information about their caregiver experience without even being asked. These respondents were especially the ones who knew that the researcher was a social worker at the hospital before. This spontaneous sharing of information by respondents may be explained as the need for counselling or the need for someone that would listen. This observation was confirmed by Benson et al (1995:416) that family members have an intense need to share their experiences when they are given the chance to do so.

Table 6.37 Spending of leisure time with ill relative

Response	Number	Percentage
Yes	33	73
No	12	27
TOTAL	45	100

The study further sought to find out whether family caregivers spend any leisure time with their ill relative. Table 6.37 presents data on the spending of leisure time with the ill person. The results show that 73 % (33) respondents indicated that they could spend leisure time with the mentally ill, while 27 % (12) were unable to spend leisure time with the mentally ill. The reasons given why family caregivers could not spend leisure time with their ill relative depend on the behaviour of the ill person. Some psychiatric patients were isolated and withdrawn while others were an embarrassment for the family caregivers because of the behaviour of the patient. It appears that the mental stability of the ill person was an important factor and that family caregivers are likely to spend leisure time with a mentally stable relative. These results are consistent with Soukop (1995:72) that some mentally ill patients are withdrawn and isolated while others are overactive, socializing and energizing.

Family caregivers stated the lack of finances as another reason for not spending leisure time with their ill relative.

Table 6. 38 Involving of the ill person in regular family activities

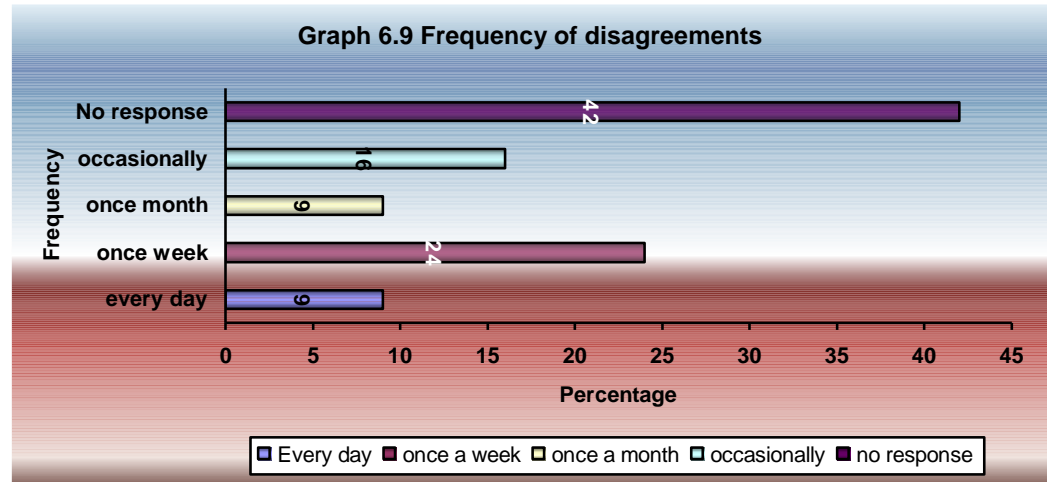
Response	Number	Percentage
Yes	35	78
No	10	22
TOTAL	45	100

Table 6.38 summarizes the data on the involvement of the ill person in regular family activities. The results portray that 78 % (35) of the respondents involved themselves in regular family activities with their ill relative, while 22 % (10) of the respondents did not involve their ill relative in regular family activities. An example for a regular family activity was the attendance of church services.

Table 6.39 Family disagreements

Response	Number	Percentage
Yes	25	56
No	20	44
TOTAL	45	100

Family caregivers were asked whether they were experienced any family disagreements because of caring for their ill relative. Table 6.39 summarizes the family experiences of family disagreements. The results illustrate that 56 % (25) respondents reported that they experienced family disagreements, while 44 % (20) of the respondents did not experience any disagreements.

Graph 6.9 Frequency of disagreements

Graph 6.9 presents data on how often disagreements were taking place. The results indicate that 24 % (11) respondents had disagreements once a week, while 16 % (7) respondents were experiencing disagreements occasionally. The result also shows that 9 % (4) respondents experienced disagreements every day and once a month respectively.

On the question as to what the reasons for the disagreements were, the family caregivers had the following to say.

Alcohol and dagga abuse was identified as one of the reasons why families have disagreements. Some patients, when intoxicated, used swear words and abusive language towards the family members and the public.

Patients who smoke cigarettes and tobacco would argue with family caregivers if they wanted tobacco or cigarettes.

The refusal of medical treatment was another cause for the family disagreements.

Some family caregivers reported having short tempers become angry easily and this could start the disagreements.

The relationship between parents and children where one of the parties was the patient was also a cause of disagreements.

Some patients are described by the respondents as misbehaving deliberately and that they are looking because of doing other unnecessary things such as messing the sugar and not flushing the toilet.

The way in which some family caregivers communicate with one another was another cause for the disagreements.

People in the community were at times influential too. They would often instigate the patient towards the caregiver and in that way cause arguments in the family.

During two interviews, disagreements took place between the patient and the caregiver. The fact that the houses that families are living in were very small and that you might overhear a conversation while people are communicating in a different room. The two patients overheard the conversation and started to disagree with the family caregivers.

Respondents were asked to indicate how they feel about the care taking of their ill relative; they could choose more than one response and the answer to this question are illustrated in the table below.

Table 6.40 Respondents' feelings about care giving

Response	Number	Percentage
Pleasure	22	49
Obligation	20	44
Burden	9	20
Embarrassment	1	2
Disappointment	1	2
TOTAL	53	117

Table 6.40 presents data on how family caregivers felt about their ill relative. Respondents could choose more than one response. The results

illustrate that 49 % (22) respondents felt that the care taking of their ill relative was a pleasure, while 44 % (20) felt it to be an obligation. In addition to that 20 % (9) of the respondents perceived the care taking to be a burden, while 2 % (1) of the respondents indicated that the care taking of the ill person was a disappointment to them.

Table 6.41 How family caregivers cope

Response	Number	Percentage
Support from extended family	21	47
Support from mental health professionals	1	2
Support from spouse	1	2
Support from church	3	7
No cope	19	42
TOTAL	45	100

Table 6.41 presents the results on how family caregivers cope with the care taking of an ill relative. The table shows that almost half of the respondents 47 % (21) coped well with the help from the extended family. It is noteworthy that 42 % (19) of the respondents indicated that they did not cope well, while 7 % (3) respondents reported that they coped with the

help from the church. These results are consistent with previous results by Webster (1992:309-329) who found that family members with a mentally ill relative learnt to cope with the situation.

Table 6.42 Whether respondent talked to or met with other family caregivers

Response	Number	Percentage
Yes	24	53
No	21	47
TOTAL	45	100

Table 6.42 presents data on the question of whether the respondents ever talked to or met other family caregivers of mentally ill patients. The results indicate that almost half of the respondents 53 % (24) talked to a family caregiver with a mentally ill relative before, while 47 % (21) of the respondent did not.

Table 6.43 Desire to meet with other family caregivers

Response	Number	Percentage
Yes	41	91
No	4	9
TOTAL	45	100

Table 6.43 summarizes data on whether respondent's caregivers would like to meet with other family caregivers of psychiatric patients. The table illustrates that an overwhelming majority of 91 % (41) respondents indicated that they were interested to meet formally with other family caregivers. However, respondents stated that group meetings should not take place during the weekdays; other respondents have church activities during certain Saturdays. Some respondents regarded it as an opportunity to talk their hearts out.

Amongst the few respondents who did not want to meet other family caregivers, they stated that the support from the extended family is enough, they do not need additional help.

6.5 Summary

In this chapter the analysis and interpretation of the results were made. These were data collected during the focus group discussions with family caregivers, documentation review of the mentally ill patients who's family caregivers were interviewed and interviews that were conducted with the family caregivers. The results shaded some light on the state of mentally ill patients and their families in Namibia.

The next chapter will be dedicated to the conclusions and recommendations of the study.

CHAPTER 7 CONCLUSION AND RECOMMENDATIONS

7.1 Introduction

Chapter six contains detailed statements of the findings of the empirical research from the individual interviews and focus group discussions with family caregivers of psychiatric patients. In addition, it contains supplementary data from the documentation review of the hospital files of all the psychiatric patients whose families were interviewed, the researcher's observations and discussions with key informants.

This final chapter reviews the findings of the research, discusses the conclusions to be drawn from them and ends with the recommendations for the research in this field.

7.2 Restatement of the objectives

Prior to concluding this research report, the objectives of the study are restated. These objectives were;

Firstly, to determine the nature and extent of family support which psychiatric patients receive.

Secondly, to investigate the needs for family and caregivers support amongst psychiatric patients.

Thirdly, to investigate options for improving family and caregiving support for psychiatric patients, and

Lastly, to suggest possible recommendations to policy makers concerning the extension of family and caregivers support with regard to psychiatric patients.

7.3 General findings

The findings of this study imply that family caregivers were more likely to provide in the basic needs of their ill relatives such as shelter, food and clothing, however, were less likely to provide emotional and advisory support. These results are in substantial agreement with Masilela & Mcleod (1998:11).

These findings also lend support to the assumption that family caregivers are not that significantly involved in assisting their ill relatives with the medicine intake. Many family caregivers take it for granted that the ill person should manage his or her medicine intake. However, it is evident that many mentally ill people are unwilling to take their medical treatment.

One may conclude that family caregivers only react when they experience difficulties at home as a result of the mental illness. When the mentally ill person is stable, family caregivers are less interested in the treatment. Family caregivers only accompany their ill relatives to the hospital when they do experience problems at home, otherwise, family members are not that much involved.

Whenever a mentally ill person was hospitalized, it was found that few family caregivers would visit the ill person in the hospital. It was encouraging to find a small number of family caregivers who were quite involved whenever their ill relative was hospitalized. A number of family caregivers reportedly do not visit their ill relative regularly if hospitalized, stating that the location of the hospital as an excuse. The psychiatric hospital is located in such a way that people without private transport have to walk a distance in order to reach the hospital.

Some family caregivers were reportedly advised by mental health professionals that the ill person should not be visited that often. This issue might need further investigation in a future research project. Other family caregivers reportedly did not have time to visit their ill relative when hospitalized.

The extended family still has a significant influence on families, specifically families with a mentally ill relative. Ndlovu (1991:1) emphasized in his study that families need support from their own social network. The involvement of the extended family was not observed in all the families.

It is also worth mentioning that the nature and degree of the mental illness was another determining factor that establishes how involved the family caregiver would be in providing support. There are severely mentally ill people who are in great need of family support, but do not get any. Where the mental illness was not that severe, family caregivers were less involved.

The duration of the illness was another determining factor. Family caregivers were reported to be more involved and supportive at the onset of the illness and would be less supportive after as years pass by.

Families will need help or assistance when living with a mentally ill person. The psychiatric hospital happens to be the most likely place where family caregivers would receive help. A number of family members were dissatisfied with the psychiatric services, stating that they would have

wanted that the ill person to be hospitalized. These findings are consistent with previous findings (Benson et al 1995:125).

Many families fail to understand that someone diagnosed with a mental disorder may function well within the community and not necessarily be in need of hospital treatment. Some families would rather prefer that their ill relatives be hospitalized and be forgotten about instead of staying with them.

A few family members expressed their disappointment when their ill relatives absconded from the hospitals, and argue that the psychiatric hospital should put better mechanisms in place to keep the ill person when hospitalized.

The findings further imply that few families maintain regular contact with mental health professionals, it is often the ill persons themselves who keep in contact with mental health professionals. This confirms earlier findings by Ndlovu (1991:1) The literature argues that there is a need for more contact between mental health professionals and family caregivers.

Some family members are facing difficulties when their ill relative behaves in such a way to be a danger to themselves, family members or the community at large. Few families resort to the help of the police, but

the police do not respond promptly. A police van parked in front of a house attracts spectators and families may feel embarrassed.

A few family caregivers sought traditional or religious forms of help with regard to their ill relative. The general feeling about traditional treatment was that it was not helpful , only charging high fees and would worsen the mental condition.

Many family caregivers could not provide all the material needs of their ill relatives due to financial constraints.

Alcohol and dagga abuse by the mentally ill was a difficulty that worsened the behaviour of the ill person. Some mentally ill persons are behaving to such an extent that they are violent and damage the family property. The safety of smaller children was mentioned as a concern by some family members, because of the unpredictable behaviour that the ill person portrays.

The mentally ill person is to a certain degree at risk of HIV / AIDS, some mentally ill was reported to have multiple sexual partners, and were not practising safe sex. In fact one family caregiver confirmed the HIV positive status of their ill relative.

The present study offers clear evidence that families lack education on mental health, families indicated that they would like to learn more about mental illness. More support from mental health professionals was another need identified, because then families will be able to be better carers of their ill relatives.

Some of the literature on family and caregiver support to psychiatric patients supports many of the findings that were presented in this study. This is an indication of generalizability.

7.4 Recommendations

In conclusion of this research report, the following recommendations are made;

7.4.1 Educational campaigns should be organized to educate the broader community about mental illness. This will bring about some attitude change on stigmatization and the discrimination of mental patients. Educating the broader community could also serve as a preventive programme.

Educational campaigns should also be conducted to families members as well as to the psychiatric patients themselves. The information to the mentally ill will of course depend on the degree of mental illness.

Educational campaigns should include the following;

- The nature of mental illness
- The onset of mental illness, and dealing with relapses,
- Medication and its side effects, and
- The caretaking of the mentally ill.

7.4.2 Psychiatry is a specialized field, therefore mental health professionals need additional training too. In-service training should be given on an ongoing basis in order to ensure quality services.

7.4.3 Mental health professionals should recognise family needs and be prepared to respond to them, even when services have been prompted by the needs of an individual family member. This recommendation shifts the focus of services from individuals to families. This will ensure that family needs are understood and emotional and practical burden of caregiving can be reduced.

7.4.4 Recognising that changes within one individual will affect the entire family and that intervention programmes on treatment need to consider the family as a unit. This recommendation is developed according to the family system theory approach that acknowledged the family unit as an important subsystem of a larger social system.

7.4.5 Many expressed their disappointments whenever the ill person is absconding from the hospitals after they made so much efforts to bring the ill person to the hospital. The family caregivers themselves requested for stricter measures to ensure that patients will not abscond from the hospital whenever they are admitted.

7.4.6 There is a lack of community resources for the mentally ill patients and their families, such as day-care facilities or rehabilitation centres. It will be helpful to both the ill person and the family if such resources can be established. It will also be a source of referral to mental health professionals.

7.4.7 Existing policies, such as the Mental Health Act and the Criminal Procedures Act need to be reviewed and amended. Furthermore, progressive policies on mental health need to be formulated in order to

improve the psychiatric service delivery and to improve on the situations of families and psychiatric patients.

7.4.8 The establishment of a mental health co-ordinating group which will enable government departments, non- governmental organizations and members of the public to contribute to policy formulation and programme implementation.

7.4.9 The formation of a Mental Health Association for Namibia. The Social worker, other professionals as well the the broader public may be part of such a body. The Social Work profession specifically may initiate programmes to the benefit of the community.

7.4.10 Support groups for caregivers is still an unknown concept, but a very useful tool to provide support to family caregivers. This will also ensure that the caretaking of the ill person will be much better. The formation of support groups with family caregivers according to the different diagnosis of their ill relatives will be useful.

7.6 Suggestions for future research

The present study has been the first of its kind in an unexplored area and will open up possibilities for future research. The following are some of the suggestions which the researcher has suggested should be further investigated;

It will be very interesting to replicate the same study, but instead of applying a cross-sectional design, apply a longitudinal design.

The specific experiences of children with mentally ill parents will also be worthwhile to investigate. The focussing of mentally ill patients with a specific mental condition would also bring about very clear answers to research questions.

Many people rely on the help of traditional healers. The incorporation of traditional healers in programs of mental health deserves a feasibility study.

7.6 CONCLUSION

In conclusion, the family caregivers need assistance from the mental health professional, while the patients need their family for support. This can only happen if the family's needs are met through education and support. Furthermore, this research is likely to be an eye opener to service providers.

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APPENDIX A:

RESEARCH TOOLS

FAMILY & COMMUNITY SUPPORT TO PSYCHIATRIC PATIENTS: A SOCIAL WORK PERSPECTIVE

DOCUMENTATION REVIEW

A: Name of patient:

B: Names of care givers:

C: Home address:

.....

.....

D: Information about patients documented from hospital file:

1. Age:

.....

2. Sex:

Male

☐

Female

☐

3. Home Language

.....

4. Religious Denomination

.....

5. Marital Status

Single

Married

Divorced

Widowed

Living Together

6. Employment Status:

Employed

Unemployed

7. Number of children of patient

1 - 2 children

3 - 5 children

More than 5 children

No children

8. Educational level of patient

No education

Primary Education

Secondary Education

Tertiary Education

9. Age of patient at onset of illness?

.....

10. Present Diagnosis

.....

11. Hospital admissions for the past 12 months

.....

12. Is the patient medicine compliant for the past 12 months?

.....

**FAMILY AND COMMUNITY SUPPORT TO PSYCHIATRIC
PATIENTS: A SOCIAL WORK PERSPECTIVE**

QUESTIONNAIRE FOR FAMILY/CAREGIVERS

Section A:

1. Age:

18 - 29 Years

30 - 44 years

45 - 59 years

60 - 70 years

Above 70 years

2. Sex:

Male

Female

3. Marital Status

Single

Married

Widowed

Divorced

Living together

4. Religious Denomination

.....

5. Educational level

No Formal Education

Primary Level

Secondary Level

Tertiary education

Section B:

6. Are you employed?

Yes

No

7. If yes, what is your occupation?

.....

8. If you are unemployed for how long have you been unemployed?

Less than 3 months

3 to 6 months

6 - 9 months

9-12 months

More than one year

9. What are the reasons for being unemployed?

Cannot find employment

Due to burden of taking care of the mentally ill

Due to poor health

Retired, housewife, student

Other reasons (Please specify)

10. What is the total household income of the family?

No income

Less than N \$ 500.00

Less than N \$ 1000.00

Less than N \$ 2000.00

Less than N \$ 3000.00

More than N \$ 3000.00

11. How do you consider this income?

Very adequate

Adequate

Inadequate

Very inadequate

12. What is the employment status of your ill relative?

Employed

Unemployed

13. If employed, what is the occupation of the person with the illness?

.....

14. If unemployed, who provides financially for the patients' needs?

Receives a disability pension

Support from family

Other (Please specify)

Section C:

15. What type of household do you have?

Nuclear

Extended

Joint

Female headed household

Male headed household

16. How many children does your ill relative have?

No children

1 - 3 children

4 - 6 children

More than 6 children

17. Who takes care of the children of your mentally ill relative?

The patient self

The family

Other (Please specify)

18. Is the house you live in your own property or a rented building?

Own house

Rented house

19. Number of people living in your household

1 - 5 people

6 - 10 people

More than 10 people

Section D:

20. What is your relationship to the person who is ill?

Parent

Sibling

Spouse

Child

Relative

Friend

Acquaintance

Other (please specify)

21. Does the person with the illness live with you?

Yes

No

22. Who is the main caretaker of your mentally ill relative?

.....

23. How often do you have contact with your ill relative?

Every day

Once a week

Once a month

Other (please specify)

24. For how many years has your relative suffered of the mental illness?

0 - 2 years

3 - 5 years

6 - 9 years

More than 10 years

25. Where do you usually get help with regard to your ill relative?

Hospital

Police

Church

Traditional Healer

Other (Please specify)

26. Was the person with the illness ever hospitalized?

Yes

No

27. If yes, how often could you visit the patient in the hospital?

I never visit my ill relative

Every day

Once a week

Once a month

Other (Please specify)

28. Did you ever contact a traditional healer to treat the mental illness?

Yes

No

29. If yes, was it helpful?

Yes

No

30. Some people believe that mentally ill people should be locked up in psychiatric hospitals. What is your opinion on this statement. Please motivate your answer.

Agree

Disagree

.....

31. What do you think are the causes of mental disorders?

Biological

Genetically

Religious

Witchcraft

Alcohol and Drug abuse

Other (Please specify)

32. Tick the one which you think is appropriate:

Mental disorders can be treated

Mental disorders cannot be treated

Section E:

33. In what ways do you help your mentally ill relative? You may tick more than one answer.

- | | |
|-------------------------------|--------------------------|
| Providing a place to live | <input type="checkbox"/> |
| Food and clothing | <input type="checkbox"/> |
| Washing clothes | <input type="checkbox"/> |
| Reminding to take a bath | <input type="checkbox"/> |
| Social contacts or recreation | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> |

34. Do the other family members also help with these tasks?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

35. If yes, how do other family members extend a helping hand?

- | | |
|------------------------|--------------------------|
| Spontaneous | <input type="checkbox"/> |
| Obtainable on request | <input type="checkbox"/> |
| On conditional basis | <input type="checkbox"/> |
| No support | <input type="checkbox"/> |
| Other (Please specify) | <input type="checkbox"/> |

36. Have there been any changes in terms of what each one of you do as a result of your relative's illness?

- | | |
|-----|--------------------------|
| Yes | <input type="checkbox"/> |
| No | <input type="checkbox"/> |

37. If yes, what are these changes?

.....

38. How do you and your family adjust to the changes imposed on you because of the illness of your ill relative?

.....

39. Do you supervise the patient with the daily intake of medicine?

I never supervise the patient

I reminds the patient to take the medicine

I see to it that patients take it's medicine

Other (Please specify)

40. Do you accompany your relative to the hospital or clinic?

Yes

No

41. Have you ever experienced any difficulties in caring for your mentally ill relative?

Yes

No

42. If yes, what were these difficulties?

.....

.....

43. Do you experience any feelings of frustration because of caring for your mentally ill relative?

Yes

No

44. If yes, what are these frustrations?

.....

.....

45. What do you see as the most serious problem that you are facing at present in the care-taking of your ill relative?

.....

.....

46. What motivates you to take care of your ill relative?

.....

47. Does the patient become violent and aggressive at times?

Yes

No

48. If yes, how do you as family and caregivers deal with the violence?

.....

.....

49. Do you think you need to learn more about handling the violent behavior?

Yes

No

50. Who do you consider the most important person to speak to about your mentally ill relative? Why?

A Doctor

Nurse

Social Worker

Family

Church leader

Friend

Other (Please specify)

51. During the past year, have you consulted any of the following Mental Health Professionals regarding the care of your ill relative?

Social Worker

Nurse

None of them

52. What are your experiences regarding social services towards your mentally ill relative?

.....

53. What form of assistance would you find helpful in the care-taking of your mentally ill relative?

.....

54. How can the Social Worker be of assistance to you and your family in the care-taking of your ill relative?

.....

55. Do you have enough information about the nature of your relative's illness?

Yes

☐

No

☐

56. If yes, what do you know and where did you learn?

.....

57. If no, would you like to learn more?

Yes

☐

No

☐

58. What information would you like to learn more regarding the care-taking of your mental ill relative? You may tick more than one answer.

The nature of mental illness

☐

Medication and its side effects

☐

How to look after a mentally ill person

☐

Dealing with relapses and emergencies

☐

Where to get support

☐

Other (Please specify)

☐

59. During the past year, have you or other family members
- | | |
|-------------------------------------------------|----------------------|
| Visited a doctor for a physical problem | <input type="text"/> |
| Visited a doctor for a psychological problem | <input type="text"/> |
| Been in hospital for your psychological problem | <input type="text"/> |
| Other (Please specify) | <input type="text"/> |
60. Is it possible to leave your ill relative alone for some periods?
- | | |
|-----|----------------------|
| Yes | <input type="text"/> |
| No | <input type="text"/> |
61. If no, what are the reasons?
- | | |
|--------------------------------------|----------------------|
| The patient might harm himself | <input type="text"/> |
| The patient might damage my property | <input type="text"/> |
| Other (Please specify) | <input type="text"/> |
62. In what ways did your role as caregiver interfere with your social role?
- | | |
|--------------------------------------------------|----------------------|
| There were no interference | <input type="text"/> |
| I gave up job because of demand of caring | <input type="text"/> |
| I went on early retirement because of ill health | <input type="text"/> |
| Had negative effects on standard of work | <input type="text"/> |
| Other (specify) | <input type="text"/> |

63. What services would you like to receive as a caregiver? You may tick more than one answer.

Home visits from mental health professionals	<input type="checkbox"/>
Help in emergencies	<input type="checkbox"/>
Help in knowing how to take care of the ill relative	<input type="checkbox"/>
Day care facilities	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>

64. Is it possible to spend any leisure time with your ill relative?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

65. Can you involve your ill relative in regular family activities?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

66. Do you experience family disagreements because of your ill relative?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>

67. If yes, how often do you have disagreements?

Every day	<input type="checkbox"/>
Once a week	<input type="checkbox"/>
Once a month	<input type="checkbox"/>
Other (Please specify)	<input type="checkbox"/>

68. What are the reasons for these disagreements?

.....

.....

Section E:

69. How would you rate your involvement towards the patient?

Involved	<input type="text"/>
Over-involved	<input type="text"/>
Disinterested	<input type="text"/>
Other (Please specify)	<input type="text"/>

70. How do you feel about the care taking of the mentally ill?

A pleasure	<input type="text"/>
An obligation	<input type="text"/>
A burden	<input type="text"/>
Other (Please specify)	<input type="text"/>

71. How do you cope having a mentally ill relative?

Confide in someone	<input type="text"/>
Support from friends	<input type="text"/>
Support from extended family	<input type="text"/>
Support from Mental Health Professionals	<input type="text"/>
No coping Mechanism	<input type="text"/>
Other (Please specify)	<input type="text"/>

72. Have you ever talked to or met other people who have mentally ill relatives?

Yes

☐

No

☐

73. Would you like to meet other people who are taking care of their mentally ill relatives?

Yes

☐

No

☐

Thank you very much for your cooperation.

FAMILY AND COMMUNITY SUPPORT TO PSYCHIATRIC PATIENTS: A SOCIAL WORK PERSPECTIVE

FOCUS GROUP DISCUSSIONS WITH FAMILY MEMBERS

- A: Introduction and explain purpose of research to the family members. Consent of participants.
- B: Introduction of family members, their first names, their relationship to the patients, whether they are living with the patient or without, and their employment status.
1. How long has relative been suffering from the mental illness? What do you think caused your relative's illness? What is your opinion on the treatment of mental patients?
 2. Do you have any knowledge about the nature of your relative's illness? What do you know? Where did you learn about it? Would you like to learn more about the illness of your relative?
 3. Can you recall the last time that your relative was ill? How did you as family experience it?
 4. Has your mentally ill relative ever been hospitalized? What was the experiences in the family before and after the hospitalization of your ill relative? Could you visited your ill relative in the hospital? Please give reasons.
 5. Some mentally ill relative can behave violent or aggressive at times. Can you give me an example of any violent or aggressive behaviour that you might have observed with your ill relative? What was your feeling about this behaviour? How did you as family caregivers deal with the violence? Would you like to learn more about dealing with the violent behaviour?
 6. Is there a specific person in the family who is in charge of your mentally ill relative? Who is that person?
 7. Can you explain to me what sort of things you did for your ill relative? Did other family members also help with these tasks?
 8. When was the last time that you involved your ill relative in family activities, for example attending of church services? Can you tell me about the last time that you spend leisure time with your ill relative?

9. Some patients have to be reminded to take their medicine regularly. What is the situation with your ill relative?
10. How is your communication with your ill relative? Has there been any changes since your relative became ill?
11. Who provides for the financial needs of your ill relative? How does this affect your family?
12. When was the last time that you or other family members had physical or psychological complaints? What do you think caused these conditions?
13. Tell me about your role in your family? Have there been any changes in roles since the onset of your relative's illness? How do you and your family adjust to the changes imposed on you because of the illness of your relative?
14. In almost every family disagreements and conflicts do occur. When last have there been any disagreements or conflicts in your family? What were the reasons for these disagreements? How did this affect your relationship with your ill relative?
15. Did having a mentally ill relative had any influence on the way you feel about yourself?
16. How different do you view your family from other families who does not have a mentally ill relative?
17. Do you experience any difficulties with the care taking of your ill relative? What is the most difficult in the care taking of your ill relative? How do you deal with these difficulties?
18. Did you ever experienced feelings of frustrations with regard to the caretaking of your ill relative? Can you give me an example of a situation where you felt experienced any frustrations? Where did you get help to deal with these frustrations?
19. Who worries the most in your family about your ill relative's condition? How do they show these worries?
20. What would you say are the most serious problem that your family is facing at present, with regard to your mentally ill relative?
21. How do you think your family is coping with regard to your mentally ill relative?

22. Can you tell me, what motivates you to take care of your relative?
23. What do you see as being the most helpful resources outside the family for your ill relative? Why?
24. When last did you or your ill relative have contact with any mental health professional? Please name these professionals? Were you satisfied with the help that was offered?
25. Tell me about any positive experience that you had with regard to care-taking of your ill relative. Why was this experience positive?
Can you tell me about any negative experience with regard to care taking. Why was this experience negative?
26. What form of assistance would you find helpful in the care-taking of your ill relative?
27. What was your experiences regarding social services towards your mentally ill relative?
28. How can the Social Worker be of assistance to you and your family?
29. Have you ever talked to or met other people who have mentally ill relatives? Would you like to meet other caregivers of mentally ill people?
30. What would you like to say to people who plan psychiatric services, if you had a chance?
- C: Summary and ending of the discussion.

APPENDIX B:
LETTER REQUESTING PERMISSION
TO CONDUCT THE STUDY

P. O. Box 8705
Bachbrecht
Windhoek
Namibia

8 June 1999

Permanent Secretary
Ministry of Health and Social Services
Private Bag 13198
Windhoek
Namibia

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

I am employed as a Social Worker at the Polytechnic of Namibia and am studying as a part time student for my Masters Degree in Social Work at the University of Namibia.

I am doing research as part of the fulfillment of the Masters Degree. The title of my research study is “ *Family and community support for psychiatric patients in Windhoek: A psychiatric Social Work perspective*”.

I would hereby like to request your permission to conduct this study. Hereby enclosed is the research proposal.

Yours faithfully

Ms. Janetta Agnes Ananias

APPENDIX C:

LETTERS GRANTING PERMISSION

TO CONDUCT THE STUDY

APPENDIX D:

CONSENT FROM