



University of Venda

**FACTORS AFFECTING FAMILY MEMBERS' SUPPORT OF STATE
PATIENTS: A CASE STUDY OF THE HAYANI HOSPITAL, IN VHEMBE
DISTRICT, OF LIMPOPO PROVINCE.**

BY

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DECLARATION

I, Nemathaga Muofheni, hereby declare that the dissertation titled “Factors affecting the family member’s support of their state patients: a case study of Hayani hospital Vhembe District Limpopo province” for the Master’s degree of Advanced Nursing Science of the University of Venda submitted by me has not been submitted at this or other Institution and that it is my own work in design and execution and all reference materials contained herein have been duly acknowledged.

Student’s Signature:

Date:

DEDICATION

This study is dedicated to:

My mother, Livhuwani and my father Mphedziseni for their motivation and support. My dearest sweetheart Malebo for his patience and support. My daughters Lesego and Mahlohonolo for their inspiration. My son, Nhlayiseko for his support. My siblings, Elelwani, Tsumbedzo, Tendani, Rendani and Azwimbavhi for their encouragement throughout this study.

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ABSTRACT

Background- Family support is the most important milieu for the treatment and rehabilitation for mental health care users. However, there are cases that are reported where mental health care users are rejected by their family members worldwide. Vhembe District is no exception.

Purpose-The study determined factors affecting family members' support of their state patients in Hayani hospital, Vhembe District, Limpopo Province.

Methodology- The study adopted a qualitative design which was explorative, descriptive and contextual in nature. Non-probability purposive sampling method was used to sample 09 family members with state patients at Hayani Hospital from the entire population. Data was collected through in-depth individual interviews and analysed through Techs method of coding. Ethical considerations and measures to ensure trustworthiness were followed throughout the study.

Results- Data revealed two themes from namely, psychological factors and sociological factors affecting family members' support.

Recommendations- This study recommends on developing a model of support for family members' with state patients at Hayani hospital. This study also recommends that department of health should consider meetings with family members.

Key Words- *Family, Mental Health Care Institution, Mental Health Care User State patient, Support.*

LIST OF ACRONYMS

MHCU: Mental health care user

MHGAP: Mental health gap action programme

USA: United States of America

IPRT: Interpersonal rhythm therapy.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

A state patient refers to a person classified by court directives in terms of section 77 or 78 of the Criminal Procedure Act, for committing a serious crime due to mental illness (Mental Health Care Act, 2002). The provision of services for mental health care users is a family obligation (Banyini, 2012). Therefore, family support is significant for the treatment and rehabilitation of mental health care users. As a result, relapses and hospitalisation rates may be reduced if there is family support (Uys & Middleton, 2014).

In terms of the Mental Health Care Act, 17 of 2002 (South Africa, 2002), mental illness is a positive diagnosis of a mental health-related illnesses. According to the Mental Health Care Act, No.17 of 2002, the individual, human dignity and privacy of all mental health care users (MHCUs) must be respected. Therefore, the rehabilitation of MHCUs also includes support for the family members of the MHCU, including the mental health care providers (South Africa, 2002). Involving family members in mental health care to socialise with MHUCUs and discussing how mental illness has an impact on all areas of an individual's life may assist to develop trust (Gale & Marshall-Lucette, 2012).

The World Health Organization (WHO) identifies the significance of mental well-being, describing health as a state of complete physical, mental and social well-being, and not necessarily the absence of disease or infirmity. In

2002, of the estimated 450 million people worldwide living with mental or behavioral disorders, 90 million were drug or alcohol-dependent, 25 million suffered from schizophrenia, and 150 million suffered from depression. Globally, approximately 10 million people are imprisoned, and the WHO indicates that the prevalence of mental health problems is 'very high', especially among female inmates. In the US, in the late 2000's, nearly one million adults with serious psychological disorders were imprisoned annually (WHO, 2012).

In a study conducted by WHO, in the Pinellas County, Florida jail, it was found that not having outpatient mental health treatment contributed to increased risk of indecent arrests and days imprisoned, and having a substance abuse disorder was associated with more days in jail, which is consistent with national imprisonment statistics. National data from the 2002 Survey of Inmates in local jails revealed that homelessness was significantly more prevalent among the inmate population, compared to the general US adult population, and inmates who had been homeless were significantly more likely than other inmates, to have mental health and substance abuse problems (WHO, 2012).

A study conducted by Avasthi (2012) in the USA revealed that many community mental health centers were established. But within a period of time, the community psychiatric approach was dishonored because state patients who were discharged did not go to the community mental health centers. They were rejected by their families, which resulted in 'trans-institutionalization'. They were kept in private nursing homes, and board-and-care institutions.

Furthermore, Avasthi (2012) indicates that in India, a strategy of involving families in the treatment of mentally-ill relatives was established. In 1957, Dr. Vidya Sagar, the then superintendent of Amritsar Mental Hospital, involved the family members of mentally-ill in the rehabilitation, by giving them an opportunity to stay with their relatives in open tents, pitched on the hospital premises. The researcher found that the patients recovered quickly and were taken back home. Based on this principle, family wards were established in the Christian Medical College, Vellore. The benefits were fast recovery and reduced relapse rates. Furthermore, family members brought change in their community because of their ability to identify other patients and guided their family members to seek help in psychiatric institutions.

Study by Avasthi (2012) also indicates that the family is a priority in the rehabilitation of people with mental illness. Families anticipated the role of family members for two reasons. First, it was because of the Indian tradition of interdependence and concern for close ones in misfortune. Because of this, most Indian family members prefer to be actively involved in all aspects of rehabilitation of their relatives despite it being time-consuming. Second, there is a shortage of trained mental health professionals required to accommodate to the huge majority of the population; hence, the clinicians depend on the family. Therefore, having a sufficient family support is a requirement for the MHCU, clinician and healthcare administrator (Avasthi, 2012).

A study conducted by Barke, Seth and Klecha (2011) indicates that Ghana is one of the countries which has been identified by the WHO initiative called Mental Health Gap Action Programme (mhGAP), to receive increased support to scale up treatment for mental, neurological and substance use disorders. As a comparatively stable democracy, with a history of psychiatric transformation and a growing advocacy movement for mental health within both the health care sector and civil society, Ghana is facing a distinctive

opportunity to introduce improved mental health care in the West African region.

A study conducted by Mathanya (2015) in South Africa, revealed that state patients feel that they are not being supported by their family members and the community. As a result, they tend to isolate themselves. This was supported by Rowaert, Vanvelde, Lemmens, Vanderplasschen Vander and Audenaert (2015) who indicates that many state patients do not have good relationships with their family members because of the anti-social behavior they displayed while still at home with their families, which includes theft, aggression and violence. Most family members do not understand the nature of illness of state patients.

The extent of the impact of mental disorders on family members can be difficult to assess and evaluate, and is consequently often ignored. However, it does have a significant impact on the family's nature of life. In addition to the health and social costs, state patients are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions (WHO, 2012).

1.2 EFFECTS OF MENTAL ILLNESS ON FAMILIES

A study conducted by WHO (2012) indicates that family members are mostly the primary caregivers of people with mental illnesses. They provide emotional and physical support, and usually have to bear the financial costs associated with mental health treatment and care. It is estimated that one in four families has at least one member currently suffering from a mental illness. In addition to the obvious frustration of seeing a loved one disabled by the consequences

of mental disorder, family members are also exposed to the stigma and discrimination associated with mental ill-health.

Furthermore, WHO (2012) indicates that family members also experience important and chronic stress due to the emotional and physical challenges of supporting a mentally ill family member. Family members also experience hopelessness, frustrations and anger. Rejection by friends, relatives, neighbors and the community as a whole can increase the family's sense of isolation, leading to limited social activities, and the denial of equal participation in normal social networks. The failure of society to recognise the burden of mental illnesses on affected families indicates that very little support is available to them (WHO, 2012).

Study conducted by Masungalo, Lusajo, Kajula and Khadija (2016) indicates that mental illness cause many psychosocial problems, such as decreased quality of life of the patient's family members, as well as increased social distance for him and the family supporting the patient. Psychosocial challenges are intensified by the stigma attached to mental illness, which is a problem affecting not only the patient, but also the family as a whole.

Furthermore, participants had difficulties in managing patients' symptoms. They expressed concern that there was no one else who would be able to handle the unpredictable behaviour of the patient. They were the only ones who had learned how to manage the patients' behaviour; therefore they had to remain at home to protect of the patient and other people from the patient's uncontrolled behaviour. The majority expressed fear of being attacked by the patient, as well as concern for safety of the patient (Masungalo *et al.*, 2016).

Masungalo *et al.* (2016) also found that resilience in the family was also affected by the patient's distractive behaviour, or by family members arguing about the concern for the safety of the mentally ill relative. This caused many family members to experience anxiety, especially when the relatives disappeared, or when they become distractive and violent.

Study by Masungalo *et al.* (2016) also revealed that family members of mentally ill patients emphasised that when their ill patients went out, they did not remember to return home. The family members had to take time and effort to look for the patient everywhere. Some patients were reported to disappear for several weeks. The family members revealed that their relatives' uncontrolled behaviour, such as temper tantrums, shouting in public, insulting people and neighbours, and hitting people, had caused them to have challenges in establishing and sustaining good social relationships.

A study was conducted by Wilhelmsson (2013) in Sweden, with the aim of analysing how psychiatric reform in Sweden affects their everyday life experiences of close relatives of persons with mental illness. The results indicate that the reform of psychiatric care in Sweden has put the solution of problems on the relatives, but there was still no consensus among the various care providers, county council, municipal and national social services that were involved in treatment were blamed for their relatives' behaviour in courts of law, causing endless conflicts between the family with the ill relative and the neighbourhood family.

The results further indicated that the relatives felt guilty about not providing enough support for the persons with mental illness. They therefore expressed a need for personal support; a need for better information, consistency throughout the rehabilitation process and professional therapy for themselves

as well. Children of parents with mental illness expressed a need for assistance, opportunities for participation in rehabilitation, and information about their parents' illness.

FACTORS CONTRIBUTING TO INSUFFICIENT INVOLVEMENT OF THE FAMILY IN LONG-TERM MENTAL HEALTH CARE.

A qualitative study was conducted by Easson, Giacco, Dirk and Prieb (2014) in the United Kingdom, to show evidence of the importance of involving the family members in the mental health care of their relatives. The findings revealed various forms, depending on the level of need and availability of services. It was discovered that mental health nurses provide family members with psychosocial education, consultation, family interventions and therapies.

However, it was found that family members are important in treatment planning. Researchers also observed patient relapses, and reacted to early warning signs, and also assisted in accessing MHCUs for appropriate intervention. Family involvement may also lead to better results from psychosocial therapies and treatment. (Easson *et al.*, 2014).

Furthermore, Easson *et al.* (2014) also indicates that family members reported that confidentiality is used by nurses as an excuse for denying the sharing of information. However, it was found that family therapy as a treatment approach is startlingly under-implemented in mental health. This led to a poor interaction between nurses and family members. Furthermore, family members felt neglected and unwilling to be involved in the treatment and

rehabilitation of their mentally-ill patients, and only responded to telephone calls during crisis periods.

Mathanya (2015) described certain family stressors experienced as a result of the mental illness of a family member. He shows that families experienced financial, marital, legal, employment, housing, and illness-related problems, as well as interpersonal conflict within the family. The phenomenon of family coping with regard to the serious mental illness of a family member was also discussed.

ATTITUDE OF FAMILY MEMBERS

A study was conducted by Chao-Yin (2015) in China, to explain the idea of expressed emotion and its application to family members with mental-ill patients, shows that expressed emotion is a useful construct for understanding the significance of involving family members in mental health care. The study also indicates that the knowledge and attitude of family members towards understanding the importance of the family dynamics in mental health care affect the quality of mental health care. Furthermore, it was found that expressed emotion concept may guide the current clinical practice and assist nurses to understand the family's experience and perspective on mental illness.

Study by Mathanya (2015) indicates that the behaviors of the families caring for psychiatric state patients were seen as efforts to solve complicated issues that taxed their adaptive abilities. Family problems that developed were seen as normal reactions, not as indications of family dysfunction. These studies focused on strengths, adaptive qualities, and coping mechanisms of the

families and not on their influence in causing or aggravating the illness of their family member.

Furthermore, Mathanya (2015) revealed that the family members' relationship with the patient may have an impact on the extent to which the patient's stigma is transferred to the family member. As such, family members who stay with the mentally-ill relative, can expect to be exposed to more stigma than those who do not, because their acquaintances are more likely to know about their relatives' 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 relatives' overlap to a greater extent.

Wilhelmsson (2011) also found that family members of the mentally-ill believed that assistance in finding resources and the availability of backup care assistance were significant in their ability to cope. Furthermore, it was noted that the parents of psychiatric states patients attempt to avoid conflict or confrontation with the mentally-ill relative as a way of providing care and coping.

ORGANISATION MANAGEMENT

Study by Easson *et al.* (2014) in the United Kingdom, shows that the negative attitudes of hospital managers and nurses were limiting the implementation of family involvement. It was further discovered that management culture neglects family members through active resistance and reluctance to overcome challenges experienced by family members. However, the value emerged from having regular multi-disciplinary team meetings to discuss the

significance of creating strategies to prioritise family involvement in a clinical practice. The study also found that routine evaluation of all family members will give a MDT a chance to ask families when conducting patient reviews that will provide valid information from the family members (Easson *et al.*, 2014).

Furthermore, the study found that nurses lack adequate supervision and training. These are obstacles in the involvement of family members. Nurses indicated that they lack the skills and dependence to involve the family members. However, there were some challenges of service delivery, such as managing family dynamics. It was found that staff skills and experience may also be influenced by supervision. Moreover, nurses also reported that the value of belief in the nursing approach and having an identity in their role are also influenced by continuous supervision support to assist nurses involve family members (Easson *et al.*, 2014).

COLLABORATION OF MULTI-DISCIPLINARY TEAMS WITHIN THE ORGANISATION

The study by Easson *et al.* (2014) shows that MDT attitudes, dedication and collaboration affect team members trained in family intervention. It was also found that collaboration is often lacking and requires the whole team to be dedicated in involving families. However, in cases where some mental health care users do not have family members, it was reported that other professionals hesitate to make referrals, family involvement services are ignored and the families themselves are not active when involved. Therefore, acting as a facilitator was found to be family involvement (Easson *et al.*, 2014).

Furthermore, the study findings suggested that support and training of nurses to implement family involvement is crucial for improving the quality of mental health care. The study also identified that in order to implement family involvement effectively, all MDT members should be trained and regularly supervised (Easson *et al.*, 2014).

EXPERIENCES OF NURSES REGARDING THE INVOLVEMENT OF THE FAMILY MEMBERS IN LONG TERM MENTAL HEALTH CARE

Fung, Chan, and Chien (2014) conducted a study to identify research involving interventions by mental health care nurses in advanced practice. The study found that mental health care nurses play important multifaceted roles and provide mental health-care services in various contexts. The findings revealed that mental health nurses can manage patients with different mental illnesses. In addition, the study shows that the nurses involve family members for pre-discharged MHCUs in order to identify contributing factors that need urgent intervention. Furthermore, it was found that nurses also respect and valued the knowledge of family members and contributions in collaborative partnerships with other health care providers when it comes to the involvement of the family in therapy.

PROMOTING THE INVOLVEMENT OF THE FAMILY MEMBERS IN LONG TERM MENTAL HEALTH CARE

Wankiiri, Karen and Kimberly (2013) conducted a study on the role of the mental health nurse in the implementation of a vision for change, in Ireland. The study proposed a comprehensive model for mental health care service and suggested that an integrated multidisciplinary approach should address

the biological, psychological and social factors that contribute to mental health difficulties. The study also emphasised that psychiatric nurses are the largest profession also working in mental health services twenty-four hours a day as a core mental health professionals who deliver comprehensive mental health care. Furthermore, all the other health professionals depend on nurses, including the family members, as well as community as a whole (Wankiiri, Karen, & Kimberly, 2013).

A study by De Almeida and Killaspy (2011) in Europe, revealed that all European countries have developed strategies to strengthen the traditional hospital-based model of mental health care. As a result they developed mental health institutions in the community for people with severe mental illnesses. The study further found that services and programs to promote social inclusion were integrated within the community. However, the care, treatment and rehabilitation were also promoted through a huge range of activities, including family therapy (De Almeida & Killaspy, 2011).

ROLE OF THE FAMILY IN THE TREATMENT AND REHABILITATION OF STATE MENTAL HEALTH CARE USERS

According to Mathanya (2015) the family unit is an important variable in the onset, progression, treatment and outcome of mental illness. The findings of the study indicates that family contributes to the development of mental disorders. This findings also shows that when an individual is affected with mental illness, the whole family is also affected. Furthermore, the findings also recommended that family members should be involved in mental health care to support and supervise treatment adherence (Mathanya, 2015).

A study conducted by Ewertzon, M., Lutzen, K., Svensson, E and Andershed, B. (2013) in Sweden, revealed that the involvement of family members in long-term mental health care and the staying powers of family needed support. Important aspects in the rehabilitation of patients with mental illness eventually reduce the burden on the family members with mentally ill relatives. However, it was also found that most family members have limited opportunity to participate in the long-term mental health treatment at any stage. Instead, most of family members seem to be satisfied with the level of mental health care in the hospitals (Ewertzon *et al.*, 2013).

A study conducted by Mathanya (2015) indicates that Family-based intervention is the most important contribution of family research to psychiatric practice. The focus of family intervention to date, has been to establish a relationship with family members based on understanding and empathy. Furthermore, the relationship should focus on the strengths of family members and assist them in identifying community resources, interventions to promote treatment adherence, interventions to promote early identification of relapse and instant resolution of the crises.

In addition, the relationships should guide families to reduce social and personal disability, guiding families to reassess expectations and moderate the effect in the home environment, guiding families to improve the vocational functioning of the patient, giving emotional support to family members and developing support groups for mutual support and networking among families. Successful family intervention reduces rates of relapse and improves quality of life for patients with schizophrenia, bipolar disorder, major depression, borderline personality disorder, and alcoholism (Mathanya, 2015).

However, in bipolar disorder, the outcomes are more varied. Results from five trials show that family therapy alone or in combination with interpersonal social rhythm therapy (IPSRT) was effective in reducing relapse, and in some cases, re-admission in patients with bipolar disorder on maintenance mood stabilizing treatment. In these trials family therapy was conducted over twenty-one sessions and included family-based psycho- education, relapse prevention, communication and problem-solving skills training. On the other hand, trials of other less intensive family-based interventions have not yielded these positive effects (Mathanya, 2015).

Moreover, in major depression, the involvement of a family therapy component led to greater improvement in patients with depression and suicidal ideation than treatment without family therapy. Patients receiving family therapy had significantly greater numbers of patients who improved and had significant reductions in interviewer-rated depression and suicidal ideation, than patients who were treated without family therapy. Family-based therapies are effective for two of the most debilitating anxiety disorders- agoraphobia with panic disorder and obsessive compulsive disorder (Mathanya, 2015).

Mathanya (2015) also found that treatment for panic disorder, and for family-based strategies have shown to be effective, or in some instances more effective, than individually-based cognitive behavior therapy for adults with OCD. The American Psychiatric Association has identified the importance of family and includes effective family treatments in its practice guidelines, most notably the practice guideline for schizophrenia. This guideline indicates that patients with schizophrenia and their families who have ongoing contact with each other should be offered a family intervention, the key aspects of which include education about illness, crisis intervention, emotional support and training in how to manage the illness symptoms and related problems. The practice guideline for bipolar disorder and the guideline for major depression

also recommend early family involvement and present the known findings about the effectiveness of family-based interventions.

A study conducted by Avasthi (2012) indicates that the role that families play in the support and rehabilitation of a relative with a mental illness has gained increasing attention over the past 30 years. The goal of psychosocial rehabilitation is to enable an individual who suffers from mental illness to develop his or her capacities to the fullest extent. In conjunction with individually-oriented interventions, psychosocial rehabilitation emphasised the significance of environmental factors in the rehabilitation of people with long-term mental illnesses. Family being the most immediate psychosocial obligation, has an important role in the rehabilitation of chronic psychiatric patients.

Avasthi (2012) reports that in developing countries, family members have a major role to play in the interaction, vocational and social skills training of the patient, not only because of close family ties that exist in these traditional societies, but also because developing countries lack rehabilitation professionals to provide these services. There is also a noticeable lack of infrastructure, financial and political support for mental health care in developing countries. Furthermore, services are mostly urban-based and therefore relatively inaccessible for the most patients who reside in rural areas. In such a situation families have become caregivers of the first and last resort.

NURSING SUPPORT TO FAMILY MEMBERS

Weimand (2012) conducted study on the experiences and nursing support to family members with severe mental illness. It was found that family members' daily life is affected, that includes negative impact on social relationships, inability to be employed and financial problems. The study revealed that the family members' experiences of sharing lives with a severely mentally-ill relatives are huge challenges. This was experienced as a challenging process in terms of balancing a complexity of considerations and dilemmas. Regarding their meetings with health professionals, it was found that family members had to balance their own behavior carefully, since any unwanted approach could easily turn against them (Weimand, 2012).

However, it has also been reported that historical negative attitudes of nurses towards involving the family members in the treatment and care had not changed. Easson *et al.* (2014) revealed that nurse's attitudes against family members have an impact on the quality of mental health care. Furthermore, facilitation of family involvement, also changes nurses' attitudes towards the value of the family as a dependable source to solve problems (Easson, *et al.*, 2014).

According to De Almeida and Killaspy (2011) the provision of long-term mental health care is a major challenge within the mental health systems. Although these illnesses have a low prevalence, De Almeida and Killaspy (2011) found that the effect they have on individuals, families and societies are essential. However, the involvement of the family members in most countries affects the development of community services as a complex process. Some studies have found that barriers exist at the policy level. However, it may occur when there are inadequate mental health policies. In

addition legislation and budgets are insufficient. It was also found that there is discrimination against persons with mental illnesses. Furthermore, there is restricted health insurance for these patients (De Almeida & Killaspy, 2011).

Study conducted by Avasthi (2012) shows that most state patients have no contact with their family members and are rejected by their community members. Furthermore, he reports that although 70% of the patients in the Agra Mental Hospital had one or more family members, more than half of them did not have a single visit from a family member in the previous two years, as supported by surveys of the mental hospitals, which indicate that huge numbers of state patients have practically no contact with their families.

1.3 PROBLEM STATEMENT

Hayani Hospital is a long-term mental health care institution which provides care, treatment and rehabilitation to mental health care users. It admits state patients in a maximum security ward in which the bed occupancy is 33. There were 22 state mental health care users of which only 6 were visited per year, with a maximum of 7 visits from 2014 to 2016. Four state mental health care users were taken home only once, for leave of absence in 2015 and 2016. No state patient was taken home for leave of absence in 2014. State patients usually complained about not being visited by their families. As a result, they felt neglected.

The researcher joined the institution in 2015 as one of the psychiatric nurses caring for the state mental health care users. Each year, the institution encouraged family members to visit their state patients by hosting a family

day in which all stake holders were invited as a means of uniting the family with their admitted relatives. Despite efforts by the hospital management, the researcher observed that most families did not attend the events. Family members were also encouraged to visit their relatives through radio interviews but this still did not help. There was a gap in the scientific data regarding the factors contributing to family member's support of state patients at Hayani Hospital. Therefore, the researcher wanted to explore and describe the factors affecting family members' support of their state patients.

1.4 RESEARCH QUESTION

The research question was: kindly explain to me, what makes it difficult for you to visit your relative at Hayani hospital?

1.5 PURPOSE

The purpose of the study was to determine factors affecting family members' support of their state patients at Hayani Hospital.

1.6 OBJECTIVES

The objectives of the study were to:

- explore the factors affecting family members' support of state patients at Hayani hospital.

- describe factors affecting the family member's support of their state patients at Hayani Hospital.

1.7 SIGNIFICANCE OF THE STUDY

On completing this study, findings and recommendations will be shared, so as to enable the following effects:

Body of knowledge

Sharing the findings of this study would contribute to the body of knowledge especially in psychiatric clinical practice regarding factors affecting family members' support of state patients.

Mental health care practitioners

The findings of the study could help mental health care practitioners to gain knowledge, hence improving their practice.

State patients

When family members are empowered to support their state patients, the mental health will improve and the patients will feel accepted.

Sharing the findings of the study may increase the chances of leave of absence, which improves the relationship between families and mental health care users.

Hospital bed occupancy

The number of hospitalised patients would then be greatly reduced, making beds available for those state patients who still require specialised in-patient care.

Sharing the findings of the study may reduce the rates of relapse in mental health care institutions.

Policy makers

The study could also be used to assist policy makers in the development of public policies related to care, treatment and rehabilitation of state patients especially with regard to family support.

1.8 DEFINITION OF CONCEPTS

A 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 a long-term mental health care institution and receiving care, treatment and rehabilitation.

A state patient refers to a person so classified by court directives in terms of section 77 or 78 of the Criminal Procedure Act for committing a serious crime due to mental illness. (Mental Health Care Act No 17 of 2002).

Within the context of this study, it refers to an individual who has been disconnected from the family, declared as a state patient by the court and admitted at a maximum security ward at Hayani hospital.

A mental health care institution refers to an institution that admits mentally ill patients for a long period as part of their care, treatment and rehabilitation (Mental Health Care Act No 17 of 2002).

In this study, the mental health care institution spoken about refers to Hayani Hospital, which admits mental health care users for a long-term care, treatment and rehabilitation.

Family refers to a primary social group consisting of parents and their offspring, the principal function of which is provision for its members (Collins, 2014).

In this study, family refers to a group of people who get each other's attention, permission, support and react to each other's needs, assumptions and related to state patient at Hayani hospital.

1.9 THEORETICAL FRAMEWORK

This study was guided by Bowen Family Systems Theory.

The Bowen Family Systems Theory was developed by a psychiatrist and researcher Dr Murray Bowen who developed this theory with its eight interlocking concepts. The Bowen Family Systems Theory is a theory of human behavior that views the family as an emotional unit. It is the nature of the family that its members are intensely connected emotionally.

Usually, people feel disconnected from their families, however, this is more emotion than fact. Families so soundly impact their members' thoughts, emotions, and actions that it usually seems as if people are living under the same 'emotional skin'. People get each other's attention, permission, and support and react to each other's needs, assumptions, and upsets. A change in one person's functioning is normally followed by changes in the functioning of others. The theory focuses on the following aspects:

Differentiation of Self

Differentiation of self refers to, “The ability to be in emotional contact with others but still independent in one’s own emotional functioning is the nature of the idea of differentiation” (Kerr, 1988).

This study focuses on family members’ support of state patients which encourage emotional contact.

Fusion

“Fusion, or lack of differentiation is where individual choices are set aside in service of getting peace in the system” (Kerr, 1998).

In families, where one member is hospitalised, fusion is affected and this study focuses on the restoration of fusion by exploring and describing factors affecting family members’ support of state patients.

Emotional Cut-off

“The idea of emotional disconnection refers to the sensation of emotional distancing, whether the disconnection takes the form of internal mechanisms or physical distancing” (Kerr, 1998).

This study focuses on family support in which the emotional distance is avoided.

The Emotional System

“The existence of a family emotional field is the result of an emotionally driven relationship process that exist in all families.... This emotional process results in people taking different functioning positions in a family” (Kerr, 1988).

This study focuses on family support which promotes re-intergration of patient.

Defining the Self

An individual can, through a slow process of learning that is changed into action, become more of a self in his/her family and other relationship systems. This process of change has been named ‘defining a self’ because visible action is taken to which others react. (Kerr, 1988).

This study focuses on family support which encourages the state patient to be attached to the family.

Unresolved Emotional Attachment

Everyone has some level of unresolved connection to his or her original family. However, well-differentiated people have much more resolution than less-differentiated people. An unresolved connection can take many forms. For example, a person feels angry that his parents do not seem to understand or approve of him. An unresolved attachment relates to the immaturity of both the parents and the adult child, but people normally blame themselves or others for the problems. (Kerr, 1998).

This study focuses on family support which encourage family members to visit the state patient to avoid feeling isolated and unapproved by the family.

Individuality and Togetherness

“The emotional system works as if it is controlled by the exchange of two counteracting ‘life forces’ ...described as individuality and togetherness” (Kerr, 1988).

“When it is possible to view the details of family interactions without being manipulated into an undue focus on specific details, then it can be observed that what family members think, feel say and do reflects an emotional process that pertains to the family as a whole. (Kerr, 1988).

This study focuses on family support which encourages Individuality and togetherness.

1.10 RESEARCH DESIGN

Babbie and Mouton (2010) describe the qualitative, explorative, descriptive and contextual design that will be discussed in detail in chapter 2. The research design for this study was qualitative, exploratory, descriptive and contextual in nature.

Qualitative

Qualitative research design explores and describes in detail human experience and reflect those in words. (Hansen, 2009). In this study qualitative design was used to allow family members to narrate the depth, richness and complexity of the factors affecting the support of their state patients.

Exploratory

Exploratory research is conducted to gain insight into a situation and it has a basic goal (De Vos, 2012). In this study, factors affecting family members support were explored.

Descriptive

The descriptive design was used to provide an accurate portrayal or account of characteristics of a particular event, individual or group in real life

situations, for the purpose of discovering new meaning, describing what determines the frequency with which something occurs and categorizing information (Polit & Beck, 2012). In this study, family members were awarded an opportunity to narrate an in depth description of the factors affecting the support of their state patients.

Contextual

Contextual studies focus on certain events in naturalistic settings. Naturalistic settings are uncontrolled real life situations. (Burns & Grove, 2013). This study was contextual in that interviews were conducted at the homes of families with state patients at Hayani Hospital.

1.11 STUDY SETTING

The study setting is the area where data is collected (Polit & Beck, 2012). This study was conducted in villages around the Thulamela Municipality in families with state patients at Hayani Hospital.

1.12 POPULATION

A population is described as the entire group of persons or objects that the researcher has interest on, regarding the topic being studied and further the group meets the criteria the researcher is interested in studying (Burns, Grove & Brink, 2012). The population for this study were family members whose relatives are state patients admitted at Hayani hospital.

1.13 SAMPLING METHOD

Polit and Beck, (2012) described sampling as the process of choosing a part of the population, so that inferences about the population can be made. Non-probability purposive sampling method was used in this study. Sampling occurred in two phases, namely, sampling of hospital and sampling of participants. Details of sampling method will be discussed in chapter 2.

1.14 DATA COLLECTION

Data collection is a step-by-step process of collecting data from a specified sample of participants about variables of interest in a research study (Brink, 2012). In this study, the researcher used in-depth individual interview as data collection techniques. Details of data collection will be detailed in chapter 2.

The researcher as a data collection instrument used effective communication skills to facilitate interview as described by Babbie (2010), De Vos, (2012) and Brink (2016). All effective communication skills will also be discussed in detail in chapter 2.

1.15 DATA ANALYSIS

In this study, a data analysis guide developed by Tech was used to analyse data. Techs provides eight steps following Creswell, (2008) that should be considered when analysing qualitative data. Details of the steps will be discussed in chapter 2.

1.16 LITERATURE CONTROL

After data analysis, factors affecting family members support were identified and the literature control was conducted. This will be discussed in detail in chapter 3.

1.17 MEASURES TO ENSURE TRUSTWORTHINESS.

Trustworthiness refers to the degree of confidence. Qualitative researchers have in their data assessed using the criteria of credibility, transferability, dependability, and confirmability (Polit & Beck, 2012). These are discussed briefly below and details will be discussed in chapter 2.

Credibility (truth value)

Credibility refers to the context of ensuring that information is being collected from the relevant people who are informative about the phenomenon under investigation, there are ways of ensuring credibility which are prolonged engagement with participants and member checks (Babbie & Mouton, 2010).

Transferability (applicability)

Transferability refers to the ability of the research to be transferred from a specific situation or case to another (De Vos, Strydom, Fouche & Delpont, 2012).

Dependability (consistency)

Lincoln and Guba, (1999) refer to consistency of data in research as important because it considers whether the findings would be consistent if the inquiry were to be replicated with the same subject or similar context.

Confirmability (neutrality)

Lincoln and Guba, (1999) describes neutrality as the degree to which the findings are a function of the participants and conditions of the research and not of other biases, motivations and perspectives.

1.18 ETHICAL CONSIDERATIONS

Ethics in research refers to a set of moral principles that are used to guide the planning, implementation, evaluation and reporting of any research project. It provides the principles, rules and guidelines to the researcher about behavioral expectations and the expected conduct towards participants in the

study, co-researchers, research assistants, fieldworkers, the institution and sponsors (Brink, 2012). This is discussed in detail in chapter 2.

The following ethical principles were adhered to during the study:

- Permission to conduct the study
- Principle of respect for person
- Principle of beneficence
- Principle of justice

1.19 OUTLINE OF THE DISSERTATION

The chapter of the dissertation were organised as follows:

Chapter 1: Orientation to the study

Chapter 2: Research methodology

Chapter 3: Discussion of findings

Chapter 4: Conclusion, limitations and recommendations.

1.19 SUMMARY

An orientation of the study detailing the factors affecting family members' support of state patients at Hayani Hospital, Vhembe district, Limpopo

province was presented. The focus of the chapter was to describe the introduction and background to the problem, problem statement, research question, purpose, objectives and significance of the study. The theoretical framework, research methodology, research design and data collection method were also described. Furthermore, data analyses, measures to ensure trustworthiness and ethical considerations were described of the study. Chapter 2 focuses on research methodology.

CHAPTER 2

RESEARCH METHODOLOGY

2.1. INTRODUCTION

This chapter describes the research design which was used, the study setting, study population, study sampling method and sample, inclusion criteria, data collection method, data analysis, measures to ensure trustworthiness and ethical considerations.

2.2. RESEARCH DESIGN

A qualitative design which was explorative, descriptive and contextual in nature was used.

Qualitative

A qualitative design was selected because the purpose of the study was to explore and describe factors affecting family members' support of state patients at Hayani hospital. The family members were given enough time to respond to the questions posed to them, without any limitations. This design was suitable for this study due to its nature of reporting detailed factors affecting family members support in their natural setting.

Exploratory

In this study, the factors affecting the family member's support of state patients at Hayani hospital were explored. This yielded new understanding and new ideas in relation to the factors affecting family members' support of state patients.

Descriptive research design

Family members were given an opportunity to describe in detail the factors affecting their support of state patients at Hayani hospital.

Contextual research design

This study focused only on those family members who are related to state patients admitted at Hayani hospital. Any other issues which were not aligned to the purpose of the study were not entertained and family members outside the selected area were not included. This study was contextual because the interviews were conducted at the homes of families with state patients at Hayani Hospital. The language that was used was Tshivenda as the Hospital is situated in a region which is predominantly constituted by Tshivenda speaking family members.

2.3 STUDY SETTING

This study was conducted in villages around Thulamela Municipality where families with state patients at Hayani Hospital resided. The Thulamela Municipality is a category B municipality, situated within the Vhembe District in the far-north of the Limpopo Province. The Kruger National Park forms the boundary in the east, while sharing the border with Makhado in the east and south-west.

2.4 STUDY POPULATION

The population refers to people with the same defined characteristics (De Vos, 2012). A target population refers to the aggregate of scenarios on which the researcher would like to generalize the findings (Polit & Beck, 2012). The target population for this study were family members of state patients at Hayani hospital.

2.5 SAMPLING METHOD

A non-probability purposive sampling method was used in this study. The researcher identified the type of people who met requirements to participate in the study. Sampling occurred in two phases; namely, sampling of hospital and sampling of participants.

Sampling the hospital

One hospital was purposefully selected because it was the only mental health care hospital which had a maximum security ward where state patients were admitted.

Sampling participants

To find the family members, the researcher went through the visitors' book to identify which state patients were not being visited, and wrote down their names. Then read through the brown files to get the state patients' addresses and family members' contact details. The researcher contacted the family members telephonically and requested permission to conduct interviews with them. 15 participants were sampled from the entire population. The sample consisted of family members with state patients at Hayani hospital.

Sample size

The question of sample size is an equally important decision to sampling strategy in data collection process. One general guideline in qualitative research is not only to study few sites or individuals but also to collect extensive detail about each site or individuals. The intent in qualitative research is not to generalize the information but to elucidate the particular and the specific (Creswell, 2014). The saturation of data was reached after nine interviews were conducted.

Inclusion criteria

The inclusion criteria specify the characteristic of the population that the researcher wants (Polit & Beck, 2012).

Family members who were selected to form part of the study were 18 years and above and related to state patients who had not received visitations for 2 months or more at Hayani hospital. The participants were Tshivenda-speaking only.

2.6 DATA COLLECTION

In this study, data collection included preparation, data collection instrument and the role of the researcher as discussed below.

Preparation

Appointments with the family members were made telephonically before the interviews. The researcher visited them at their homes and explained to them that they are the relevant sources of information for the study being conducted as outlined on the participant information sheet. (See Annexure D). The researcher also explained that they will be given an opportunity to describe the factors affecting family members support through participation. Family members were given informed consent forms to read and sign before the interview and they were informed that they can give verbal consent. Appointments were then made at their homes at a convenient time for them.

The dates were given, time and venue were agreed to by the participants. Contact numbers of the researcher were given to the participants so that they could contact the researcher in case of changes in the arrangement. Participants were informed that their names would not be mentioned during the interviews to protect their identity. They were also informed that they were not obliged to participate in the study and that they could withdraw from participation at any time if they no longer wanted to participate.

Participants were also informed that the participation was voluntary, therefore no payments would be made. The researcher also requested permission to use a tape recorder during the interviews and also explained how to operate it so that the participants knew what to do in case they wanted to pause the recorder. The participants were contacted telephonically to confirm the appointments and interviews were then conducted on the agreed date and time at the participant's homes.

The dressing code was smart casual to avoid intimidating the participants by wearing formal clothes or uniform. Interviews were conducted on off-duty days when the mind was focused. The physical appearance was natural for the participants to feel comfortable. A note book was prepared for writing biographical data and incidences that were important.

The interviews were conducted in a conducive environment where there were no distractions and free from noise. The sitting arrangement was organised in such a way that there were no barriers. The chairs were opposite to each other whereby the researcher and the participants were facing each other without a table between them so that the participants felt free to talk.

The tape recorder was tested by making a record for 1 minute. The recorder was then played back to make sure that it was operating well. All the buttons were pre-tested to make sure that they were also functional. The recorder was tested before all the interviews to make sure that no information was missed.

Data collection instruments

A research instrument is the device used to collect data in research studies (Brink, 2016). Data was collected through in-depth individual interviews with family members of state patients at Hayani hospital. The interviews were conducted in a manner which allowed the family members to describe the factors affecting their support of state patients without limitations at their homes. The interview was guided by the following question which was followed by probing questions:

Kindly explain to me, what makes it difficult for you to visit your relative at Hayani hospital?

The researcher also served as a research instrument during data collection by probing on the responses of family members to get more clarity on what they were saying while answering questions posed to them by the researcher.

Pre-testing

Prior to the actual data collection process, the researcher selected two family members of state patients in one of the villages in Vhembe district and

interviewed them to check whether the question was phrased in a manner which they understood. It was realised that the question was not clear after interviewing the first participant, because the participant asked for clarity and the response of the participant were not relevant to the research topic. The pre-test was guided by the following question:

What do you think are the factors affecting family members' support of state patients at Hayani hospital?

Consultation was then done with the research supervisor and the question was phrased in a different way and the second family member was interviewed. After the second interview, the researcher noticed some improvement from the family members' response. During the interviews with the two family members, the researcher realised that there was no probing for the family members to talk more. The rephrased question was:

Kindly explain to me what makes it difficult for you to visit your relative at Hayani hospital?

The role of the researcher

The role of the researcher was that of being the main research instrument. The researcher observed, interviewed, recorded, analysed and interpreted what the participants said during the interviews. The researcher started by establishing rapport and trust where she displayed an attitude of acceptance, respect, empathy, honesty and openness.

Furthermore, the researcher explained that they should feel free to describe the factors affecting their support and that their names will not be mentioned during the interview. The researcher also explained that there was no right or wrong answer but just different perceptions. The researcher appeared comfortable and natural. The researcher also made sure that her non-verbal responses were consistent throughout the interview to encourage the participants to talk more. The researcher as a data collection instrument used effective communication skills to facilitate the interviews as described by Babbie (2010), De Vos, (2012), and Brink (2012).

- **Listening:** The researcher listened actively to the participants throughout the interview process.
- **Probing:** Probing questions were asked, which emanated from the participants' answers, to allow them to give more clarity.
- **Minimal verbal responding:** Minimal verbal responding by nodding the head, saying "mm", "Yes", "continue" to allow free flow of information and to encourage participants to talk. This made participants feel more relaxed and more willing to talk about the factors affecting their support of state patients.
- **Clarifying:** The researcher always sought clarification on statements that she did not understand, in order to avoid assumptions.
- **Reflecting:** Reflection was demonstrated by repeating the statement as mentioned by the participant in a question form in order for the participant to expand more on the specified points. She then reflected

back to the participant in her own words to understand what was being said by the participant.

- **Focusing:** Participants were given full attention as they described the factors affecting their support in order to help them focus. This was demonstrated by the way of a sitting arrangement, where the researcher ensured that when interview was conducted, chairs were the same, with no table between the researcher and the participant. A non-threatening environment was maintained throughout the interview to enable participants to relate their stories without fear. All interviews were conducted at a time that was convenient to participants. The interviews were conducted in a private, comfortable place accessible to the participants in their homes as agreed. The researcher was respectful towards the participants; all of these kept participants focused on the interview.
- **Paraphrased:** The participant's words were rephrased in another form but with the same meaning. This encouraged the participants to give more information. Furthermore, the researcher paraphrased the responses from the participants before posing the next question.
- **Using Silence:** The researcher used silence by keeping quiet to allow the participants to think and continue to talk at own pace without interference. Maintained eye contact, remained silent while demonstrating to participants that she was there listening to them. The researcher demonstrated awareness and hearing. The researcher listened actively to what the participants were saying.

- **Establishing a trust relationship:** The researcher immersed self in the participants' life world in order to better understand the factors affecting their support of state patients. Mutual trust was ensured to gain cooperation of the participant and also improve the quality of collected data. The researcher responded in a manner that showed that the participants were worthy of their disclosure and did not condemn or oppose the participants. A pleasant interpersonal relationship was maintained throughout the interviews.

2.7 DATA ANALYSIS

Data analysis is the organization of information in ways that give meaning and facilitate insight to examine a phenomenon from a variety of angles in order to understand more clearly what is being described (Creswell, 2014).

The data analysis guide developed by Tesch (in Creswell, 2014) was used to analyse data. Tech provides eight steps following Creswell (2014) that should be considered when analyzing qualitative data which were applied as follows:

Step 1: Get a sense of the whole

The researcher sat down and listened to the recorder and started to transcribe verbatim. The researcher paused and replayed the recorder when the information was not clearly heard. The researcher replayed the tape repeatedly to make sure that the correct information was transcribed without any missing information.

Step 2: Reading through the transcripts

The researcher picked one transcript at a time and read through transcript. The researcher then re-read the transcripts and jotted down the similar points in the margin.

Step 3: Listing the topics

When the researcher had completed the task for several participants, a list was made for all the topics. Similar topics were clustered together to form columns. From these topics into columns, columns were arranged as major topics, unique topics and leftovers. Finally, different colour pens were used to simplify the task.

Step 4: Went back to data

The researcher took the list and went back to the data then abbreviated the topics as codes and wrote a code next to the appropriate segments of the text. Thereafter, the researcher tried to preliminary organise scheme to see if new categories and codes emerge.

Step 5: Described the topics

The researcher made use of tables to convey findings of analysis. The tables were arranged according to the themes, categories and subcategories that the researcher was presenting.

Step 6: Abbreviated categories

A final decision was made on the abbreviation for each category and codes, and they were arranged alphabetically. This was done after going through the codes for several times making sure that all codes were noted.

Step 7: Assembled data

Data material belonging to each other were assembled and a preliminary analysis was done. These made it easier for the researcher to come up with the themes, categories and subcategories based on the grouping list.

Step 8: Recording

Existing data was recorded to ensure that no data was missing.

Literature control

The findings of the study were supported through books, scientific journals, dissertations, thesis and other documents as they contained the most recent information relevant to the study. A computerised database like the internet was consulted. Information from these sources served to enrich the research knowledge. The literature control will be will be discussed in detail in chapter 3.

2.8 MEASURES TO ENSURE TRUSTWORTHINESS

In this study, trustworthiness was ensured through credibility, transferability, dependability and confirmability.

Credibility

In this study, credibility was ensured through prolonged engagement and member checking.

Prolonged engagement

The researcher visited the participants before the interviews to build trust and rapport so that the participants feel free to explain the factors affecting their support of state patients. The participants were then briefed about the research question, its purpose and the significance.

Member checking

The research findings were discussed with the participants. After data was fully analysed, the researcher went back to the participants for final member check to determine if what was transcribed is what they meant during interviews.

Transferability (Applicability)

In this study, transferability was ensured by describing the background information of participants, research methodology, population and sampling method well.

Dependability (Consistency)

In the present study, dependability was ensured through following ethical protocols.

Conformability (Neutrality)

In the present study, conformability was ensured through availability of raw data and tape recorder.

2.9 ETHICAL CONSIDERATIONS AND PROTECTING THE RIGHTS OF RESPONDENTS

Ethics in research refers to a set of moral principles that are used to guide the planning, implementation, evaluation and reporting of any research project. It provides the principles, rules and guidelines to the researcher about behavioral expectations and the expected conduct towards participants in the study, co-researchers, research assistants, fieldworkers, the institution and sponsors (Brink, 2016).

Ethical considerations in the conduct of this study were followed to avoid ethical dilemmas. To ensure ethical adherence of the study, permission to conduct this study was obtained from the following:

- The Limpopo Department of Health research committee.
- The Vhembe district Department of Health research committee.
- The Chief executive officer of Hayani hospital.
- The University of Venda research committee.
- Participants of the study.

Principle of respect for persons

Participants have the right to decide whether to participate in a study without any risk of penalty or harmful treatment.

- **Informed consent**

Informed consent ensures that the participants fully understand the research project that they are going to participate prior the commencement of the research study. Informed consent was obtained from participants prior to their participation in the study and the study will be voluntary.

The right to self determination

The right to self-determination is based on the ethical principle of respect for persons and it indicates that humans are capable of controlling their own destiny (Burns & Grove, 2012).

The participants were informed that participation in the study was voluntary and that they have a right to withdraw from participation at any time if they no longer wished to participate in the study. In addition, the purpose of the study was explained to the participants.

Respect for human dignity

The researcher informed the participants of their right to decide whether or not to participate in the research. The values, norms and personal beliefs of the participants were respected. The setting for collecting data was also respected and not changed in any way just because of the study.

- **Privacy**

Privacy is the freedom of the participant to determine the time, circumstances and extent to which private information will be shared (Burns & Groves, 2012). I ensured privacy by ensuring that the participants are in a closed setting when conducting interviews. In addition, the room was free from destruction, where in participants provided answers without the possibility of later being embarrassed based on their responses. Finally, the tape recorders were used with the participants' consent.

Principle of beneficence

Beneficence means that the researcher is required to do well and above all do no harm (Brink, 2016). The well-being of participants was secured and protected from discomfort and harm. It was explained that there were no legal implications as a result of them giving their opinion about the factors affecting their support of state patients.

Principle of justice

Participants were selected fairly, conveniently and were treated fairly. Furthermore, their participation was voluntary.

Confidentiality

Confidentiality means that the information obtained through the research is not made available to other people. The researcher maintained confidentiality by ensuring that the information provided by the participants in this study was not shared with other people outside the interview room section, research workshops, reports and articles.

Anonymity

Anonymity prohibits the researcher from making available any information that can lead to the identification of the research participants (De Vos *et al.* 2012).

Numbers were to identify participants' information, therefore, the names of the participants were not revealed. Finally, the researcher did not define the participants' condition or state, including abnormalities and attire in correlation with the information during interviews conducted, to ensure that the participants remained anonymous. The tapes will be destroyed upon completion of the study by the research assessors.

2.10 SUMMARY

This chapter, discussed the research design which was followed, described how data was collected and analysed, discussed sampling method and sampling, ethical considerations and measures to ensure trustworthiness

were also discussed. The next chapter discuss the research findings and literature control.

CHAPTER 3

DISCUSSION OF RESEARCH FINDINGS

3.1. INTRODUCTION

The previous chapter discussed the methodology that was used to conduct this study. This chapter describes the findings of analysed and interpreted data, as presented by Tech from family members of state patients on factors affecting family members' support of state patients at Hayani Hospital.

Two themes emerged from the interviews, each one of which lasted between 30 to 45 minutes. The themes, categories and sub categories generated from the study are described in this chapter. The results will be discussed in relation to the literature available to either support or give a different view, based on the themes.

3.2 DESCRIPTION OF THE SAMPLE

The demographic profile of the sample for this study comprised of nine participants. Data was collected from nine family members of state patients at Hayani hospital. The age of family members ranged from 25 to 65 years. All the family members interviewed were Tshivenda speaking.

Table 3.1 illustrates the sample profile of the participants.

Table 3.1 Sample profile of the participants

NO	GENDER	AGE	RELATIONSHIP
1	Male	25 years	Niece
2	Male	52 years	Brother in law
3	Female	65 years	Aunt
4	Female	63 years	Mother
5	Female	34 years	Sister
6	Female	51 Years	Sister
7	Female	46 years	Wife
8	Female	59 years	Aunt
9	Female	43 years	Sister

3.3. DISCUSSION OF FINDINGS

Data was analysed using Tecsh's eight steps of data analysis. Two themes emerged from the analysed data, namely, psychological and social factors affecting family members support and their categories. The presentation of data was done according to themes and discussed separately.

3.3.1 Theme 1: Psychological factors affecting family members support

Table.3.2 illustrates the theme, categories and subcategories.

Table 3.2: theme 1

THEME	CATEGOTY	SUB- CATEGORY
1. Psychological factors affecting family members support.	Fear of the patient	<ul style="list-style-type: none"> • Afraid of the patient • Uses deep vulgar words • He beats a lot • Burns clothes • Destroys properties • He hears voices • Doesn't like visitors • Patient is very powerful
	Anger	<ul style="list-style-type: none"> • Feeling bitter • Troublesome-chasing after people. • Makes me angry

Discussion of themes

Psychological factors emerged as major factors that affected family members causing them to not support their state patients at Hayani Hospital. A study conducted by Pickard (2013) indicates that most of the family members of state patients in the study, claimed that they experienced psychological and social problems which affected their support of their state patients. The factors of this study include fear and anger, which are discussed as follows:

Fear of the patient

Most family members experienced fear of the patient, because of anti-social behaviour which the state patient displayed while still at home. Family members claimed to be afraid of the patient, claiming that they use deep, vulgar words, beat a lot, burn clothing, destroy properties, hear voices, do not like visitors, and that the patient is very powerful. The following quotes depict how the family members experience fear.

One participant said, *“...I feel so scared of going to visit my brother because he used to insult me with vulgar words and it’s very painful you know. My mind is still focused on what he used to do in the past, I cannot forget it. What if it happens again? What if I go and visit him then he start insulting me? He doesn’t hesitate to speak using the deepest vulgar words. He used to steal property at home and break things. I remember I once stopped to greet him while I was driving and he removed the car keys. Can you imagine...?”*

Dube (2013) indicates that family members experience helplessness, fear and vulnerability caused by the aggression and violence that the patient displayed before admission to a psychiatric hospital. Furthermore, family members felt a deep sense of fear including powerlessness and helplessness which was an outcome of unpredictable behaviours of the state patients such as aggression, unpredictable mood swings, bitterness, vulgar words and mood fluctuation.

One participant said, “...*I have fear of my uncle because of what he used to do at home. He did not like visitors, he would chase them away and insult them with vulgar words and threaten to beat everyone. He always thought that whoever came to visit us was actually planning to kill him. So I feel like if I go and visit him he will chase me away or even beat me...*”.

Masego (2015) shows that families of mentally-ill family members experienced psychological problems such as fear as a result of mental illness of a family member. Similarly, Mathanya (2015) reports that family members with state patients experience tension, stress, anxiety, resentment and depression which leads to fear of their state patients and that eventually affects their support to this state patients.

Another participant said, “...*my brother was troublesome, I used to fear him because he used to break doors, insult people in vulgar words and it was very painful. Sometimes he would just pick up a hammer and threaten me. I had to run away, I could not stand it. It was bad. I can't even face him now...*”.

Uys and Middleton (2014) indicate that family members become anxious and scared because of the patients who become aggressive during acute episodes of their mental illness. Similarly, Masunga (2016) found that state patients

often get involved in behaviors that are intimidating, irritating, uncontrollable, or at least annoying, and many family members are forced to control, manage, or tolerate these behaviors which gives them fear of this patient. Thus, family members do not support their state patients, even when hospitalised in a long term psychiatric institution.

Another participant said, “...*I have fear of this person whom we sent to Hayani hospital for admission, secondly, I have fear because I am not sure whether he is getting treatment for what got him admitted. I usually feel afraid of all this things. He says he hears voices talking to him while he is sitting in the house, telling him to get up, walk and burn things, so I feel afraid, what if I go to visit him then those voices tell him to stand up and beat me? It’s not easy because I must be patient with him, there was trouble. That’s why you hear me saying that I have fear...*”.

Rowaert, Vandeveld, Lemmens, Vanderplasschen, Vander Beken, Vander L. and Audenaert (2015) indicates that family members of state patients experience emotional distress, which is often caused by the patient who was involved in criminal activities. Furthermore, family members are strongly affected by certain behaviours that come along with having a family member who is a state patient. These behaviours include aggression. These family members are usually the victims of the crimes committed by this state patients and this affects them in a bad way. Furthermore, family members experience psychological problems and desperate feelings, such as guilt, hopelessness, frustration and embarrassment of their patients’ behaviours.

One participant said, “...*He beats a lot, even his mother feels so hurt because of that. She becomes the victim sometimes. It’s very painful, he doesn’t listen,*

even if he goes home he is going to do it again. It's more painful to his mother as a parent. It hurts. It's not good at all. How do you live with such a person?..."

Rowaert (2018) reports that family members also feel emotionally affected, describing themselves as feeling institutionalised, frightened and inadequate by supporting a state patient who was involved in criminal activities, in some cases, family members themselves were the victims of this crime. The findings of the study revealed how the families living with a mentally ill family member had bad experiences. The experiences such accusations, challenges and pain, witchcraft and spirituality, vulnerability or murder and health challenges.

Another participant said, *"I just feel like if I go to the hospital and his illness recurs, what if he chase me away and tells me he doesn't want to see me because he doesn't like visitors at all. I have fear that he will chase me away and beat me or accuse me of planning to kill him because he always say that. So fear is what makes me not to go and visit him..."*

Saunders (2010) states that family members experience psychological distress, which was a significant predictor of family functioning. Family members reported that some of the most distressing problems for them resulted from living with the positive and negative symptoms of their family members. The most commonly identified psychological problems for the family members were obsessive-compulsiveness, anxiety, depression, interpersonal sensitivity, and paranoid ideation. All these emotions led to fear of the patient.

This findings were also supported by Wankili, Karen and Kimberly (2013) who indicate that family members experienced challenges while living with a mentally ill family member. Family members used words like, 'dreadful',

‘offensive’, ‘shocking’, ‘obnoxious’, and ‘horrid’, as they expressed feelings resulting from living with a mentally ill family member. The behavior of the mentally ill family member was found to be intolerable. Family members described the behavior of the mentally ill family member as unmanageable, unacceptable or tormenting.

In addition, Wankili *et.al.* (2013) shows that the mentally ill family members behaved in ways that were perceived as challenging by family members. They perceived the mentally ill as troublesome, having unreasonable complaints, as well as behaving immorally and intolerably. This kind of behaviour leads to fear of the state patients by their family members. The family members perceived the mentally ill being annoyed, irritated, or exasperated always.

One participant said, “... *he is very scary, very troublesome. When he is at home he joins his old friends, who drink and smoke dagga which means he also drinks and smokes. Once he does, he starts shouting and harassing people. From there he starts being violent either at home or in the streets. People are forced to run away from him because of his behaviour...*”

Study by Monyaluoe, M., Mvandaba, M., Plesis, E.D., Koen, M.P. (2014) reports that families are at risk of being injured or murdered by their violent and aggressive mentally ill family member, and as such, family members live in fear. Some family members reported that they were attacked by their mentally ill family members. Destruction to property was reported as experienced by most family members.

Furthermore, the results of the study revealed that it is one of the risks of injuries. The family members also reported how they are afraid of being

murdered when the mentally ill destroy their property. However, families also developed other behavioural reactions, such as adjusting to the situation as if it were normal, making use of prayer, finding meaning in the patient's communications, ignoring the patient's behaviour (Monyaluoe *et al.*, 2014).

Contrary to findings of other researchers, Seloilwe (2006) states that some family members work together with mentally ill relatives, they do not compete or provoke them, and at times, family members control their feelings and let that of the mentally ill family member take precedence, and to manage with daily activities, families often discuss the support. In addition, some families have developed strengths and strategies on how manage while living with a mentally ill family member. It is also evident that some families do get support.

One participant said, "...I don't hate him and I don't fear him, I don't have any problem with him. He is my brother. I do think of him and I would go and visit him if it was possible for me. He was aggressive but I understood that it was because of his illness so I accept the situation. It's just that things are difficult for me. I really wonder how he is doing there..."

Rowaert *et.al* (2016) indicate that most family members still provide support in these cases by visiting the patients at psychiatric institution and acting as informants for professionals. Furthermore, it was revealed that in the face of all these problems, family members of state patients still develop better self-coping machanisms, including communication with other family members to reduce their stress and visiting their relative, encouraging feelings of forgiveness, responsibility and patience.

Another participant said, *“...he is my husband, I don’t have any problem with him although he was troublesome, I know how to handle him during those times, he even tells the nurses at hospital that he doesn’t know where he would be if it wasn’t for me. I just don’t have money for transport to the hospital, the little I get for social grant covers for things like tomatoes and other things we need at home...”*.

Dube (2013) found that in spite of negative experiences and the burden the families living with mentally ill families have, some families do cope and have the strength to live with a state patient. This findings were supported by Masego (2015) who indicates that despite the challenges the families seem to be experiencing, the family members as a unit and individual members have their own manner of coping and finding some kind of fulfilment within the bounds of the misfortune of having a mentally ill family member. Furthermore, what was also good about other family members was that they wanted to support their state patient despite the challenges they were going through. Participants reported that they never wanted to neglect the family instead they wanted to know and understand their state patient better (Masego,2015).

The researcher found that most family members have fear of their state patients because of the anti-social behaviour they displayed at home, such as violence, destruction of properties, and verbal aggression. As a result, family members live in fear and do not support their state patients because of fear.

Anger of family members

A few participants reported that they felt angry because of the destructive behavior that the patient displayed while at home. Participants claimed to be feeling bitter because the patient was troublesome- chasing after people, Making them angry.

One participant said, “...I just feel angry, I become angry when I think of what he used do at home, this person used to beat other people. You wouldn’t like it. It’s not good at all. Every time I look at him I... just feel bitter, thinking that he might do it again. It’s very painful, especially to the mother. Why can’t he go home and stay without causing trouble? No one has to be a victim because of him... ”

Masego (2015) reports that family members experience anger because of how their state patients behaved while they were still at home, they were hurt because the state patients would do things that were intolerable, such as undressing in public, and behaving like children. Behaviour of the mentally ill family member was found to be uncontrollable. Family members described the behaviour of the mentally ill family member as unbearable, unacceptable or excruciating.

Another participant said, “...uncle did not like visitors at all, when they spent some time, uncle begins to think that those people are planning something like killing him, that’s what he used to say, so he felt it was better to chase those people away in a violent manner. If they did not understand he would end up beating them until we as a family advise them to leave because we know that uncle is mentally ill...”

Banyini (2012) indicates that anger may be directed towards the patient but it is more frequently felt by family members, mental health professionals or the whole health care system. Furthermore, anger within family relates to differing perceptions of the patient and ideas on how to manage the illness.

This findings were supported by Mathanya (2015) who indicates that family members with state patients experience tension, strain, fear, bitterness and misery with feelings of hopelessness, powerlessness and devastation, in their daily lives. It was further indicated that families with state patients experience much social rejection. Due to poor socialisation between the family and the state patient, the state patient may develop much emotional disturbances, which may result in feelings of frustrations, anger, verbal and physical aggression.

CONCLUSION

Fear and anger are the main factors which affects family members' support because of the aggression and violence displayed by the state patients while they were still at home.

3.3.2 Theme 2: Sociological factors affecting family members support

Table 3.3 illustrates the theme, categories and subcategories of sociological factors affecting family members support

Theme 2	Category	Sub-category
2. Social factors affecting family members support	Financial problems	<ul style="list-style-type: none"> • No money • Depend on social grant • Unemployed • No source of income
	Poor relationship with the patient.	<ul style="list-style-type: none"> • He is boring • Sees me as an enemy • Taking other people's properties • Selling house hold properties • Difficult to live with • No communication

Financial problems

Few participants report that they have financial problems because they do not have money due to unemployment, and they were depending on the patients' social grant, and had no other source of income. Some participants lost their jobs because they had to stay at home and take care of their patients while they were still at home.

One participant said, *“... it is quite difficult to get money for transport to travel to Hayani Hospital because I am not employed and I don’t have any source of income. I am just on my own, I don’t have an in-law or anyone else. It is hard to even make means to provide basic needs...”*

Uys & Middleton (2014) indicate that family members experience financial burdens, such as transport costs and providing food. This findings were also supported by Masunga (2016) who states that family members experienced financial problems because most were unemployed.

Another participant said, *“... I don’t have money to travel to Hayani hospital, it’s expensive to go there. Where will I get money to visit often? I only wait for month end to get money for social grant. That is the only time I get money. But still, it is not enough for me to travel to the hospital every time. It’s a distance from here to the hospital...”*

Rowaert (2018) indicates that families experienced financial problems due to unemployment. The poor financial status in the family further increased the risk or vulnerability. Furthermore, the provision of care to a family member suffering from mental illness burdens the family financially, because the individual with the mental problem is likely never to work, and the family members’ may be forced to quit their professions to look after the patient.

Another participant said, *“I am not working and I had many job opportunities, so many opportunities, you know. I would receive calls from people offering me jobs but I had to turn down the offer because my husband was troublesome while he was still at home, I could not go to work and leave him alone because he was going to sell everything. Now that he is admitted No one is offering me*

a job. I only depend on children's social grant because my husband grant was stopped since admission. I really do not have money for transport to go and visit him".

Senthil (2017) reports that the provision of care to a family member suffering from mental illness burdens financially the family, because the individual with the mental problem is likely never to be employed and the family members' may be forced to quit their profession the moment the care expenses are increased.

Another participant said, *"... money is a problem, it's not easy to get money. I can't just go and visit without buying him anything. I also have to leave him with some money so that he can buy something for himself when he feels like it. I cannot afford to pay for transport and buy him things at the same time. It is costly and I also have other responsibilities which need money as well ..."*

Senthil (2017) reports that financial problems which affected the support of mentally ill patients. Most informants expressed concerns about financial strain caused by increased cost for patient care, most of the family members were living a long distance from the hospital and they had to travel either by taxi or by public transport for patient follow-up. This caused most family members to have more financial difficulties with the small amount of money they had. For psychotic patients, some used to take taxis, but the easiest and most accessible transport was public. The most significant concern was how to get the money for the transport. Some failed totally to go to the hospital for more than two months.

One participant said, *“...I don’t have any problem with my brother. The only problem is money for transport. I did not abandon him, really, I did not abandon him. Only if I could get money for transport then I would visit him regularly. I am unemployed so I don’t have any source of income or anyone one to assist me financially...”*

Dube (2013) found that financial problems were expressed by many family members, and this took several forms. For some, financial problems were experienced as an outcome of the family members having to quit their jobs to take on a care giving role. For others, the responsibility of supporting the mentally ill family members lay within the family, and they had to make sure that they finance the patients’ up-keep.

Furthermore, this led to long-term dependence on small pensions, through older family members taking early retirement as well as quitting from the workforce, and loss of benefits that employment brings. In one case, absenteeism from work due to the patient's mental health problems resulted in the family members being dismissed from work and losing their main source of income (Dube, 2013).

Another participant said, *“... money is another serious problem. Hei! It is quite expensive to travel to the hospital. I depend on piece jobs for survival and I use the money to buy the most important things at home like food which leaves me with no money to travel to the hospital. It’s really hard. It’s not easy at all...”*

Masunga (2016) indicates that financial or material assistance was mentioned to be very significant, but there was no source of income and close relatives who had good financial status did not offer any financial assistance because

they did not want to get involved in the support of the state patient. This findings were supported by Rowaert (2018) who shows that families experienced financial and employment difficulties. The poor financial status in the family further increased the risk or vulnerability.

Wakiri, *et.al.* (2013) also indicates that the provision of care to a family member suffering from mental illness burdens financially the family, because the individual with the mental problem is likely never to work and the family members' may be forced to quit their profession the moment the care expenses are increased.

Poor relationships with the patient

A few participants reported that they were having poor relationships with their state patients which was a result of the antisocial behavior they displayed while they were still at home with their family members. These behaviors had a negative impact on the relationships between the patients and family members. In most cases, family members were confused, not knowing how to communicate or act towards the patient after all the trouble caused by the patient.

Rowaert (2018) found that violent behaviour by patients affects family members because they cause disintegration of relationships between family members and behavioural problems, which in turn created more family emotional distress. These stressors continued to affect the family's ability to adjust and function effectively. The patient anti-social behaviour affects all

aspects of family functioning. Most family members found it difficult to maintain their relationship with their state patients.

One participant said, “... *how can we get along after all this trouble? We always fight when he is at home and it is not good. When he arrives home, we all have to run away or hide for safety because you will never know what he is up to at that moment. It’s not a good idea to sit and talk to him because anything can happen...*”.

Senthil, (2017) indicates that the social stigmatization and social isolation compose usual consequences when having a family member who committed crime. The social isolation being an outcome of the anti-social behaviour of the patient. As it concerns the inner family relations, the consequences that result from mental illness depend on the quality of relation with the mentally suffering. In the matrimonial relations, the roles are redefined, reciprocity gives ground and misunderstandings usually lead to separation. Emotions of guilt and ‘mourning’ appear in the parental relations, while the siblings reported emotions of shame, guilt, fear and anger.

Another participant said, “...*I ask myself if there will ever be communication between him and I. I don’t know if our relationship will be well again, I don’t know what will happen if he sees me, will he see me as an enemy? Or someone who wants to help him? I really don’t know...*”

Rowaert (2018) indicates that these families experience difficulty in maintaining family relationships, which is enhanced by enforced separation between patients and their families, the geographical distance between the institution and the family home the security routines, and the organizational

and cultural characteristics of the forensic psychiatric care units. Furthermore, matters were complicated in that family members are themselves often victims of crimes committed by the patient

One participant said, "...it is very difficult to be close with this person especially when the illness recurs. He is so unpredictable. When you think he is stable, that's when everything changes and it gets ugly. So you can't tell when he is really, really stable. There is nothing which can go right at all. I don't want to be a victim. Its better he remains at the hospital..."

A study by Dube (2013) shows that family members experienced physical harm in the form of assault especially when the patient had relapsed. Similarly, Masego (2015) indicates that most state patients do not have good relationships with their family members because of the anti-social behavior they displayed while still at home with their families, which includes theft, aggression and violence.

This findings were supported by Masunga (2016) who indicates that the uncontrolled behaviour of the mentally ill family members such as temper tantrums, shouting in public, insulting people and neighbours and hitting people had caused family members to have challenges in forming and maintaining good relationship with the patient. Maintaining a good relationship with mentally ill relatives that caring for someone with mental illness can be a challenging and very difficult experience because the patients were physically and verbally aggressive to their family members.

Another participant said, “... *it was never easy when he was around. He was very stubborn hei! You know, he wouldn't listen to anyone, he would just insult people. I just looked at him and kept quiet. The best thing was just to stay away from him to avoid unnecessary problems. He easily got irritable even when there is no reason ee! It was tough, very tough*”.

Dube (2013) indicates that relationships with neighbours and the community at large can be strained. At times, the family members were socially isolated due to the patients' behaviour during the episode as some patients became either physically or verbally aggressive. This made it difficult for neighbours to understand the condition

This findings were supported by Senthil (2017) who reports that the anti-social behaviour displayed by the state patients led to disruption in the family integration, interpersonal relationships of family members and overall family functioning. It has also been seen that people with poor quality of marital relationship are heavier drinker. Husband undermining behaviours negatively affected the mental health and functioning of their wives.

Furthermore, Senthil (2017) indicates that stress builds problems in the entire family and family members are pushed to have a declination in their satisfaction with life. This can lead to problems and decline in physical health and mental health of family members, which further diminished the social interaction, proper role performance in life, so the massive disruption in the lives of family members. In the matrimonial relations the roles are redefined, reciprocity gives ground and conflicts often lead to divorce. Emotions of guilt and 'mourning' appear in the parental relations, while the siblings report emotions of shame, guilt, fear and anger.

CONCLUSION

Financial problems due to unemployment and poor relationships with the state patient affects family members' support.

3.4 SUMMARY

Chapter 3 discussed the findings of the study and literature. Two themes were established from data analysis namely: Psychological factors affecting family members support and sociological factors affecting family members support. Chapter 4 focus on conclusions, recommendations and limitation of the study.

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter concludes the study about the factors affecting family members support at Hayani hospital. This chapter outlines the risks, limitations, interpretation of the research findings, recommendations and further research.

4.2 EVALUATION OF THE STUDY

This study was evaluated according to the purpose and objectives as set in Chapter 1

The purpose of the study was to to determine factors affecting family members' support of state patients at Hayani Hospital. The purpose of the study was achieved through in-depth individual interviews with the participants.

The objectives of the study were to:

explore the factors affecting family members' support of state patients at Hayani hospital.

describe factors affecting the family member's support of state patients at Hayani Hospital.

The objectives of the study were met as factors affecting family members' support were explored and described in detailed.

4.3. CONCLUSIONS

Two themes emerged from the study, namely, psychological factors affecting family members support, and sociological factors affecting family support

4.3.1 Theme 1: Psychological factors affecting family members support

Fear

The findings of this study revealed that family members experienced fear because of the anti-social behaviour displayed by the patients while at home. The anti-social behaviour included violence, destruction of properties, verbal aggression and, in some cases, family members were victims of this behaviour. Family members were affected mentally, physically and emotionally therefore developing fear of the patients. Some family members cannot forget what happened, their minds are still focused on the past. Furthermore the fear that family members had made them hesitate to support

their patients because they were afraid that what happened at home would happen again even in the hospital. They were also concerned about how their state patient would react if visited.

Anger

The findings of this study also revealed family members also experienced anger because the patients were aggressive and violent they were still at home. Furthermore, some family members were victims of crime committed by the patients. Anger affected them in such a way that they could not even go to visit the patients because looking at them reminded them of the past.

4.3.2 Sociological factors affecting family members support

Financial problems

This study revealed that most family members experienced financial problems. The transport cost was expensive for some family members because the long distance to Hayani Hospital. Family members also depend on social grants to provide basic needs and in some cases they were dependent the patients social grant. Some were unemployed because they lost their jobs while caring for their state patients while they were still at home.

Poor family relationships

The findings of the study revealed that state patients had relationships with their family members. Family relationships were disintegrated because the patients anti-social behaviour while they were still at home thus, some family members distanced themselves from their state patients. Some relationships were disrupted during admission because state patients blamed them for admission.

4.4 LIMITATIONS OF THE STUDY

The anticipated number of participants was not reached because some of the participants agreed to participate but changed their minds on the date of appointment.

4.5 RECOMMENDATIONS

Recommendations to the family members

The researcher recommends that family should be work shopped on mental illness so that they understand the progression of mental illness.

Family members should be educated about the importance of visiting their state patients.

Family members should be trained on how to manage the patient during leave of absence to improve re-integration

Recommendations to the community

The community should also be educated on mental illness to avoid stigmatisation of the patients.

The community should be encouraged to form support groups to support the family members.

Recommendations to the hospital management

The institution should delegate a multi-disciplinary team to conduct home visits to support family members.

Recommendations on further research

Based on the findings of this study, the researcher recommends a study to develop a model on family members' support of state patients.

4.6 SUMMARY

In this chapter, which is the final chapter of the study, the following were outlined: conclusion, limitations of the study as well as recommendations of the study.

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ANNEXURE A

**RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR**

NAME OF RESEARCHER/INVESTIGATOR:

Ms M Nemathaga

Student No:

11616356

PROJECT TITLE: Factors affecting family members support of their patients: A case study of Hayani Hospital, Vhembe District, Limpopo Province.

PROJECT NO: SHS/17/PDC/46/0410

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

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Prof ML Nelshikweta	University of Venda	Co-Supervisor
Ms M Nemathaga	University of Venda	Investigator - Student

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: October 2017

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. G.E. Ekosse

UNIVERSITY OF VENDA DIRECTOR RESEARCH AND INNOVATION 2017 -10- 12 Private Bag X5050 Thohoyandou 0950



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ANNEXURE B

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To whom it may concern.

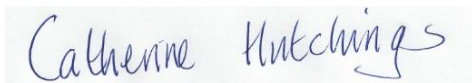
**I hereby confirm that I edited
NEMATHAGA MUOFHENI's
MCur thesis,**

Title:

**FACTORS AFFECTING FAMILY MEMBERS' SUPPORT OF STATE
PATIENTS: A CASE STUDY OF HAYANI HOSPITAL, IN THE
VHEMBE DISTRICT, LIMPOPO PROVINCE**

in April 2017.

I wish this student well in their endeavours.



Catherine Hutchings

ANNEXURE C

INFORMED CONSENT LETTER

University of Venda

P O box 5050

Thohoyandou

0950

Dear participant

My name is Muofheni Nemathaga. I am a nursing Master's degree candidate studying at the University of Venda, South Africa. I am interested in exploring the factors affecting family members' support of their state patients at Hayani Hospital Limpopo Province, South Africa.

To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed, as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.

- You have a choice to participate, not participate or stop participating in the research. You will not be penalised for taking such an action.
- The research purpose is to determine the factors affecting family members' support of state patients at Hayani Hospital
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking below as applicable) whether or not you are willing to allow the interview to be audio recorded.

I can be contacted at:

Email: muofheninemathaga@webmail.co.za

Cell: 079 591 0240

My supervisor is Dr Mary Maluleke who is attached to the School of Health at the University of Venda.

Thank you for your contribution to this research.

Consent

I..... (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participate in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

Signature

Date

Consent to audio record interview

The researcher will be making audio recordings of the interview for data collection and transcription purposes. Any identifying data will not be

included in the write up of the report and pseudonyms will be used. Also, the recordings will be destroyed upon completion of the study. Your permission is sought in order to record the interview. Please indicate by ticking the box below whether you consent to having the researcher make an audio recording of the interview for data collection and transcription purposes.

- Willing to be audio-recorded.
- Not willing to be audio-recorded.

Signature

Date

ANNEXURE D

PARTICIPANT'S INFORMATION SHEET

Title:

“ factors affecting family members support of state patients: a case study of Hayani hospital, Vhembe District, Limpopo Province”.

The purpose of the study:

The purpose of the study was to determine the factors affecting family members' support of state patients at Hayani Hospital in Vhembe District, Limpopo province.

The objectives of this study were to:

- explore the factors affecting family members' support of state patients at Hayani Hospital
- describe the factors affecting family members' support of state patients at Hayani Hospital

Significance of the study:

The beneficiaries of this study were:

Body of knowledge:

Sharing the findings of this study would contribute to the body of knowledge especially in psychiatric clinical practice regarding factors affecting family members' support of state patients.

Policy makers:

The study could also be used to assist policy makers in the development of public policies related to care, treatment and rehabilitation of state patients especially with regard to family support

Harm:

There was no harm or threats expected to family members through participating in the study.

Benefits:

You will be given an opportunity to share the factors affecting your support of state patient

Rights as a participant in this study:

Your participation in this study was entirely voluntary and you can decline to participate, or stop at any time, without stating the reason.

Withdrawal:

You can withdraw from the study if you consider it not to be in your best interest. If you do not follow the regulations of the study facility and guidelines of the study, you can be withdrawn from the study at any time.

Ethical approval:

This study was submitted to the University of Venda and written approval was granted, Permission to conduct the study was granted by the provincial, district and hospital managers (CEOs) of Department of Health.

Confidentiality:

All information that were obtained during the course of this study, including personal and research data, were kept strictly confidential. Only codes was used so that anonymity can be maintained.

Source of information:

If you want any information regarding your rights as a research participant, or have complaints regarding this research study, you can contact the following individuals:

Supervisor: Dr M Maluleke 076 394 9752

Co-supervisor: Prof L. Netshikweta072 615 5399

Student: Nemathaga M.....076 178 8933

ANNEXURE E

INTERVIEW TRANSCRIPT NO 1.

R: good afternoon!

P: good afternoon

R: how are you?

P: I am fine thanks and how are you?

R: I am fine thank you

R: It's windy today

P: yes it's quit windy, coldness is no longer there, and heat is now approaching

R: indeed, we are going to feel hot.

R: Like I said, my name is Muofheni Nemathaga

P: yes

R: I work at Hayani Hospital

P: yes

R: I am also a student at the University of Venda

P: mmm...

R: so I am conducting a research at the University of Venda, regarding family members with patients admitted at Hayani Hospital

P: yes

R: it came to my knowledge that you also have a patient there

P: yes

R: so as we agreed to meet at this time, do you still agree to participate in this interview?

P: yes, let's go ahead

R: if there is any information that you don't want me to record on the tape, let me know then I will pause and we talk

P: no problem

R: then when we are done, I will continue recording.

P: no problem at all

R: your name will not be mentioned, I only need information

P: yes

R: yes and the information will be disclosed to my supervisors

P: yes

R: don't be afraid

P: yes, no problem.

R: may we start now?

P: yes, we may start

R: mmm... what are the factors causing family members not to visit their patients?

P: you mean patients at Hayani hospital?

R: yes

P: I was unable to visit because of transport

R: mmm... transport was not available?

P: yes it was unavailable, it used to beat me and I could finish two months then when I had the money I would go and visit.

R: you did not have money?

P: yes, but it was hurting me because I was unable to visit my husband and even the day I got money it could only be for transport. I could not buy him anything.

R: mmm...

P: yes you see? It was not there. So I would just go there then he ask about cool drink. I told him that I only got money for transport and that I don't have money for cool drink.

R: mmm...so are you not employed?

P: yes I am not employed, actually, most of the jobs passed me because of my husband's mental illness. The way it was tough, it was difficult to go out because if I went out he would just take blankets and leave.

R: ee!

P: he would even take furniture. I would just receive a call while he is at Masase, then I would follow him, that was the job.

R: mmm...

P: I would even hesitate to visit my relatives because it was tough. I had to go at that time and come back home quickly.

R: mmm...

P: yes so I would hesitate to get a job because people would be calling me saying "yowee" Can you see him? So I just settled at home to see it at home.

P: sometimes he would just take things but if he found me at home, I would warn him then he would leave. But if I am not at home, he would just come back and take blankets.

R: mmm...

P: jobs used to come, kitchen jobs, outside jobs, but it was the same I could not leave that person. It was even difficult or me to go to Thohoyandou but even when I was there I would just be thinking of him.

R: mmm...

P: sometimes I would not see him the whole day because he would leave in the morning and come back during the night. If I went out and realises that that there is no one, not even a single child, he would just take things and leave.

R: mmm...

P: it was difficult, it caused me not be employed, I could not leave home.

R: you said you could not get a job because you felt you could not work when he was home.

P: yes

R: so when he went to Hayani hospital was there no any other plan?

P: I used to do piece jobs like doing laundry and it was a job for one day. Somebody would just ask me to iron then I iron and that was it.

R: mmm... is there any other cause?

P: when he was still getting grant it was much better, I was using it for basic things. Not having money is a problem.

R: I understand, is there any other information we left out?

P: no there is nothing else.

R: thank you for your time and information. I will come back to verify this information with you.

P: you are welcome.

ANNEXURE F

INTERVIEW TRANSCRIPT 02

R: good afternoon!

P: good afternoon!

R: how are you?

P: I am fine thanks, just sitting under shade. I don't want to get burned.

R: it's very hot, even the mealies are burnt.

P: eish! You know, let's just watch.

R: there is no rain, but it was said that it's going to rain.

P: It's up to Him hey, Almighty Father is the one who knows when He is going to make it rain. He doesn't want to tell Mr Mugeru the reality of the weather.

R: laughs

P: Mr Mugeru did not ask Almighty Father to tell him whether it will rain or not.

R: eish! you know.

P: yes, because long time ago when we were still at school we were taught that whether changes from time to time because you can say that it will rain and it doesn't rain. Then you say that it won't rain and it heavily rains.

R: Indeed, it is just like that.

R: like I said, my name is Muofheni

P: mmm...

R: I am a student at the University of Venda

P: mmm...

R: so I am conducting a research, regarding family members with state patients at Hayani hospital in maximum security ward.

P: mmm...

R: so when I went through the visitors books, I found that you also have a patient there.

P: mmm...

R: that was when I called you to request an appointment.

P: yes

R: we made arrangements to conduct this interview at this day and time.

P: Indeed!

R: what you should know is that your name will not be mentioned during this interview, I only want information.

P: mmm...

R: your participation is voluntarily, you don't get paid.

P: mmm...

R: this interview will be recorded, so that the information doesn't get lost. But if during the interview there is information that you don't want me to record, you can just say it or press the red button yourself then we will talk. After that I will continue recording.

P: mmm...

R: so do you still agree to participate to conduct the interview?

P: like you said that there is no payment, I just agree that we are only helping each other, so let's carry on, so we can help others.

R: Kindly explain to me, what makes it difficult for you to visit your patient at Hayani hospital?

P: mmm..., this things princess, mmm..., it's a bit heavy.

R: mmm....

P: the first thing is that I have fear of that person whom I took to Hayani hospital, secondly I fear if that person is getting treated, thirdly, will there ever be an understanding between me and him? When he sees me, will he see me as an enemy or someone who wants to help him? So these things don't treat me well because I have fear about everything.

R: mmm...

P: because not even a single day we took him home was there an employee who came at home, to check how it was going.

R: mmm..., you indicated that you have fear of this person, kindly explain to me where the fear came from.

P: mmm...for that person to go to Hayani, and get admitted at maximum, it was because of tsutsuru tsutsuru (trouble), which happened where he was staying.

R: mmm...

P: he said when he stayed in the house he heard voices in the house which told him to talk, walk, burn things like beds and his mother's clothes. So it reminded me of someone who told me that in a person's life there is something called Thanatos which tells you to do something then after doing it will say, you did it, what happened to you? nothing. No one is going to do anything to you.

P: so I am also afraid, what if what caused him to go there just recurs and tells him to stand up and beat me? So, tsutsuru tsutsuru which was there was not easy, so I still have fear thinking it might happen again. That's why I am saying that I am still having fear because it might happen again. I don't know if he is getting treatment for his illness as in medicines to cure the illness which he is said to be having. You see? Tsutsuru tsutsuru means trouble in Venda. That is why I say I have fear.

R: mmm...

P: only if we were being informed by one person, to go and visit him when he is better, so since that person went there, we have never seen a single nurse, coming to tell us that our relationship should carry on, I just think if there was communication, it was going to help us to be informed about his condition. When we go to him how should we be? What should we carry for him? What kind of language do we use to talk to him? Because those things are very important.

R: mmm...

P: so I have never seen it that is the fear.

R: mmm..., so besides fear is there any other cause?

P: yes, as a person who is admitted at Hayani, like I said before, I am not sure if his illness is being treated, what are we going to observe to show that he is being treated?

R: mmm...

P: is it possible to go with him? Another thing is, is our relationship going to carry on? What if it recurs when I am alone? It's one thing that I think government employees should conduct workshops and invite us to teach us what to do when the condition is not stable. And also give us assurance that when we take him home, people will come and visit us to see how we are coping. We have to be taught what to do when something happens in the presence of the patients. Even if it's allowed to ask for permission to take him home, we need to be reassured that we will be visited because we don't even know how it goes. The eating patterns, the sleeping patterns, the times because a hospital is not like home.

R: mmm...

P: In this house when we wake up in the morning we drink tea, in the morning, during the day we eat pap and also in the evening. We do not consider eating times, you can just wake up in the morning and decide it's still early to eat. I can eat lunch at 3 O'clock but in hospital they have specific time and we won't know that if we are not taught. I think there should be lessons.

R: mmm...

P: Even in the government honestly, are they being educated because some patients went there being able to write, or do they memorise or is there a small school there? At home we go to church. Is there a church there?

R: I understand, so when you are unable to go there do you ever think of calling to ask how he is doing or write a letter or send him something?

P: mmm..., we do wish for that but honestly, we don't call, who will we call and talk to because even this nurses sometimes when you just look at them they always have answers. We will call and they will say what you want me to do because you brought him here, without knowing the cause. So I am afraid of "bomepome shata muzwala wau" (blame games) to say hah! Come and take him so we can rest.

Those who spend time with him should tell us what is happening because I heard rumours that if you stay with this person he will pretend to take medications. He will tell you that he is going to the toilet, while he is going to spit it out. So we wont know if he swallowed them or not, doing what we heard that others do. Just like the food we would take there, we are not sure whether he will eat or not. So you see. It will be difficult. Even this kids should know that he is our relative, he was not abandoned, but with us, we just say "tsho nduma tsho mbva" (relieved).

R: mmm...

P: even the government, I've never heard anyone asking about the clothes and houses he burned. I am expected to take him, where will I stay with him? This should also pass by the civic, they should also check if the place is good enough to stay in. We should be taught about how to manage him at home. Maybe tell us what to do when he becomes like this, and teach us to have patience. I get scared. What if I say good morning and he says I saw it, then a fight starts? They should teach us how to talk to him. I would tell him that I will take him back to Hayani if he's not behaving.

But because you are doing research maybe you will go and find out how it's going there. What is the government doing? Is there a pastor who teach about forgiveness, for example, he clapped his sister and it ends like that. When it is taken to court they say he is mentally ill but the one who was beaten no longer has teeth. Do you think there will be forgiveness? Even when you are driving him you won know if you are driving well or not. We should be taught about communication.

R: I understand, if I heard you correctly you said you have fear because the patient heard voices which instructed him to be aggressive and burn property and that you fear that his illness might recur.

P: yes that is correct.

R:so besides fear, is there any other reason of not visit him at the hospital?

P: no, fear is the first thing. The other things come at the end. I am scared to sit under one shade with him because I don't know if what took him there won't happen again. How will he see me now? Doesn't he take it that I am the one who separated him with people? And me? Don't I think that he can repeat what he did in the past?

P: mmm...

R: that is that, if fear could be made to go away between me and him, I think things will go right. When a month goes without being visited, its difficult.

R: I understand, thank you so much for your information. What I am going to do now is to stop the recorder, and play it back so that you can listen to our conversation and verify the information. Even after that, I will make an appointment and come back to verify the information.

P: no problem, you are welcome.

