THE ROLE OF THE FAMILY IN HELPING PSYCHIATRIC PATIENTS COPE WITH PSYCHIATRIC ILLNESS

by

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ABSTRACT

The present study investigated the role that is played by family members in helping psychiatric patients cope with their illnesses. Twenty-seven psychiatric patients participated in the study. Of these, eighteen had been admitted to the local hospital for various complaints, and had been referred to the psychologist for psychotherapy. Nine participants were seen during private consultation sessions with the author/researcher.

A convenient sample was used in that the criterion for inclusion of participants in the sample was based on patients suffering from certain psychiatric illnesses for example mood disorders, psychotic disorders or anxiety disorders.

A semi-structured questionnaire was used to collect data for the study. The questionnaire covered participants' biographical information, details about psychiatric patients' illness such as their initial reactions to the diagnosis, knowledge about the illness, the level of support they received from family members and the community and the perceived causes of the illness.

The procedure for data collection involved directed conversations in which patients reflected on their experiences both in and out of the hospital, for example the level of support they received from the family and community members, and information about
their psychiatric conditions after being discharged from hospital. In addition, family members were asked to express their feelings and perceptions about the patients' conditions including the challenges they encountered as a result of having a family member with a psychiatric illness.

The results of the study were that many psychiatric patients reacted with shock, fear and confusion to their illness diagnosis. Many also appeared to have some knowledge of the illness, including the belief by some that they had been bewitched. Some of the patients were unemployed as a result of being mentally ill, and this led to financial strains in the family. The main finding of the study was that most psychiatric patients still continue to be discriminated against in the communities in which they live. Most family members, however, were found to be supportive to their mentally ill relative. Some of the challenges faced by family members included a lack of knowledge about the illnesses affecting their relatives.

The results of the study are generally consistent with the findings by other investigators regarding the important role that is played by family members in helping their relatives cope with psychiatric illnesses. In addition the study highlighted an urgent need by the government to improve mental health services by, among other things, providing adequately qualified professionals who may facilitate the process of integrating mentally ill persons with their communities.
# TABLE OF CONTENTS

## CHAPTER 1: INTRODUCTION

1.1 Introduction .......................... 1  
1.2 Motivation ........................... 2  
1.3 Value of the study ................. 4  

## CHAPTER 2: LITERATURE REVIEW

2.1 Mental illness, psychiatric illness, or mental disorder 6  
2.2 Scale of the problem of psychiatric illnesses .............. 7  
2.3 Classification of mental illnesses ....................... 9  
   2.3.1 The Multi-axial approach .................. 9  
2.4 Perspectives on the etiology and treatment of psychiatric illnesses 11  
   2.4.1 Biological model ........................ 12  
   2.4.1.1 Etiology of mental illness .......... 12  
   2.4.2 Psychodynamic perspective .......... 14  
   2.4.3 Socio-cultural model .................. 15  
   2.4.4 The stress-vulnerability model of psychiatric disorders 17  
       2.4.4.1 Biological vulnerability ...... 17  
       2.4.4.2 Stress .......................... 18  
       2.4.4.3 Protective factors .......... 18  
   2.4.5 Significance of the cultural context .......... 19  
       2.4.5.1 Etiology of psychiatric illness .. 20  
       2.4.5.2 Religious beliefs .......... 21  
   2.4.6 Relationship between the models .......... 22  
2.5 Family reaction to mental illness ........... 22  
2.6 Impact of psychiatric illness .......... 24  
   2.6.1 Impact on the individual ............. 24  
   2.6.2 Impact upon the family .............. 25  
   2.6.3 Impact of parental mental health on children 26  
       2.6.3.1 Mechanism and routes of impact 27  
           2.6.3.1.1 Exposure to parents’ symptoms 27  
           2.6.3.1.2 Disruptions in parenting 28  
   2.6.4 Impact on other family members .......... 29  
2.7 Psychiatric illness and stigma ........... 30  
   2.7.1 Effects of stigma on the psychiatric patient 31  
       2.7.1.1 Stigma at the workplace ..... 31  
   2.7.2 Psychiatric illness and family stigma .......... 31  
       2.7.2.1 Discrimination and shame ........ 33  
       2.7.2.2 Blame and contamination ...... 34  
       2.7.2.3 Contamination of children by parents 35  

iv
2.8 Resilience in families with psychiatric illness
2.9 The concept of social support and its relation to illness
  2.9.1 Nature and importance of social support
  2.9.2 Family support and psychiatric illness
    2.9.2.1 Scope of family support
    2.9.2.1.1 Adherence to medication
2.10 Determinants of quality of life in psychiatric patients
  2.10.1 Social support and quality of life
  2.10.2 Community health services and quality of life

CHAPTER 3: RESEARCH METHODS

3.1 Qualitative methods
3.2 Quantitative methods
3.3 Participants
3.4 Diagnoses of patients’ illnesses
3.5 Instrument for data collection
3.6 Procedure of data collection
3.7 Intervention during data collection
3.8 Data analysis

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Personal histories of participants
4.2 Demographic details
  4.2.1 Age of the participants
  4.2.2 Participants’ gender
  4.2.3 Participants’ marital status
  4.2.4 Participants’ level of education
  4.2.5 Duration of diagnosis
  4.2.6 Types of psychiatric patients’ illnesses
4.3 Patients’ reaction to illness
4.4 Knowledge of the illness and its perceived causes
4.5 Effect of illness on the family
  4.5.1 Financial strains
4.6 Attitude/reaction of the community
4.7 Role of the family in helping patients cope with their illness
  4.7.1 Patients’ perceived support from family members
  4.7.1 Family members’ perception of help given to patients
4.8 Patients’ satisfaction with support
4.9 Implications for intervention
CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

5.2 Recommendations
   5.2.1 Dealing with stigma of mental illness
   5.2.2 Need for psychotherapy of patients and their family members
   5.2.3 Formation of self-help groups
   5.2.4 Need to improve mental health services
   5.2.5 Need for further research

CHAPTER 6: SUMMARY

REFERENCES

APPENDIX 1: LETTER OF REQUEST FOR PARTICIPATION

APPENDIX 2: RESEARCH INSTRUMENT

APPENDIX 3: PARTICIPANTS’ CONSENT FOR FAMILY PARTICIPATION

LIST OF TABLES

Table 1: Age of participants
Table 2: Duration of diagnosis
Table 3: Types of psychiatric patients’ illnesses

LIST OF FIGURES

Figure 1: Participants’ gender
Figure 2: Distribution by marital status
Figure 3: Level of education
Figure 4: Patients’ reaction to diagnosis
CHAPTER 1: INTRODUCTION

1.1 Introduction

Patients and family members are frequently unhappy about the information and advice they receive from professional staff in preparation for discharge. Research in this area appears to suggest that the role of the family or significant others may have a significant effect on the long-term recovery of many psychiatric patients, and prevention of relapse (Kaplan & Sadock, 2003). Yet, there is frequently inadequate recording by staff of discharge plans and information given, and poor understanding by patients and their families of the former's illness and care or coping plans after discharge.

In many situations, psychiatric patients are given medication which must be taken regularly; however, psychosocial issues are frequently downplayed despite well-documented research that social support in the form of family members or significant others is important in patients' ability to cope with a variety of illnesses (Mfusi, 2002). With respect to psychiatric conditions, family members may possess little or no information regarding what to do with the patient in order to help them deal with the illnesses.

Psychiatric conditions, such as schizophrenia, depression, bipolar, and so on are often as devastating to the family as they are for the person afflicted. Family schedules, social life, and finances are frequently put in total disarray. Compounding the problem for many families is the traditional perception that many psychiatric conditions are familial (Holmes, 1994; Comer, 2003), which may lead to the assumption that family members
are responsible for the sick person’s condition. This may contribute to psychological strains such as anxiety, tension, sadness, and resentment (Bouwer, Dreyer, & Lock, 2003). Furthermore, the effect of stigma of having a psychiatric illness may subsequently make it difficult for patient and family to become truly integrated in the communities in which they reside.

1.2 Motivation

Psychiatric illnesses tend to carry a stigma, since many people are reluctant to believe that psychiatric patients can ever fully recover. Employers and credit agencies may discriminate against such patients. It is therefore imperative that the family role and ability in dealing with such issues be understood and conceptualized.

The needs of psychiatric patients in the community are universal and diverse. Treatment does not end in hospital but continues in the community. It has been argued that one of the reasons for patients’ relapse is the absence of treatment compliance, and shortages or absence of community clinics. The family coping resources may be stretched in these situations.

Subsequent to discharge from the psychiatric hospital, the psychiatric patient becomes a burden to the family, friends, relatives, and the community. The family, however, is the primary role player in the patient’s surroundings. Any differences or conflicts in the family may affect the patient directly, leading to relapse of illness in the patient; and even to the more serious issue of suicide. The main issue is whether the family is able to
provide the psychiatric patient with the necessary support and console during stressful times.

Ample evidence appears to suggest that the nature of the perceptions that psychiatric patients have about their relatives has a direct bearing on the patients' ability to cope with and recover from their illnesses. Thus, there appears to be a clear research mandate to study such relationships between patients and their families.

Some psychiatric disorders can have their origins in the broader social or community structure in which people live, and the role they are required to play. In such cases, social and community pressures may overwhelm and disable the individual, leading to serious psychiatric disorders. A clear understanding of the nature of such discourses is therefore necessary.

Most practitioners tend to focus more on psychiatric illness and its medical treatment, than on the importance of psycho-educating the patients and their families about the nature and management of their psychiatric conditions. As a result, patients, their families and the community do not know much about the psychiatric conditions. Yet, research documents that the more patients know and understand the nature of their illnesses, the better are the chances of coping and adjusting to their illness.
1.3 *Value of the study*

Like with other chronic conditions (e.g. diabetes mellitus, cardiovascular diseases), people with psychiatric illnesses should be able to manage their own illnesses. Sensitizing the family of the patients' psychiatric conditions will ensure that patients are themselves empowered with accurate information and support from others who understand.

The study will also contribute towards helping patients and their families resolve some of the interpersonal and social problems they may experience, and thus facilitate community adjustment of the patients.

The study will open up avenues in which patients will be encouraged to, in future, seek relevant information from psychiatric institutions regarding their illness.

Teaching people ways of dealing with stigma and discrimination associated with their conditions is usually an enormous task. The present study will therefore contribute towards helping patients deal and cope with any stigma and discrimination that may undermine their rights as human beings.

In view of the diverse problems encountered by most psychiatric patients in their communities, the present study will serve to facilitate the advocacy of individual, and group, or family therapy as an adjunct to medical treatment of psychiatric illnesses.
The study will add to the available literature how psychiatric patients and their families can be helped to develop more insight into their problems, and learn relevant skills to deal with them in the future.

Although the main focus of the study will be on patients and their families, it will have a direct impact or bearing on the whole community in which the patients live, and as such as a catalyst to other areas of the province.

Given the negative conditions under which psychiatric patients have lived, any study that aims to improve their well-being must always be welcomed; particularly if such a study will help patients to maintain hope, build resilience and sustain recovery.
CHAPTER 2: LITERATURE REVIEW

2.1 Mental illness, psychiatric illness or mental disorder

Significant advances in the understanding of and treatment of psychiatric illness have brought greater recognition to the field of psychology and medicine. Such recognition has offered various ways in which the terms psychiatric illness, mental illness, and psychological disorder can be defined.

According to Schweitzer (2006), mental illness is a broad term used to define “a wide range of diagnosable psychiatric illnesses that impair a person’s ability to think, feel and behave in a manner that allows optimum functioning in day to day life” (p.1).

Human beings go through stages in their lives when they experience uncontrollable feelings of fear, stress, depression, anxiety, and so on. Although such periods may be extremely distressing, they are not generally considered as mental illness.

Psychiatric illness, on the other hand, refers to the impairment the individual experiences as a result of mental illness (Hall-Flavin, 2005). Although the terms psychiatric illness and mental disorder are sometimes used interchangeably, mental illness refers to the actual disorder.

The term mental disorder implies a distinction between “mental” disorders and “physical” disorders (APA, 2000). For some authors (for example, Barlow & Durand, 2002), mental or psychological disorder is used to refer to “a psychological dysfunction
within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected” (p.2)

Like many other concepts in the field of psychology and science, the three concepts appear to lack consistent operational definitions that cover all situations. In the present study, the concepts mental illness, psychiatric illness, and mental disorder are used interchangeably to refer to any condition that leads to a significant reduction in an individual’s ability to function psychologically, socially, occupationally or interpersonally.

2.2 Scale of the problem of psychiatric illnesses

Overall mental health problems affect more than twenty-five percent of all people at some point in their lives, and rates are increasing (WHO, 2001). Mental health problems are universal and occur in all societies and cultures, and are present at any one time in about one in ten people (Smith, 2004). According to the World Health Organization report (2001), about twenty percent of patients seen by health care professionals have mental health problems, and one-in four families has at least one member with a behavioral or mental health disorder.

In relation to major psychiatric illnesses, depression is the most commonly occurring mental health problem and is between 1.5 and three times more common in women than in men (Duncan, 2000). Although rates do vary slightly across populations, worldwide it is estimated that six percent of men and nearly ten percent of women will experience a depressive episode, serious enough to receive a psychiatric diagnosis of depression.
According to Smith (2004), the incidence of diagnosed depression is highest in the middle ages, but rates in young adulthood and adolescence are increasing. Depression is usually associated with social and economic status, and is more prevalent in people with low income than those with high income (Hay, Pawlby, Sharp, et al; 2001). Community studies have, however, demonstrated that a significant proportion of depression, particularly in women, is undiagnosed. These studies suggest that the rate of depression in community populations (especially women) may be as high as thirty-five percent; and this may indicate that cases that come to professional attention provide an underestimate of the real scale of depression in mothers (Smith, 2004).

Schizophrenia is considerably less common than depression, with estimated point prevalence of 0.4 percent. It tends to onset in late adolescence or early adulthood, and occurs equally in women and men, although onset tends to be slightly later in women (WHO, 2001).

The other significant mental health problem is substance abuse. According to the World Health Organization (2001), good estimates of the prevalence of substance abuse in its different forms are difficult to obtain. Indications, however, are that prevalence of substance abuse is rising, particularly in young women (WHO, 2001).

Anxiety disorders are another common disorders and society's most expensive mental disorders (Comer, 2003). Anxiety is generally an unpleasant emotional state with the qualities of apprehension, dread, distress and uneasiness. Although such qualities of
anxiety may have an adaptive function – for example preparing the person for action, some people may suffer from such continuous and disabling feelings that they are unable to lead a normal life. In these cases, individuals are said to have an anxiety disorder (Kaplan & Sadock, 2003).

2.3 Classification of psychiatric illnesses

The need to classify various types of mental disorders has long been recognized, and the classification systems have been revised in order to incorporate new knowledge and changing viewpoints (American Psychiatric Association, 2000). A classification statement or diagnosis places a disorder within a system of conventional groupings based on important similarities in symptoms (Sarason & Sarason, 2005). Most classification systems in psychology are organized in hierarchical fashion, for example a manic episode is a subdivision of bipolar disorders, which in turn is a subgroup in the family of mood disorders.

2.3.1 The Multi-axial Approach

The multi-axial classification system is designed to summarize the diverse information relevant to an individual case rather than to provide a single label. Instead of merely assigning a case to a category (for example schizophrenia), clinicians who use the multi-axial system can describe an individual in terms of a set of clinically important factors or axes. The Diagnostic and Statistical Manual of Mental Disorders (DSM-II) was the first multi-axial system developed by the American Psychiatric Association in 1980, and has been revised twice to accommodate several changes. The latest edition (DSM-IV-TR) was published in 2000.
The axes of the DSM-IV provide information about the biological, psychological, and social aspects of a person's condition. Its use to make a diagnosis is subject to the evaluation of a client's condition on five separate axes, or branches of information (APA, 2000) such as the following:

Axis I consists of an extensive list of clinical syndromes that typically cause significant impairment in a person. Among the syndromes included in the axis are anxiety disorders, mood disorders, schizophrenia and other psychotic disorders, and substance related disorders.

Axis II deals with personality disorders and mental retardation, both of which begin in childhood or adolescence and usually persist into adult life.

Axis III describes general medical conditions that seem relevant to a case, for example the presence of diabetes might influence how one will deal with a depressed client.

Axis IV describes psychosocial and environmental problems such as housing problems, a negative life event, or family stress. In some cases, these problems may stem from adjustment difficulties created by the disorder.

Axis V is a global assessment of the individual's psychological, social, and occupational functioning at the present time and for the highest level of functioning during the past year. The clinician makes a global assessment of functioning (GAF) rating on a scale
from 1 to 100. Low ratings indicate that individuals pose dangers to themselves or others, while high ratings indicate good or superior functioning.

Although many changes have been effected in order to improve the diagnostic system for abnormal behavior, a number of problems are still inherent in the DSM. One problem is that whenever an individual is put into a category, some of that person's uniqueness is lost, and something important about the person may be missed. Secondly, the DSM tends to reflect Western view of mental disorders, and is therefore limited in its global applicability to the diverse ethnic, racial, and cultural groups (Regier, 2002). For example, there may be similarities among members of the South African population; there are also important cultural and ethnic differences. Research evidence suggests that even when social and cultural factors are controlled, ethnic or racial background must be considered in making evaluations and treatment plans (Fletcher-Janzen, 2002). For these reasons and others, most authors are of the opinion that the DSM might best be viewed as a set of guidelines for characterizing clinical problems, rather than the final word on the subject of diagnosis (Minsky, 2003).

2.4 Perspectives on the etiology and treatment of psychiatric illnesses

There are a number of theoretical perspectives for viewing and understanding abnormal behavior, or more specifically psychiatric illnesses. This has resulted from shifts in values and beliefs over the past century and improvements in the quality and quantity of clinical research (Holroyd, 2002). The models that will be discussed in this section are the biological, psychodynamic, socio-cultural, and stress-diathesis.
2.4.1 Biological model

The biological model is one of the oldest perspectives that explain abnormal psychology. According to (Pinker, 2002), its influence has been especially strong since the middle of the twentieth century when several kinds of effective psychotropic drugs were produced to alleviate symptoms of mental illness.

The main assumption of the biological model is that a full understanding of an individual’s functioning must include an understanding of the biological basis of his/her thoughts, emotions, and behavior. Once this understanding is attained, the most effective interventions for the problems that may arise will be biological ones (Bruer, 1999).

2.4.1.1 Etiology of mental illness

Biological theorists view psychopathology as originating from the malfunctioning parts of the organism, particularly the brain. The brain comprises about one hundred billion nerve cells (neurons) and thousands of billions of support cells (glia). Neurons in the brain regions control many important functions such as emotions, memory, and motivation. This is done through the secretion by each neuron of a chemical called neurotransmitter (Beminger & Richards, 2002).

According to the biological model, mental disorders are linked to problems in brain-cell functioning. The problem may be anatomical, for example the size or shape of the brain may be abnormal, or biochemical, such as when there is a malfunction in the manner in which neurotransmitters are secreted by neurons. These difficulties may be the result of
various factors, for example excessive stress, infections, tumors, physical injury, and inadequate blood supply. Research on the effects of psychotropic drugs on the various parts of the brain has led to insights about mental disorders and how they can be alleviated (Berninger & Richards, 2002).

Biological researchers have identified a number of neurotransmitters, the abnormal secretions of which may result in many psychiatric disorders. It is noteworthy that any one neurotransmitter may operate in more than one area of the brain. This may account for a combination of otherwise unrelated symptoms in some disorders. For example, the neurotransmitter that is responsible for depression also plays a role in appetite, and this explains why depressed persons show changes in appetite.

One of the most common and expensive mental illness, namely anxiety has been explained on the basis of insufficient activity of neurotransmitter gamma aminobutyric acid (GABA). Tranquilizing agents such as benzodiazepines are commonly used somatic therapy in the treatment of anxiety (Dobson, 2001).

Schizophrenia is thought to be due to high levels of a neurotransmitter called dopamine that operate in the areas of the brain that are responsible for thought processes. To correct that problem, persons with schizophrenia are administered drugs that limit or block the action of dopamine (deSilva & Marks, 1999).

The incidence of affective disorders has been attributed to a number of malfunctioning neurotransmitters. Unipolar depression, for example is chemically explained as being
caused by deficiency in neurotransmitters serotonin and norepinephrine. Prescription of antidepressants, for example monoamine oxidase (MAO) inhibitors, tricyclics, and selective serotonin reuptake inhibitors (SSRI's) is usually aimed at alleviating symptoms of depression. Bipolar disorder, a mental illness that involves episodes of mania and depression, is caused by high epinephrine activity in the brain. The drug lithium has been found to reduce epinephrine activity at key sites in the brain (Sarason & Sarason, 2005).

2.4.2 Psychodynamic perspective

The psychodynamic model is the oldest and most famous of all theories of psychopathology. Its proponent, Sigmund Freud (1856-1939) believed that a person’s behavior, whether normal or abnormal, is determined to a large extent by underlying psychological forces of which the person is not consciously aware. These forces are considered dynamic because they interact with one another, and their interaction gives shape to an individual’s behavior, thoughts, and emotions (Holmes, 1994).

For Freud, the ego, as the executive of personality, had to allow for the expression of unconscious drives in a way that took into account both external reality and internal moral standards. To accomplish its goals, the ego relied on a variety of unconscious defense mechanisms, which allowed for at least partial discharge of drive tensions in socially and personally acceptable ways (Crider, Goethals, Kavanauh, et. al., 1983).

Abnormal behaviors or symptoms are viewed as resulting from the interaction of drives and ego-defense mechanisms. Disorders result when drives are not maturely channeled into behavior and mental activity, when internal moral prescriptions are overly severe,
and when defense mechanisms are rigid and inflexible. This imbalance among contending structures of personality leads to negative emotional states like anxiety and guilt, and poorly integrated mental activity: the symptoms of psychological disorders. Freud attributed the impaired psychological activity to various developmental arrests and fixations during childhood (Kaplan & Sadock, 2003; Crider et al., 1983).

Although psychodynamic therapies often differ in their theories and approaches, they all emphasize the fact that past experiences play significant roles in present functioning. Another common element is the influential role that is played by the unconscious in human behavior. An important part of psychodynamic psychotherapy is to make the unconscious conscious, and to help the patient understand the origin of actions that are troubling so that they can be corrected (Sarason & Sarason, 2005).

2.4.3 Socio-cultural model

An individual is a social being. This means that he/she is surrounded by other people and institutions, and is a member of a family and society, participating in social and other relationships. This suggests that external forces always operate on individuals, setting rules and expectations that guide and sometimes pressure him, helping to shape his behavior, thoughts, and emotions.

According to the socio-cultural model of psychology, abnormal behavior can best be understood in the light of the social and cultural forces brought to bear on an individual (Comer, 2003). The studies of human relationships and social groups have proposed that societies can generate abnormal behavior in their members. For example, certain
communities may be so disorganized that many of their members are forced to engage in odd behavior in order to adapt to the community's norms and standards. Similarly, anthropologists have found that some patterns of abnormal psychology vary from society to society and from culture to culture (Pederson, 2002). For example, while ancestral spirit possession may be understood as normal in many African cultures, it may be perceived as some form of pathology by other cultures.

The socio-cultural view is also expressed in the community mental health programs that attempt to improve the mental health of the communities living in clearly defined catchment areas (Edwards, 1999; Seedat, 2001). According to Ahmed & Pretorius-Heuchert (2001), mental health care is integrated with other services and forms part of a broader primary-health care framework.

A key aspect of the community mental health programs is prevention, the mandate of which is to prevent or at least minimize mental disorders. Ahmed and Pretorius-Heuchert (2001) have mentioned three types of prevention, namely primary, secondary, and tertiary prevention.

Primary prevention consists of efforts to improve community attitudes and policies, with the goal of preventing mental disorders. Community workers may, for example, lobby for community recreational programmes, and consult with local school boards to help formulate curricula, or offer public workshops on stress.
Community workers engaged in secondary prevention try to identify and treat mental disorders at their earliest stages of development in an attempt to prevent the disorders from reaching more serious levels.

Finally, tertiary prevention seeks to prevent moderate or severe mental disorders from becoming long-term problems. This is done through providing appropriate and effective treatment when it is needed (Ahmed & Pretorius-Heuchert, 2001; Comer, 2003).

In South Africa, the success of the community mental health approach will depend on how health care is restructured, including whether the government allocates funds to promote community-based programmes.

2.4.4 The stress-vulnerability model of psychiatric disorders

According to the stress-vulnerability model (also known as stress-diathesis model), three critical factors are responsible for the development of a psychiatric disorder and its course over time, namely biological vulnerability, stress, and protective factors (Sorensen, 2002).

2.4.4.1 Biological vulnerability

For a person to develop a psychiatric disorder, he or she must have some biological or tendency to that disorder. The actual amount of vulnerability varies from one person to the next, as does the severity of the disorder. An individual’s vulnerability is thought to be determined from genetic factors and early biological factors. Postulated vulnerabilities to schizophrenia include deficits in the processing of complex information, dysfunctions in psychophysiology, and impairments in social competence (Kaplan & Sadock, 1997).
2.4.4.2 Stress

The stress aspect of the model postulates that a variety of stressors - such as internal and external events requiring adaptation - can convert vulnerability into symptoms. Therefore, coping strengths and supports that diminish stress should minimize or prevent the clinical expression of vulnerability. Examples of stressors include life events, such as the death of a loved one; tense relationships, and lack of useful, productive activity.

2.4.4.3 Protective factors

Protective factors reduce the person's biological vulnerability and stress. One important factor is the medication, which can lessen symptoms and lower the risk of relapses. Good coping skills in the patient and relatives (for example communication and problem-solving skills) and a supportive environment can prevent stress from increasing symptoms. The provision of such meaningful structures as volunteer work, day treatment, and household chores to the patient can also protect him or her from stress (Zheng Li & Arthur, 2006).

The stress-vulnerability model points to several areas in which the family can play an important role in improving outcome by building-up protective factors and these are outlined by Sorensen (2002) as follows:

i) The first area relates to the support that can be given to a patient who is taking medication. Such a patient should also be discouraged from abusing alcohol and drugs.
ii) The family must develop good communication and problem-solving skills so that patients as well as other people involved can cope with stress.

iii) A positive family life must be created in which the patient's efforts are recognized and small steps forward are encouraged.

iv) The symptoms of the disorder must be monitored, and the treatment team be alerted immediately if some changes are suspected or noticed, so that rapid treatment can be provided if necessary.

In summary, the stress-vulnerability model of psychopathology points out that a positive outcome of a psychiatric disorder is more likely if environmental stress is minimized or managed well, medication is taken as prescribed, and alcohol and drug abuse are avoided. Relatives and patients working together can improve the long-term course of a psychiatric disorder, resulting in a better quality of life for all family members.

2.4.5 Significance of the cultural context

As in most African countries, Western medicine in South Africa coexists with indigenous medicine. Western or "biomedicine" refers to the scientific, empirical medical tradition usually associated with the First World societies. In this approach, practitioners symptomatically treat disorders on the basis of biochemical criteria. Patients are treated as individuals with little or no regard for their interpersonal relations or socio-cultural orientation (Herselman, 2003).

Indigenous medicine refers to the system of health care of so-called "traditional" or indigenous societies in which the experience of a disorder or the socio-cultural meaning
of health and illness is emphasized. In this approach, patients are not treated as individuals, but holistically, first as members of a specific kin-group, and secondly, as members of a larger community. According to Herselman (2003), the concept of health does not only concern the individual’s physical well being, but also his or her emotional and material well being. Health behaviors and illnesses are explained on the basis of traditional religious belief system.

The foregoing implies that each medical system fulfills an essential function for those who participate in it. In South Africa, it is reported that greater numbers of black patients are turning to biomedicine (Hammond-Tooke, 1989), particularly in urban areas where there is a large concentration of biomedical facilities. However, many blacks still retain traditional health beliefs and behavior, but still consult a doctor or nurse, dentist, or physiotherapist. This implies that the provision and maintenance of health care in South Africa is frequently provided in a multicultural context.

2.4.5.1 Etiology of psychiatric illness

For many patients a condition becomes meaningful once a cause has been ascribed to it. Consequently the identification of a cause is a significant factor in a patient’s decision about subsequent coping strategies, such as who should be consulted and the form of treatment that should be followed. In most black patients in South Africa, for example the Zulus, illness causation may be rooted in a patient’s socio-cultural environment, and in the system of health beliefs as part of that environment in particular.
A number of psychiatric illnesses found among the Zulu are believed to be hereditary. The concept of heredity is reflected in Zulu expressions such as “ufuzo”, which literally refers to anything that is transmitted through heredity (Hadebe, 1986). In this context, the term “ufuzo” refers to a mental illness that, according to Ngubane (1977) is “believed to run in families” (p.23) and is incurable. Included under the term “ufuzo” are mental illnesses such as “ukuhlanya” which refers to all versions of schizophrenia and psychosis. The idea that “ufuzo” is hereditary and incurable is sometimes reflected in the lack of initiative on the side of the individuals responsible for the sick to seek treatment for the victim (Hadebe, 1986).

2.4.5.2 Religious beliefs

Many psychological disorders among the Zulu are believed to have a religious origin such as failing to perform a certain ritual for amadlozi (ancestral spirits). As a result the ancestral spirits cause a mental disorder in one member of the family concerned. According to Hadebe (1986) it is not uncommon to perceive “ukuhlanya” (schizophrenia or psychosis) as being caused by ancestral spirits who are angry or who have turned their attention away from the sick or from the patient’s family. In such cases, an intervention strategy is always “ukulungisa idlozi” (making peace with the ancestral spirits). The process of making peace with the ancestral spirits is a religious rite that involves slaughtering of a beast or a goat, depending upon the specialist’s prescription (p. 19).
2.4.6  *Relationship between the models*

The models that have been discussed above differ in the dimensions of behavior, emotion, and thought they focus on; the assumptions and concepts they employ; and the conclusions they reach. Marmor (1987) pointed out that the proponents of each theory of psychopathology tend to value their models at the expense of the other perspectives. Yet, each model helps us to appreciate a critical dimension of human functioning, and each has important strengths as well as limitations.

The understanding of psychiatric illnesses can be more complete if all the perspectives are appreciated. For example, schizophrenia may be explained on the basis of biological factors such as the malfunction in synaptic transmission; psychological in the case of an individual’s internal conflicts; and socio-cultural when there are problems in the family structure and communication, and societal stresses.

2.5  *Family reaction to psychiatric illness*

Psychiatric illness often causes a prolonged disruption in the lives of individuals who are experiencing the illness. Their ability to function psychologically, physically, socially, economically, and spiritually is affected. The profound losses and challenges that often accompany psychiatric illness affects not only the life of the individual with the illness, but the entire family, such as parents, siblings, spouses, and offspring (Hatfield & Lefley, 2006).
Research suggests that if a family member is diagnosed with psychiatric illness, this is usually followed by specific concerns, emotions, and questions about the disorders (Koenig, 2006). To date, the perspective that has been used to explain families’ reaction to mental illness in their family members is based on the emotional continuum of denial, anger, bargaining, depression, and acceptance devised by Kubler-Ross (1997) to explain reaction to describe response stages of individuals facing death.

As adapted to explain mental illness reaction by family members, the model proposes that relatives of mentally ill patients also enter into a loss and grief process similar to that of families experience in confronting other traumatic events such as death, disability, or serious physical illness (Hatfield & Lefley, 2006). By definition, loss means “a state of being deprived of or being without something one has had” (p. 23). This is usually accompanied by an array of emotions including sorrow, shock, numbness, fear, and so on. Mental illness results in “ambiguous losses” for the individual diagnosed with mental illness and family members. Culturally, customs and rituals are provided to ease the pain for those who lose someone through death. However, there is little support or practice that eases the pain of those who suffer a loss as a consequence of mental illness (Boss, 2006).

According to Boss (2006) ambiguous loss can cause personal and family conflicts not because of those experiencing the loss, but because of situations beyond their control or outside their constraints that block the coping with the grieving process. Ambiguous loss is confusing, and always leaves people baffled and immobilized. They do not know how
to make of the situation; they cannot problem-solve because they do not know whether the problem is final or temporary.

There is no doubt that any major illness is likely to affect the whole family and changes the way everyone goes about their daily life. At the same time, family members of those diagnosed with mental illness are likely to experience indefinite uncertainties about the condition of their relatives.

2.6 Impact of psychiatric illness

Mental illness has far-reaching effects not only to the individual suffering from the illness, but to other family members as well. While the study of the family impact on the family has been reported in the specialized mental health literature, it has not received much attention from social scientists (Munetz, Frese, & Frederick, 2001).

2.6.1 Impact on the individual

Butler and Pritchard (1999) have suggested that in order to understand the impact of psychiatric illness upon the individual, one has to compartmentalize artificially a process that is in reality a tightly interlocked system that occurs within the person. At the start of the breakdown the patient may sense a vague feeling of unease with uncontrollable ideas breaking into his or her conscious thoughts. This may create a sense of confusion within the patient’s mind and disrupts normal, logical thinking. The patient generally struggles against these imposed ideas and attempts to retain a sense of equilibrium.
Within our culture, people are expected to retain control of their emotions except under exceptional circumstances such as sudden bereavement. Fear of loosing control and displaying strong emotions such as tearfulness or intense misery, therefore, are extremely worrying. Lefley (2000) reports that at this point, many patients may begin to question their own state of mind and express fears about going mad. Ideas about what mentally ill people usually do, how they are viewed and treated by others, all begin to trouble the patient.

Butler and Pritchard (1999) report that at the onset of schizophrenia, patients undergo high levels of stress as they try to accommodate themselves into two realities, that of inner world and the world as experienced by other people. Their perceived world is often in a state of flux, creating a shifting state of equilibrium to which they are constantly trying to adjust.

2.6.1 Impact upon the family

An individual’s self identity is maintained by the response of other people. People perform different roles, for example sister, worker, father, mother and so on. In the case of mental patients, such roles may be disrupted as the individual may find it harder to meet his or her responsibilities and expectations of others (Lefley, 2000).

The family may respond to mental illness with feelings of incomprehension, and this may bring about disharmony within the family members. Distortion of communication and the strain of coping with someone who is mentally ill usually open up cracks within the family. Some family members may be fearful of mental illness and the images that it
portrays in the family. Subsequently, they may conceal the facts from friends and neighbours thereby isolating themselves and the patient (Nair, 2004).

Some research studies have focused on the financial impact as a major source of burden to those families affected by mental illness. According to O'Neale and Mckinney (2003), many families suffer severe economic hardships when a key wage earner is forced to leave his or her job because of mental illness. In other instances, spouses may take long leave or quit their jobs completely in order to care for a mentally ill partner. The financial burden of mentally ill person, therefore, may affect the standard and quality of life of all household members, leading to food insecurity, malnutrition, poor hygiene, loss of opportunity and other related factors to poverty.

2.6.3 Impact of parental mental health on children

There is ample evidence that both paternal and maternal mental health can impact on children, although not necessarily in the same extent (Smith, 2004). Furthermore, Rutter and Quinton (1984) found an association between the mental-health of parents; that is where one parent has mental health problems the other parent is also likely to have them.

In relation to maternal depression, negative child impacts have been observed in measures of language development and intelligence, social and emotional competence, sleeping problems, and the parent-child relationship and attachment behaviors (Hay, Pawlby, Sharp, et. al, 2001). The authors also pointed out that although the impacts on cognitive development are not insignificant, they do not normally result in the child being
placed in a problem category; however, the children of postnatally depressed mothers were more likely to have special educational needs.

In addition to language and cognitive development, Beardslee (1998) found associations with longer-term outcomes for children's mental health and well-being. For example, by young adulthood someone with an affectively ill parent had a forty-percent chance of experiencing major depression him/herself.

According to Smith (2004), the effects of parental mental health on children are evident throughout development, and are social as well as physical and psychological. Although the risk of all psychiatric problems is significantly increased in children of substance abusing parents, some studies suggest that these are most likely to manifest in children as high rates of depression and anxiety disorders, as well as attention problems, and later alcoholism.

2.6.3.1 Mechanism and routes of impact

There are many possible routes or mechanisms by which parental mental health might impact on children, and these include children's exposure to symptoms and disruptions to parenting.

2.6.3.1.1 Exposure to parents' symptoms

Some of the theories relating to the mechanisms of impact of parents' mental health imply direct effect of parental symptoms on children, while others imply an effect via an
intermediate factor or factors. An example of a direct effect would be the distress and disruption to the child exposed to the parent’s unpredictable or irrational behavior, or a delusional mother may actively include her child in her delusions – to the extent that the behavior is abusive to the child. According to Duncan and Reder (2000), the association between parent and child disorder was strongest when the parent’s symptoms impinged directly on the child, for example when they were victims of hostile or aggressive behavior, or were the target of delusional behavior, or neglected because of the parent’s illness. This may, therefore, suggest that for some children, direct exposure to the parent’s symptoms may be an important mechanism for the negative impacts.

2.6.3.1.2 Disruptions in parenting

Explanations of the less direct impacts of parental mental health on children are based on the assumption that parental mental illness will in most cases impair parenting ability. A depressed mother, for example may be preoccupied and withdrawn, and thus uncommunicative with, and unavailable to her child (Duncan & Reder, 2000).

Disruptions to parenting may explain the finding relating to differential impacts depending on the age of the child. According to Murray and Cooper (1997), the age of the child will largely determine their vulnerability and resilience to different disruptions in parenting behavior, or their relationship with the parent. For babies and young children, bonding and the development of attachment behaviors are of primary importance to their well being and development, and so disruptions to the mother-child relationship are the main areas of impact on the child. In an earlier study, Radke-Yarrow
(1991) had found that young children of depressed mothers were less likely to have secure attachments. This finding was consistent with the conclusion reached by Murray, Fiori-Cowley, Hooper et al, (1996) that mothers who were depressed postnatally were less sensitively attuned to their children, and were less affirming and more negating of infant experience.

A number of aspects of parental behavior that are likely to be disrupted by parental health problems have been identified; and these include self-preoccupation, emotional unavailability, distorted expectation of reality, and irritability. Although parental mental health may impact on parenting in a number of ways, Berg-Nielsen, Vikan, and Dahl (2002) conclude that the two most significant dimensions of disruption in relation to child outcomes may be parental negativity and harsh or ineffective discipline practices.

2.6.4 Impact on other family members

Nicholson, Sweeney, and Geller (1998) report that the strains associated with having a family member with mental illness may extend to other family members such as spouses, grandparents, and other extended family members. Mentally ill mothers may have a perception that their husbands do not understand mental illness, blaming them for problems that may arise. In this way, husbands may reinforce the “sick role” for mothers with mental illness and neglect to consult them or to consider their wishes in making decisions about children.

Grandparents are sometimes viewed as extremely helpful or quite undermining. They may pitch in when mothers are feeling overwhelmed or may be perceived as overstepping
boundaries and interfering with or indulging children. Grandparents may have been
dysfunctional parents themselves, and as a result mothers may not fully trust the child-
care provided by grandparents (Nicholson et al., 1998). In other instances, though,
grandparents may provide welcome respite for mothers with mental illness. This suggests
that in any type of intervention with mentally ill mothers, their strengths and weaknesses
as parents must be identified, and the services that they need be determined.

2.7  
Psychiatric illness and stigma
Considerable research has documented the stigmatization of people with psychiatric
illnesses and its consequences. Recently, it has been shown that stigma may also
seriously affect families of psychiatric patients, although little empirical research has
addressed this problem (Little, 2003).

Stigma can be described as a mark or token of shame, disgrace, or reproach in a person as
a result of that person’s attributes, behaviors, or condition. It is a social process that
allows for construction of exclusion, rejection, blame and devaluation of the identified
group or individuals (Hall-Flavin, 2005). According to Phelan, Bromet, and Link (1998),
stigma is a reality for people with psychiatric illnesses, and their greatest barrier to
complete and satisfying life. It is associated with labeling, stereotyping, separation, loss
of status and discrimination of those that are identified as being different. People feel
uncomfortable about psychiatric illness, and it is not seen like other illnesses such as
heart disease and cancer.
2.7.1 Effects of stigma on psychiatric patients

Much of the stigma of psychiatric illness is engrained in deep and ancient attitudes held by virtually every society. These attitudes govern the decisions that are made about mentally ill patients. Stigma ascribed to mental illness insinuates itself into policy decisions, access to care, health insurance, and employment discrimination (Jamison, 2006).

2.7.1.1 Stigma at the workplace

For many people with mental health difficulties work is an important coping mechanism providing a sense of purpose and value as well as important social contacts. Yet, all too often people with mental health issues are excluded from work on grounds of discrimination (Little, 2003). Most people with a diagnosis of serious psychiatric illnesses are economically inactive or unemployed. Most of them believe that they have been turned down for a job in the past possibly because of their mental health. According to Little (2003) less than sixty percent of people with anxiety and depression – the group most likely to be employed – were employed on a full-time basis. One in three of these people believed that bullying at work had contributed to their mental health problem. This clearly shows that the need to address and deal with the mental health and de-stigmatize it is still a priority.

2.7.2 Psychiatric illness and family stigma

Stigma associated with psychiatric illnesses does not only harm people who are affected by the illness, but also injures family members who are associated with these individuals.
Corrigan and Miller (2004) have called this courtesy stigma: the prejudice and
discrimination that is extended to people not because of some mark they manifest, but
rather because they are somehow linked to a person with the stigmatized mark. Family
stigma, therefore, may be conceived vis-à-vis relationship to a person with a psychiatric
illness that may suggest that the family member is somehow “tainted” by his or her
association with relatives with the disorder. The harm that results from this association is
due to some pernicious quality of the person marked by the illness.

The study of stigma associated with psychiatric illness has been largely informed by two
independent traditions, namely the psychological and sociological paradigms (Farina
(2000). Most of the research, however, has concentrated on the former, in which
cognitive and motivational processes lead individuals to stigmatize. According to
Corrigan and Miller (2004), there are two hypothesized reasons why the public may
extend the stigma of psychiatric illness to families:

i) People who appear together in public seem alike,

ii) If someone opts to associate with a marginal person, he or she cannot be
worth much.

Research has shown that family members of people with psychiatric illnesses may
experience significant discrimination in various social spheres. For example, in one study
(Ostman & Kjellin, 2002), about a fifth family members reported strained and distant
relationships with extended family and/or friends because of a relative that has psychiatric illness. However, another study found a much smaller rate with a ten percent of a sample reporting occasional avoidance by a few people (Phelan, Bromet, & Link, 1998). Viewing education as a proxy, the authors provided three interpretations of this association:

i) Higher status individuals might be more perceptive of avoidance,

ii) They may be overly sensitive and misinterpret others’ comments as rejections,

iii) Their presumably higher educated friends and relatives may be less tolerant of the family member with mental illness

2.7.2.1 Discrimination and shame

Avoidance is closely related with the sense of shame reported by many families with psychiatric illness. For example Shibre, Negash, Kullgren et al (2001) found that between a quarter and a half of family members believed that their relationship with a person with mental illness should be kept hidden or otherwise be a source of shame to the family. Another study showed that family shame was forty times more prevalent in families with people with psychiatric illness compared to families who have members with cancer (Ohaeri & Fido, 2001).

According to Corrigan and Miller (2004), the relationship between shame and avoidance is complex. Shame is used in most studies as a nonspecific component of stigma. It does not delineate the attitudes that might lead to harmful result. Moreover, it is not clear whether shame’s effect on avoidance is the result of public stigma or self stigma. In terms
of public stigma, shame is what the general population might expect family members to feel because of their association with relatives psychiatric illness. In order to prevent this shame from rubbing off on them, the public opts to avoid family members. Alternatively, the relationship between shame and avoidance may be understood in terms of self-stigma. In this case, family members who are ashamed by a relative with mental illness may want to hide from the public. There appears to be a need for further studies to clarify the relative functions of shame as public versus self-stigma in terms of discrimination and avoidance.

2.7.2.2 Blame and contamination

Research on the stigma experienced by people with mental illness has found that the community frequently blames them for their symptoms and disabilities (Corrigan et al, 2004). Research has also suggested that the community views family members, especially parents as responsible for the relative’s mental illness. In terms of this view, the notions of blame emanate from parents’ sense of responsibility and concern about anything that happens to their children. According to Corrigan and Miller (2004), the model on the cause of serious mental illness was dominant in the 1900’s, and focused on parental weaknesses as causing the early developmental problems of children. Although such models have diminished somewhat their influence remains prevalent and have spread to community notions about parental blame.

In describing causal attributions about human behavior, Peterson and Docherty (2004) distinguished between onset and offset attributions. As applied to health
conditions, onset attributions answer questions regarding how a set of symptoms started. Offset attributions reflect questions about what conditions are necessary for a set of symptoms to remit; for example, in what treatments must a person participate to experience a cure. According to Greenberg, Kim, & Greenley (1997), siblings and spouses are always blamed for a relative’s disease offset; namely, they fail to help the person with mental illness stay treatment adherent so the person unnecessarily relapses. According to Corrigan and Miller (2004), sibling blame seems to mirror public expectations that family members who are somehow currently associated with adult children with mental illness or who have opted to live with an adult have greater responsibility for current status. This is evident by reduced shame experienced by family members who do not live with relative with mental illness, compared to those who do.

2.7.2.3 Contamination of children by parents

Early researchers writing about stigma identified a common stereotype experienced by those with health conditions, namely contamination. Close association with the stigmatized person would lead to diminished worth. This might result from an infectious process in which the disease would jump from a patient to a peer causing him or her to develop the same symptoms. Alternatively, it may represent a more subtle psychological process that results from associating with a person with mental illness. Given the nature of the relationship, children would be especially likely to be perceived as contaminated by a parent’s mental illness (Corrigan & Miller, 2004).
This kind of stereotype has been demonstrated in a variety of studies. For example, in one investigation (Veltman, 2002), students with a father who was depressed, alcoholic, or an ex-convict were likely to be viewed as having more difficulties than the other group. Similarly, Mathew, Corrigan, Smith et al (2003) found that a sample of adolescents was more likely to rate teenagers with stigmatized parents as more socially negative than teens without parents with mental illness or alcoholism. In short, these results appear to strongly suggest that children may experience contamination from the stigma of their parents. It must be noted, however, that these results may be interpreted alternatively, in which case more work must be done in order to sort out whether perceptions representing contamination are accurate perceptions or stigmatizing perceptions.

2.8 Resilience in families with psychiatric patients

The study of families with a psychiatric patient has tended highlight the strenuous relationships between family members and the mentally ill person (Laing & Esterson, 1987). Recent approaches have differed significantly from earlier ones because they are less likely to blame the family or specific family members for causing the illness. Instead, the focus is on the family processes in order to promote the treatment and rehabilitation of the patient (Enns, Reddon, & Medonald, 1999).

Researchers have begun to look for signs of resilience in families with a mentally ill person, which might reduce the effects of the burden associated with caring for a family member with mental illness. Resilience is defined by McCubbin and McCabbin (1988) as "those characteristics, dimensions, and properties of families which help families to be
resistant to disruption in the face of change and adaptive in the face of crisis” (in Hawley DeHaan, p. 284; 1996).

The concept of family resilience offers a useful framework to identify key processes that enable families to surmount crises and persistent stresses. The resilience approach can help to inoculate families in order to deal with ordinary and exceptional circumstances. According to Walsh, (1996), it is important to note that the objective and subjective dimensions of the stressors remain in investigations of resilience. However, the research seeks to identify specific strengths and competencies that the family can utilize in order to deal with the effects of the crisis or stressor. Marsh (1996), for example identified signs of resilience in a sample of 131 family members who had one relative with a mental illness. The finding suggests a need for mental health professionals to collaborate with family members in the care and rehabilitation of relatives suffering from a mental illness. Furthermore, the finding also indicates that while the burdens associated with the care of a relative with psychiatric illness can be great, the personal strengths of family members must also be considered.

2.9 The concept of social support and its relationship to illness

Interest in social support and its relationship to mental health, physical health, and stress resistance has surged in the past few decades (Sarason & Sarason, 2005). Several theorists have proposed that people who generally respond to life stress with optimism, constructive coping strategies, and resilience are more likely to adjust to, and fight off illness than those who do not (Ma, 1995). Furthermore, research evidence suggests that
the availability of support from significant others is likely to protect individuals from stress, poor immune functioning, and help them adjust to both medical and mental illnesses (Mfusi, 2000).

2.9.1 Nature and importance of social support

Social support has been defined as information from others that one is loved and cared for, esteemed and valued, and part of a network of communication and mutual obligations (Cobb, 1976). In his conceptualization of social support House (1981) has stressed “the transaction between two or more people in which emotional concern, instrumental aid, information, or appraisal occurs” (p.6).

Researchers have suggested that social support may take several forms, for example, appraisal support, tangible assistance, information, and emotional support (Cohen, 1988; Willis, 1991).

i) Appraisal support includes helping the individual to understand a stressful event better and what resources and coping strategies may be mustered to deal with it. Through such exchange of appraisals, the individual facing stress can determine how threatening a stressful event is likely to be and benefit from suggestions as to how to offset the stressful aspects of the event.

ii) Tangible assistance involves the provision of material support, such as services, or financial assistance.
iii) Family, friends, and significant others can provide information by suggesting specific actions an individual can take to combat a stressor. The person under stress can try out his or her definition of the problem and potential solutions, and supportive friends and family can provide feedback.

iv) Emotional support can be provided by family and friends by reassuring the person that he or she is a valuable individual who is cared for by others. The warmth and nurturance provided by others can enable a person under stress to approach it with greater assurance (Taylor, 1995).

Research studies have explored the relationship between social support and patients’ adjustment and ability to cope with mental and physical illnesses, and the general finding has been that higher level of social support is associated with better psychosocial adjustment (Ma, 1998). Social support effectively reduces distress during times of stress, and also appears to reduce the risk of mortality due to serious disease (Taylor, 2003).

Exactly how social support moderates the effects of stress has been subject to research controversy. However, one hypothesis, known as the buffering hypothesis, maintains that the health and mental health benefits of social support are chiefly evident during periods of high stress, for example being affected a psychiatric illness. In such conditions, social support may act as a reserve and resource that blunts the effects of stress or enables the individual to cope with stress more effectively when it is at high levels (Taylor, 1995).
2.9.2 Family support and psychiatric illnesses

Families throughout the world must adjust to the onset of a psychiatric disability and its resulting complications and challenges. In most countries families are an essential resource to members who have either a physical or a mental illness, providing general social and psychological support (Finley, 1998). In some cases, family members may be perceived as allies and integral to the treatment process. They may travel long distances and live in close proximity to the hospital in order to “wait out” the hospitalization of a family member. Family members also participate in the feeding, nursing and medication monitoring of the mentally ill family member (Wai Tong, Chan, Morrissey, et al, 2005).

Research evidence suggests that better prognosis for many severe and persistent psychiatric illnesses may be attributed to the care-taking role that is provided by the patient’s family members. The family role in assisting the patients is often perceived as a valued involvement providing psychological, emotional, and economic buffers (Finley, 1998).

According to (Thurman, 2002), over the past two decades the family therapy literature has promulgated the importance of applying a multi-dimensional approach to the study of families. According to him, an individual’s behavior can best be understood within the context in which it occurs. Psychiatric patients can, therefore, be understood within the contexts of their families. With the current trend of community care for psychiatric
patients, there is likelihood that more family intervention may reduce patient relapse and re-hospitalization, and enhance patients’ coping capabilities (Wai Tong et al., 2005).

2.9.2.1 Scope of family support

Family members of psychiatric patients usually have little or no knowledge about the nature and prognosis of a relative’s illness. Consequently, they may lack information regarding what to do in order to help the patient about his or her symptoms.

2.9.2.1.1 Adherence to medication

Adherence to medication regiments is central to effective care for many psychiatric disorders such as schizophrenia and the major affective disorders (Corrigan, 2002). Research suggests that some patients with serious psychiatric illnesses fail to receive relevant medications as prescribed. The reasons for the poor adherence have been explained by Cramer and Rosenbeck (1998) as follows:

- Some psychiatric patients may lack insight into their condition and how it impacts on the breath of their life functioning domains. Such lack of insight predicts poor outcome and diminished treatment compliance. As a result, these patients can neither identify the importance of medication regiments, nor the symptoms the medications are to remediate.

- Specific psychiatric conditions show general cognitive impairments, for example diminished memory and deficits in executive functioning that interfere with health behaviors.
The harmful side effects of certain medications may yield negative expectations about the treatment. The APA (1997) reports that some medications yield side effects that have deleterious impact on almost every organ system in the body, especially abnormal and involuntary movements. Patients may, therefore, evaluate the costs of adherence to such medications more negatively than its benefits.

According to Corrigan, and Miller (2004), patients' adherence to treatment is largely a social behavior in which patients interact with health care providers regarding the appropriate strategies for coping with their symptoms. Because many family members as well as friends are themselves invested in continued medication, they frequently become involved in issues regarding their relatives' adherence to treatment. As Craig (1998) points out, some patients may have poor alliances with health providers. In such cases, the role of the family members to ensure patients' adherence becomes pivotal. Family members do not only help their sick relatives with decisions relating to adherence, but also provide vital assistance on such practical matters as traveling to appointments and drug stores, tracking medication use and providing funds when the person is financially strapped.

2.10 Determinants of the quality of life in psychiatric patients

Studies investigating quality of life in psychiatric patients have tended to focus on patients with schizophrenia. Severe mental illness, however, is likely to include other
psychiatric conditions such as bipolar disorder, major depression, and some of the personality disorders.

According to Hansson (2006), efforts must be increased to improve subjective quality of life in people suffering from psychiatric illnesses. Such efforts must include monitoring of psychiatric conditions; and also pay special attention to assessment of and interventions against the patients’ unmet needs, including a strengthening of the social support of the patients.

2.10.1 Social support and quality of life

Hansson (2006) has suggested that if the view to social situation of people with psychiatric illness was broadened, a general link between social support and different aspects of health and well being can be observed. Social support, however, has both a structural aspect that refers to qualities of social relations, and a functional aspect that refers to more qualitative aspects such as type of interactions with other people and satisfaction with social and emotional relationships.

Studies investigating the relationship between social support and quality of life in some severe psychiatric patients have shown significant associations regarding the size of the social network and the qualitative aspects of such networks. A larger network has shown a moderate association with a better quality of life, at least up to a certain size of the network (Caron, Tempier, Mercier, et. al, 1998). Satisfaction with the social network or social relations has also been demonstrated to be associated with a better subjective
quality of life (Bengtsson-Tops & Hansson, 2001). An interesting and potentially important finding has been provided by Yanos, Rosenfield, and Horwits (2001) who showed that negative social interaction was related to a worse quality of life, particularly if the interactions were perceived as stigmatizing by the individual. These findings are likely to open a new interesting perspective that puts a focus on the general relationship between stigma and quality of life.

2.10.2 Community health services and quality of life

One of the most important issues relating to the changes in the delivery of mental health services to the community care is whether the shift has actually been reflected in improvements in quality of life among people with mental illness. Bobes and Gonzales (1997) observed that levels of satisfaction among community-based people with severe psychiatric illnesses, such as schizophrenia were high although it has been shown to be lower than quality of life in the general population. The specific areas of dissatisfaction that have been noted concern finances, social relationships and health. Comparative studies indicate that patients in community care settings have a better subjective quality of life than patients in hospital settings (Hansson, 2006). Furthermore, improvements in subjective quality of life have also been reported as patients move from inpatients care settings to community care settings (Ritsner, Bond, & Drake, 2003).
CHAPTER 3: RESEARCH METHODS

The aim of this study was to investigate the role that was played by family members in helping psychiatric patients cope with their psychiatric illnesses. In particular, the objectives of the study were to explore the extent to which the following impact psychiatric patients’ coping with their illness:

- The patients’ perception of support provided by family members
- The patients’ knowledge of their psychiatric illnesses
- Family members’ supportive role in helping patients cope with their illness
- The effects of having a family member with a psychiatric illness
- The challenges facing the mentally ill persons and their families as a result of the illness

The present chapter describes the methods that guided the researcher in collecting, analyzing, and interpreting the observed data. In order to achieve the study’s objectives, both qualitative and quantitative methods were used.

3.1 Qualitative methods

Qualitative research is generally characterized as the attempt to obtain an in-depth understanding of the meanings and definitions of the situation presented by informants, rather than the production of a quantitative measurement of the characteristics or behavior (Boje, 2001). Qualitative research methods are often called naturalistic because
in a naturalistic paradigm "reality" or "truth" is considered multiple and socially constructed (Farzanfar, 2005; p. 6). The methods are therefore designed to help researchers understand people and the social and cultural context within which they live.

According to Myers (2006) the use of qualitative research evaluations in mental health promotion and disease prevention has been on the rise because it makes it possible to explore users' opinions in depth and detail and facilitate understanding of users' expectations, preferences, and likes and dislikes.

Just as there are various philosophical perspectives that can inform qualitative research, so there are various qualitative research methods for example, case study research, ethnography, and grounded theory. In the present study, a grounded theory approach was used.

A grounded theory is a theory that is discovered or generated from data rather than being abstract and tentative (Neuman, 2000). It is a qualitative method that enables the researcher to study the interactions among people and meanings thereof as related to the context in which such interactions or meanings occur (Cresswell, 2003).

According to Glazer and Strauss (1967), grounded theory embodies a number of characteristics associated with the qualitative paradigm, including an emphasis on the importance of viewing the meaning of experience and behavior in context and in its full complexity; a view of the scientific process as generating working hypotheses rather than
immutable empirical facts; and an attitude towards theorizing that emphasizes the grounding of concepts in data rather than in a priori theory.

The grounded theory approach has recently been proven to be a potent research tool particularly in its ability to blend the different stages of research into a single stage. For example, Isherwood, Burns, and Rigby (2006) successfully used a grounded theory approach to identify principle themes from the responses of subjects with learning disabilities and mental health problems. The results were subsequently used to recommend psychosocial interventions as an adjunct to routine pharmacological treatment for people experiencing psychosis. Similarly, Mostafanejad (2006) used the grounded theory approach to develop measures of how mental health workers can help reduce young adults’ isolation as a result of living with a mental illness.

In the present study, through in-depth interviews with psychiatric patients and their families certain themes emerged about the way both patients and their families cope with psychiatric illnesses. Through systematic observation and study of the data, a model for intervention strategy was developed.

3.2 Quantitative methods

Casebeer and Verhoef (2002) define quantitative research as “the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect” (p. 3). The use of a
quantitative method in the present study was to show the objective responses of the patients with regard to their perception of support given by relatives.

In the present study, the questionnaire was used as an objective scale aimed at quantifying the responses for more objective comparisons to the data obtained qualitatively from the interviews. The data were subjected to statistical analyses to see if there were any statistically differences related to participants’ age, gender, level of education, and frequency of relapse between those psychiatric patients who regularly took their medications and those who did not. Such an objective measure ensures that data is generalized to other similar situations even though the sample of in-depth interviews was small.

3.3 Participants

Twenty-seven psychiatric patients as well as their family members were interviewed. Eighteen of the patients had been admitted to the hospital for various complaints, and had been referred to the clinical psychologist for psychotherapy. Nine of the patients attended private consultations with the researcher. Family members of both groups of patients were contacted, with a written consent from the patient, to participate in the treatment planning of the mentally ill person. A convenience sample was used in that the criterion for inclusion into the sample was based on patients suffering from certain psychiatric disorders, for example psychotic disorders, mood disorders or anxiety disorders. All participating family members were required to report their relationship to the patient.
These included members of the patients' immediate family, namely parents, siblings, spouses or partners, sons or daughters, and so on.

3.4 Diagnoses of patients' illnesses

The diagnoses of the psychiatric patients' illnesses were made after the various symptoms and circumstances that prompted them to seek help had been obtained. It is important to mention that in some cases, details about the patients, for example personal history, were obtained from the patients' family members as collateral information. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) was used to verify the diagnoses.

3.5 Instrument for data collection

A semi-structured questionnaire guided the researcher in the collection of data for the study. The questionnaire was pilot-tested using five respondents, and modifications were made to the format and content of the questionnaire. The first part of the questionnaire required demographic characteristics of the psychiatric patients such as age, gender, the first time a psychiatric diagnosis was made, and educational level.

The second part of the questionnaire required information about the psychiatric patients' illness, for example their initial reactions to the diagnosis, knowledge about their mental illnesses, the level of support received from family members and the community, and the causes and impact of mental illness. The third section of the questionnaire included information obtained from the mental patients' family members, for example their reaction to the relative's illness, the amount of support given to the patients and the
challenges they faced as a result of their relative’s mental illness. Some of the interviews were audio taped after obtaining consent from the participants. In other cases, where participants expressed anxiety about the use of the tape recorder interviews were transcribed directly from their verbalizations.

3.6 Procedure of data collection

Permission was requested from the hospital manager to conduct the study with the hospital patients. The information for the study was collected after the scheduled psychotherapy with the patients had been completed. The cognitive functions of all the participants were intact during the interviews. All the interviews were conducted in the psychologist’s office and the participants were assured of anonymity and confidentiality.

The interviews consisted of two elements, the first of which constituted “directed conversations” (Henning, 2004) in which psychiatric patients were asked to reflect on their experiences both in and out of hospital, for example the amount of support (or non-support) they received from their family and community members, and information about their psychiatric conditions when being discharged from hospital.

Secondly, the patients’ family members were asked to express their feelings and perceptions about the patients’ psychiatric conditions, and the difficulties or challenges (if any) they encountered as a result of having a family member with a psychiatric illness.
3.7 Intervention during data collection

Information from the patients and their relatives was followed by family type of intervention in which the author provided professional counseling for the families. The type of intervention used ranged from individual therapy with the patients to a family-type of therapy in which both the patients and their relevant relatives participated. For example, as patients told their stories about mental illness appropriate intervention by the researcher was given. In some instances, the patients and their family members jointly participated in the sessions to address issues that were perceived by the researcher as of mutual concern.

3.8 Data analysis

Both quantitative and qualitative analyses informed the process and act of conceptualizing the data in the present study. Quantitative analysis was utilized for the psychiatric patients' biographical data such as age, education, employment and marital status. Data were presented into frequency tables for easy interpretations.

Qualitative data analysis is an approach of making sense of social research observations by utilizing methods of examining social research data without converting them to a numerical format (Babbie & Mouton, 2001). It is an inductive process of organizing data into categories and identifying patterns and relationships among categories. In addition, qualitative data analysis affords the researcher an opportunity to move into a deeper understanding of the data and making an interpretation of the larger meaning of data (Creswell, 2003).
In the present study, the first stage of qualitative data analysis involved the transcription of all the data obtained during the interviews. The raw data were then organized into categories and themes were created, for example reaction to mental illness, impact of mental illness to the family, role of family support, the attitude of the community and patients' satisfaction with support. The summaries of the data were presented in the form of diagrams and charts to facilitate the organization of ideas and systematically investigate relations in the data.

This chapter has described the various methods of research that were used in the present study. Although the primary goal of research is to use a sample that is representative of the population, the present study used a small collection of cases in order to illuminate the social lives of psychiatric patients and enhance what other researchers can learn about the processes involved in the lives of the patients.
CHAPTER 4: RESULTS AND DISCUSSION

The present chapter presents the results and discussion of data obtained from the participants and their family members. The first section presents the personal histories of all the psychiatric patients that were interviewed; different codes were used to refer to the individual patients. This is followed by an analysis of the patients’ biographical details. The final section consists of the analysis of the themes based on the verbalizations of the patients and their relatives. Each section is followed by a detailed discussion.

4.1 Personal histories of participants

Thm - Bipolar Disorder

Thm has been taking treatment for her mental illness since 2004. She could not say exactly what her illness was. The hospital staff did not inform her about her illness. A description of her symptoms appeared to suggest that she suffers from a bipolar disorder. She had not consulted a psychologist prior to the interview. Her illness has affected her studies; her boyfriend who made her pregnant insisted that the pregnancy be terminated when he learned that Thm was mentally ill. She has not seen him since then. Other community members are not aware that Thm has a mental illness.

Mrs. N. M. – Major Depression (with psychotic features)

Mrs. N M., a 55-year old mother of five children came to the hospital accompanied by her daughter and her friend. This was after she had suddenly collapsed while working in her office. During the assessment interview, she complained of headache, neck pains and
other general bodily pains. Further details revealed that she had recently lost her son through a motor vehicle accident. Her son, who was a medical doctor was reportedly very close to Mrs. N. M. Mrs. N. M. daughter reported that since the death of her brother, Mrs. N. M. had been manifesting poor vegetative functions, for example lack of appetite and poor sleep. Mrs. N. M. also mentioned that after the death of her son she had been experiencing visual hallucinations of a woman giving birth.

Mrs. W. — Schizophrenia (Culture-bound psychosis)

At the insistence of her husband, Mrs. W. was referred to the author for psychotherapy by a hospital psychiatrist. According to her she had been taking anti-psychotic medication for the previous fourteen months for symptoms consistent with schizophrenia. During this time she had been free of hallucinations (both visual and auditory). Her husband stated that recently, his wife had had an “outburst” of hallucinations in which certain people demanded that she go and get medicines from the nearby forests. Her psychiatrist had then decided to admit her because she posed danger both to herself and others. Further details about Mrs. W. revealed that her grandmother was a traditional healer, and that when Mrs. W. experienced dreams in which she was summoned to train as a diviner, she consulted a local priest who prayed for her. She did experience some relief after the prayer, but her situation later worsened at which point she consulted her current psychiatrist.


**Mr. M. - Bipolar Disorder**

Mr. M. is a 26-year old student who did not know the identity of his biological parents, but was raised by foster parents who had always treated him as their own child. He stated that he had been on medication for schizophrenia since he was a child. Among other things, Mr. M. stated that his illness had always been kept as “secret” because of fear of being stigmatized. In one of the sessions, his adoptive mother related how Mr. M’s bride failed to turn up for their wedding ceremony after her family had discovered that Mr. M. was on anti-psychotic medication. At the time of the consultation, Mr. M. was dating a fellow student who was aware of his condition, and was always supportive of him.

**L. - Schizophrenia**

L. is a twenty-two year old male who is doing second year studies at a tertiary institution. He first manifested symptoms of schizophrenia in 2002. He and his parents were shocked when he first experienced hallucinations and became violent. At first his mother thought that he was on drugs; later all family members accepted the fact that L. had a mental illness. Since then they have supported him by all means and ensured that he does not skip his medication. Although L. is an active community member he feels that other people in the community view him with suspicion. L’s elder brother thinks that he has been bewitched although a visit to a traditional healer did not help.
Mrs Sk, a 32 year old mother of two, was brought to the hospital by her husband complaining of severe headache, poor vegetative functions, and general bodily pains; this was after a series of conflicts first with her husband of six years, and then with the church. During the initial interview, Mrs. Sk was tearful most of the time; her cognitive functions were however intact. During her stay in the hospital, she was regularly visited by her husband and children.

Mrs. F.M. – Schizophrenia

Mrs. F.M. lives with her husband and their three children. The couple has been married for approximately 20 years. Mrs. F.M. stated that she usually suffers from severe headache, during which time she wants to harm her children; clings to her husband, and hears voices of people shouting at her. The symptoms began in 1993 and she has been on medication since then. Mrs. F.M.'s husband is evidently concerned about his wife’s state of health, and always ensures that there is an elderly person in the house in the event of an unexpected attack by illness on the patient.

B.L. – Dementia due to medical (HIV) condition

B.L. is a 48-year old unmarried female who lives with her two children. She was diagnosed as HIV positive in 2004. As a result, she has been in and out of the hospital. When she was first referred to a psychologist for psychotherapy, she complained of poor concentration, forgetfulness, and presence of auditory hallucinations in which some females were singing in front of her. She also complained of a severe headache in which
she felt as if “her brain was moving”. B.L.’s symptoms appeared to be direct consequence of human immuno-deficiency virus (HIV) disease.

Nox. – Dysthymia

When Nox. came for psychotherapy, she complained of loss of energy, overeating, low mood, insomnia, and feeling sad most of the time. She had been having these and other related symptoms for the past four years. She reported that she was the last born of the four children in her family. Her family relations were poor, especially with her first-born sister who reportedly abused her physically when they were still children. Her son was disobedient, and sometimes insulted her in the presence of other people. Nox’s cognitive functions were intact, but she had very poor eye contact and seemed tense and anxious at first.

Mrs. B. – Major Depression

Mrs. B. is a thirty-six years old married mother of four children. She lives with her husband and children. She was first admitted to hospital in 2005 for symptoms consistent with major depression. Most of the support she gets comes from members of her family of origin particularly her younger sister. She feels that her husband does not think that she can be relied upon because of her illness. However, she is generally satisfied with the level of support she gets from everyone. In her view community members think of her as self-centered and thinking about herself only. Some of her family members think that she must perform a ritual for the ancestors who they think are angry about something about her or her family.
T.S. – Panic Disorder Without Agoraphobia

T.S., a 37-year old teacher, was admitted into the hospital complaining of shortness of breath, palpitations, headache, and strange sensations all over his body. According to him, the first attack occurred when he had just finished one of his classes where he teaches. He experienced the second attack while he was resting in his bedroom. Of note was the fact that he began to have the attacks after re-uniting with his former girlfriend who had earlier left him to get married to someone else. Somehow, the marriage did not work for her, and she decided to reunite with Mr. T.S. Although his family did not approve of the reunion, they continued to support him, including taking him to a traditional healer.

T.G. – Bipolar Disorder

T.G. is a twenty-five years old student whose symptoms are consistent with a bipolar disorder. She lives with her parents and two siblings. She has been taking her medication for the disorder since 2003. Her family members are supportive to her although she would prefer that they communicate with her more often, particularly about her disorder. Her illness has affected the way she interacts with other students. She has read about her illness and knows more about it. Her mother and other family members were shocked and scared when T.G. first manifested the symptoms of her illness. The mother initially thought she was just being silly.
Chet. N – Dysthymia

The patient was brought to hospital by her relatives after she collapsed in her kitchen while preparing a meal. During the interview she complained of severe headache, dizziness, and neck pains. She stated that her appetite was normal but that she had been experiencing poor sleep in the past four months or so. Her history revealed that in 2002 she was divorced by her husband who also “kidnapped” her four children to New Zealand. Despite a lengthy legal battle, she was neither re-united with her children nor had any communication from them. Despite her difficulties, she managed to keep her job as a school teacher and managed to build a home for herself. This was through the assistance of her family. In 2005 she was called by her eldest son who expressed a desire to return to the country to live with her. However, he stayed for only four months after which he complained about the standard of education in South Africa, and later returned to New Zealand. At an invitation of her New Zealand in-laws, Mrs. Chet. visited her children and stayed with them for five weeks. At the time of her consultation she manifested both anxiety and depressive symptoms but could not meet the criteria of both.

M. Bis – Alcohol Dependence

M Bis is a 47-year old SAPS employee who was referred for psychotherapy by his station commander for symptoms consisted with alcohol dependence. He presented himself for psychotherapy accompanied by his wife, Mrs. M.Bis. During the interview, Mr. M.Bis consistently blamed his wife for his continuous drinking, stating among other things that she was not supportive to him. Mrs. M.Bis in turn, stated that Mr. M.Bis did not bring
money home, and that she had been forced to sue him for the maintenance of their three children despite the fact that they all lived together as one family. As part of the intervention, arrangements were made for Mr. M.Bis to check into a rehabilitation center where he spent a maximum of five weeks. At the center Mr. M Bis underwent both individual and group psychotherapy, and Mrs. M.Bis paid him regular visits during his stay at the rehabilitation center.

Ms B. – Post Traumatic stress Disorder

When Ms B. came for consultation she appeared apprehensive and worried. She stated that sometime in 2004 one of her school colleagues was shot dead by her boyfriend who also threatened other staff members with a firearm. Ms B. and two other females fled into a nearby forest for fear of their lives. While Ms B. and other female staff were running away one of them was also shot dead and Ms B. stumbled onto her body. Ms B. stated that since the incident occurred she had always been on the edge, suffered from insomnia, and experienced flashbacks. Her family had always been supportive of her, taking her to different practitioners, including a sangoma. However, her symptoms did not subside.

Ev. – Bipolar Disorder

Ev. Is fifty-nine years of age, unemployed and lives with her husband and their five children. She was first diagnosed with bipolar disorder in 1991. One of her children is mentally retarded and the other smokes dagga and also takes other drugs. Ev’s main problem is that she in noncompliant to her medications. Her husband has always been supportive to her but her children always shout at her, and call her names, for example
they refer to her as a “madcap”. The community is aware of Ev’s condition although she hardly attends community gatherings. Since she does not attend such gatherings, she cannot describe the attitude of the community members toward her mental illness.

*Ler. - Attention Deficit Hyperactive Disorder*

Ler. is 12 years old, the second child out of a family of two children. His father died of HIV/AIDS and Ler. and his elder brother have been living with their mother since then. He was referred for psychological assessment at the insistence of his class teacher because of his poor concentration and disruptive behavior in class. During the initial interview which was also attended by his mother, Ler. appeared anxious, bored, and had difficulty settling down to any task that was given to him. According to his school report, he was disruptive in class, had a short attention span and also tended to show limited reflection about most of the questions asked by his schoolteacher. In short, Ler. manifested symptoms consistent with ADHD. Intervention included referring him to a local physician who prescribed the relevant medication. His mother was also assisted in finding a government school that caters for children with Ler’s difficulties.

*Fiv. - Schizophrenia*

Fiv. is a twenty-one year old Standard 10 pupil who started to hear strange voices of unknown people in 2005. His grandmother is reported to have been schizophrenic. Fiv. attended the interview accompanied by his aunt. His parents died some time ago and he has been under the guardianship of his aunt. He acknowledged the support given to him by his family including ensuring that he takes his medications regularly. He is, however,
critical of his family for thinking that “he is still crazy.” They don’t want him to do things on his own. After his discharge from the hospital no information was given to him by the hospital staff. Members of the community continue to call him names as a result of his psychiatric condition. He was once taken to a traditional healer who told him that he had “amafunyane.” Fiv’s family does not know much about his illness. They were confused and scared when he first showed signs of mental illness.

P.K. – Antisocial Personality Disorder

P.K., a 23-year old university student, came for psychological consultation on the advice of the student guidance unit. Information obtained from the guidance unit was that P.K had met a female student at the library who he invited to his hostel room. It was alleged that while there he tried to force her into having sexual intercourse with him. P.K. also said that he was not in talking terms with his uncle whom he had beaten with a brick during a family function.

Mw. – Schizophrenia

Mw is a forty years old father of four children. He was first diagnosed with schizophrenia in 2002 and has been on medication since that time. No history of mental illness in his family was reported. Mw is unemployed. He stopped working in 2002 as a result of his illness. He depends on his family for financial and emotional support. His mental condition seems to affect the family relations in that he spends much of his time alone in his room. His wife and other family members help him with regular intake of his medications. The wife appears to understand his condition and has arranged for him to
attend counseling sessions as well as support groups. Mw’s wife also fears that her husband will experience a relapse of illness. As a result, she always makes sure that when they communicate she avoids discussing topics that might upset her husband. The community members discriminate not only against Mw but against the whole family.

C.P. – HIV-related Dementia

C.P. and her husband were diagnosed as HIV positive in 1999. She has one child and her husband died in 2003. Her father had schizophrenia. C.P. showed extensive knowledge of HIV/AIDS including its progression to dementia. She had undergone a series of emotional reactions at the time of the initial diagnosis, for example shock, anger, anxiety and distress. Her family members are generally supportive although some of her sisters have distanced themselves ever since she experienced confusion and psychotic features. She thinks that the attitude of the community is negative, but seems not to care much about what other people think or say about her.

Mrs. X. – Schizophrenia

Mrs X. is a thirty-year old divorced mother of two children. She lives with her parents and other family members. Her condition is schizophrenia. Her family looks after her children because she swears at them and becomes aggressive “when she is attacked by her illness”. In general, she is not satisfied with the amount of support she gets from her family. Mrs X’s mother is mainly responsible for the patient and her children. Being a pensioner, Mrs. X’s mother has difficulty in maintaining both Mrs X and her children. She was shocked and scared when she first noticed her daughter’s symptoms. Family
members ensure that Mrs. X. take her medication regularly, but are always concerned about Mrs X’s children. The children cannot cope with the fact that their mother is mentally ill. The community is sympathetic to Mrs. X’s mother but the attitude toward Mrs X is negative. The community avoids having contact with her.

*M. – Transient Tic Disorder*

M., a 14-year old male came for psychological evaluation accompanied by his mother. She reported that M. was troubled by a presence of a persistent left eye blinking. M and his family were extremely distressed by these symptoms as he was being teased by other children both at school and at home. During the initial interview, M stated that he simply could not control the eye blinking. It also emerged that the family had very strong beliefs in witchcraft and that M. may be a victim of sorcery.

M’s symptoms appeared to be consistent with Transient Tic Disorder. In view of the family’s strong belief in traditional customs and values, it was suggested that M’s family slaughter a fowl and brew traditional beer for their ancestors. When M’s mother came for the next session some two weeks later, she reported that after the ritual had been performed, there was a significant improvement in the frequency of M’s tics!

*Gd. – Post-Traumatic Stress Disorder*

Gd. is thirty-nine years old father of four children. He is employed as a captain in South African Police Services. He came for counseling at the advice of his employers. His problems started when one of his junior officers accused a senior staff member of “blocking” his promotion. An argument ensued and Gd. attempted to defuse the situation
by suggesting that the matter be referred to a station commander. The junior officer then took out his firearm and killed Gd’s colleague. Since the incident Gd had been unable to eat and sleep well. He experienced nightmares and flashback about the incident.

_Nt. – Generalized Anxiety Disorder_

Nt. is thirty-seven years of age. She is employed as one of the most senior professionals in one of the government departments. She lives with her child, mother and two siblings. When she presented herself for psychotherapy, she complained that she had poor sleep and spent most of the nights thinking that she had some chronic illness. During the day she was restless and had difficulty focusing on her work. Her family, especially her mother was concerned about Nt. and thought that she should go for a thorough check-up at the hospital.

_Ber. – Schizophrenia_

Ber. a Std. 10 pupil at a local school, came for consultation accompanied by his uncle. The patient had started to hear voices of people shouting at him, and during these episodes he would lock himself in his room. During the interview, his uncle stated that his nephew’s problems began when he had conflict with some girl. He had stopped attending school as a result of his problems. Although no physical confrontation ensued, Ber. and his family were convinced that he had been bewitched. Collateral information from the school principal revealed that Ber. had been suspended from school for dagga smoking. Ber.’s symptoms appeared to be consistent with substance-induced psychotic disorder. Intervention included intensive therapy with Ber. and his family regarding the
origin of his symptoms. In addition, his school was also involved in the management of his problems.

Tel. – Major Depression

Tel is a forty-eight years old mother of five children and is unemployed. She was first diagnosed with major depression in 2005. She left her employment at the request of her employers who complained of her underproduction. Her children are supportive to her both financially and emotionally. Tel. had two hospital admissions in 2005 but none in 2006. The family members were scared when Tel first manifested the symptoms of her illness. Other community members are not aware of Tel’s condition; and she is not actively involved in any community activities.
4.2 Demographic Details

4.2.1 Age of the participants

Table 1: Distribution of participating patients by age

<table>
<thead>
<tr>
<th>AGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 - 19</td>
<td>3</td>
</tr>
<tr>
<td>20 - 29</td>
<td>6</td>
</tr>
<tr>
<td>30 - 39</td>
<td>11</td>
</tr>
<tr>
<td>40 - 49</td>
<td>6</td>
</tr>
<tr>
<td>50 - 59</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 1 above shows that the age of the participants ranged from 10 to 59 years. The youngest patient was 14 years of age and the oldest was 55. The majority of the patients’ age ranged between 30 and 39 years.
4.2.2 Participants’ gender

Figure 1: Distribution by Gender

As shown in Figure 1 above, of the twenty-seven patients interviewed 16 were female while the remaining 11 were male.

4.2.3 Participants’ marital status

Figure 2: Distribution by marital status

As shown in Figure 1 above, of the twenty-seven patients interviewed 16 were female while the remaining 11 were male.
The majority (55%) of patients interviewed in the present study were single, 26% were married, 11% were divorced and .07% widowed.

4.2.4 Participants' level of education

Figure 3: Level of educational

Figure 3 shows the educational level of the participants in the study. Of the 27 participants interviewed 11 had educational level of grade 7 or below, 10 were between grades 8 and 10 and 6 had attained tertiary education.
4.2.5 Duration of diagnosis

Table 2: Duration of diagnosis (in years)

<table>
<thead>
<tr>
<th>Duration in yrs.</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 3</td>
<td>21</td>
</tr>
<tr>
<td>4 – 6</td>
<td>3</td>
</tr>
<tr>
<td>7 – 9</td>
<td>1</td>
</tr>
<tr>
<td>10 years or more</td>
<td>2</td>
</tr>
</tbody>
</table>

The duration of mental illness for most patients in the present study was between 1 and 3 years. 3 had been mentally ill for periods between 4 and 6 years, 1 between 7 and 9 years and 2 patients had been mentally ill for more than 10 years.
4.2.6 Types of psychiatric patients’ illnesses

Table 3: Types of psychiatric patients’ illnesses

<table>
<thead>
<tr>
<th>Type of Disorder</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>7</td>
</tr>
<tr>
<td>Major Depression</td>
<td>4</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>4</td>
</tr>
<tr>
<td>Dysthymic Disorder</td>
<td>2</td>
</tr>
<tr>
<td>HIV-related Dementia</td>
<td>2</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>2</td>
</tr>
<tr>
<td>Alcohol Dependence</td>
<td>1</td>
</tr>
<tr>
<td>Panic Disorder Without Agoraphobia</td>
<td>1</td>
</tr>
<tr>
<td>Attention Deficit Hyperactive Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Transient Tic Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>1</td>
</tr>
</tbody>
</table>

Most participating patients in the present study had a diagnosis of schizophrenia (7). 4 had major depression, 4 had bipolar disorder, 2 had dysthymic disorder, 2 had HIV-related dementia and 4 had anxiety-related disorders such as panic attacks, generalized anxiety disorder and Post-Traumatic Stress Disorder. The remaining four patients were diagnosed with ADHD, antisocial personality disorder, alcohol dependence and transient tic disorder.
4.3 Patients’ reaction to diagnosis

Figure 4: Patients’ reaction to diagnosis

![Patients' Reaction to diagnosis](image)

Figure 4 above shows that most psychiatric patients reacted with trauma and shock to the diagnosis of their mental illness. Most of these patients had been diagnosed either with schizophrenia, bipolar disorder or depression and described their first psychiatric hospitalizations as traumatic. One of the participants described the impact of hospitalization as particularly negative because he was physically restrained.

“I kept on asking myself: Is this me”

Related to the shock and trauma reported by the participants were feelings of fear and confusion. One of the greatest sources of fear reported by patients diagnosed with schizophrenia was the apparent loss of personal identity of a normal person. According to
Brady and McCain (2004), psychiatric illness often causes a prolonged disruption in the lives of individuals who are experiencing the illness. Their ability to function psychologically, physically, socially and spiritually is seriously affected. Literature has documented that this is usually a gradual process accompanied by fear of being labeled as a mental patient (Adewuya, Ola, Mosaku et.al; 2006). Acquiring the role of mental patient is especially difficult if the disorder occurred during one’s early life when peer acceptance is crucial. M. described his anguish after his first hospitalization:

“This was the time when I was supposed to enjoy life by dating, getting married, and have children of my own. As a result of this illness, I knew that in future I will be rejected by all women because mental patients are considered as crazy, unpredictable, and erratic. Who would want to marry a ‘madcap? I literally spent most of the time in the company of my family.”

Thus, perceived social isolation from one’s peers and withdrawal from the environment as well as internal responses to symptoms may intensify the fear of a changed identity during the transition to the role of being a psychiatric patient.

The challenges that often accompany mental illness affect not only the lives of individuals with the illness, but their relatives as well. In the present study, relatives of psychiatric patients reported having experienced loss and grief. According to Saunders and Byrne (2004), loss in this case refers to a state of being deprived of or being without something one has had, namely a healthy son, brother, or sister. The loss experienced by
patients’ relatives is usually accompanied by an array of painful emotions including “yearning for what once was, sorrow, dejection, fear, agitation, anger, and disbelief” (p. 220). Resentment and anger towards what has been lost often lead to guilt and shame. Feelings of helplessness and hopelessness are common, as illustrated by Ms B.’s mother:

“I was at a loss as to what we should do in order bring back the life of our daughter. Maybe God is punishing us for something that we have done.”

In the present study, some family members reported that feelings of helplessness occasionally led to conflicts in which members of the family blamed one another for their relative’s illness. According to Brady and McCain (2004), such conflicts may be a result of the family’s lack of knowledge of what to do in the circumstance. The family cannot problem-solve because they do not know whether the relative’s problem is final or temporary.

4.4 Knowledge of the illness and its perceived causes

For many patients a condition becomes meaningful once a cause has been ascribed to it. Consequently the identification of a cause is a significant factor in a patient’s decision about subsequent coping strategies including who should be consulted and the form of treatment that should be followed.

In the present study the majority of psychiatric patients as well as their relatives reported that they knew and understood the symptoms of their illnesses. In most cases, such
information had reportedly given to them by mental care practitioners. Yet, when asked about the possible causes of their illnesses, many thought that the illness had some supernatural causes, for example being bewitched by a known person. It is, therefore, possible that the participants' perception of illness cause was generally rooted in their socio-cultural environment. Indeed, belief in witchcraft is still prevalent in South Africa, and is still regarded as the cause of illness. However, the view of the present study is that poor knowledge of the causes of mental illness, especially an attribution to supernatural causation, may be more common in African communities.

In some cases, though, knowledge of illness and its perceived causes were related to the participants' educational level. For example, Mrs. N.M. an elderly school principal explained the perceived cause of her illness:

"I think that I am now too old to cope with these young teachers. They simply don't listen to anything I say. It causes me a lot of stress because the department is always pressurizing me about schoolwork. I am the principal and must account for every wrong thing in my school".

In cases where patients appear to have insight into the causes of their conditions, the role of a psychologist or other mental care workers is likely to be easier, particularly in issues that relate to treatment compliance.
4.5 Effect of illness on the family

Mental illness brings about many changes in the lives of psychiatric patients and their family members and these may require some level of adjustment for both the patients and their relatives. The changes may include the loss of income and employment, drop-out from school and generally strained family relations.

4.5.1 Financial Strains

Many participants reported that their families were struggling financially because of the costs of mental illnesses. Although some obtained the government social grants, they felt that the money was not enough to support a family that had no breadwinner. Other participants said that most of the money was spent on traditional healers. They believed that traditional medicines were more effective than psychiatric drugs that are obtained from the clinics or hospitals.

With respect to employment, some participants said that they had left their employment either because they could not cope with occupational duties because of mental illness or had been forced by their employers. One patient said that once he started to take his medication he felt better. However, when he went back to work he was told that his job had been given to someone else. He said:

“Because I do not have education it is not easy to get another job”.

76
The financial burden reported by the participants reflects the negative effects of having a mental illness. In addition, it highlights the high level of unemployment in the whole country, and in Eastern Cape province in particular. Many districts are rural and poverty-stricken, and the majority of people are unemployed. According to (O’Neile & Mckinney, 2003), for many families with a mentally ill member, the financial impact can be a major source of burden. Economic hardships result when a key wage earner is forced to leave a paying job either because of mental illness or to care for a sick relative. Some participants complain that in some cases the medical aid schemes either pay very little or do not cater for some of their relatives’ illnesses.

4.6 Attitude/reaction of the community

Of the 27 participants interviewed, 15 stated that the attitude of community members was generally negative; 3 reported positive and supportive attitude, and 9 said they did not know how the community would react to their illnesses since information about their psychiatric conditions had been concealed from people outside their families.

Some of the participants said that the community members had a tendency to judge everything they said or do negatively. They felt that community members tended to see a mad person rather than the individual. One participant said:

“In community gathering, I am being discriminated against. They don’t listen to anything I say. They think I am a lunatic”.
One participant said that some people in the community think that his illness is related to drugs, just because his elder brother used to smoke dagga. “It is being found guilty by association”, he said.

Another participant said that before his illness started, he used to be a youth leader at the apostle church. He stated that since his illness when he goes to church, he feels that other members see him as a crazy person that is all.

The participants’ perceptions of the negative attitude by the community toward mental patients was expected. Research has documented that most people in the community tend to view mental patients with suspicion for example they are perceived as unpredictable, violent and dangerous (Angermeyer & Dietrich, 2006). As a result, many would be afraid to even have a conversation with someone known to have a mental illness. Only a few would consider such person for friendship. The closer the intimacy required for the interaction, the stronger the community’s desire to keep a distance (Gureje, Lasebikan, & Olusola, 2005).

Although there are various similarities between mental disorders as concerns public beliefs and attitudes, there are also marked differences. For instance, people with schizophrenia and other psychotic disorders are more frequently considered as unpredictable and violent than those with depression and anxiety disorders. Thus, rejection is likely to be more pronounced toward people with schizophrenia than those
with depression and anxiety disorders (Angermeyer & Dietrich, 2005). In the present study, one participant said:

"My family had completed all the arrangements for my wedding. We were all waiting at the church for my bride and her family to come. The priest, my family and friends were all there. At the last moment, she and her family decided not to turn up for the ceremony after learning that I had schizophrenia".

A report by a participant who had been hospitalized for one week for major depression gave a contrasting view, for example she stated that after her discharge from the hospital, her colleagues rallied around her. She said she was given unqualified support, including being assisted to catch up on the work that was outstanding. She had frequent visits from her congregation who prayed for and wished her speedy recovery.

The two contrasting reactions from the community appear to suggest that some psychiatric illnesses are more stigmatized than others. According to Gujere, Lasebikan and Olusola (2005), schizophrenia and other psychotic disorders are more likely to be routinely mocked and misrepresented, and are less likely to generate compassion.

The fact that nine of the participants had decided to conceal their diagnosis from the community may also serve to highlight the fears of the stigma that is associated with psychiatric conditions. One patient said:
"They don’t know about it (mental illness). I don’t want them to think that I am crazy".

There have been reports that some people with mental illnesses are even reluctant to seek treatment for fear of being given a label. They believe that once members of the community including friends find out about their illnesses, they will be scorned. Some may even try to hide their symptoms and not stick to treatment regimen (Corrigan, 2004). Some studies have reported that mental patients are usually discriminated against in the workplace, and even been subjected to physical and verbal abuse (Fakhoury & Priebe, 2006). Such reports call for an increased role of community psychologists and other mental health practitioners to create awareness and educate the public about the nature and facts of mental illness.

4.7 Role of the family in helping patients cope with their illness

4.7.1 Patients' perceived support from family members

Family members include one or both parents, spouses of either gender, grandparents, siblings and other extended family members. Some children may be under the guardianship of foster parents or other family members. Extended family members are sometimes temporary caregivers or designated guardians for children whose biological parents were deceased, incapable of caring for their offspring, or were psychiatric patients themselves.
The majority (21) of psychiatric patients interviewed in the present study thought that they received a significant amount of support from their family members (as measured on a 5-point scale). The support reported by the patients ranged from accompanying the patient to a clinic to caring for the children in the case where one of the spouses was mentally ill. Some of the patients described their spouses as helpful with daily parenting tasks and in emergencies in the event of an ill spouse being hospitalized. One patient said:

"If I did not have a responsible and supportive husband, I would not even have had my children. I would probably be dead by now. He does the cooking and even wash the dishes".

Some young participants said that having family members such as parents and siblings around them was a relief. The patients said that they had no fear of being called names, or ill-treated. One said: "My parents do everything they can to support me".

On the other hand, some female participants described their husbands as passively or actively undermining their partners’ efforts to cope with the mental illness, or found an opportunity to engage in extramarital relationships. One participant said:

"My husband’s behavior was very funny. When I was discharged from the hospital he did not want me to take the medication. I developed the feeling that he didn’t want my condition to improve, and that my children were afraid of me"
because of what he had said to them namely; I am crazy. I guess he needed more time with his girlfriends”.

Another female participant said: “My husband is such a thug. I just want him to stop assaulting me. Instead of looking after my children, he was busy chasing other women”.

Clinicians and researchers are becoming increasingly aware of the extent to which some mental patients have been victims of trauma and abuse by their spouses (Canavan, 2000). This often has a negative impact on children. According to Berle, Mykletun, Daltveit, et.al, (2006), what is probably less understood is the way in which childhood trauma that is perpetuated by family members reverberates through the lives and parenting careers of mothers with mental illness. The repercussions of childhood trauma may also be revealed in situations where parents who are abusive and not supportive of their spouses are awarded custody of the children.

4.7.2 Family members’ perception of help given to patients

There was generally consistency between the psychiatric patients’ perception of support and that of their family members. Many family members said that when their relatives had been given the relevant medication for their illnesses, much of the work was done at home. The supportive roles reported by family members included accompanying the patient to the clinic or hospital, and monitoring whether treatment was taken regularly.
Having a family member with a mental illness can be stressful at times. Whether the ill person is a son, husband, or brother, family members are also affected by the illness. Many family members in the present study expressed the view that a person with a psychological disorder often needs love, help, and caring. At the same time, the problems, fears, and behavior of the ill relative usually strain the ability to cope. One participant whose son had Attention Deficit Hyperactive Disorder said:

“Who else will look after him? Yes, sometimes I feel anxious and frustrated by his actions. But I tell you I would have to take care of him even if he had an ear as long as my arm (Nguni saying).

Some of the challenges reported by family members included a lack of sufficient knowledge about the illnesses affecting their relatives. Most expressed fear and anxiety associated with what to do when the patient experiences a relapse of illness. They said that not enough information was given to them by the hospitals or clinics regarding their relatives’ illnesses. This suggests that there is a need by both medical and psychological practitioners to get more involved in educating the public about mental disorders.

The finding that family members of mental patients wanted to know more about mental illnesses and their origin is significant in that if such knowledge is imparted to them, it can potentially reduce or remove the burden of guilt and blame from family members’ shoulders. The view that many family members of mental patients feel responsible for the causes of their relatives’ illnesses has been reported extensively (Gujere et al. 2005).
Some family members may be angry and resentful toward the parents of those with mental illness, for example blaming them for all the problems that arise.

Another important finding from the present study was that if the mental patient was a parent, some children continued to respect and consult with him or her before making vital decisions about household issues. One participant said:

"Look, I am more than forty years old, married and have a family of my own. The fact that my mother is sick does not mean that I must make decisions without her consent. She is my mother who brought me into this world".

The reports obtained from the psychiatric patients and their relatives suggest that family members attitudes and behaviors may serve to facilitate or hinder the patients’ ability to cope with their illnesses. It appears that when mental patients feel that they are loved, valued, and cared about, feelings of confidence and self-reliance may increase.

The amount and adequacy of family support to mental patients may play an important role in both vulnerability and coping. For example an increase in family support is likely to give the patient security and increase the self-esteem, whereas its absence may make the patient more vulnerable to both physical and psychological breakdown.

Research has documented a strong link between social skills and support from others (Sarason & Sarason, 2005). People with low levels of support may not believe that other
people could be interested in them. This belief may increase their vulnerability to stress, especially in situations that called for interaction with people. With respect to psychiatric patients and their family members, the role of community psychologists would be, among other things, to train these people in social skills in order to increase their interpersonal effectiveness. This would help reduce their perception of social isolation.

4.8 Patients' satisfaction with support

Most of the psychiatric patients in the present study said that they were generally satisfied with the level of support they obtained from their family members. In addition, many felt that their family members must learn more about their illnesses so that they could intervene appropriately in the event of a relapse. However, some expressed dissatisfaction with mental health services, for example in some instances patients traveled long distances to their clinics or hospitals, only to be told to return at a later date because there were no medications for their illnesses. According to some participants, this led to them seeking help from traditional healers whose treatment was found to be expensive. One family member said that she had spent in excess of five hundred rand for traditional treatment of her relative’s illness.

The shortage or lack of mental health professionals for example psychologists and psychiatrists was reported by many participants. The importance of psychologists was cited as being important in the understanding of the patients’ illnesses and the supportive role of all mental health professionals was emphasized.
4.9 *Implications for intervention*

The results of the present study suggest that involving family members in the treatment of mental patients is beneficial for the clinician’s management of a case. Many issues can be discussed with the patients and key relatives in the context of a family consultation. This can offer an opportunity to share both the family’s observations that offer a unique insight into the patient’s environment and the clinician’s knowledge. Also, whilst some literature often reflects the difficulties presented when working with severe mental patients and their relatives (Rahi, Manaras, Tuomainen et. al, 2004), there is also evidence that some professionals enjoy the complexity of working with such families (Grafham, Matheson, & Bond, 2004). In fact, patient involvement and family involvement are listed amongst the tools that mental health practitioners need to deploy for the effective management of patients with mental illness (Hyoven & Nikkonen, 2004).

The study has also shown that if mental health practitioners’ involvement is coupled with that of mental patients and their family members may give patients an opportunity to take greater responsibilities for the management of their conditions.

From a standpoint of community psychology, the management of mental health problems may have psychiatric and community dimensions. The problems experienced by psychiatric patients are sometimes compounded by the attitude of the community toward the patients. Thus, psychological treatment must include psychiatric and social dimensions of mental illness.
5.1 Conclusion

This study investigated the role that is played by the family in helping psychiatric patients cope with their mental illness. The general finding was that family members are the most important source of personal support to the psychiatric patients. Because most of the unusual behaviors associated with mental disorders are beyond the control of the person with the illness, most family members are called upon to play a care-giving role. However, the care-giving role of family members is often impeded by their lack of information about mental illness.

The study also found that having a mentally ill member in the family does emotionally strain other family members. Family members worry about how the person with the illness will behave, and whether the symptoms are temporary or permanent. In some instances, family relations are strained as a result of multiple problems, but family members are tolerant to patients’ behavior. In addition, the financial burden of having a mentally ill family member affects the standard and quality of life of all household members. Factors related to poverty lead to food insecurities and loss of opportunities.

The role of the community in the prevention and care of mental illness is widely acknowledged and regarded as the most appropriate for the development of health programmes. However, many participants’ reports suggest that their communities still reflect negative attitudes, perceptions, and stigma toward those with mental illness. The
The stigma associated with mental illness was found to be damaging to the mental patients because it appeared to impair their self-esteem, help-seeking behaviors, medication adherence and overall recovery. Rejection by friends, employers and the community causes feelings of distress and loneliness in psychiatric patients. Their participation in normal family life and community activities is curtailed. The myths, misconceptions and negative stereotypes about mental illness have a detrimental effect on the ill person’s recovery, access to services and the type of support they receive in the community.

The Eastern Cape is one of the most rural, poorest, and underdeveloped provinces in South Africa. The apparent lack of government commitment to improving mental health care services means that medications for the treatment of psychiatric disorders are severely limited. This makes the job of the mental health professionals even more difficult than it already is, and the speedy recovery of patients less likely. In addition, the general shortage of qualified psychologists and psychiatrists in the country, and Mthatha in particular raises much concern because much of the workload is carried out by nurses, and psychologists and psychiatrists visit the patients either weekly or monthly. The closure of some psychiatric units in preference of primary healthcare clinics poses a particular problem due to the specialized nature of psychiatry and the specialized care that most psychiatric patients need.
5.2 **Recommendations**

In addition to providing emotional support for their relatives, family members also help their mentally ill relatives to remain oriented, stay on medications and attend scheduled hospital or clinic appointments. Family members can further benefit their relatives by helping them eat a well-balanced diet and getting regular exercise.

5.2.1 *Dealing with stigma of mental illness*

Individuals with mental illness and their relatives report that the diagnosis of their illness was followed by increased isolation and loneliness. The typical reaction encountered by someone with mental illness is fear and rejection. Due to the stigma associated with mental illness many people lose their self-esteem and have difficulty to make friends. This study revealed the need for educational programs to be designed with the primary aim of teaching awareness to the public about the nature and facts about mental illness.

Most surveys on stigma associated with mental illness have found that selective media reporting reinforces the public's stereotypes linking violence and mental illness and encourages people to distance themselves from those with mental disorders (Heather, 2006). Because of its power to influence public opinion, the media can, therefore serve as a powerful tool to eradicate stigma of mental illness. Through the media health practitioners must challenge the public prejudices by initiating public debate and projecting positive human stories about people who live with mental illness. Through
public education and awareness, understanding and research some level of success can be achieved in eradicating the stigma associated with mental illness.

5.2.2 Need for psychotherapy of patients and family members

Many patients continue to suffer enduring symptoms of their illnesses in spite of regularly taking their medications, and this has been a challenge to mental health service providers (Williams, Newton, Roberts et. al, 2002). In some instances, family members report that their mentally ill relatives do not respond to treatment, or may relapse while taking it (Corrigan, 2004). Psychotherapeutic intervention is necessary not only to assist the patients with these issues but also to assist patients and their family members with strategies of problem-solving, psycho education, enhance social functioning, reduce the distress associated with the illness and increasing patients’ self-esteem. Mental health practitioners also need to develop more working alliances with family members of mental patients and encourage them to seek skills necessary to cope with their relatives’ illnesses.

5.2.3 Formation of self-help groups

In addition to seeking therapy for themselves, family members of psychiatric patients must be encouraged to join or form their own support groups. According to Yip (2005), participating in a self-help group for families with mental patients may reduce family members’ sense of burden, aloneness and stress. In many communities self-help support groups for families of the mentally ill are set up by families in similar situations. Sharing
one's burden with others and getting more information about the illness and other community resources can empower family members.

5.2.4 Need to improve mental health services

There is generally a critical shortfall of adequately trained professionals to deal with mentally ill persons in the Eastern Cape province. It has been reported that most qualified psychologists and psychiatrists are concentrated in larger and wealthier cities such as Johannesburg and Cape Town, with pitifully few operating in poor provinces. There is therefore a need for the government to re-examine and restructure primary health care in the country so that rural communities also benefit from appropriate health care services.

5.2.5 Need for further research

The plight of mental patients and their family members has not received much attention in this country. The manner in which family members of patients with psychiatric illnesses perceives themselves, the way in which mental health providers regard and support these families and the factors that determine mental patients' satisfaction with services have not been considered. Research into the social situation of mental patients and their family members must be broadened to include these areas. Furthermore, few studies have investigated the relationship between social support and quality of life in people with mental illness (Hansson, 2006). In short, future studies must continue to include family member participation, and further research is needed to determine whether the results of this study resemble the findings of more inclusive studies.
The purpose of the present study was to investigate the role that is played by family members in helping psychiatric patients cope with their psychiatric illnesses. The study was conducted in Mthatha in the Eastern Cape, one of the provinces that are most rurally situated in South Africa. Factors that motivated the study were the following:

- Literature has documented that psychiatric illnesses tend to carry a stigma, since many people are reluctant to believe that psychiatric patients can ever fully recover. In addition, psychiatric patients are often perceived as dangerous and unpredictable. As a result, some communities, employers and credit agencies may discriminate against such patients. It is therefore imperative that the family role and ability in dealing with such issues be understood and conceptualized.

- The needs of psychiatric patients in the community are universal and diverse. Treatment does not end as soon as the patient is discharged from hospital, but continues even when the patient returns the community. It has been argued that one of the reasons for patients’ relapse is the absence of treatment compliance, and shortages or absence of community clinics. The family coping resources may be stretched in these situations

- Subsequent to discharge from the psychiatric hospital, the psychiatric patient becomes a burden to the family, friends, relatives, and the community. The
family, however, is the primary role player in the patient’s surroundings. Any differences or conflicts in the family may affect the patient directly, leading to relapse of illness in the patient; and even lead to a more serious issue of suicide. The main issue is whether the family is able to provide the psychiatric patient with the necessary support and console during stressful times.

- Ample evidence appears to suggest that the nature of the perceptions that psychiatric patients have about their relatives has a direct bearing on the patients’ ability to cope with and recover from their illnesses. Thus, there appears to be a clear research mandate to study such relationships between patients and their families.

- Most practitioners tend to focus more on psychiatric illness and its medical treatment, than on the importance of psycho-educating the patients and their families about the nature and management of their psychiatric conditions. As a result, patients, their families and the community do not know much about the psychiatric conditions. Yet, research documents that the more patients know and understand the nature of their illnesses, the better are the chances of coping and adjusting to their illness.
Research Methods

The research methods used in the present study were the following:

Research participants

Twenty-seven psychiatric patients participated in the study. Of these, eighteen had been admitted to the hospital for various complaints, and had been referred to the clinical psychologist for psychotherapy. Nine of the patients attended private consultations with the researcher. In addition, family members of both groups of patients were contacted, with a written consent from the patient, to participate in the treatment planning of the mentally ill person. A convenience sample was used in that the criterion for inclusion into the sample was based on patients suffering from certain psychiatric disorders, for example psychotic disorders, mood disorders and anxiety disorders. All participating family members were required to report their relationship to the patient. These included members of the patients’ immediate family, namely parents, siblings, spouses or partners, sons or daughters, and so on.

Diagnoses of patients’ illnesses

The diagnoses of the psychiatric patients’ illnesses were made after the various symptoms and circumstances that prompted them to seek help had been obtained. In some cases, details about the patients, for example personal history, were obtained from the patients’ family members as collateral information. The Diagnostic and Statistical Manual of Mental Disorders (DSM – IV) was used to verify the diagnoses.
**Instrument for data collection**

A semi-structured questionnaire guided the researcher in the collection of data for the study. The questionnaire was pilot-tested using five respondents, and modifications were made to the format and content of the questionnaire. The first part of the questionnaire required demographic characteristics of the psychiatric patients such as age, gender, the first time a psychiatric diagnosis was made, and educational level.

The second part of the questionnaire required information about the psychiatric patients' illness, for example their initial reactions to the diagnosis, knowledge about their mental illnesses, the level of support received from family members and the community, and the causes and impact of mental illness. The third section of the questionnaire included information obtained from the mental patients' family members, for example their reaction to the relative's illness, the amount of support given to the patients, and the challenges they faced as a result of their relative's mental illness. Some of the interviews were audio taped after obtaining consent from the participants. In other cases, where participants expressed anxiety about the use of the tape recorder, interviews were transcribed directly from their verbalizations.

**Procedure of data collection**

Permission was requested from the hospital manager to conduct the study with the hospital patients. The information for the study was collected during the scheduled psychotherapy sessions with the patients or after the sessions had been completed. All the
interviews were conducted in the psychologist’s office and all the participants were assured of anonymity and confidentiality.

The interviews consisted of two elements, the first of which constituted “directed conversations” (Henning, 2004) in which psychiatric patients were asked to reflect on their experiences both in and out of hospital, for example the amount of support (or non-support) they received from their family and community members, and information about their psychiatric conditions when being discharged from hospital.

Secondly, the patients’ family members were asked to express their feelings and perceptions about the patients’ psychiatric conditions, and the difficulties or challenges (if any) they encountered as a result of having a family member with a psychiatric illness.

Results and discussion

Age and gender of the participants

The age of the participants ranged from 10 to 59 years. The youngest patient was 14 years of age and the oldest was 55. The majority of the patients’ age ranged between 30 and 39 years.

With respect to participants’ gender, of the twenty-seven patients interviewed 16 were female while the remaining 11 were male.
Marital status and educational level

The majority (55%) of patients interviewed in the present study were single, 26% were married, 11% were divorced and .07% widowed.

Of the 27 participants interviewed 11 had educational level of grade 7 or below, 10 were between grades 8 and 10 and 6 had attained tertiary education.

Patients' reaction to diagnosis

Most psychiatric patients reacted with trauma and shock to the diagnosis of their mental illness. Most of these patients had been diagnosed either with schizophrenia, bipolar disorder or depression and described their first psychiatric hospitalizations as traumatic. One of the participants described the impact of hospitalization as particularly negative because he was physically restrained.

"I kept on asking myself: Is this me"

Related to the shock and trauma reported by the participants were feelings of fear and confusion. One of the greatest sources of fear reported by patients diagnosed with schizophrenia was the apparent loss of personal identity of a normal person. According to Brady and McCain (2004), psychiatric illness often causes a prolonged disruption in the lives of individuals who are experiencing the illness. Their ability to function psychologically, physically, socially and spiritually is seriously affected. Literature has documented that this is usually a gradual process accompanied by fear of being labeled as a mental patient (Adewuya, Ola, Mosaku et.al; 2006). Acquiring the role of mental
patient is especially difficult if the disorder occurred during one’s early life when peer acceptance is crucial. One participant described his anguish after his first hospitalization:

“This was the time when I was supposed to enjoy life by dating, getting married, and have children of my own. As a result of this illness, I knew that in future I will be rejected by all women because mental patients are considered as crazy, unpredictable, and erratic. Who would want to marry a ‘madcap’? I literally spent most of the time in the company of my family.”

Thus, perceived social isolation from one’s peers and withdrawal from the environment as well as internal responses to symptoms may intensify the fear of a changed identity during the transition to the role of being a psychiatric patient.

The challenges that often accompany mental illness affect not only the lives of individuals with the illness, but their relatives as well. In the present study, relatives of psychiatric patients reported having experienced loss and grief. According to Saunders and Byrne (2004), loss in this case refers to a state of being deprived of or being without something one has had, namely a healthy son, brother, or sister. The loss experienced by patients’ relatives is usually accompanied by an array of painful emotions including “yearning for what once was, sorrow, dejection, fear, agitation, anger, and disbelief” (p. 220). Resentment and anger towards what has been lost often lead to guilt and shame.
Feelings of helplessness and hopelessness are common, as expressed by one of the participants’ mother:

“I was at a loss as to what we should do in order bring back the life of our daughter. Maybe God is punishing us for something that we have done.”

In the present study, some family members reported that feelings of helplessness occasionally led to conflicts in which members of the family blamed one another for their relative’s illness. According to Brady and McCain (2004), such conflicts may be a result of the family’s lack of knowledge of what to do in the circumstance. The family cannot problem-solve because they do not know whether the relative’s problem is final or temporary.

Knowledge of the illness and its perceived causes

For many patients a condition becomes meaningful once a cause has been ascribed to it. Consequently the identification of a cause is a significant factor in a patient’s decision about subsequent coping strategies including who should be consulted and the form of treatment that should be followed.

The present study found that the majority of psychiatric patients as well as their relatives knew and understood the symptoms of their illnesses. In most cases, such information had reportedly given to them by mental care practitioners. Yet, when asked about the possible causes of their illnesses, many thought that the illness had some supernatural cause, for example being bewitched by a known person. It is, therefore, possible that the
participants' perception of illness cause was generally rooted in their socio-cultural environment. Indeed, belief in witchcraft is still prevalent in South Africa, and is still regarded as the cause of illness. However, the view of the present study is that poor knowledge of the causes of mental illness, especially an attribution to supernatural causation, may be more common in African communities.

In some cases, though, knowledge of illness and its perceived causes were related to the participants' educational level. For example, an elderly participant who is a school principal explained the perceived cause of her illness:

"I think that I am now too old to cope with these young teachers. They simply don't listen to anything I say. It causes me a lot of stress because the department is always pressurizing me about schoolwork. I am the principal and must account for every wrong thing in my school".

In cases where patients appear to have insight into the causes of their conditions, the role of a psychologist or other mental care workers is likely to be easier, particularly in issues that relate to treatment compliance.

Effect of illness on the family

Mental illness brings about many changes in the lives of psychiatric patients and their family members and these may require some level of adjustment for both the patients and their relatives. The changes may include the loss of income and employment, drop-out from school and generally strained family relations.
Many participants reported that their families were struggling financially because of the costs of mental illnesses. Although some obtained the government social grants, they felt that the money was not enough to support a family that had no breadwinner. Other participants said that most of the money was spent on traditional healers. They believed that traditional medicines were more effective than psychiatric drugs that are obtained from the clinics or hospitals.

With respect to employment, some participants said that they had left their employment either because they could not cope with occupational duties because of mental illness or had been forced by their employers. One patient said that once he started to take his medication he felt better. However, when he went back to work he was told that his job had been given to someone else. He said:

“Because I do not have education it is not easy to get another job”.

The financial burden reported by the participants reflects the negative effects of having a mental illness. In addition, it highlights the high level of unemployment in the whole country, and in the Eastern Cape province in particular. Many districts are rural and poverty-stricken, and the majority of people are unemployed. According to (O’Neile & Mckinney, 2003), for many families with a mentally ill member, the financial impact can be a major source of burden. Economic hardships result when a key wage earner is forced to leave a paying job either because of mental illness or to care for a sick relative. Some
participants complain that in some cases the medical aid schemes either pay very little or
do not cater for some of their relatives' illnesses.

*Attitude/reaction of the community*

Of the 27 participants interviewed, 15 stated that the attitude of community members was
generally negative; 3 reported positive and supportive attitude, and 9 said they did not
know how the community would react to their illnesses since information about their
psychiatric conditions had been concealed from people outside their families.

Some of the participants said that the community members had a tendency to judge
everything they said or do negatively. They felt that community members tended to see a
mad person rather than the individual. One participant said:

“\[In community gathering, I am being discriminated against. They don’t listen to anything\]
\[I say. They think I am a lunatic\].”

One participant said that some people in the community think that his illness is related to
drugs, just because his elder brother used to smoke dagga. “It is being found guilt by
association”, he said.

Another participant said that before his illness started, he used to be a youth leader at the
apostle church. He stated that since his illness when he goes to church, he feels that other
members see him as a crazy person.
The perceived negative attitude by the community toward mental patients was expected. Research has documented that most people in the community tend to view mental patients as with suspicion for example they are perceived as unpredictable, violent and dangerous (Angermeyer & Dietrich, 2006). As a result, many would be afraid to even have a conversation with someone known to have a mental illness. Only a few would consider such person for friendship. The closer the intimacy required for the interaction, the stronger the community's desire to keep a distance (Gureje, Lasebikan, & Olusola, 2005).

Although there are various similarities between mental disorders as concerns public beliefs and attitudes, there are also marked differences. For instance, people with schizophrenia and other psychotic disorders are more frequently considered as unpredictable and violent than those with depression and anxiety disorders. Thus, rejection is likely to be more pronounced toward people with schizophrenia than those with depression and anxiety disorders (Angermeyer & Dietrich, 2005). In the present study, one participant said:

"My family had completed all the arrangements for my wedding. We were all waiting at the church for my bride and her family to come. The priest, my family and friends were all there. At the last moment, she and her family decide not to turn up for the ceremony after learning that I had schizophrenia"

A report by a participant who had been hospitalized for one week for major depression gave a contrasting view, for example she stated that after her discharge from the hospital,
her colleagues rallied around her. She said she was given unqualified support, including being assisted to catch up on the work that was outstanding. She had frequent visits from her congregation who prayed for and wished her speedy recovery.

The two contrasting reactions from the community appear to suggest that some psychiatric illnesses are more stigmatized than others. According to Gujere, Lasebikan and Olusola (2005), schizophrenia and other psychotic disorders are more likely to be routinely mocked and misrepresented, and are less likely to generate compassion.

The fact that nine of the participants had decided to conceal their diagnosis from the community may also serve to highlight the fears of the stigma that is associated with psychiatric conditions. One patient said:

“They don’t know about it (mental illness). I don’t want them to think that I am crazy”.

There have been reports that some people with mental illnesses are even reluctant to seek treatment for fear of being given a label. They believe that once members of the community including friends find out about their illnesses, they will be scorned. Some may even try to hide their symptoms and not stick to treatment regimen (Corrigan, 2004).

Some studies have reported that mental patients are usually discriminated against in the workplace, and even been subjected to physical and verbal abuse (Fakhoury & Priebe, 2006). Such reports call for an increased role of community psychologists and other mental health practitioners to create awareness and educate the public about the nature and facts of mental illness.
Role of the family in helping patients cope with their illness

Patients' perceived support from family members. Family members include one or both parents, spouses of either gender, grandparents, siblings and other extended family members. Some children may be under the guardianship of foster parents or other family members. Extended family members are sometimes temporary caregivers or designated guardians for children whose biological parents were deceased, incapable of caring for their offspring, or were psychiatric patients themselves.

The majority (21) of psychiatric patients interviewed in the present study thought that they received a significant amount of support from their family members (as measured on a 5-point scale). The support reported by the patients ranged from accompanying the patient to a clinic to caring for the children in the case where one of the spouses was mentally ill. Some of the patients described their spouses as helpful with daily parenting tasks and in emergencies in the event of an ill spouse being hospitalized. One patient said:

"If I did not have a responsible and supportive husband, I would not even have had my children. I would probably be dead by now. He does the cooking and even wash the dishes."

Some young participants said that having family members such as parents and siblings around them was a relief. The patients said that they had no fear of being called names, or ill-treated. One said: "My parents do everything they can to support me".
On the other hand, some female participants described their husbands as passively or actively undermining their partners' efforts to cope with the mental illness, or found an opportunity to engage in extramarital relationships. One participant said:

"My husband's behavior was very funny. When I was discharged from the hospital he did not want me to take the medication. I developed the feeling that he didn't want my condition to improve, and that my children were afraid of me because of what he had said to them namely; I am crazy. I guess he needed more time with his girlfriends".

Another female participant said: My husband is such a thug. I just want him to stop assaulting me. Instead of looking after my children, he was busy chasing other women”.

Clinicians and researchers are becoming increasingly aware of the extent to which some mental patients have been victims of trauma and abuse by their spouses (Canavan, 2000). This often has a negative impact on children. According to (Berle, Mykletun, Daltveit, et.al, 2006), what is probably less understood is the way in which childhood trauma that is perpetuated by family members reverberates through the lives and parenting careers of mothers with mental illness. The repercussions of childhood trauma may also be revealed in situations where parents who are abusive and not supportive of their spouses are awarded custody of the children.

*Family members' perception of help given to patients*

There was generally consistency between the psychiatric patients' perception of support and that of their family members. Many family members said that when their relatives
had been given the relevant medication for their illnesses, much of the work was done at home by the family members. The supportive roles reported by family members included accompanying the patient to the clinic or hospital, and monitoring whether treatment was taken regularly.

Having a family member with a mental illness can be stressful at times. Whether the ill person is a son, husband, or brother, family members are also affected by the illness. Many family members in the present study expressed the view that a person with a psychological disorder often needs love, help and caring. At the same time, the problems, fears and behavior of the ill relative usually strain the ability to cope. One family member whose son had Attention Deficit Hyperactive Disorder said:

"Who else will look after him? Yes, sometimes I feel anxious and frustrated by his actions. But I tell you I would have to take care of him even if he had an ear as long as my arm (Nguni saying).

Some of the challenges reported by family members included a lack sufficient knowledge about the illnesses affecting their relatives. Most expressed fear and anxiety associated with what to do when the patient experiences a relapse of illness. They said that not enough information was given to them by the hospitals or clinics regarding their relatives' illnesses. This suggests that there is a need by both medical and psychological practitioners to get more involved in educating the public about mental disorders.
The finding that family members of mental patients wanted to know more about mental illnesses and their origin is significant in that if such knowledge is imparted to them, it can potentially reduce or remove the burden of guilt and blame from family members’ shoulders. The view that many family members of mental patients feel responsible for the causes of their relatives’ illnesses has been reported extensively (Gujere et al. 2005). Some family members may be angry and resentful toward the parents of those with mental illness, for example blaming them for all the problems that arise.

Another important finding from the present study was that if the mental patient was a parent, some children continued to respect and consult with him or her before making vital decisions about household issues. One participant said:

"Look, I am more than forty years old, married and have a family of my own. The fact that my mother is sick does not mean that I must make decisions without her consent. She is my mother who brought me into this world".

The reports obtained from the psychiatric patients and their relatives suggest that family members attitudes and behaviors may serve to facilitate or hinder the patients’ ability to cope with their illnesses. It appears that when mental patients feel that they are loved, valued, and cared about, feelings of confidence and self-reliance may increase.

The amount and adequacy of family support to mental patients may play an important role in both vulnerability and coping. For example an increase in family support is likely
to give the patient security and increase the self-esteem, whereas its absence may make the patient more vulnerable to both physical and psychological breakdown.

Research has documented a strong link between social skills and support from others (Sarason & Sarason, 2005). People with low levels of support may not believe that other people could be interested in them. This belief may increase their vulnerability to stress, especially in situations that called for interaction with people. With respect to psychiatric patients and their family members, the role of community psychologists would be, among other things, to train these people in social skills in order to increase their interpersonal effectiveness. This would help reduce their perception of social isolation.

Conclusion

This study investigated the role that is played by the family in helping psychiatric patients cope with their mental illness. The general finding was that family members are the most important source of personal support to the psychiatric patients. Because most of the unusual behaviors associated with mental disorders are beyond the control of the person with the illness, most family members are called upon to play a care-giving role. However, the care-giving role of family members is often impeded by their lack of information about mental illness.

The study also found that having a mentally ill member in the family does emotionally strain other family members. Family members worry about how the person with the illness will behave, and whether the symptoms are temporary or permanent. In some
instances, family relations are strained as a result of multiple problems, but family members are tolerant to patients’ behavior. In addition, the financial burden of having a mentally ill family member affects the standard and quality of life of all household members. Factors related to poverty lead to food insecurities and loss of opportunities.

The role of the community in the prevention and care of mental illness is widely acknowledged and regarded as the most appropriate for the development of health programmes. However, many participants’ reports suggest that their communities still reflect negative attitudes, perceptions, and stigma toward those with mental illness. The stigma associated with mental illness was found to be damaging to the mental patients because it appeared to impair their self-esteem, help-seeking behaviors, medication adherence and overall recovery. Rejection by friends, employers and the community causes feelings of distress and loneliness in psychiatric patients. Their participation in normal family life and community activities is curtailed. The myths, misconceptions and negative stereotypes about mental illness have a detrimental effect on the ill person’s recovery, access to services and the type of support they receive in the community.

The Eastern Cape is one of the most rural, poorest, and underdeveloped provinces in South Africa. The apparent lack of government commitment to improving mental health care services means that medications for the treatment of psychiatric disorders are severely limited. This makes the job of the mental health professionals even more difficult than it already is, and the speedy recovery of patients less likely. In addition, the general shortage of qualified psychologists and psychiatrists in the country, and Mthatha
in particular, raises much concern because much of the workload is carried out by nurses. Psychologists and psychiatrists visit the patients either weekly or monthly. The closure of some psychiatric units in preference of primary healthcare clinics poses a particular problem due to the specialized nature of psychiatry and the specialized care that most psychiatric patients need.

**Recommendations**

In addition to providing emotional support for their relatives, family members also help their mentally ill relatives to remain oriented, stay on medications and attend scheduled hospital or clinic appointments. Family members can further benefit their relatives by helping them eat a well-balanced diet and getting regular exercise.

**Dealing with stigma of mental illness.** Individuals with mental illness and their relatives report that the diagnosis of their illness was followed by increased isolation and loneliness. The typical reaction encountered by someone with mental illness is fear and rejection. Due to the stigma associated with mental illness many people lose their self-esteem and have difficulty to make friends. This study revealed the need for educational programs to be designed with the primary aim of teaching awareness to the public about the nature and facts about mental illness.

Most surveys on stigma associated with mental illness have found that selective media reporting reinforces the public’s stereotypes linking violence and mental illness and encourages people to distance themselves from those with mental disorders (Heather,
Because of its power to influence public opinion, the media can, therefore serve as a powerful tool to eradicate stigma of mental illness. Through the media health practitioners must challenge the public prejudices by initiating public debate and projecting positive human stories about people who live with mental illness. Through public education and awareness, understanding and research some level of success can be achieved in eradicating the stigma associated with mental illness.

**Need for psychotherapy of patients and family members.** Many patients continue to suffer enduring symptoms of their illnesses in spite of regularly taking their medications, and this has been a challenge to mental health service providers (Williams, Newton, Roberts et al, 2002). In some instances, family members report that their mentally ill relatives do not respond to treatment, or may relapse while taking it (Corrigan, 2004). Psychotherapeutic intervention is necessary not only to assist the patients with these issues but also to assist patients and their family members with strategies of problem-solving, psycho education, enhance social functioning, reduce the distress associated with the illness and increasing patients’ self-esteem. Mental health practitioners also need to develop more working alliances with family members of mental patients and encourage them to seek skills necessary to cope with their relatives’ illnesses.

**Formation of self-help groups.** In addition to seeking therapy for themselves, family members of psychiatric patients must be encouraged to join or form their own support groups. According to Yip (2005), participating in a self-help group for families with mental patients may reduce family members’ sense of burden, aloneness and stress. In
many communities self-help support groups for families of the mentally ill are set up by families in similar situations. Sharing one’s burden with others and getting more information about the illness and other community resources can empower family members.

Need to improve mental health services. There is generally a critical shortfall of adequately trained professionals to deal with mentally ill persons in the Eastern Cape province. It has been reported that most qualified psychologists and psychiatrists are concentrated in larger and wealthier cities such as Johannesburg and Cape Town, with pitifully few operating in poor provinces. There is therefore a need for the government to re-examine and restructure primary health care in the country so that rural communities also benefit from appropriate health care services.

Need for further research. The plight of mental patients and their family members has not received much attention in this country. The manner in which family members of patients with psychiatric illnesses perceives themselves, the way in which mental health providers regard and support these families and the factors that determine mental patients’ satisfaction with services have not been considered. Research into the social situation of mental patients and their family members must be broadened to include these areas. Furthermore, few studies have investigated the relationship between social support and quality of life in people with mental illness (Hansson, 2006). In short, future studies must continue to include family member participation, and further research is needed to
determine whether the results of this study resemble the findings of more inclusive studies.
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http://hopeallianz.com/Resources/LossGrief.html


http://psychiatry.ouhse.ed/safeprogram/


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http://counselling.uchicago.edu/vpt/quot/what.html


Dear participant

My name is Sikhumbuzo Mfusi and doing an investigation on the role of the family in helping psychiatric patients cope with their illnesses. The research is for a doctoral degree with the university of Zululand, and my promoter is Professor S.D. Edwards. Your participation in the study is humbly requested.

Please feel free to answer all questions honestly; I give the assurance that all information given to me will be treated in the strictest confidence.

Thank you for your cooperation.

Yours sincerely

SK Mfusi
APPENDIX 2

RESEARCH INSTRUMENT

1. Patient’s biographical Details

Name/Code of Patient: ..........................

Age/Date of Birth: ..........................

Town/City of Residence: ..........................

Marital Status: .................

Live with family/relatives/friends ..........................

Employment: ..........................

Diagnosis: ..........................

Date/Year diagnosis made: ..........................
First admission to hospital: ..........................

Family history (of psychiatric illness)

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2. Patient’s perception of support from family members

2.1 How did your family members react to the diagnosis of your illness?

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2.2 Do you receive any support from your family? Y/N
If yes, what type of support do you get from your family?

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134
2.3 How does your illness affect your relations with your family?

2.4 In general, are you satisfied with the amount of support you get from your family? (Rate from 1 to 5: satisfied – unsatisfied)

2.5 What would you like your family to do in order to show support for your illness?

2.6 What is (was) the community’s reaction/attitude towards your illness?

2.7 How is your relationship with members of your community? (e.g. any close ties/relationship)

2.8 How has your illness affected your employment?
3. **Knowledge of the illness**

3.1 On your admission to hospital, were you given information about the nature of your illness (including the effect of the medical treatment)?

3.2 How much do you know about your illness?

3.3 What is the cause of your illness?

3.4 Did your physician/doctor refer you to a clinical psychologist? Y/N
   If yes was the psychologist of any assistance to you in terms of the understanding and management of your illness?

3.5 What information was given to you on your discharge from hospital?

3.6 How often do you take your medication?

3.7 How does your illness affect your family financially?

3.8 Is there a center/clinic where you collect your regular medication? Y/N
   If not, how do you collect your medication?
3.9 Have you ever (taken) to a traditional healer in order to know more about your illness? Y/N Explain
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4. Family support to patient
(Information gathered from patients' family members)

4.1 What is your relation to the patient? (e.g. brother/sister/spouse)
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4.2 What is your understanding of the patient's illness?
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4.3 How was your relative's illness identified?
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4.4 What was your reaction when you first saw the symptoms in your relative?
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4.5 Was the patient ever taken to a traditional healer? If yes, please explain.
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4.6 How does your relative's illness affect your family?
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137
4.7 What information was given to you by the physician/hospital regarding the management of the relative's illness?

4.8 Does the patient’s illness affect the family’s financial situation? Y/N
If yes, how does the family cope?

4.9 Is there any support that you offer to your relative? If yes, please explain.

How satisfied is your relative with the amount of support he gets from you?
(Rate from 1 to 5: not satisfied to very satisfied)
1 2 3 4 5

4.10 How has the patient’s illness affected family relations? Please explain

4.11 What does the family do to help the patient cope with the illness?

4.12 What are the challenges facing your family in relation to your relative’s illness

138
4.13 Is there any support system available to the patients (e.g. support groups, rehabilitation, etc.)?

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4.14 Please describe the attitude of community members in relation to your relative's illness?

Toward you:
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Toward the patient:
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4.15 Is the patient generally satisfied with the support he/she gets from you?

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4.16 Any other information

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APPENDIX 3:

PARTICIPANTS' CONSENT FOR FAMILY PARTICIPATION

I _____________________________(name of participant) hereby give consent that my family members can give information to my therapist regarding my illness

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Signature