

**EXPERIENCES OF FAMILIES TOWARDS PSYCHIATRIC STATE PATIENTS
DURING LEAVE OF ABSENCE IN LEPELLE NKUMPI, CAPRICORN DISTRICT OF
LIMPOPO PROVINCE.**

by

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DECLARATION

I, Moloko Elizabeth Mathanya, declare that the mini-dessertation “Experiences of families towards state patients on Leave of absence (LOA) at Lepelle Nkumpi Municipality in Capricorn district of Limpopo Province” hereby submitted to the University of Limpopo, for the degree of Master of Curationis (MCUR) has not previously been submitted by me for a degree at this or any other University, that is my work in design and in execution, and that all materials contained herein have been duly acknowledged.

Moloko Elizabeth Mathanya :

Date signed :

DEDICATION

This dissertation is dedicated to all Psychiatric state patients and their families in the Capricorn District, and to my grandparents, the late Ngoako Jacob Mathanya and Mabotsi Welheminah Mathanya, My Parents Mahlare Eric Mathanya and Dimakatso Suzan Mathanya; my daughter, Rorisang Precious Mathanya; my husband, Serame Jacob Maphoto; my two brothers, Matome Michael Mathanya and Thabang Ngoako Mathanya; and my sister, Khomotjo Makolobe Mathanya.

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ABSTRACT

The purpose of the study was to investigate the experiences of families towards psychiatric state patients during LOA. A qualitative, phenomenological, exploratory, descriptive and contextual design was used. Non-probability sampling of the purposive type was used to explore and describe the experiences of families towards psychiatric state patients during LOA. Data were collected from ten (10) families by using semi-structured face-to-face interviews. Data were audio recorded and field notes were also written. Trustworthiness was ensured by applying credibility, transferability, confirmability and dependability. Transferability was ensured by utilizing purposive sampling to include participants. Confirmability was ensured by collecting data from the participants who have experience on the problem studied. Data were analysed qualitatively by using Tech's open coding method. Results from the study shows that families experiences uncontrolled and disruptive behaviour from the psychiatric state patients during LOA. Guidelines for the study include: Families of psychiatric state patients should receive counselling and be involved in family therapy prior and after the psychiatric state patient's LOA. Family members of psychiatric state patient experience emotional pain, therefore they need support from multidisciplinary team members to assist them to facilitate promotion, maintenance and restoration of their mental health as an integral part of their health. Recommendations include improvement of aspects in nursing practice, nursing education and nursing research.

Key words: Experiences, family, psychiatric state patients, Leave of absence.

DEFINITION OF CONCEPTS

Family refers to a primary social group consisting of parents and their offspring who functions in a bio-psychosocial manner to facilitate the promotion, maintenance and restoration of health as an integral part of health to achieve his/her quest for wholeness (Chaloner & Coffey, 2000).

Within the context of this study it refers to a person related to state patient and also living/staying with state patient in the same house hold.

Leave of absence (LOA) refers to a period of leave granted to state patient by head of an establishment (Mental Health Care Act no 17 of 2002).

Within the context of this study it refers to when the user may be granted a permission go home (for about 3-6 months) only when declared stable

Mental health care user refers to a person receiving care, treatment and rehabilitation (South Africa's Mental Health Care Act no 17 of 2002)

Within the context of this study it refers to a person who is identified as suffering from mental illness and who has been admitted to psychiatric hospital and receiving care, treatment and rehabilitation

State patient refers to a person so classified by court directives in terms of section 77 or 78 of criminal procedure act committing serious crime due to mental illness. (Mental health care act no 17 of 2002)

Within the context of this study it refers to person who was charged with murder due to mental illness and is admitted at psychiatric hospital, receiving care, treatment, rehabilitation.

LIST OF ABBREVIATIONS

DoH- Department of Health

LOA- Leave of absence

WHO- World Health Organisation

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INTERVIEW GUIDE

The interview guide is the formal instrument, used in structured self-report studies, that specifies the wording of all questions to be asked to participants (Polit & Hungler, 1997). In this context the open-ended questions that were asked to the participants includes:

1. What are the problems that you have experienced staying with the state patient on LOA?
2. What are your fears (if there are any) when staying with the state patient on LOA?
3. Explain the relationship between you and the state patient on LOA?
4. What are your supportive measures towards state patients on LOA?
5. What is the destructive behaviour that state patients express when on LOA?

APPENDIX 5

EXAMPLE OF A CONDUCTED INTERVIEW

PARTICIPANT 10

Date: 2014-01-20

Unstructured interview obtained from ten interviews conducted.

My name is Moloko Mathanya, a student from University of Limpopo. Principles of consent form explained in full. Thanking her for participating.

Researcher: thank you for allowing me to ask you questions about your husband. Please explain your experiences with psychiatric state patient when at home.as he sometimes be given LOA to come at home.

Participant: When he was at home, when he wakes up, when we were staying with his parents it was better. He goes to next door neighbour whom they live together most of the time. He goes there early in the morning then they buy alcohol and dagga then he will come home when he doesn't even know his name. He will not come when you call him, as I wake up then start to prepare breakfast. When he comes back he starts to accuse us then we will start running around. He is troublesome and I don't even want to think about him.

Researcher: As you say when he wakes up he goes to his neighbour, then what happens when he goes there?

Participant: He will even wake that man, they will go buy alcohol, start drinking alcohol and even smoking dagga, then when he comes back he will start arguments. Even when you try to ignore him, he will continue talking. Then he will even send the children to go buy the dagga, he tell them to go look for that dagga until they get it, he will tell them that they will not sleep until they get that dagga.. The children are even afraid of him. I even thought that I must go back home because of the way he treat us but his family said that I must stay here because they will send him back to the hospital. So the problem is the children are afraid of him. When they come back with the dagga. We will not sleep that day.

Researcher: Why are the children so afraid of him?

Participant: He even beat me at times, so my boy who is in grade 9 will try to help me. He is now older though he is in grade 9 he can see what is happening so he wants to fight with his father. But when we were staying with his parents it was better because we suspected that he smokes dagga but we were not sure about it as he will hide himself when smoking. But here at our home, he says there is no one who can tell him anything.

Researcher: So these are the problems that you experience. Does he take the treatment when he is at home?

Participant: He does take the treatment when at home, but the problem is the alcohol and dagga.

Researcher: He does take his treatment but does he mix those the medication with alcohol and dagga?

Participant: The problem is you cannot tell him anything, if you say something he says you are talking back at him but even when you keep quite he will ask you why are you so quite?. The children are even saying that we must tell them in time when he is coming back so that they can go and live with their grandparents. I am also afraid of him. We hide the sharp objects as he threatens to kill and he even blames everyone at home. He even tried to kill her sister in law with an axe,

Researcher: Did he kill her?

Participant: No he didn't but, the sister in law was admitted at the hospital then she is no longer staying at her in-laws house, she has left, she is no longer staying there. The incidence happened when we were still staying at his parents' house. They tried to talk to her, begging her not to go back home but she left.

Researcher: What happened?

Participant: As this was happening, I was not at my in-laws house, I was at our house. So the father in-law came and asked me to come to the house as he is saying that he wants his wife and his children and he is threatening to kill everyone. So it was very difficult for me as I had a 1 month old baby and was breastfeeding her, but luckily with the grace of the Lord I did go and nothing happened. But it was very difficult to stay with him at that time, I was waiting for his time to go back to the hospital. Then I took him back to the hospital and explained everything that had happened during his stay.

Researcher: So you all live in fear when he is at home?

Participant: I used to hide all the dangerous objects when he is at home but he demand to carry them and he will be aggressive when he wants them. And when he sleeps, he put the knife and the spade near him, he says that they are for his own protection, so he can be able to fight if someone attacks him. We all live in fear, especially the children, I repeat, they even said that I must tell them in time if he is coming home, so they can go to their grandparents house. And I also have fear for my children.

Researcher: How does he behave when at home, on LOA?

Participant: He is not taking treatment when at home, he says that he is no longer ill, and there are so many people in the village that are mentally ill but they are only given injection. So he won't take the tablets. But when I met him, I did not believe that he was mentally ill but nowadays.....it's a problem.

Researcher: what are other destructive behaviours that you experience when he is at home/ does he sleep during the night?

Participant: He does sleep at night as he will be high and the other thing is because he roams around during the day. But before he sleeps, he will start making a lot of noise, talking and verbally aggressive and he always start the arguments, and he will even beat for no apparent reason and he will beat me in front of the children. That's why I am saying one day my second born said that" you dad, one day you will kill our Mother in front of us".

But sometimes he does not sleep, he will start swearing at me, starting stories that are not there and even force you that I gave you money, he will even beat me in front of the children. As one of my children, my second born, will sleep with dangerous objects on his bed, so he says that it's for protection as they think that their father will kill me so, he said that it's for protection. And he is still young but he behave strangely. He said that this objects are for protecting me as their mother because their father beats me in front of them so he said that he wants to protect me, so I suspect that he can even commit murder like killing his father because he is behaving strangely.

Researcher: Does he get disability grant when at home?

Participant: I once broke my leg so I used to get money for that, so I would not worry much about money. He does buy food at home but at that time he was not buying anything as I told him that I will buy the food but he must be aware that that money is for short while. But when I did not receive that grant he will buy food then the rest for the money that is left he will use it to buy dagga. When he is at home, most of the time he is with his friend, who lives in the neighbourhood, they will smokes dagga together and even attend the weddings or any other gathering that is here, and they will behave strangely there and be destructive. But now that he is not at home, we depend on the children's grant. So now we do not have money as I only get grant for only two children. It is a problem as we now do not have food in the house. We are really struggling.

Researcher: What are the Supportive measures towards your husband?

Participant: I am sure he is surprised that I did not come to visit him at hospital, as I do not have money to go visit him. So when he was given LOA, at least for 3 days he will stay at home but when he is given an LOA of a month or more, he does not cope at all. I do visit him at hospital when I have money. I give him support by encouraging him to take medication but he will refuse. I even want to go to hospital to request that they at least give him some few days, at least three days to come and stay at home. The problem is I cannot stay with for a long time. As he becomes uncontrollable and stop taking his medication.

Researcher: But do you have an idea on how he take his medication?

Participant: Yes I do have an idea as I monitor him when taking the treatment. But when my last born was still baby I couldn't as I focused on my baby.

Researcher: do you supervise him when taking his medication?

Participant: Yes, but it was a bit challenging as I had a baby, so I could not supervise him as I was taking care of the baby.

Researcher: what are the supportive measures of other family members nor relatives?

Participant: It's only me and his siblings who provide support but His father said that he does not want to hear anything about and he does not want him to come home. He said that he must come home when he is dead. His father said that, if he is not kept at the hospital, he will kill us all. I do want to stay with him but the problem is I can't stay with him for a long time. But I do not agree with his father, if I had money I will go and request that he be given an LOA for at least 3 days. And his father will not see him as he will come and stay at our house for that 3 days.

Researcher: What are other things that you can add that have experienced?

Participant: if he can be aware that I am outside the house, maybe go out of main house to the kitchen, he will smoke dagga in the house, in the children's bedroom,

Researcher: And where will the children be at that time?

Participant: They will be sleeping. They will be covered by huge smoke in the house.

Researcher: How does the children behave when he is at home?

Participant: They are so afraid of him that even the younger one cries a lot when his father tries to touch him. It's been a long time that he has been at the hospital now, but the problem is I do not have money but I do want to visit him.

Researcher: Thank you so much for participating, unless if you have anything to add or any question?

Participant: I just want to ask if I go to hospital and request that they release him for at least three days, will they agree?

Researcher: yes, they will agree

Participant: It has been a long time since he was admitted now, I even think that it is not fair for him to stay at the hospital for such a long time without coming home for a short period of time. I also think that other relatives will even think that I do not care about him. Please tell him that I would have come visit him but the problem is I do not have money.

Researcher: Thank you again for your participation

Participant: Thanks

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

Across the nation, many countries have strict in patient's commitment laws. A potential outcome of strict laws is that family members have to witness a loved one in a psychotic state, suffering from an extended period of time before they can access treatment, having to witness a loved one becoming progressively less psychologically stable on daily basis, and this can be very difficult and even traumatic (American Psychiatric Association (APA), 2000). It is a helpless feeling to know that your loved one is in great need of psychological assistance but cannot be accessed until they are homicidal or commit murder. There are also occasions, after a state patient is finally admitted to a hospital, that they are released too soon. Hospital stays are much shorter than they used to be. When such situations arise, families have a desire to report their experiences with mental health system but no such places exist. It is important to know about experiences of these families. The public and policy makers need to know about these experiences. (American Psychiatric Association (APA), 2000)

Beebe (2010), mentioned that most of the patients that are granted LOA's, become very aggressive to the members of the family due to heavy use of tobacco, alcohol and drugs, have multiple sex partners, abuse drugs and suffer financial instability. It is also believed that the state patients suffer emotional circumstances due to lack of family support as the family members fear them, thinking of what the psychiatric state patient have committed. The worst problem is that the state patients refuse to take treatment when at home or under supervision from the family members and this result in chronic problem with mental functioning including irritability, outbursts of anger, difficulty in concentration and sleeping disturbances.

In another study by Large, Saleeby, Hicks & Dana (2008), homicide due to mental disorder was looked in to. In England and Wales over a 50 year period, from 1946 to

2004, the researchers discovered that the total rate of homicide in the general population and as well as homicide rate by people with mental illness rose until the mid-1970. Since then the rate of homicide in the general population continued to rise, while the number of homicides committed by people with mental illness has fallen to historically low levels. Although the rates may vary from one year to another, the pattern has been that the risk of being killed by someone with a mental illness has declined and remained very low.

The researchers suggested that the decrease in the number of killings by people with mental illness is due to better treatment, including use of antipsychotics medications and increased awareness of the treatment of psychosis in primary care (Soliman, 2005).

In the mental health field, two major developments have impacted on family caregiving. Firstly, the de-institutionalization movement has been moving people with severe and persistent mental illness from hospitals to the community since the 1960s. The movement has accelerated in view of the growing concern for the nontherapeutic aspects of hospital care and the civil rights of the patients. Secondly, de-institutionalization has become possible with the introduction of the major tranquillizers. The psychotropic medications have had a dramatic effect on some mentally ill patients by greatly reducing behaviours that were previously difficult to manage in the community (Hatfield, 2010).

In South Africa, there is a shortage of resources in the communities for mentally ill persons because of financial constraints. The problem is exacerbated by the lack of policy on rehabilitation and the de-institutionalisation of mental health care (Sokhela & Uys, 2013). In Europe, on the other hand, the policy of the de-institutionalisation has created a positive move towards the provision of mental health care in the community (Hetherington & Baiston 2001). In rural Ethiopia, families are the sole care givers of their severely mentally ill relatives and the family network is strong and important (Shibre, Kebede, Alem, Negash, Deyassa, Fekadu, Fekadu, Jacobsson & Kullergren, 2003). Families in Canada stress the need for training programmes for people who care for mentally ill people, stating that mentally ill people need somebody who can listen to and talk to them (Piat, Perreault, Lacasse, Loannou, Pawlock & Bloom, 2004)

According to the study conducted by the centre for the study of health policy (1997), titled "The need for improved Mental Health Care in South Africa", mental health is often seen as secondary to physical health and is relegated to fringes of health care and health planning. Faculties within mental health lag far behind other areas of healthcare and for majority there is no care at all. This includes a lack of knowledge of the families of mentally ill persons about the care for their mentally ill members. (National Directorate of Mental Health and Substance abuse, 1997)

In Australia, Jubb & Shanley (2002) found that education for families in the form of information was inadequate, they were not satisfied with the level of emotional support they received from the hospital staff.

Historically people with mental health problems have lacked a voice. Neither they nor their families have been involved in decision-making on mental health services, and they continue to be at risk of social exclusion and discrimination in all facets of life. In a mental health context, empowerment refers to the level of choice, influence and control that users of mental health care needs (Stahler, 2006).

Hatfield (2005) writes that mentally ill persons have rights like any other human beings; they need to be treated with respect and dignity. They need freedom of movement and independence, though the ability to live independently depends on the ability to budget and manage money, hygiene, keep surroundings safe and do shopping.

According to WHO (2012), persons experiencing mental problems are more vulnerable than others in their social dealings and as result, are at risk of having their human rights and freedom violated, including the:

- Rights to liberty.
- Rights to integrity of the person, for example, not to be unduly subjected to mental or physical harm.
- Rights to control their own resources, for example, they should not be automatically removed on the mere grounds of status as a mental patient but should be judged on their actual ability to manage resources. The relatives of

mentally ill person need to ensure that the mentally ill person's rights are not violated. Families of mentally ill need to take care of their mentally ill relative.

The majority of the families studied did acknowledge feeling burdened by the serious and persistent mental illness of a member (Coyne, Kessler, Tal, Turnbull, Wortman, & Greden, 2000).

Fadden, Bebbington, & Kuipers, (2008) also said that the Disruption of family functioning is experienced by families. Disruption of family functioning was an important aspect revealed by many of the carers. In cases where the mentally ill relative was a man, his role as the head of the family and the breadwinner no longer existed, and the wife or the mother had to take on multiple roles in the family. Harmony in the family was also affected by carers sometimes losing their tempers or by family members disagreeing about the management of the mentally ill relative's affairs. Financial strain was a commonly mentioned issue. It was caused by the impairment of the ill relative's earning capacity, coupled with expenditure arising out of the relative's treatment and ill-effect on health.

Francell, Conn, & Gray, (2011) found that the carers experienced a lack of support in dealing with their relatives' problems. The social- support needs expressed by these carers were categorized into informational, emotional, and professional support. The carers expressed a need for information not change, and focus on the pragmatic family issues, which were within their control. Regarding symptomatic behaviour, the severity and number of symptoms would clearly be expected to increase the family members' fear of stigma as well as the actual stigmatizing responses of others. Psychosis is particularly considered in-comprehensible, disturbing, frightening, and corresponds most closely with public conception of mental illness, positive symptoms of psychosis should be particularly stigma- inducing. There is also evidence that psychiatric labels themselves can elicit stigmatizing responses above and beyond those attributable to symptomatic behaviour. Certainly, the fact of psychiatric hospitalization or the presence of a psychiatric diagnosis are the most dramatic and potentially stigmatizing labels. Among psychiatric patients, all of whom have been labelled in these fundamental ways, more subtle variations in labelling may also influence stigma.

Gibbons, Horn, Powell, & Gibbons, (2011) said that the two maladaptive coping strategies, avoidance and denial, were found in two carers respectively. These maladaptive emotional responses did not contribute positively to the caregiving, yet they served to mediate the stresses encountered and thus protected the carers to some extent. Families also reported that the psychiatric state patient do not help in house-hold work and this is distressing. Disrupting of routine of household activities as the caregiver (often the spouse) had to spend more time looking after the psychiatric state patient and had to abandon his/her usual duties. As a consequence this led to neglect of other members of the family especially children. Also psychiatric state patient's problem behaviours such as irritability, sleeplessness and withdrawal were reported to disrupt family routine.

Grad & Sainsbury, (2010) some carers sought religious support and said that their religious practice gave them peace of mind and helped them endure the caregiving situation. These carers believed that praying was likely to reduce the suffering on the part of the ill relative as well. An alternative for caregiving was considered because carers understood that there were limitations to their capacity to provide ongoing care for their ill relatives. The mounting psychological pressure and the physical strain in providing continuing care made the situation difficult to tolerate permanently. They considered giving up or seeking institutional care in the long run.

Gubman, Tessler, & Willis, 2007; Noh & Avison, (2010) also said that the mental illness causes disruption of families social life. The carers revealed that their relatives' uncontrolled behavior, such as temper tantrums or shouting in public places, together with the need for constant care had caused them deprivation in their social lives.

Noh & Turner, (2008), discovered that the most deeply rooted beliefs were that the families of psychiatric state patients generates a lot of social rejection, excessive family burden and patient suffering. The concerns mentioned with greatest frequent were dangerousness, social rejection, lack of information scarcity of resources and excessive family burden.

Pai & Kapur, (2010); and Thompson & Doll, (2002) elaborated on the nature of the burden experienced by these families. Family members reported tension, stress, anxiety, resentment, depression with accompanying feelings of hopelessness and powerlessness, a sense of entrapment, a disruption in their family life and relationships, financial difficulties, physical ill health, restrictions in social and leisure activities, and an overall decrease in the quality of life as a result of having a seriously mentally ill member (Doll, 2012; Lefley, 2013).

Several studies documented specific family stressors experienced as a result of the mental illness of a loved one (Chafetz & Barnes, 2009; Schooler, 2007). These studies showed that families experienced financial, marital, legal, employment, housing, and illness-related stressors as well as interpersonal conflict within the family unit. Other studies discussed the phenomenon of family coping with regard to the serious mental illness of a relative.

Fadden et al. (2008) identified several cognitive coping strategies, such as wishing the situation would go away, looking for a silver lining, or hoping for a cure someday, as those most frequently used by the spouses of persons with an affective disorder. Obtaining specific information regarding the mental illness and strategies for managing client behaviour emerged as very important coping strategies as well (Lefley, 2013; Norbeck, Chafetz, Wilson, & Weiss, 2010).

Norbeck, Chafetz, Wilson & Weiss (2010) also found that family caregivers of the mentally ill believed that help in locating resources and the availability of backup care assistance were significant to their ability to cope. Chafetz & Barnes (2009) identified a pattern of coping in families with mentally ill members that included turning to other family members and close confidants for support first and then seeking support from "experienced others" or peers with psychiatrically disabled family members.

Chesla (2011) noted parents of psychiatric states patients attempt to avoid conflict or confrontation with the ill child as a way of providing care and coping. These studies suggest that these families use cognitive as well as behavioural strategies to cope with the burden, stressors, and difficult realities of their loved one's illness. Recently the

literature pertaining to the families of the mentally ill has come to include studies that have documented the impact of various types of interventions on family outcomes. This group of studies viewed these families as similar to families dealing with other disabling diseases (Hill & Balk, 2007).

The behaviours of the families caring for psychiatric state patients were seen as efforts to solve very complex problems that taxed their adaptive abilities. Family problems that developed were viewed as normal reactions, not as signs of family pathology or dysfunction. These studies focused on strengths, adaptive qualities, and coping skills of the families and not on their influence in causing or exacerbating the illness of their loved one (Abramowitz & Coursey, 2001; Martins, 2009).

The family member's relationship to the patient may affect the extent to which the patient's stigma is transferred to the family member. Such as, family members who live with the ill relative, they can expect to be exposed to more stigma than those who do not, because their acquaintances are more likely to know about their relative's illness and because interaction heightens the acquaintance's probability of contact with the patient. Similarly, spouses may be exposed to greater stigma than parents because their social networks and the ill relative's overlap to a greater extent. Consistent with this idea, Freeman & Simmons (2001) found that spouses of recently released mental patients expressed more concern about stigma than did parents. Alternative predictions might be drawn concerning the relationship of family socioeconomic status to stigma.

The interventions that have been used to date with the families of the psychiatric state patient can be classified as educational, supportive, or a combination of both. Educational interventions, which provided information regarding such topics as mental illness, symptoms, causes, treatment, role of the family, and resources available to the family, have been found to be effective in producing positive family outcomes (Kane, Sidley, Smith, & Howells, 2011; Hill & Balk, 2007; Smith & Birchwood, 2000).

Abramowitz & Coursey (2001) used an intervention that had both an educational and a supportive component and found that participating family members reported significantly reduced anxiety and personal distress and significantly more active coping behaviours

such as increased use of community resources and better management of home life with their ill member.

Another study compared behavioural and supportive family treatment programs to determine their effect on patient and family outcomes. The family outcomes of each program were similar and positive in that the interventions led to a reduction in family conflict, improvements in families' awareness of community resources, and general lessening of global family burden (Zastowny, Lehman, Cole & Kane, 2000). This study showed that the family carers had a poor understanding of the relative's diagnosis and the management of the associated problems. The carers' expressed needs for support paralleled the findings in social support needs (Norbeck, Chafetz, Wilson, & Weiss, 2010).

In a study conducted by Mott & Pellegrini (2000), entitled "a profile of selected psychiatric outpatients in South Africa", it was revealed that the families of psychiatric patients experience financial hardships, since so few of the psychiatric patients receive disability grants. Since most families do not visit their mentally ill family members or attend clinic with them, the contact between them and the potential helpful professional staff seems limited.

Mentally ill individuals are mostly cared for by totally unprepared family members. It becomes the responsibility of health care workers to assist their mentally ill family members. (Corsini & Wedding, 2012; Link, 2000). Because of poor patterns of interaction between the family and the mentally ill family member, the mentally ill family member may develop a lot of emotional disturbances which may result in feelings of frustrations, anger, verbal and physical aggression, these feelings could interfere with the mental health restoration and maintenance phase (Andreasen, 2011; Scott, 2010; Markson, 2009).

Because families are expected to play their parts in the care of their ill relatives, it is unfair to expect the carers to have adequate knowledge and skills to attend to the needs and problems of the ill relative without some form of support. To cope with a relative's serious mental illness, family carers need to be provided with practical advice,

information, and education, such as the symptoms, proper use and knowledge of medications, and practical behavioural management of the manifestations of chronic mental illness (Derth & Labenski, 2011).

Research has shown that families that had received information and had been taught coping strategies about schizophrenia experienced fewer negative emotions perceived less burden, and experienced less family conflict (Ostman & Hansson, 2001; Gullekson, 2010).

1.2. PROBLEM STATEMENT

Thabamoopo is the psychiatric hospital where the psychiatric state patients are admitted. According to the new plan of hospital's revitalization, the hospital has 400 bed capacity while there are more patients (480) currently that are admitted in the hospital, so stable patients should be discharged to accommodate the expected number. If the psychiatric state patients stay in the hospital though they are stable, this may affect the hospital to reach its goal of 400 bed capacities.

Most psychiatric state patient's LOA's seems to be unsuccessful then the psychiatric state patients return to the psychiatric hospital (which is Thabamoopo). The family members do not do follow-ups on this matter nor visit the psychiatric state patients unless after the negotiations from the social worker. This motivated the researcher to want to find out the reasons based on that, what are the experiences of families of psychiatric state patients during LOA.

Though the psychiatric state patients are granted LOA's to visit their families, or stay with them for a while (3 to 6 months or even more) they (psychiatric state patients) do not stay as expected, so the researcher wants to find out the cause based on this matter, that what are the experiences of families of psychiatric state patients during LOA.

1.3. AIM OF THE STUDY

The aim of the study was to investigate the experiences of families towards psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province.

1.4 OBJECTIVES OF THE STUDY

- To explore the experiences of families towards psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province.
- To describe the experiences of families towards psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province.
- To develop guidelines to support families of psychiatric state patients during LOA

1.5. RESEARCH QUESTIONS

What are the experiences of families towards psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province?

1.6. METHODOLOGY

A qualitative, descriptive, explorative and contextual research method was used in this study to explore the experiences of family's towards the psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district. The descriptive study was used to describe the experiences of families towards psychiatric state patient during LOA. The population of the study comprised of all members of families of psychiatric state patients (that have committed murder) staying at Mamaolo and Seleteng village in Nkumpi Municipality, Capricorn District of Limpopo Province, and were admitted at Thabamopo hospital and had unsuccessful LOA's. A non-probability sampling of the

purposive type was used to select participants for the study. Data collection was done through semi-structured interviews. Tech's open-coding was used for data analysis. Details of the research methodology will be discussed in Chapter 3 of the study.

1.7. SIGNIFICANCE OF THE STUDY

The study may help to identify if there are any problems experienced by families when staying with the psychiatric state patients during LOA's; then the result might require the hospital committee's intervention in assisting the families to solve and overcome those problems, which in turn might help the psychiatric state patients to live with their families, feel loved, cared for and welcomed by their families. This may help to bring the families together again.

As the Constitution of South Africa states that all people have rights to freedom, then this study might help to exercise the rights of psychiatric state patients, as the psychiatric state patients will have rights to movement, have freedom by de-institutionalization.

This might also help the psychiatric hospitals to reduce the high rate of psychiatric state patients in their ward and save state's resources and money.

1.8. Conclusion

This chapter presented an overview of the study, including its background, problem statement, purpose of the study, research question and objectives, research methodology and significance of the study. The next chapter will deal with the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

This chapter discusses literature relevant to the research topic namely; experiences of families towards psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn District of Limpopo Province. The review of literature involved in-depth evaluation of published scholarly literature in journals, books and an electronic literature search was also conducted.

2.2 Stigma experienced by family members of psychiatric state patients

State patients arguably comprise one of the most stigmatized groups within our society. The psychiatric state patient may contribute to the negative feelings of some of the public that has toward mentally disordered offenders. For patients without a co-morbid personality disorder, a moderate correlation was found between mental blame and time elapsed. But after the psychiatric state patients have committed an offence, psychiatric

hospital stays help them gain a sense of personal responsibility for their offences (Fisher, 2012).

Attributions are explanations that people construct likely to facilitate their understanding of the previous behaviour of either themselves or others (Shine, 1997). People's attributions impact their actions and emotions (Fox & Leicht, 2010; Abram, 2005) and contribute to the formation of attitudes (Kemdal & Montgomery, 2011). The application of Attribution Theory toward mentally ill offenders can help with the development of two important forensic research areas.

Understanding public perceptions of mentally ill offenders and conceptualizing state patients view and feel about their offences. Attitudinal research on state patients has been well documented that mental illness is associated with stigma due to the potential misconceptions and negative attitude of the general public (Martin, Pescolido, & Tuch, 2010; Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Rusch, Angermeyer, & Corrigan, 2005). Indeed, a review of the population-based research on attitudes towards the mentally ill indicates that much of the public fears mentally ill people because they are perceived as unpredictable and dangerous (Angermeyer & Dietrich, 2012).

However, public perceptions of mentally ill persons as criminally dangerous are greatly exaggerated (Stuart & Arboleda-Florez, 2012). Partly to blame is the informal norm of the news industry to report somewhat sensationalistic news stories (Corrigan et al., 2005), as well as the public's exposure to media sources--including magazines, newspapers, and television--that portray mental illness using a negative frame that focuses on violence (Sieff, 2008). For example, Swartz, Borum & Wagner (2011) reported that the majority of news stories about people inflicted by mental illness focus on negative aspects like dangerousness, unpredictability, and unsociability and that the single largest focus of newspaper stories about mentally ill people is on their dangerousness and crime.

Media sources like newspapers often fail to cover positive aspects of mental illness such as recovery (Wahl & Richards, 2012). The dominant negative messages of the

mass media have arguably resulted in a misrepresentation of the frequency of indictable offences committed by mentally ill persons (Philo, Platt, Henderson, McLaughlin, & Burnside, 2012).

The exaggeration of dangerousness in mentally ill persons is unfortunate as the proportion of violent offences committed by individuals with severe mental illnesses is small (Matthias & Angermeyer, 2010). While some studies have suggested that there is a relationship between psychotic disorders and violence, the associated risk is minute, and moreover, is limited to specific groups of symptoms (Borgen & Foldemo, 2010). For example, psychotic patients are more likely to be violent if they specifically have persecutory delusional beliefs (Nester, Haycock, Doiron, Kelly, & Kelly, 2011).

2.3 Social problems experienced by family members of psychiatric state patients

Most families experiences social problems towards the psychiatric state patients. Inconvenience resulting from patient's not going to work, school, or college, was reported by families. More common, however, was complete or partial cessation of normal recreational activities, which 86 % of relatives experienced it as a problem though only 30 % reported actually abandoning a planned leisure activity such as a vacation or family re- union due to the patient's illness. About 77 % of the families reported that the patient's illness was using up their leisure time, leave or holidays. A similar proportion (76 %) experienced that the illness was also disrupting the normal routine of household activities as the caregiver (often the spouse) had to spend more time looking after the patient, and had to abandon his/her usual duties. As a result, this led families/carers to neglect other family members especially children who often missed meals or school. Patient's problem behaviours, e.g. irritability, sleeplessness and withdrawal or compulsions were reported to disrupt the family routine in about 40 % of the cases. Family members have been implicitly or explicitly blamed for the mental illness of their loved one (Giger & Davidhizar, 2012).

In years past, the literature pertaining to the aetiology of serious mental illnesses, such as schizophrenia and bipolar disorders, contained references to dysfunctional families.

The expressed emotion literature suggested that these families may be responsible for the relapse and hospitalization of their loved one because of the emotional climate within their family units (Ruane, 2012, & Blow, 2004).

2.4. Burdens experienced by families of psychiatric state patients

Families endure the pain they experience when staying with psychiatric state patients on LOA. The majority of the families studied did acknowledge feeling burdened by the serious and persistent mental illness of a member (Fadden, Loss, Wiese, Israel, Wallerstein & Fuller, 2008). Several of the studies elaborated on the nature of the burden experienced by these families. Family members reported tension, stress, anxiety, resentment, depression with accompanying feelings of hopelessness and powerlessness, a sense of entrapment, a disruption in their family life and relationships, financial difficulties, physical ill health, restrictions in social and leisure activities, and an overall decrease in the quality of life as a result of having a seriously mentally ill member (Fadden et al, 2008). Several studies documented specific family stressors experienced as a result of the mental illness of a loved one (Zastowny, Lehman, Cole & Kane, 2008). These studies showed that families experienced financial, marital, legal, employment, housing, and illness-related stressors as well as interpersonal conflict within the family unit. Puskar (2012) discussed the phenomenon of family coping with regard to the stage of mental illness of a relative. If the mental illness is severe, then the families of the psychiatric state patient will not be able to cope. Puskar (2012) identified several cognitive coping strategies, such as wishing the situation would go away, looking for a silver lining, or hoping for a cure someday, as those most frequently used by the spouses of persons with an affective disorder. Obtaining health education/information regarding the mental illness and strategies for managing client behaviour emerged as an important coping mechanism (Haber & Hoskins, 2005).

Award & Vuruganti, (2008) also found that family caregivers of the mentally ill believed that help in locating resources and the availability of backup care assistance were significant to their ability to cope. Ruane (2012) identified a pattern of coping in families

with mentally ill members that included turning to other family members and close confidants for support first and then seeking support from "experienced others" or peers with psychiatrically disabled family members.

These studies suggest that these families use cognitive as well as behavioural strategies to cope with the burden, stressors, and difficult realities of their loved one's illness. The literature pertaining to the families of the mentally ill has come to include studies that have documented the impact of various types of interventions on family outcomes. This group of studies viewed these families as similar to families dealing with other disabling diseases (Johnson, 2010; Gerolamo, 2011).

The behaviours of the families caring for mentally ill members were seen as efforts to solve very complex problems that taxed their adaptive abilities. Family problems that developed were viewed as normal reactions, not as signs of family pathology or dysfunction. These studies focused on strengths, adaptive qualities, and coping skills of the families and not on their influence in causing or exacerbating the illness of their loved one (MacPherson, Varah, & Foy, 2009).

2.5 Lack of coping mechanisms experienced by families staying with psychiatric state patients on LOA

In another study that was conducted by Phakathi (2005), she discovered that families experienced uncertainty in understanding and coping with their family members' mental illness and that their experience was influenced by the family's cultural beliefs and tradition on how they understand and cope with the illness.

Mentally ill individuals are mostly cared for by totally unprepared family members. It becomes the responsibility of health care workers to assist them and especially to provide them with guidelines to assist their mentally ill family members who have

committed crimes. Because of poor patterns of interaction between the families and the mentally ill family member may develop a lot of emotional disturbances which result in feelings of frustration, anger, verbal and physical aggression, feelings of worthlessness and hopelessness. These feelings could interfere with mental health restoration and maintenance phase. (Jordaan & Jordaan, 2011)

When the family visit the hospitalized relapsed patients, they are confronted with feelings of anger, shame, guilt and depression, which is the reaction of internal and external stimulus. This becomes part of the process of mental illness and may serve as a trigger for relapse of their discharged mentally ill family member. In other cases the family may blame themselves for their family members' mental illness, and think are responsible for the occurrence of mental illness (Magliano, 2012; Willer & Egrig, 2010).

Carers, families and friends have needs of their own. Care giving can be a positive experience but for most families it is described as a burden. WHO also estimated that the burden to family and community is caused by those who committed crime due to mental illness (WHO, 2002).

A study by WHO (2008) in five European countries (Italy, England, Germany, Greece and Portugal) reported that caregivers and families for psychiatric state patients spent an average of 6–9 hours per day providing care.

- 95% of carers are members of service users' families;
- 29% provide support and care for more than 50 hours per week;
- 90% are adversely affected by the caring role in terms of leisure activities, career progress, financial circumstances and family relationships;
- 60% have a significantly or moderately reduced social life;
- 33% find that family relationships are seriously affected; and
- 41% have significant or moderately reduced mental and physical health.

It should be remembered that informal caregivers are not an amorphous group. A particular focus should be given to the fact that 82% of carers are female (mothers, in 90% of cases); 70% are aged over 60 years and 33% over 70 years. Moreover, the

perception of burden may vary between different cultures in terms of being more or less of accepting of disability and seeing hope for the future (WHO, 2008).

Health care has increasingly been seen as a partnership between providers and users and their families. The sensitive nature of mental health problems, however, means that there can be particular difficulties in relation to confidentiality and the sharing of information, compounded by differences of practitioners' opinions on what information can be shared. The practitioner must balance the value of information sharing – sometimes crucial to the well-being of both psychiatric state patients and families– against ethical and legal duties of confidentiality to both psychiatric state patients and family members independently. Unfortunately, many mental health practitioners never receive training on dealing with these complex issues or addressing the different needs of users and carers. As a result, they lack confidence and so avoid giving any information, often citing confidentiality as the reason. (WHO, 2008).

2.6 Lack of support experienced by families staying with psychiatric state patients on LOA

The quality of support varies, and many family members of psychiatric state patients feel marginalized by services that seem unaware of their huge contribution as informal caregivers. The essential message is that services should support families and friends responding to their own needs as carers and enabling them to care most effectively (Freeman & Simmons, 2010).

In a study conducted by Rogers (2013), it is also defined that there are certain characteristics and qualities that the families of psychiatric state patients must be empowered with, for them to be able, to take care and live with psychiatric state patients. Some external conditions and internal qualities are important.

- Hope and respect
- Reclaiming one's life
- Feeling connected

- Understanding that people have rights
- Learning skills that the individual defines as important
- Moving from secrecy to transparency
- Growth and change that are never ending and self-initiated (Rogers, 2013).

2.6.1 Hope and respect

Hope and respect are essential to growth. A hopeful person believes in the possibility of future change and improvement; without hope, making an effort can seem pointless. Yet some professionals who label their patients incurable or chronic seem also to expect them to be motivated to take action and make changes in their lives, despite the overall hopelessness such labels convey. Families need to show respect for the inherent dignity and individual autonomy of people with mental health problems, including acceptance of difference as part of human diversity and humanity.

As part of the process of psychiatric diagnosis and treatment, users and their families have had their lives, their personal stories, transformed into case histories. Part of the empowerment process is therefore the reclaiming of these life stories (Morris, Steadman & Veysey, 2013).

2.6.2. Reclaiming one's life

Similarly, the process of empowerment should include a reclaiming of one's sense of competence, and recognition of the often hidden power relationships inherent in the treatment situation. In the early stages of participation in self-help groups, for example, members often tell one another their stories; both the act of telling and that of being listened to are important for group members (Torrey, 2012).

2.6.3. Feeling connected

Not feeling alone Empowerment does not occur to the individual alone, but has to do with experiencing a sense of shared experience and connectedness with other people.

2.6.4. Understanding that people have rights

Understanding that people have rights, the self-help movement among psychiatric service users is part of a broader movement to establish basic legal rights. There are parallels between this movement and other movements of oppressed and disadvantaged people, including racial and ethnic minorities, women, gay and lesbian people, and people with disabilities. The struggle for equal rights has been part of all these liberation movements. Through understanding their rights, people increase their sense of strength and self-confidence (Link, 2010).

2.6.5. Learning skills that the individual defines as important

Health professionals sometimes complain that users have poor skills and cannot seem to learn new ones. At the same time, the skills that professionals define as important are often not the ones that users find interesting or important. When users are given the opportunity to learn things that they want to learn, they often surprise professionals (and sometimes themselves) by being able to learn them well (Karp, 2011; Groffain, 2012).

2.6.6. Moving from secrecy to transparency

People with devalued social status who can hide that they are mental health care users, often choose to do so, but this decision takes its toll in the form of decreased self-esteem and fear of discovery. Those who reach the point where they can reveal their identities as mental health service users are more likely to display self-confidence (WHO, 2008).

People can be helped to make decisions about disclosure through support in recognizing that they have multiple characteristics, many of which are positive. It is also important for people with mental health problem, families and society to recognize and accept that mental health problems are a source of learning, growth and development, and bring additional skills and qualities (WHO, 2008).

2.6.7. Growth and change that are never ending and self-initiated

Families need to understand that they need to be empowered so to be able to live with the psychiatric state patients and Empowerment is not a destination, but a journey. No one reaches a final stage at which further growth and change are neither possible nor beneficial (WHO, 2005).

2.7. Support system from families towards psychiatric state patient

According to Andrews & Boyle (2012) and Stanhope & Lancaster (2010) a family is the basic social unit which provides the context in which health promotion and maintenance are defined and carried out by family members within cultural diverse communities. The participants expressed that family involvement is necessary in the management and treatment of mental illness. They expressed that families have an influence over the medication of the mental health care user and decide which type of medication is suitable for the mental health care user; therefore they cannot exclude families in the treatment process.

Frisch & Frisch (2012) and Liska (2012), are of the opinion that a family is like a system that is connected to each other. If a significant event like mental illness affects one family member it will have an impact on others as well. These authors further indicated that a family works to achieve a state of equilibrium, if one is affected by mental illness the equilibrium is upset and the relationships, supports, and tasks of everyday living need to be readjusted. In this study the systems approach is used because the state of

equilibrium is being maintained by mental health care practitioners whose role is to empower the families in the management and treatment of mental health care users.

The goal of treatment is to achieve equilibrium. In this study more than half of the participants expressed that mental health care users who are admitted to the hospital are being supported by their family members; they are viewed holistically and cannot be treated in isolation (Rowe, 2010).

Geldard (2012), view of family as a system is supported by Uys & Middleton (2011) when they state that the families of people with mental illness usually shoulder the greatest part of the burden of caring for them and the family is the main resource of the person suffering from mental illness. Families act as caregivers; they support other families with similar problems.

Kneisl & Trigoboff (2009) state that involving family members in a client's treatment plan serves two main goals: firstly: enlisting the family as an ally in promoting and bringing about therapeutic progress and secondly: supporting family caregivers. These authors believe that whilst families are supporting the patients, as caregivers they need to be supported as well. In this study families are supported by the mental health care practitioners.

The support of the family becomes very important when the mental health care user is admitted to or discharged from the hospital because the family is viewed as the context in which continued treatment and management of the condition takes place (Wilson & Kneisl, 2010).

The interventions that have been used to date with the families of the mentally ill can be classified as educational, supportive, or a combination of both. Educational interventions, which provided information regarding such topics as mental illness, symptoms, causes, treatment, role of the family, and resources available to the family, have been found to be effective in producing positive family outcomes (Zastowny et al, 2011). Haber (2005) used an intervention that had both an educational and a supportive component. The author discovered that participating family members reported significantly reduced anxiety and personal distress and significantly more active coping

behaviours such as increased use of community resources and better management of home life with their ill member. Yet another study compared behavioural and supportive family treatment programs to determine their effect on client and family outcomes. The family out- comes of each program were similar and positive in that the interventions led to a reduction in family conflict, improvements in families' awareness of community resources, and general lessening of global family burden (Zastowny et al, 2011).

The intervention studies represented attempts to reduce the burden and stressors by enhancing the ability to cope. The intervention studies were undergirded by a philosophy that did not presuppose family dysfunction but rather focused on family strengths and adaptive capabilities. The interventions were successful in producing positive family outcomes, but one might wonder if the extent and magnitude of the success might be enhanced by documenting the particular areas of family health and strength before developing the specific interventions.

2.8. Conclusion

This chapter presented the detailed literature review of the study. The next chapter will deal with the research design and the methodology of the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. Introduction

In chapter two, literature review was presented. In this chapter the research methodology is described comprehensively and a detailed description of data collection methods was presented. The study adopted a qualitative research method and the rationale for the study was outlined. Data collection was carried out through field work in the home setting of family members of psychiatric states patients, permission had to be obtained families of psychiatric state patients by signing the consent forms. The actual period of data collection began in January 2014 and was concluded in the following month.

The researcher initially went to all families of psychiatric states patients to gain permission to conduct study. The research topic and benefits to the families were discussed. The response was positive and the families volunteered to take part in the research study. Appointments for interviews in their homes were finalised.

The pilot interview was conducted with a family (the mother) of the psychiatric state patient. Not much information was collected from the mother.

3.2. Research methodology

3.2.1 Qualitative Research

According to Merriam (2001) qualitative research study is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. Merriam further explains that qualitative researchers are interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experiences they have in the world (Merriam, 2001).

Based on the above explanation this study is based on a qualitative approach and it attempts to understand the viewpoints of participants with their experiences staying with

state patients; the qualitative approach of this study attempts to explore and describe the experiences of families when staying with state patients on LOA.

De Vos et al (2002) defines qualitative research as the research that elicits participants' accounts of meaning, experiences or perceptions. It also produces descriptive data in the participants' own written or spoken words. Linking the definition to the study, the researcher will explore and describe the experiences of families staying with state patients on LOA.

3.3. Research design

According to De Vos et al (2002) research design is "a detailed plan for how a research study is to be conducted." Yegidis & Weinbach (1996) are of the opinion that a research design is implemented to attempt to find answers to the researcher's focused questions. It is "a response to a series of decisions about how best to answer focused questions.

3.3.1. Phenomenology Research

A phenomenological research according to Hansen (2006) is a methodological design that is interested in people's experiences with regard to the phenomenon under study and how they interpret their experiences. Welman, Kruger & Mitchell (2005) further describe the aim of phenomenological research design to focus on the understanding of the social and psychological phenomena. In this study, the researcher aimed at exploring and describing experiences of families towards psychiatric states patients on LOA at Lepelle Nkumpi Municipality, in Capricorn district of Limpopo Province.

3.3.2. Exploratory Research

Exploratory research according to Yegidis & Weinbach (2009) is appropriate when problems have been identified but our understanding of them is quite limited. It is

conducted to lay the groundwork for other knowledge-building that will follow”. Exploratory research as the name implies is conducted to explore a topic i.e. to know more about the phenomenon under study. Mouton and Marais (1990) in De Vos (2005) state that “the aim in exploratory studies is to gain new insights into phenomenon, undertake a preliminary investigation prior to a more structured study of the phenomenon, explicate the central concepts and constructs, determine priorities for future research and develop new hypothesis about an existing phenomenon”.

In this study, the researcher explored the experiences of families staying with state patients on LOA in Lepelle Nkumpi Municipality, Capricorn District of Limpopo Province.

3.3.3. Descriptive Research

According to Burns & Grove (2011), a descriptive study is designed to gain more information about characteristics within a particular field of study. It provides a picture of a situation as it naturally happens. The researcher observed the behaviour of participants, described what was observed and explores and documents aspects of the situation under study. In this study the design used to describe the family’s experiences towards state patients on LOA in Lepelle Nkumpi Municipality of Capricorn district in Limpopo Province.

3.3.4. Contextual research

According to Babbie & Mouton (2010), the aim of qualitative research is to describe and understands events within the concrete natural context in which they occur. After description and exploration of the family’s negative experiences when staying with State patients on LOA, the findings were understood within the context of family’s experiences.

In this study the families were interviewed in their homes, which is their natural setting environment.

3.4. POPULATION AND SAMPLING

3.4.1. Population

Polit & Hungler (2007) describes population as the entire set of individuals (or objects) having some common characteristics. Their description is similar to Yegidis & Weinbach (2009) as they states that it is the entire population of people or elements that share some defined characteristics. In this study, the population comprised of all members of families of state patients (only those that have charged with murder) that are admitted at Thabamooopo Hospital in Lepelle Nkumpi Municipality, Capricorn District of Limpopo province and that were granted unsuccessful LOA's. The population size comprised of fifty (50) families of psychiatric state patients.

3.4.2. Sampling

Sampling refers to the process used to select a portion of the population for study. (Maree, 2007), and De Vos et al (2005) states that is a small portion of the total set of objects or persons which together comprise the subject of our study. A sample is studied in order to understand a population from which it was drawn or sometimes there may not be sufficient time to study a large population. De Vos et al (2005) is of the opinion that the use of samples may therefore results in more accurate information than might have been obtained if one had studied the entire population.

According to Brink (2012) a sample is a part or fraction of the whole or subset of a larger set selected by the researcher to participate in a research project. Sampling criteria refers to the characteristics for inclusion in the target population (Burns & Grove, 2011). In this study the non-probability sampling of the purposive type was used to select participants. The researcher chose the typical characteristics of the participants to be included. Fifteen participants were selected to participate in this study.

According to Polit & Hungler (2007) the non-probability sampling of the purposive type is a general term for judgmental sampling in which the researcher purposively selects

certain groups of individuals for their relevance to the issue being studied. In purposive sampling members of a sample are chosen with a purpose to represent a location or type in relation to a key criterion.

Non-probability and purposive sampling were relevant for the study as met the needs of the study by, exploring the experience of families staying with state patients on LOA in Lepelle Nkumpi Municipality of Capricorn District of Limpopo Province.

3.4.3. Inclusion criteria

The sample of this study comprised a total of fifteen families but data saturation was reached by tenth interview. All participants were families who have stayed with psychiatric state patient who were given unsuccessful LOA's.

The interviewed families displayed the following characteristics: All ten families live in rural black community (Mamaolo and Seleteng villages) in Capricorn district of Limpopo province.

- One family comprised of both parents of psychiatric state patient
- Two families comprised of single mothers of psychiatric state patient
- One family comprised of widowed father of psychiatric state patient
- Two families were wives of psychiatric state patient
- Two families were the sisters of psychiatric state patient
- One was the sister-in-law of psychiatric state of patient
- One was the grandmother of the psychiatric state patient
- Gender dominated by the females (eight females and two males), as the males were at work during data collection and some are not staying with the psychiatric state patient when on LOA's. The families of state patient who were given unsuccessful LOA's repeatedly at Thabamoopo hospital in Capricorn district of Limpopo province.
- They all spoke and understood Sepedi

- The families were staying and have stayed with the psychiatric state patient for a month or more when on LOA.

3.5. DATA COLLECTION

Data was collected from families of psychiatric state patients on LOA, using in-depth, semi-structured interviews, Field notes were also taken. The home environment was conducive to collect data as the participants were relaxed in their natural setting. An in-depth, semi-structured interview was a preferred method as the interviewer was able to determine whether the participants have understood the questions. (Polit & Hungler, 2007). The interviewer was in position to observe or judge the participants level of understanding.

3.5.1. Setting up appointments

The researcher set-up appointments with the participants and made sure that the appointments were honoured according to agreed time and place. All participants were interviewed at their homes. Interviews were conducted during the day.

3.5.2. Interviews

All participants were encouraged to talk about the problems they experienced when staying with the psychiatric State patients on LOA. The researcher met the participants individually before the actual interviews to discuss ethical considerations and the reasons why the interviews were conducted by the researcher. Once the researcher had explained to them the procedure of the interviews, including the use of the tape recorder, they seemed to be satisfied. Interviews were held with participants. Interviews were tape recorded with the permission of the participants and field notes were also taken during the interviews.

The interviews were recorded and transcripts were made and translated into English by the researcher. The researcher then met with the supervisor and the Independent coder, who has obtained a Master's degree, PhD and has facilitated a research workshop, to reach a consensus regarding the identification of themes and sub-themes.

3.5.3. Recording the Interview

A tape recorder was used to capture the interviews which subsequently were transcribed verbatim. Using a tape recorder during interviews allowed the researcher to devote her full attention to listen to the participants and to probe in depth. Using a tape recorder was done with the permission of the participants as it was included in the consent forms. During the recording the researcher was able to get accurate, verbatim record of interview including hesitations in tone by participant.

3.5.4. In-depth interview

In-depth interview was used to guide the study. This approach was used as it focused mainly on lived experiences (Streubert & Carpenter, 2011). The families described their experiences they experienced when staying with State patients on LOA. According to Polit & Hungler (2007), an in-depth interview refers to "a conversation with purpose". Families were interviewed using this method in order to explore their experiences. Open-ended questions were used. Participants were asked common question "Please tell me, what are the problems that you experience when staying with the State patients on LOA?"

3.5.5 Probing

According to Polit & Hungler (2007), probing is the technique used by the interviewer to elicit more useful or detailed information from a participant than was volunteered in the initial reply. The researcher probed the participants by encouraging them to talk about the problems their experiences when staying with the State patients on LOA. The questions were directed at exploring the problems they experienced while staying with the psychiatric State patients and follow-up questions were also asked for clarity.

3.5.6 Reflecting

Reflecting is one of communication strategies that facilitate effective communication between individuals or group of people. According to Streubert & Carpenter (2011), reflexivity describes believe that the language that the individuals use to describe an experience reflects that particular experience and also all other experiences in each individual's life.

The researcher was engaged in dialogue with participants to reveal each individuals influencing behaviour (Streubert & Carpenter, 2011). The researcher probed the participants using reflection as a communication strategy to encourage alternative explanations or interpretations of the phenomena under the study that was relevant or important.

3.5.7 Field notes

Field notes refers to the documents generated from the observations (Streubert & Carpenter, 2011). These notes were recorded about people and places where study was conducted. The researcher documented the information she heard, experienced and observed during the interviews. According to Polit & Hungler (2007), field notes are sometimes categorised according to the purpose they will serve during the analysis and integration of information, namely, 1. Observational, 2. Theoretical, 3. Methodological, 4. Personal notes.

3.5.7.1. Observational notes

According to Polit & Hungler (2007), these are objective description of events, conversations and information such as time, place and activity. In this study the researcher described the place where data was collected, the time of collecting data, how data was collected, and the conversations with the participants.

3.5.7.2 Methodological notes

These are instructions about how subsequent observations will be made. (Polit & Hungler, 2007). The researcher then wrote instructions about the observations that were made during data collection.

3.5.7.3 Theoretical notes

These are records of existing data that can be used when available data are exercised in a new way in order to answer specific research (Polit & Hungler, 2007). The researcher also did the theoretical notes by reviewing the existing data.

3.5.7.4 Personal notes

These can be explained as notes taken of the researcher's own feelings during the interview that were used to obtain better understanding of the data (Polit & Hungler, 2007). The researcher has written notes during the interview and were also used when analysing data.

3.6. PILOT STUDY

According to Polit & Hungler (2007), pilot study is a small scale, or trial run, done in preparation for the major study. Its function is to obtain information for improving the project or for assessing its feasibility. The researcher conducted pilot study by interviewing five participants prior the major study. This was done in order to identify any problems with data collection tool, to refine the design of choice and to offer the researcher an opportunity to practice using the audiotape recorder.

3.7. DATA ANALYSIS

In a qualitative study, data analysis started during data collection. The researcher used the methods suggested by Tesch's (Creswell, 2013) to analyse the collected data.

1. Get the sense of the whole. The researcher read carefully through all the transcriptions, made notes of ideas that came in mind.
2. The researcher selected one interview and read it to try to understand and to get the meaning in the information writing down thoughts coming to mind.
3. After going through transcripts, the researcher arranged the similar topics in groups by forming columns labelled major topics, unique topics and leftovers.
4. The researcher then abbreviated the topics as codes and wrote the codes next to the appropriate segment of the text. The researcher observed the organisation of data to check if new categories or codes emerged.
5. The researcher found the most descriptive wording for the topics and converted them into categories.
6. A final decision were be made on the abbreviation of each category and the codes were arranged alphabetically.
7. The data material belonging to each category were put together in one place and preliminary analysis performed.
8. Recording of data was done (De Vos 2012).

In this context, the researcher replayed the tape to listen to the contents and the responses of the participants during the interview. The transcriptions were read and re-read, the field notes were reviewed to check for accuracy. The researcher used reflexivity and bracketing to exclude preconceived ideas or biases about the phenomenon under the study (Burns & Groove, 2011)

The researcher picked he most interesting transcript and highlighted recurring words and phrases identifying differences and interrelationships. Thoughts that occurred during the transcription were written in the margin. The researcher made a list of all the

topics that emerged. Data were broken down into manageable themes and sub-themes and meaningful units.

Themes were derived from the interviews conducted with 10 participants. Sub-themes reflected patterns of participants' experiences when staying with psychiatric state patients on LOA. Sub-themes were presented in each theme. Themes reflect an in-depth understanding which is central to the phenomenon (Creswell, 2013).

After discussion with the researcher and the independent coder agreed on the wording to be used in the formulation of themes and sub-themes.

The descriptions were allocated themes and sub-themes. Raw data were formulated to an independent coder. The independent coder, a nurse researcher, was familiar with conducting qualitative data analysis. The independent coder allocated the codes from the original raw data given by the researcher. A meeting was held to achieve consensus on the categories reached independently. Final remarks on data analysis were written after agreement had been reached (Burns & Groove, 2011).

3.8. MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is the ability of the researchers to convince themselves and participants that the findings of the inquiry are trustworthy, (Mouton, 2004). Trustworthiness is enhanced by credibility, transferability, dependability and conformability.

3.8.1 Credibility

Polit & Hungler (2007), explains credibility as confidence in the truth of the data. In this study the following strategies were used to ensure credibility of this study: prolonged engagement with participants, triangulation and member check.

- **Prolonged engagement with participants**

Polit & Hungler (2007) defines prolonged engagement as the investment of sufficient time in the data collection activities to have an in-depth understanding of the culture, language, or views of the group under the study and to test for misinformation and the

distortions. In this study the researcher collected data for 2 months so that the researcher may be able to know and understand the participants better.

- **Triangulation**

When using triangulation the researcher uses different methods of collecting data, that is, in this research study the researcher used in-depth semi-structured interviews and observation (Polit & Hungler (2007)). In this study the researcher observed participants while collecting data, observing any behaviour or if the participants were telling the truth. The researcher also used tape recorder when collecting data and used participants language verbatim when analysing data.

- **Member checks**

According to Polit & Hungler (2007), Member checks refers to providing feedback to the study participants regarding the data and the researchers emerging findings and interpretations and securing the participants reactions. In this study the researcher went back to the participants to give feedback about data collected and checked if the data was analysed correctly. The researcher also consulted experts in the field to assist in analysing data.

3.8.2. Transferability

According to Polit & Hungler (2007), transferability essentially refers to the generalization of the data (the extent to which the findings from the data can be transferred to other settings or groups). In this study the transferability was ensured by using thick description of the methodology meaning the researcher stated and explained the methods and designs used to collect and analyse data.

3.8.3. Confirmability

According to Polit & Hungler (2007), confirmability refers to the objectivity or neutrality of the data, such that there will be agreement between two or more independent people about the data's relevance and meaning. In this study the researcher asked the supervisor and the co-supervisor to listen to the tapes, check field notes and memos so

that they may be able to reach agreement about data and its meaning. The independent coder, who has obtained a Master's degree in Nursing, PhD and has facilitated research workshop, was also given the notes and the tape to listen to, so as to confirm the meaning of the data and the correctness of the English.

3.8.4 Dependability

If a study is to be judged dependable (alternative term to reliable) it must be consistent and accurate. This is audit trail in which researchers provide details description of the path of the research, so that readers can follow the decision-making process (it is also called decision trail by some researchers such as Golafshani (2009). Peers and readers are then able to carry out an inquiry audit in which they follow the path of the researcher. So in this study the researcher explained all the methods used to collect data.

3.9. ETHICAL CONSIDERATIONS

According Polit & Hungler (2007), this refers to when humans are used as the study participants and great care must be exercised in ensuring that the rights of those human beings are protected before the study will be conducted. Ethical considerations include permission to conduct study, informed consent, principle of beneficence, confidentiality and privacy. In conducting the study the researcher complied with the professional ethics so as to ensure the success of the study. De Vos et al (2012) defines ethics as a set of moral principles which is suggested by an individual or group is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students.

3.9.1. Permission to conduct study

The research proposal was sent to the University of Limpopo ethics committee where a clearance certificate was obtained from the Medunsa Research and Ethics Committee and the Limpopo Provincial Department of Health and Social Development.

The researcher also wrote the letter to Headman of the two villages, Mamaolo and Seleteng requesting their permission to conduct the study in their villages. The researcher also required the participants to sign the consent form prior to the start of the study.

3.9.2 Informed consent

Ruane (2006) expresses that the principle of informed consent is about the right of individuals to determine for themselves whether or not they want to be part of a research project. Research participants have rights to be informed about the research project and should not be forced into participating. In this study in order to ensure that participants volunteer before the interviews are conducted, they were given consent forms to sign as a proof that they were not forced to participate out of their will. Informed consent forms also reminded them that they have a right to withdraw at any point during the study. In the forms the purpose of the study, the research methodology and the rights of participants were clearly stipulated. They were also informed that a tape recorder would be used.

- **Information**

This is when the researcher must provide the participants with comprehensive and clear information regarding his/her participation in the study. In order to obtain participants consent, the researcher provided information to the participants regarding the study including all important information, e.g. the title of the study, study population, how data

will be collected, confirmation of anonymity, voluntary participation and refusal to participate or withdrawal at any time.

- **Understanding**

After receiving the above information, the subjects must understand that information. So the researcher used the language that the subjects understood and asked questions to ensure that the subject understood the information provided.

- **Choice**

This is when the researcher is responsible for ensuring that the subject invited to participate in the study is not unduly influenced to participate, or coerced, which is that she/he is made to feel that he/she must participate. (Brink, 2012).

The researcher explained to the participants that they were not forced to participate in the study and they had the right to withdraw from participating at any time without any penalty.

3.9.3. Principle of beneficence

Brink (2012) says principle of beneficence is when the researcher needs to secure the wellbeing of the subject, who has the rights to protection from discomfort and harm, be it physical, emotional, spiritual, economic, social or legal. Participants can be harmed physically or emotionally. Emotional harm to participants may be difficult to predict beforehand. The participants were informed beforehand about the potential impact of the investigation. Researcher had to remove those participants who were vulnerable during investigation so that they can withdraw beforehand. So in this study the researcher informed the participants that they had the right to withdraw or terminate their participation at any time without any penalty, if they felt that continuing will result in harm e.g. stress or injury. Then the researcher also avoided asking the participants sensitive questions when collecting data.

3.9.4. Confidentiality and Anonymity

Ruane (2006) mentions that participants' right to privacy requires the researcher to pay attention to sensitivity of the information; location or setting of the research and the disclosure of the study's findings. In this study the researcher was aware of the sensitivity of the topic about state patients, interviews were held where there was privacy and cell phones were switched off to avoid any disturbances. To ensure confidentiality, the researcher collected information in such a way that it cannot be linked to any participant.

Brink (2012) states that the principle of justice includes the subjects' rights to fair selection and treatment. The researcher assured the participants that information was treated with confidentiality. The researcher also ensured that no names of participants used were disclosed or linked to information given during data collection and the tape recorded cassette used during data collection was used for verification of data findings and was only used by the researcher and the expert (supervisor and/or co-supervisor, and the independent coder) in the study.

3.10. CONCLUSION

In this chapter a detailed description of the research design and methodology was discussed. The data collection methods were discussed as well as detailed description of data analysis. The researcher described qualitative approach, descriptive, exploratory and contextual designs. Data verification methods were also mentioned and lastly ethical considerations considered during investigation were also discussed. The next chapter includes discussion of the results.

CHAPTER 4

DISCUSSION OF THE RESULTS AND LITERATURE CONTROL

4.1 INTRODUCTION

In chapter three (3) the methodology of the study was discussed. This chapter focused on discussion of the results of the study and literature control.

4.2. DISCUSSION OF THE FINDINGS

Table 4.1 shows an overview of the themes and sub-themes from the family's description of their experiences when staying with the psychiatric state patient on LOA. Four (4) themes emerged from the study namely: the psycho-social effects, refusal of taking treatment, psychological effects and physical effects.

Table 4.1: Themes and sub-themes regarding the experiences of family members when staying with psychiatric state patient when on LOA.

Main-themes	Sub-themes
1. Psycho-social effects	1.1.Uncontrolled and disruptive behaviour 1.2 Smoking dagga and drinking alcohol 1.3 Aggression (physical and verbal) 1.4 Isolation 1.5 Lack of support
2.Refusal of treatment	2.1 Defaulting treatment
3.Psychological effects	3.1 Fear, Distrust and insecurity 3.2 Lack of coping mechanism
4.Physical effects	4.1 Physical exhaustion 4.2 Lack of sleep

4.2.1. Theme 1: Psycho-Social effects

Most families reported that when staying with the psychiatric state patient on LOA, they experience uncontrollable behaviour from the psychiatric state patients as they drink too much alcohol and use drugs. They also reported that they do not get any support from their extended family members, friends and relatives. Families also reported that the psychiatric state patients isolate themselves when at home.

4.2.1.1 Sub-theme 1.1. Uncontrolled and disruptive behaviour

In interviews conducted in this study, families of psychiatric state patient mentioned that it was difficult for them to stay with the psychiatric state patients when on LOA as they behaving badly and uncontrollably. These experiences were expressed as follows:

Participant 05: *“he is dangerous, he wakes up at night, roams around in the house, and turns on the radio very loud”*.

Participant 08: *“he comes back home very late in the evening, start banging doors and making a lot of noise”*.

Participant 09: *“early in the morning when he woke up, he goes and buy alcohol and dagga, without even eating breakfast nor taking his medication, when I try to talk to him about taking medication he will start making a lot of noise”*.

Participant 10: *“one day he will come home start telling you that you are not his blood sister, and the big problem is that he drinks too much alcohol, he smokes dagga and he always carry “panga” on him, so I will become very afraid of him”*.

This was supported by Rose (2011) stating that many families have the frightening experience of realising that they have no control over the psychiatric state patient especially if he/she is aggressive towards them.

4.2.1.2 Sub-theme 1.2: Smoking dagga and drinking alcohol.

Most families reported that when the psychiatric state patients are at home on LOA, they use drugs such as dagga, so their families will experience problems due to effects of using substances and drinking too much alcohol. Most of families experiences the effects of psychiatric state patients' use of dagga and drinking too much alcohol. This was evidenced by the participants whom said that:

Participant 3: *"the problem is dagga, he smokes dagga more than anything, and after smoking it, he will start behaving strangely and we become very afraid of him. But I think if he stop smoking dagga everything will be ok"*.

Participant 6: *"when he is at home, he drinks too much alcohol and smokes dagga, he started when he was in grade 9"*

Participant 7: *"he was a very good boy but later during his early 20's he started smoking dagga. Since he started smoking dagga and drinking alcohol, he is very problematic and it became very difficult for me to control him"*.

Participant 8: *"he started to be mentally ill when he was 18 years old, I think it was after he started smoking dagga, he even went to "Moshate" (Palace) and smashed all the house windows"*.

Participant 09: *"early in the morning when he woke up, he goes and buys alcohol and dagga, without even eating breakfast nor taking his medication, when I try to talk to him about taking medication he will start making a lot of noise"*.

Participant 10: *"the big problem is that he drink too much alcohol, he smokes dagga and I am not sure if he also smoke "nyaope", so it is very difficult for me to stay with him"*.

The findings of this study were similar to those of Beebe (2010) who also found out that most of the psychiatric state patients that are granted LOA's, suffer from financial instability due to use of tobacco, alcohol and drugs which make them to be very aggressive towards their family members. They also have multiple partners.

4.2.1.3 Sub-theme 1. 3: Aggression (physical and verbal)

Most of the families revealed that the psychiatric state patients become very aggressive towards them and for no apparent reason. They indicated that the psychiatric state patient will become aggressive both verbally and physically. Some of the family members said:

Participant 5: “ when he is at home....he is very dangerous, he will wake up during the middle of the night, and turn on the radio very loud, carry dangerous objects with him and when you try to talk he will make a lot of noise, I am his wife but one day he threatened to kill me”

Participant 8: “in 2012 when he was here at home, he did a cruel thing, he slapped a certain woman who was passing by the street, and when the woman scream, he threw some stone at her and he did this for no apparent reason”

Participant 9: “he assaulted his sister in-law with an axe, he nearly killed her.....”

Participant 10: “one night, he came back home very angry, he was swearing at me calling me a witch, I locked the door so he could not enter in the house, he was saying that ‘a witch will die today’ and he was carrying an axe”

Feder (2012), in his study of psychiatric state patients had earlier also found that 60% of psychiatric state patients shows aggressive behaviour towards their care givers and that aggressive behaviour is a prevalent problem among psychiatric state patients.

4.2.1.4 Sub-theme 1.4. Isolation

Most of the families reported that the psychiatric state patients isolate themselves when at home. They isolate themselves and not talk to anyone in the family. Some families reported that:

Participant 3: *“when he is at home, he is much better during his early days but after some few weeks he will sit alone and not talk to anyone in the house”*

Participant 4: *“he sits alone most of the time, even talking alone at times”*

This was supported by Dvoskin and Steadman (2011), when they stated that the biggest problem is that the state patients refuse to take treatment when at home or under supervision from the family members and this result in chronic problem with mental functioning including irritability, outbursts of anger, difficulty in concentration, isolation and sleeping disturbances.

4.2.1.5. Sub-theme 1.5: lack of support

In these study, families reported that they experienced lack of support from other family members, relatives and friends. This results in feeling of loneliness and abandonment, as they expressed their experiences as follows:

Participant 04: *“As her sister I try by all means to show her my support but the problem is the other siblings does not care about her, I think they still holding the grudge that she killed our mother, they do not understand that it was because of her mental illness”*

Participant 05: *“I am the only one who supports him, together with our children but his family does not care and they have never visited us since he killed their mother”*

Participant 09 : *“as his wife I am the only one who is supportive, I even wanted to visit him, but his father said that it is better to let them keep him at the hospital, as he will kill us all, so this shows that I am the only one who is showing support to him”*

Supported by Rose (2011), stated that mental illness can wreak havoc in the family. The destructive behaviour of the mentally ill can cause trauma, tension, guilt, and bitterness. It can tear marital relationships to shreds and cause resentment and even hatred between siblings.

Francell, Conn, & Gray, (2011) also found that the carers experienced a lack of support in dealing with their relatives' problems. The social- support needs expressed by these carers were categorized into informational, emotional, and professional support.

4.2.2. Theme 2: Refusal of treatment

Complying with treatment is the only way that the mentally ill individuals will maintain their mental stability. But if the mentally ill individuals do not comply with their prescribed medications, they may present with psychotic symptoms. This is caused by few factors that could mostly have been avoided, but because of lack of knowledge and different believes, patients still decide to stop taking their treatment.

This is supported by Hatfield (2010), in the mental health field, two major developments have impacted on family caregiving. Firstly, the de-institutionalization movement has been moving people with severe and persistent mental illness from hospitals to the community since the 1960s. The movement has accelerated in view of the growing concern for the nontherapeutic aspects of hospital care and the civil rights of the patients. Secondly, de-institutionalization has become possible with the introduction of the major tranquillizers. The psychotropic medications have had a dramatic effect on some mentally ill patients by greatly reducing behaviours that were previously difficult to manage in the community.

Another study conducted by Large et al, (2008) the researchers suggested that the decrease in the number of killings by people with mental illness is due to better treatment, including use of antipsychotics medications and increased awareness of the treatment of psychosis in primary care. Large et al (2008) also said that psychiatric state patients have problems involving violence, the importance of antipsychotic medications, including the atypical antipsychotic agents, cannot be overemphasized. Evidence also supports the use of other agents such as beta blockers, carbamazepine, selective serotonin reuptake inhibitors, and lithium. In addition, behavioural, cognitive, and psycho-educational techniques emphasizing anger management have been used in the treatment and management of violence. The treatment help the patients to deal with practical problems of daily living so it is important for patients to comply with their prescribed medications.

4.2.2.1. Subtheme 2.1 Defaulting treatment

Most families reported that psychiatric state patient refuse to take prescribed medications on LOA. The families in this study also raised experiences that the psychiatric state patients did not want to take their medications as they believed that they are not mentally ill anymore. They reported that they also refuse to be supervised to take medications. They also reported that the defaulting of treatment results in relapse and presenting with psychotic symptoms. Some participants said:

Participant 07: *“the problem is he does not take his medication, so he is out of control and he refuses to be supervised because when you tell him to take his medications, he become very aggressive and even threaten you”*

Participant 08: *“he refuses to take his treatment when at home, he slapped his mother while advising him to take his medication”*

Participant 10: *“ he was granted three months LOA in May 2013 , but I could not stay with him for a month as he defaulted his treatment after three weeks of LOA”*

This was supported by Dvoskin and Steadman (2011), when they stated that ,the most problem is that the state patients refuse to take treatment when at home or under supervision from the family members and this result in problems such as irritability, outbursts of anger, difficulty in concentration, isolation and sleeping disturbances.

4.2.3. Theme 3: Psychological effects

Most families reported that they experience fear, distrust and feel insecure when they staying with the psychiatric state patient. They reported that this affects them psychologically. They also reported that they do not trust the psychiatric state patients as they think that they will commit murder again. The families also reported that they are unable to cope when the psychiatric state patients are a home.

4.2.3.1 Sub-theme 3.1 Fear, distrust and insecurity

Eight participants said that they no longer feel safe when they are around psychiatric state patients. They stated that they do not trust them anymore due to their experiences and what they have previously done. The participants expressed their experiences as: Most families experienced feelings of persecution related to suspicion, burden, fear for their lives and doubt.

Eight families reported that, they were frightened by the behaviour of the psychiatric state patient when on LOA, as they said:

Participant 03: *"we sometimes fear him, as he isolates himself and shouts when spoken to"*

Participant 04: *"we are afraid of her, especially when she is angry, it also affects the children, because we fear that she might do what she has done before"*

Participant 05: *"I am his wife but I am afraid of him, because he killed his mother, he is dangerous, and we cannot trust him"*

Participant 06: *I am afraid of staying with him, because when he comes back at night, he comes straight to my bedroom, knocks, demanding that I must open the door so that he can come in, I am afraid of him, as he demands to have sex with me"*

Participant 4: *"I really do not trust her especially after what she has committed before, even her children always ask if it is safe to stay with her"*

Participant 5: *"I am his wife but one day he wanted to kill me, I had to sleep with the children in the same room. So we do not trust him anymore"*

This is supported by Johnson (2000) stating that just one betrayal may create distrust and once established, distrust is extremely resistive to change. Family members reported tension, stress, anxiety, resentment, depression with accompanying feelings of hopelessness and powerlessness, a sense of entrapment, a disruption in their family life and relationships, financial difficulties, physical ill health, restrictions in social and

leisure activities, and an overall decrease in the quality of life as a result of having a seriously mentally ill member.

4.2.3.2 Sub-theme 3. 2: lack of coping mechanism

Eight families felt that they could not cope with stressful situations of staying with psychiatric state patient on LOA. Chesla (2009) noted parents of psychiatric states patients attempt to avoid conflict or confrontation with the ill child as a way of providing care and coping. These studies suggest that these families use cognitive as well as behavioural strategies to cope with the burden, stressors, and difficult realities of their loved one's illness.

In this study the participants reported their experiences of lack of coping mechanism as follows:

Participant 05: *"I have filed for divorce as I cannot stay with him at all, I cannot take it anymore and I can't cope when he is at home, he will never be stable or be better and we live in peace when he is not at home"*

Participant 09: *"it is very difficult when he is home, we do not cope, I even wanted to go back to my parents' house. I also remember one day my older son (2nd born) was sleeping with dangerous objects under his bed, I suspect that he wants to kill his father"*

Participant 10: *"he always carry "panga" around so it is very difficult for me, especially thinking about what he has done before", so I always stay in locked room"*

Other studies discussed the phenomenon of family coping with regard to the serious mental illness of a relative. Fadden et al. (2008) identified several cognitive coping strategies, such as wishing the situation would go away, looking for a silver lining, or hoping for a cure someday, as those most frequently used by the spouses. The primary functions of these coping devices are to facilitate the resolution of emotional conflict, provide relief from stress, cushion emotional pain, avoid or alleviate anxiety.

Link, (2000) also said that mentally ill individuals are mostly cared for by totally unprepared family members, and this results in frustrations and lack of coping mechanisms due to lack of knowledge and poor patterns of interaction between the family and the mentally ill member. It becomes the responsibility of health care workers to assist their mentally ill family members.

Wiese, Israel, Wallerstein & Fuller, (2008) mentioned that several of the studies elaborated on the nature of the burden experienced by these families. Family members reported tension, stress, anxiety, resentment, depression with accompanying feelings of hopelessness and powerlessness. They also reported that, a sense of entrapment, a disruption in their family life and relationships, financial difficulties, physical ill health, restrictions in social and leisure activities, and an overall decrease in the quality of life as a result of having a seriously mentally ill member.

4.2.4. Theme 4. Physical effects

It is important for families of psychiatric state patient to have strength to take care of them. But it is difficult for the families to provide care for the psychiatric state patient as they encounter problems such as sleeplessness due to psychiatric state patients' uncontrollable behaviour.

4.2.4.1. Sub-theme 4.1 Physical exhaustion

Physical exhaustion due to lack of sleep and rest were also experienced. Most families experienced physical exhaustion due to lack of sleep and rest, chasing and restraining someone who is restless.

Participant 06: *“sometimes I do not sleep at all, when he comes home late in the evening, I will wake up, listen to every movement that he is making, if he makes a lot of noise towards my bedroom, I will use the backdoor to escape....”*

Participant 06: *“I don't sleep at night, thinking about him, this is really difficult for me, I tried to talk to his father about his behaviour but he does not listen to me”*

Participant 07: *“he once assaulted the lady who did not say anything to him, he assaulted her until he was restrained by the community members and one day he assaulted me and was restrained by the neighbours”*

Participant 08: *“So when he comes back home, the problem starts there, as there will be fights in the house and even with the neighbours”*

Participant 09: *“when he beat me the older son will start fighting with him”*

Participant 09: *“he will sent the children to go and buy dagga, we won’t sleep until they get it and come back with it”*

Supported by Rose (2011) when said that Patients problem behaviours, e.g. irritability, sleeplessness and withdrawal or compulsions were reported to disrupt the family routine in about 40 % of the cases.

WHO, (2012) also discovered that: Sleep deprivation induces significant reductions in performance and alertness. Reducing your nighttime sleep by as little as one and a half hours for just one night could result in a reduction of daytime alertness by as much as 32%.

Memory and Cognitive Impairment: Decreased alertness and excessive daytime sleepiness impair your memory and your cognitive ability.

Stress Relationships: Disruption of a bed partner's sleep due to a sleep disorder may cause significant problems for the relationship.

4.2.4.2. Sub-theme 4.2. Lack of sleep

The families of psychiatric state patients also reported that they do not sleep well at night due to the fact that when the psychiatric state patients are at home, they do not sleep at night, they make a lot of noise during the night and even roaming around at night. Some participant said:

Participant 06: “ *sometimes when he comes home late in the evening, I will wake up, listen to every movement that he is making, if he make a lot of noise towards my bedroom, I will use the backdoor to escape....*”

Participant 06: “*I don't sleep at night, thinking about him, this is really difficult for me, I tried to talk to his father about his behaviour but he does not listen to me*”.

Participant 09: “*he will sent the children to go and buy dagga, we won't sleep until they get it and come back with it*”

Rose (2011) support the findings of this study that sleeplessness and withdrawal or compulsions were reported to disrupt the family routine in about 40 % of the cases. The biggest problem is that the state patients refuse to take treatment when at home or supervision from the family members and this result in chronic problems with mental functioning including irritability, outbursts of anger, difficulty in concentration and sleeping disturbances.

4.3. CONCLUSSION

In this chapter the results of the study were discussed. Data was classified in to themes and sub-themes. Four themes and sub-themes emerged from the study and, were discussed. The next chapter will discuss guidelines, limitations of the study and recommendations.

CHAPTER 5

GUIDELINES, LIMITATIONS AND RECOMMENDATIONS

5.1. Introduction

In chapter 4, the research results were discussed and literature incorporated as control of the findings. In this chapter guidelines were described for the Multi-disciplinary team members to provide support to the families of state patients in Capricorn district of Limpopo Province, and to assist them to live together as any other family.

A literature control was carried out to validate and verify the proposed guidelines for the study.

5.2. Aim of the study

- The aim of the study was to investigate the experiences of family members towards psychiatric state patients on LOA in Lepelle Nkumpi Municipality Capricorn district, Limpopo Province.

5.3. Objectives of the study

- To explore the experiences of families towards state patients on LOA in Lepelle Nkumpi Municipality Capricorn district, Limpopo Province.
- To describe the experiences of families towards state patients on LOA in Lepelle Nkumpi Municipality Capricorn district, Limpopo Province.
- To develop guidelines for the support of families of psychiatric state patients during LOA.

5.4 Conclusion of the study

A qualitative, exploratory, descriptive and contextual research design was used to find answers to these question. In-depth, semi-structured interviews were conducted with families who met the sample criteria of this study. The result of interviews conducted and field notes taken during interviews suggest the occurrence of experiences of families of psychiatric state patients who participated in the study.

The results show that the families experienced emotional pain, stress and lack of support and social discrimination by their loved ones.

Based on the results, guidelines were developed for the Multi-disciplinary team members to assist families to cope and to provide support to the families.

It can thus be concluded that the research question of this study has been answered.

5.5. Guidelines

Theme 1: Social effects

This was supported by Dvoskin and Steadman (2011), when they stated that, the problem is that the psychiatric state patients refuse to take treatment when at home or supervision from the family members. This result in chronic problems with mental

functioning including irritability, outbursts of anger, difficulty in concentration, isolation and sleeping disturbances. If the psychiatric state patients adhere to their treatment, this may be avoided. The families will be able to stay with the psychiatric state patients without experiencing any social effects.

Disruption of social life. The families revealed that their relatives' uncontrolled behaviour, such as temper tantrums or shouting in public places, together with the need for constant care had caused them deprivation in their social lives:

Disruption of family functioning. Disruption of family functioning was an important aspect revealed by many of the participants. In cases where the chronically mentally ill relative was a man, his role as the head of the family and the breadwinner no longer existed, and the wife or the mother had to take on multiple roles in the family. Harmony in the family was also affected by carers sometimes losing their tempers or by family members disagreeing about the management of the psychiatric state patient's affairs.

Francell, Conn, & Gray, (2008) found that the carers experienced a lack of support in dealing with their relatives' problems. The social- support needs expressed by these carers were categorized into informational, emotional, and professional support.

The researcher developed guidelines that may help the families that experienced social effects as follows:

- Families must be educated about supporting each other and also offer support to the psychiatric state patients. These will help the families to live together in harmony and avoid any psycho-social effects between families. As the families experiences fear, insecurity, mistrust around the psychiatric state patients, they must be counselled by the professional health care workers before the psychiatric state patients are granted LOA's so that they may be able to gain trust, understand them and live them. The families may also be referred to support groups so to share their experiences and coping mechanisms.
- Psycho-educational programmes must be designed to educate families about state patients and help them manipulate their environment and alter normal communications patterns to minimize symptomology and relapse.

- These programs may also help in achieving objectives by forging alliances between professionals and families in which mental health practitioners become consultants to the family and in turn, families become extension of the mental health profession providing specific information about psychiatric state patients. e.g. evidence of medication compliance.
- The combination of educational, supportive and behavioural techniques to develop effective strategies to deal with psychiatric state patients. e.g. positive and negative symptomatic management, reduction of relapse or re-hospitalization, clarification of the role of health system and strategies for the future.
- Multi-family and single family sessions must also be held, so as to support the families and addressing their concrete needs and burdens.
- Family therapy must also be provided so that the families of psychiatric state patient can be able to talk about their fears and to rebuild relationships with their loved ones.
- There is a need for patient and family therapy as many patients continue to suffer during symptoms of their illnesses in spite of regularly taking their medications, and this has been a challenge to mental health service providers (Corrigan, 2012).

Theme 2: Refusal of treatment

As most families have mentioned that, the psychiatric state patients refuse to take treatment when on LOA, so psychiatric state patients and their family members need to be educated regarding psychiatric treatment. They must also be educated about mental illness and importance of taking medications to avoid complications. They must both be educated on importance of adherence to treatment. Families must also be educated on how to provide support and supervision for the psychiatric state patients to take medications as prescribed. Patients should also be encouraged to listen to their family members and accepts their support.

Large et al (2008) also said that for this psychiatric state patients, a large number of whom have problems involving control and violence, the importance of antipsychotic medications, including the atypical antipsychotic agents, cannot be overemphasized. Evidence also supports the use of other agents such as beta blockers, carbamazepine, selective serotonin reuptake inhibitors, and lithium. In addition, behavioural, cognitive, and psycho-educational techniques emphasizing anger management have been widely used in the treatment and management of violence.

Guidelines developed that may help the Families that experienced refusal of treatment by psychiatric states patients are as follows:

- The psychiatric treatment help the patients to deal with practical problems of daily living so it is important for patients to comply with their prescribed medications.
- Psychotherapeutic intervention is necessary not only to assist the patients with their 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 their illness and increasing patients' self-esteem.(Corrigan, 2012)
- The families groups meet for a specified duration to cover topics of demonstrated importance to families. e.g. medications, how to assist in compliance of medication, recovery and allow exchange of ideas.

Theme 3: Psychological effects

Large et al (2008) said that, behavioural, cognitive, and psycho-educational techniques emphasizing anger management have been widely used in the treatment and management of violence. If the psychiatric state patients default their treatment this result in frustration of family members. Once the treatment is started and adhered to, the patient can be able to stay with his/her family without experiencing any negative behaviour.

Guidelines developed by the researcher that may help the families that experienced psychological effects are as follows:

- The family member's needs must be assessed so that they may help to overcome their burdens they experience when staying with psychiatric state patients on LOA. The family members must be given a chance to talk about the psychological effects that they experience and counselling must be offered to alleviate the effects. Family members must also be educated about coping strategies when staying with psychiatric state patients on LOA.
- The multi-disciplinary team members must also take part in supporting the family members of psychiatric state patient, example; the psychologist must provide family counselling before the psychiatric state patient can be given an LOA.

Theme 4: Physical effects

Families experience physical effects as a result of psychiatric state patients' behaviour. Before psychiatric state patients can be granted LOA's, they must be educated about the anti-social behaviours and on how to take care of themselves when on LOA.

Guidelines that were developed by the researcher that may help the families that experienced physical effects are as follows:

- The health care professionals' should educate the families about management of psychiatric state patient's behaviour to avoid physical exhaustion.
- The combination of educational, supportive and behavioural techniques to develop effective strategies to deal with psychiatric state patients. e.g. positive and negative symptomatic management, reduction of relapse or re-hospitalization, clarification of the role of health system and strategies for the future.
- Multi-family and single family sessions must also be held, so as to support the families and addressing their concrete needs and burdens.

- Family therapy must also be provided so that the families of psychiatric state patient can be able to talk about their fears and to rebuild relationships with their loved ones.
- There is a need for patient and family therapy as many patients continue to suffer during symptoms of their illnesses in spite of regularly taking their medications, and this has been a challenge to mental health service providers (Corrigan, 2012).

5.6. Recommendations

Nursing practice, nursing research, nursing education and policy perspective

Nursing practice

- It is clear from the research results that the family members need professional help and support.as the nursing play a major role as they are the people who come in contact with the patients, thus during this stage they will be able to assess the needs of the family members and support them.
- Nurses must take the responsibility of identifying and assessing the needs of families of psychiatric state patients before LOA can be granted and even after LOA has been granted.
- Nurses must take the responsibility of giving health education to the families of psychiatric state patients especially about mental illness, its effects and the coping mechanisms. There is lack of knowledge regarding mental illness by families as well as communities.
- There is a need for a vigorous drive for Public Education. This can be in the form of quarterly Mental Illness Awareness campaigns targeting schools, clinics, and churches. Open Days could also be held on regular basis and not only once a year. Media as a means of communication can be utilized to educate the public about mental illness.

- The Department of Health will have to take adequate responsibility for Mental Health Care and refrain from underfunding it. There is a great need to increase the budget to be on par with other Health components so that more specialized staff can be employed.

Nursing education

The nursing curricular should include topics on mental illness and the experiences of families with mental ill family members, as well as the effects of mental illness on the family. Nurses should take the responsibility for educating the community about mental health and mental illness. e. g. mental health awareness campaigns.

Nursing research

Further research to be conducted on:

- Larger group to validate the research findings
- Effects of support by nurses
- And effects of support on immediate family, extended family and the society

Administrative Perspective

- The Department of Health will have to take adequate responsibility for Mental Health Care and refrain from underfunding it. There is a great need to increase the budget to be on par with other Health components so that more specialized staff can be employed.
- The Mental Health Care Act (17 of 2002) does not cater for homeless mental health care users admitted to hospitals; even if they are rehabilitated they are still kept in the hospital. It is recommended that the Act could be amended so that Half Way Houses can be built for those mental health care users who are rehabilitated so that they can stay independently.
- Mental health care users are not able to compete in the open labor market with other workers long after they have been rehabilitated. In this study it has been

established that mental health care users are faced with unemployment; thus it is recommended that policies should be changed so that a certain percentage of them can be employed in the government institution or private sectors as is the case with the physically disabled.

Achievement of set objectives

Chapter 1 of the study outlined the objectives of study and the researcher managed to achieve the set goals. The first objective was to explore the experiences of families of psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province. The objective was achieved as the families of psychiatric state patients expressed their experiences when staying with psychiatric state patients. Different views and experiences were expressed by the families of psychiatric state patients.

The second objective of the study was to describe the experiences of families of psychiatric state patients during LOA in Lepelle Nkumpi Municipality, Capricorn district, Limpopo Province. These objective was also achieved as the families have described their experience of staying with the psychiatric state patients on LOA.

The third objective was to develop guidelines to support the families of psychiatric state patients. These were outlined in Chapter 5, section 5.5.

5.7. Limitations of the study

Some difficulties were encountered during this period since some families did not allow the researcher to use tape recorder during the interview. Some families were not cooperative, becoming angry and were under the impression that the researcher is instructing them to stay with the psychiatric state patient at home, so the interview had to be abandoned.

- The families were interviewed at their home setting, at times the researcher would find that, they have visitors or were not at home, despite that the appointments were made.

- Interruptions during interview due to ringing of cell phones, visitors coming or children crying
- Some family members refused to be recorded though the researcher has explained that confidentiality will be carried out, so in this cases, only field notes and observations were taken and used for the study.

6. CONCLUSION

This chapter has presented the conclusions, study limitations and recommendations that have been put forward in relation to the significance of the study. The chapter also covered suggestions for further research opportunities in the field.

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APPENDIX 1

UNIVERSITY OF LIMPOPO (Medunsa Campus) ENGLISH CONSENT FORM

Statement concerning participation in a Clinical Trial/Research Project*.

Name of Project / Study / Trial* Experiences of families towards psychiatric State Patients during leave of absence (LOA) in Lepelle Nkumpi Municipality, Capricorn district at Limpopo Province.

.....
.....
.....
.....

I have read the information on */heard the aims and objectives of* the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that photographs / electronic images / sound recordings* will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name / and hospital number* is / are* not revealed. Regarding images of the face, I understand that it may not be possible to disguise my identity, and I consent to the use of these images*.

I understand that participation in this Clinical Trial / Study / Project* is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Trial / Study / Project* has been approved by the Medunsa Research Ethics Committee (MREC), University of Limpopo (Medunsa Campus) / Dr George Mukhari Hospital. I am fully aware that the results of this results of this Trial / Study / Project* will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Trial / Study / Project*.

..... Name of patient/volunteer
Signature of patient or guardian.

..... Place. Date.

Witness _____

Statement by the Researcher

I provided verbal and/or written* information regarding this Trial / Study / Project* I agree to answer any future questions concerning the Trial / Study / Project* as best as I am able. I will adhere to the approved protocol.

..... Name of Researcher Signature
Date Place

TLALELETŠO 1

UNIVERSITY OF LIMPOPO (Medunsa Campus) SEPEDI CONSENT FORM
--

Setatamente mabapi le go tšea karolo ka go Protšeke ya Dinyakišišo tša Teko ya Klinikhale *.

Leina la Protšeke / Dinyakišišo / Teko*

MAITEMOGELO A BA LAPA GO BALWETSI BA MONAGANO BA MMUSO GE BA DUTSE GAE LEBAKANYANA KUA MASEPALENG WA LEPELLE NKUMPI, DISTRICTING YA CAPRICORN, PROFENSENG YA LIMPOPO.

Ke badile/ke kwele ka ga tshedimošo mabapi le *maikemišetšo le morero wa* dinyakišišo tšeo di šišintšwego gomme ke ile ka fiwa monyetla wa go botšiša dipotšišo gomme ka fiwa nako yeo e lekanego gore ke naganišiše ka ga taba ye. Ke tloga ke kwešiša maikemišetšo le morero wa dinyakišišo tše gabotse. Ga se ka gapeletšwa go kgatha tema ka tsela efe goba efe.

Ke a kwešiša gore go kgatha tema Protšekeng/Dinyakišišong tše tša Teko ya Klinikhale* ke ga boithaopo gomme nka tlogela go kgatha tema nakong efe goba efe ntle le gore ke fe mabaka. Se se ka se be le khuetšo efe goba efe go kalafo yaka ya ka mehla ya maemo a ka gape e ka se huetše le ge e ka ba tlhokomelo yeo ke e humanago go ngaka yaka ya ka mehla.

Ke a tseba gore Teko/Protšeke/Dinyakišišo tše* di dumeletšwe ke Medunsa Research Ethics Committee (MREC), Yunibesithi ya Limpopo (Khamphase ya Medunsa) / Dr George Mukhari Hospital. Ke tseba gabotse gore dipelo tša Teko/Dinyakišišo/ Protšeke tše * di tla dirišetšwa merero ya saense gomme di ka phatlalatšwa. Ke dumelelana le se, ge fela bosephiri bja ka bo ka tiišetšwa.

Mo ke fa tumelelo ya go kgatha tema Tekong/Dinyakišišong/ Protšekeng *.

.....
Leina la molwetši/ moithaopi

Mosaeno wa molwetši goba mohlokomedi.

UNIVERSITY OF LIMPOPO
Medunsa Campus



MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

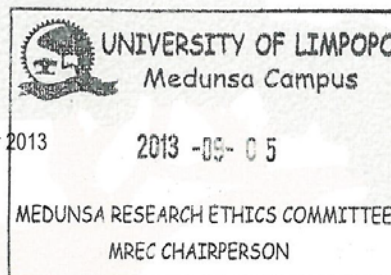
MEETING: 07/2013
PROJECT NUMBER: MREC/HS/202/2013: PG
PROJECT:
Title: Experiences of families towards psychiatric state patients during leave at absence in Lepelle Nkumpi, district of Limpopo Province
Researcher: Ms M Mathanya
Supervisor: Dr JC Kgole
Co-supervisor: Prof ME Lekhuleni
Department: Nursing & Human Nutrition
School: Health Sciences
Degree: MCur Nursing Science

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 05 September 2013


PROF GA OGUNBANJO
CHAIRPERSON MREC



The Medunsa Research Ethics Committee (MREC) for Health Research is registered with the US Department of Health and Human Services as an International Organisation (IORG0004319), as an Institutional Review Board (IRB00005122), and functions under a Federal Wide Assurance (FWA00009419)
Expiry date: 11 October 2016

Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.





LIMPOPO

PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Selamolela Donald

Ref:4/2/2

Mathanya M
University of Limpopo
Sovenga
0727

Greetings,

**Re: Experience of families towards psychiatric state patients during leave at absence in Lepelle Nkumpi,
District of Limpopo Province.**

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
3. Kindly be informed that:-
 - Further arrangement should be made with the targeted institutions.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, a copy should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.

Your cooperation will be highly appreciated.

Head of Department

DEPARTMENT OF HEALTH HEAD OF DEPARTMENT DR KABANE S.
Date 02 -12- 2013
SIGNED:..... PRIVATE BAG X9302 POLOKWANE 0700 LIMPOPO PROVINCE

INDEPENDENT CODER CERTIFICATE

Qualitative data analysis

Masters degree in Nursing Science

MATHANYA MOLOKO ELIZABETH

THIS IS TO CERTIFY THAT:

Prof M.N. Jali

Has coded the following qualitative data:

10 Individual interviews and field notes

For the study:

**EXPERIENCES OF FAMILIES TOWARDS PSYCHIATRIC STATE PATIENTS
DURING LEAVE OF ABSENCE IN LEPELLE NKUMPI, CAPRICORN DISTRICT
OF LIMPOPO PROVINCE**

I declare that adequate data saturation was achieved as evidenced by repeating themes.

PROF MN JALI: *MN Jali*

**Revd. Dr. Lutz Ackermann
(Independent Researcher)
198 Berrymead Avenue
Mondeor, 2091
Tel: +27 72 3487010
e-mail: DRLA4 @ directbox.com**

31 Oct 2014


TO WHOM IT MAY CONCERN

This is to confirm, that I, Dr Lutz Ackermann, have read the Thesis entitled

“Experiences of families with state patients on Leave of Absence
from the Lepelle Nkumpi Municipality, Capricorn District of the Limpopo Province”

by Miss **Moloko Elizabeth Mathanya**

and that I am satisfied with the quality of work she has produced in terms of structuring the document, in terms of style, grammar and spelling. Suggestions for suitable corrections and improvements have been made to the candidate.


Lutz Ackermann
(Revd Dr Lutz Ackermann, Mondeor)