An investigation into repeated admission of abused women with mental illness in a psychiatric institution: A case study of selected outpatients in Port Elizabeth

Submitted in fulfilment of the requirements for the Master of Social Work of the

University of Fort Hare

By

Monica Priscilla Swelindawo (Ndyamara)

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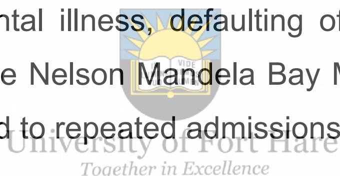
ABSTRACT

The aim of this study was to investigate causes of repeated admissions of mentally ill women in a psychiatric institution. The study was conducted in the Nelson Mandela Bay Municipality, which comprises Port Elizabeth, Despatch and Uitenhage. A focus group and unstructured interviews were used to collect data. The focus group consisted of 9 participants, which comprised 7 family members or caregivers of mentally ill women with repeated admissions in a psychiatric institution and 2 professionals, a psychiatric social worker and a doctor.

Since this is a relatively new area of study, thus a qualitative research method was used for the researcher to interact with participants in their natural habitat. Snowball sampling was used to locate members of the population. Literature review has demonstrated that continued exposure to abuse has a negative effect on the mental health of the survivor. Some of the women were mentally fit before the abuse, but due to abuse at the hands of their husbands or partners, and sometimes families, became mentally ill. Neglect, lack of understanding of mental illness, defaulting of medication and lack of trained psychiatric professionals in the Nelson Mandela Bay Municipality were found to be the most common reasons that led to repeated admissions.



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DEUS SPES NOSTRA (The Lord is our hope).

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DECLARATION

I declare that this dissertation for the Master of Social Work is my own work and has not previously been submitted for assessment or completion of any postgraduate qualification to another university.

I also declare that all sources cited have been acknowledged.

Name: Monica Priscilla Swelindawo (Ndyamara)

Signature:…………………………………….

Student number: 9602151

Date: December 2019

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LIST OF ACRONYMS

DVA:	Domestic Violence Act
EXAMS:	Examinations
GBV:	Gender Based Violence
HIV:	Human immunodeficiency virus
ID:	Identity Document
IPV:	Intimate Partner Violence
MIW:	Mentally Ill Women
MRC:	Medical Research Council
NGO:	Non Governmental Organizations
PE:	Port Elizabeth
POWA:	People Opposing Women Abuse
PTSDS:	Post Traumatic Stress Disorder Syndrome
RDP:	Reconstruction and Development Program
SAPS:	South African Police Service
UNICEF:	United Nation Children's Fund
UNISA:	University of South Africa
WHO:	World Health Organization

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CHAPTER 1

1.1 INTRODUCTION AND BACKGROUND TO THE STUDY

It is not an exaggeration that South Africa has one of the highest rates of women abuse in the world. According to the statistics released in 1999, South Africa had already had the highest rate of intimate killings reported than anywhere in the world (Van Schalkwyk, Boonzaier & Gobodo-Madikizela, 2014).

According to Statistics South Africa (2018) on Crime against Women in South Africa, "gender-based violence in South Africa is unacceptably high". Statistics South Africa (2018) further correctly states that the fear of crime 'has consequences for women and girls and their ability to achieve their potential in every sphere of social and productive life". Fear of crime impacts negatively on women to the extent that it compromises their freedom enshrined in the Constitution of the Republic of South Africa. Women cannot visit open spaces as they wish, cannot dress in the way they want without being harassed and use public transport without some form of harassment. They become vulnerable and are easy targets of physical and psychological abuse by community members, their partners or loved ones.

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Abuse is so rife today that not a single day goes by without reading or hearing a gruesome story of abuse in the media or one's neighborhood. In our societies, women are brutally abused, strangled and killed by their husbands and partners who are supposed to protect and love them. The increase on prevalence of abuse against women cannot be denied.

In South Africa, a lot is being done by the government, civil organizations, religious and cultural organizations to make a significant reduction to the scourge of women abuse, but it seems the solution remains elusive. One of the instruments developed by the government to deal with women abuse is the Domestic Violence Act, 1998 (Act No.116 of 1998) (DVA). According to the DVA of 1998, domestic violence means the following:

(a) Physical abuse;

(b) Sexual abuse;

(c) Emotional, verbal and psychological abuse;

(d) Economic abuse;

(e) Intimidation;

(f) Harassment;

(g) Stalking;

(h) Damage to property;

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(i) Entry into the complainant's residence without consent, where parties do not share the same residence; and

(j) any other abuse-controlling or abusive behavior towards a complainant.

However, still abuse is a problem in South Africa. Although abuse is found on both sides of the gender divide, abuse against women has generated much deserved interest. More cases of women abuse are reported in the media, and incidences of women dying in the hands of their husbands or partners bear testimony to the growth of this phenomenon. This is relevant and is of significance to this study because mentally ill women suffer abuse at the hands of their partners or husbands. Mentally ill women are

more vulnerable to abuse by their partners and cannot speak for themselves. The researcher assumes that this situation may be responsible for repeated admissions.

1.2 DEFINING WOMEN ABUSE

Payne and Gainey (2009) define abuse as “sexual coercion or assault, physical intimidation, threats to kill or harm, restraint of normal activities or freedom and denial of access to resources”. As can be deduced from this definition, abuse manifests in various forms. It has a physical dimension, sexual dimension as well as psychological and emotional dimensions.

There is also evidence to suggest that constant exposure to abuse can be associated with a variety of mental disorders. Trevillion, Oram, Feder and Howard (2012) made a startling discovery that being a victim of domestic violence is common among people with mental disorders.

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The researcher has always been concerned with the plight of mentally ill women because for some of these women, a psychiatric institution becomes a second home. Now and again, after being discharged from the psychiatric institution, they relapse and are readmitted. These shocking revelations, namely, the impact of abuse on the survivors’ mental health, prompted the researcher to engage in the current research study, with a view to look into the home circumstances of abused mentally ill women with repeated admissions in a psychiatric institution.

1.3 CURSORY LOOK AT RELEVANT LITERATURE

Despite the scarcity of literature on abused mentally ill women, there is abundance of literature on the impact of abuse on mental health. Gilroy, Nava, Maddoux, McFarlane, Symes, Koci and Fredland (2015) argue that women who are constantly exposed to physical as well as sexual abuse present higher levels of mental health symptoms. The study cited above mentions depression as the most common mental illness victims of abuse suffer from.

Olawande, Jegede, Edewor and Lukman and Fasasi (2018) citing the World Health Organization (WHO, 2005), describe mental health as an integral part of an individual's capacity to live a life of fulfillment, including the ability to maintain social relationships and making day-to-day decisions. Due to continued exposure to abuse, some mentally ill women lose the capacity to live a life of enjoyment, as described above, and depend on their husbands and partners for everything. In turn, their dignity as human beings become compromised.

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These findings are further corroborated by Buzawa, Buzawa and Stark (2017) who point out that women exposed to partner violence experience significantly high levels of depression and Post Traumatic Stress Disorder. In addition to the physiological symptoms like, pain in the heart, chest or sleep disturbances, Buzawa *et al.,* (2017) contend that this form of victimization can be particularly harmful for victims and leads to chronic mental health problems. The above argument demonstrates the devastating

effect of abuse on women's mental health, which leads to dependence, of some of the victims, on psychiatric intervention for the rest of their lives due to the chronic nature of their illness.

1.4 PROBLEM STATEMENT

De Vos, Strydom, Fouche and Delport (2012) state that problem formulation is the researcher's broad conceptualization of the problem that should be refined in due course. In literature that focuses on effects of abuse on mentally ill women, there is a deafening silence about causes of repeated admissions of mentally ill women in a psychiatric institution. This research study, therefore, attempts to investigate whether abuse of mentally ill women can lead to repeated admissions.

1.5 RESEARCH QUESTIONS AND OBJECTIVES OF THE STUDY

1.5.1 AIM OF THE STUDY

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The aim of the study is to establish possible causes of repeated admissions of mentally ill women in a psychiatric institution in Nelson Mandela Metropolitan Municipality (NMMM).

1.5.2 OBJECTIVES OF THE STUDY

The following are the objectives of this research study:

- To investigate possible causes for readmissions of mentally ill women.
- To examine the nature and extent of abuse meted upon mentally ill women.
- To explore intervention strategies that can be applied to reduce repeated admissions of mentally ill women into psychiatric institutions.

1.6 RESEARCH QUESTIONS

The following are research questions to this research study:

- What are the possible causes of abuse on mentally ill women admitted to a psychiatric institution?
- What is the nature and extent of abuse meted upon mentally ill women?
- What preventative strategies can be applied to minimize repeated admissions of mentally ill women into psychiatric institutions?

1.7 SIGNIFICANCE OF THE STUDY

As mentioned above, this a relatively new area of research, and there is paucity of literature on causes of repeated admissions of mentally ill women. It is the hope of the researcher that the findings of this research study will make a contribution to the knowledge gap on repeated admissions of mentally ill women into a psychiatric institution. It will also, hopefully, be a basis upon which further studies can be conducted.

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Understanding causes of repeated admissions of mentally ill women will also help in the development of effective strategies that may reduce these admissions.

Finally, findings of this study will contribute towards the identification of some practices that contribute in creating conditions for mentally ill women to relapse.

1.8 THEORETICAL FRAMEWORK

Payne (2014) defines a theory as generalized sets of ideas that describe and explain our knowledge of the world in an organized way. The researcher based the study on following two theoretical frameworks:

- The Empowerment and Advocacy Theory; and
- The Feminist Theory.

1.8.1 THE EMPOWERMENT AND ADVOCACY THEORY

Payne (2014) states that advocacy seeks to represent the interests of powerless clients to powerful individuals and social structures. What Payne (2014) means is that professionals who utilize advocacy become advocates of the clients who cannot help or speak for themselves.

Birkenmaier, Berg-Weger and Dewees (2014) assert that speaking out for clients is one of the original cornerstones of the profession's commitment, although its intensity has varied somewhat according to the political climate.

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This is the basis upon which the current research study stands, namely, to speak on behalf of abused mentally ill women. Abused, mentally ill women need to be listened to through their caregivers or family members who can provide the required information to the researcher. The abused, mentally ill women need to be empowered by, among other things, linking them, their caregivers or families to government and community agencies where they can find relief.

It is not only survivors of abuse that need help but if any progress towards breaking the cycle of abuse is to be made, the perpetrators also require empowerment.

1.8.2 FEMINIST THEORY

Shamase (2017) cites Achufusi (1987) who defines feminism as a politic directed at changing existing power relations between women and men in society. Mukhuba (2016) corroborates the above definition, saying that feminism is a belief that women are and should be treated as potential intellectual equals and social equals to men. According to Shamase (2017), feminism and feminists are political labels showing support for the aims of the new women's movement which emerged in the early 1960s. Throughout the history of its existence, feminism has always posed a challenge to patriarchy, with a view to eradicating sexism (Shamase, 2017).

Therefore, the feminist theory was used in this research study. Payne (2014) explains that feminist perspectives contribute to social work and focus on explaining and responding to the oppressed position of women in many societies.

The present study sought to challenge femininity, which is a fertile ground for promoting inequality between men and women. The feminist theory promotes not only the rights of women, but is premised on the principle of equality between men and women. Jakobsen (2014), in addressing the dangers of what is called "emphasized femininity", asserts that femininity is made up three norms. The first norm says that relations between husband and wife should be unequal. The second norm says that in this unequal relationship, the husband should be the head. The third norm says that women should submit to the husband, who is the head.

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Jakobsen (2014) goes further and contends that for women, in their conduct of performing femininity, it is not only the husband who has expectations, but the

community also expects the woman to perform as required. In other words, there are cultural sanctions to what is expected of a woman's conduct. Citing Anderson (2009), Jakobsen (2014) says that men are more able to achieve control through micro-regulation of performance of gender because the performance of masculinity involves controlling others.

The feminist theory assisted the researcher to identify and interprete possible causes of abuse on mentally ill women. Issues of dependence on the husband or male partner, according to McCann and Kim (2013), differentiate between what they term *hegemonic feminism* and *multiracial feminism*.

McCann *et al.,* (2013) argue that hegemonic feminism is predominantly white and ignores class and race analysis, whilst multiracial feminism is radical and race- and class-conscious. Put differently, multiracial feminism highlights weakness inherent in hegemonic feminism, namely, that hegemonic racism does not go far enough in exposing structural problems on which gender inequality rests.

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Jakobson (2014) states that "expectations of how men and women should behave are key to understanding doing gender". Jakobson (2014) further explains that "conceptualizing these expectations as hegemonic gender beliefs enables Gramscian analyses of how the dominated become complicit in their own domination by sharing the ideas legitimating it".

Payne (2014) argues that structural problems, among others, relate to social structures and relationships in society that privilege men and male views of social priorities, excluding and devaluing women in society. Women with little social and economic

power are the most affected. It is encouraging to note that feminism is slowly, but surely, making inroads into policy making structures of some countries.

In South Africa, in particular, the influence of feminism is beginning to yield positive results, and women are beginning to reap the benefits. The Gender Commission is one of the examples of institutions established through struggles inspired by feminism. Mainly, the Gender Commission exists to address and challenge issues of gender inequality seen to be contributing significantly to women abuse in our society.

1.9 RESEARCH DESIGN AND METHODOLOGY

The researcher used the qualitative method of research to understand the natural setting of the abused mentally ill women, their caregivers or families after being discharged. According to Creswell (2014), the qualitative approach is a means for exploring and understanding the meaning individuals or groups ascribe to social or human problems.

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1.10 METHODS EMPLOYED FOR DATA COLLECTION

1.10.1 IN-DEPTH INTERVIEWS WITH INDIVIDUAL PARTICIPANTS

In-depth interviews or unstructured interviews are a suitable instrument for data collection and were, thus, used to collect information from caregivers or families of mentally ill women with repeated admissions in a psychiatric institution.

The motivation for utilizing unstructured interviews is that questions are open-ended and give participants enough space to express themselves in the language of their choice.

Translation services were also available to participants in this study. A tape recorder and note-taking were used.

1.10.2 FOCUS GROUP

Apart from in-depth interviews, a focus group consisting of caregivers or families of mentally ill women were also used as another source of information. Muruyama and Ryan (2014) state that a focus group consists of between six to ten individuals. For the current study, seven participants constituted the focus group. Jackson *et.al.,* (2016) assert that the sample should be chosen to reflect those segments of the population who will provide the most meaningful information in relation to the project objectives. Participants should have something to say about the topic of interest or something to demonstrate when using focus groups to understand processes.

Based on the above stated argument, two professionals, that is, one medical practitioner and one social worker, both of whom have an experience of working with mentally ill women, were another vital source of information. A hospital medical practitioner's input is critical in that he or she deals with the patient from the time the patient is admitted to the psychiatric institution to her discharge, while a psychiatrist, more often, acts as a consultant to the medical practitioner. In other words, the medical practitioner possesses detailed knowledge about the patient's history.

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The social worker is a direct link between the family of the patient and the psychiatric institution and, thus, has vital information about the home circumstances of the patient. The psycho-social information from the social worker is critical when discussing and planning the future of the patient.

1.11 POPULATION UNDER STUDY

It needs to be emphasized that although the research study is about abused mentally ill women with repeated admissions in a psychiatric institution, mentally ill women were not part of the focus group because their compromised state of mind did not make it possible for them to participate. The caregivers or families who come from the same community were the population of this research study. The population of the study has the same characteristics and experiences of living with mentally ill women with a history of repeated admissions in a psychiatric institution.

1.12 SAMPLING AND SAMPLING PROCEDURES

De Vos, Strydom, Fouche and Delport (2012), citing Royse (2004), say that the notion behind sampling theory is that a small set of observations can give an idea of what can be expected in the total population of the intended study.

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The sample of the current research study were made up of seven caregivers or family members of abused mentally ill women with a history of repeated admissions in a psychiatric institution, who come from the same community. Two (2) professionals, namely, a medical practitioner and a social worker were also included. Non-probability sampling methods were used, given the widely dispersed scope of the population of the present research.

1.13 LIMITATIONS IN THE RESEARCH DESIGN AND METHODOLOGY

Although literature on possible causes of repeated admissions of mentally ill women is scarce, it is the researcher's view that this research study could serve as a basis to further research on this phenomenon. The researcher is aware of the existence of

repeated admissions on males, but only females with repeated admissions in a psychiatric institution were the subject of this research. The reason for the focus on women relates to the fact that this phenomenon, that is, repeated admissions, is rife among women. The researcher is aware of the existence of repeated admissions among males but the high incidence of GBV and femicide in South Africa compeled the researcher to put the spot light on women. According to Van Schalkwyk *et al.* (2014) South Africa has the highest rates of women abuse and femicide.

Olawande *et al.* (2018) argue that women are the most afflicted by mental health challenges and that their susceptibility relates to marital status. The following statistics from the psychiatric unit of Dora Nginza Hospital are the case in point. In the hospital just mentioned above the statistics of repeated admissions from the psychiatric unit for the period beginning from April 2018 to the end of March 2019 were as follows;

The total number of repeated admissions for both genders was 1624. Of interest to the researcher and relavant to this study is that females constituted one percent above the total number of the repeated admissions, i.e, 51% against males who made 49% of the total number of repeated admissions. As shown by the numbers mentioned above, males are also prone to repeated admissions but females are more vulnerable.

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The findings of the research are difficult to generalize because the hospital is in an urban area, and mentally ill women in rural areas may not have the same experiences as urban women. In addition, the study was conducted only among women of African descent.

1.14 ETHICAL CONSIDERATIONS

Saldana and Omasta (2018) say that while specific guidelines at various institutions differ, there are a number of points that are nearly universal that both qualitative and quantitative researchers should be familiar with. The following are ethical guidelines taken into account when conducting a research study.

1.14.1 CONSENT

Saldana *et al.,* (2018) say that gaining informed consent of the participants is one of the most important legal and ethical issues researchers need before embarking on a research study. It is also important to advise participants who do not have a good command in English to use a language they are comfortable in expressing themselves in. Participants in the present research study were informed about the study and what would be done with information gathered. It was further explained to them that, apart from English, they could use a language of their choice. The consent form was signed by those willing to participate in the study.

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1.14.2 CONFIDENTIALITY

Saldana *et al*., (2018) point out that confidentiality is one of the cornerstones of the ethical considerations. It involves assuring the participants that their identities and information they share will be protected. The participants in the present study were assured of confidentiality of their information and identities in line with the stipulations of the ethical requirements of research.

1.14.3 VOLUNTARY PARTICIPATION

Aurini (2016) states that an informed decision means that participation is voluntary. The participants in the current study were informed about the purpose of their involvement and the purpose of the study in order for them to take an informed decision about participating. Voluntary participation also means that participants, although not ideal, are free to pull out of the study at any time.

1.14.4 RESPECT OF PRIVACY AND ANOMITY OF PARTCIPANTS

Jackson, McDowall, Mackenzie-Davey, and Whiting (2016) state that privacy means the right not to participate. It also means that participants are free to join and, although not ideal, are also free to pull out of the research study. Codes for the participants were used to protect their identity. This means that information of the participants is kept confidential.

1.14.5 PROMISES AND RECIPROCITY

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Jackson *et al.,* (2016) advise that if any promises are made to participants, like "*giving them a copy of the final report, the promise must be kept".*

1.14.6 AVOIDANCE OF HARM

De Vos *et al*., *(*2011) state that the basic rule of social research is that participants must be protected from harm. The researcher ensured that the sensitive nature of this research is always kept in mind. Questions or statements that might harm the participants emotionally were avoided. Where the researcher noticed that harm occurred, debriefing was done.

1.14.7 AVOIDING DECEPTION OF PARTICIPANTS

It is unacceptable for the researcher to deceive participants by withholding information or deliberately giving them falls information (De Vos *et al.,* 2011). In other words, the researcher should avoid being dishonest with the participants about everything pertaining to the study. Participants must also be treated fairly and equally.

1.15 CHAPTER OUTLINE

CHAPTER ONE: GENERAL INTRODUCTION TO THE STUDY

This is an introductory chapter which deals with the general route followed in the research study. This includes taking a cursory look at relevant literature pertinent to the research study: the aim and research objectives, research questions and research methodology to be employed. Finally, the chapter covers ethical considerations that guided the study.

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CHAPTER TWO: LITERATURE REVIEW

This chapter presents an in-depth look at literature pertinent to this research study. This includes literature on abuse in general and literature on the negative impact of abuse on women’s mental health. The researcher hopes that the knowledge gap on the causes of repeated admissions is identified.

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

This chapter presents an in-depth discussion of the qualitative method; research design; data collection; population and sampling strategy.

CHAPTER FOUR: INTERPRETATION OF FINDINGS AND DATA ANALYSIS

This chapter deals with the interpretation of the findings and data analysis.

CHAPTER FIVE: SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This chapter focuses on summarizing the findings in relation to the success of the identified aims and objectives. It stipulates conclusions and recommendations of the research study.

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CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

De Vos, Strydom, Fouche and Delport (2012) state that a" review of literature is aimed at contributing to a clear understanding of the nature and meaning of the problem that has been identified". They further elaborate on the purpose of literature review by citing Bak (2004) who says "the purpose of literature review is to establish the theoretical frame work for the study, to indicate whether the study fits into the broader debate''.

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Taking into cognizance the breadth and diversity of the literature that relates to the research topic under review, the researcher will now embark on the task of reviewing the existing literature in order to gain insights from what other authors have to say about the impact of abuse on abused mentally ill women who are repeatedly admitted in a psychiatric institution.

From the outset the researcher would like to point out that not much has been produced in this area of research, namely, the repeated admissions of abused mentally ill women.

There is a scarcity of literature on the impact of abuse on abused mentally ill women. Olawande, Jegede, Edewor and Lukman, Fasasi (2018) cite Aniebue and Ekwueme (2009) argue that ‘’ socio-cultural practice such as male dominance (patriarchy) and the stigmatizing nature of mental illness, in which women are possibly more susceptible than men could explain the observed gender differences in health seeking behaviour of people living with mental disorder.’’ The above cited study bears testimony to an African understanding of mental illness and particularly the extent to which male domination affects women.

The current study cannot be done in a vacuum and in isolation from the abuse of women in general, hence the researcher will start by exploring women abuse in general and how it is defined.

2.2 VARIETY OF TERMINOLOGY USED FOR WOMEN ABUSE

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Before delving into studies on women abuse and how it impacts on women’s mental health, the researcher will start by focusing on defining the key terms that will be used throughout this research study. Different terms are used for women abuse but for the purposes of this study the researcher is going to restrict herself to domestic abuse/domestic violence and Intimate Partner Violence (IPV). These terms will be used interchangeably.

2.2.1 INTIMATE PARTNER VIOLENCE (IPV)

Alvarez, Bachman (2014) state that ‘’the term ‘intimate’ as it is used in IPV generally refers to spouses, ex-spouses, boy/girlfriends and exes’’. All of these terms will therefore be used interchangeably. The women who are the subject of the research will

include married and unmarried women who have stayed together with their partners in a long-term relationship (e.g. cohabitation).

2.2.2 DOMESTIC VIOLENCE

Buzawa, Buzawa and Stark (2017) assert that it is not an easy task to define domestic violence given what they call fundamental controversies surrounding the definition of domestic violence. Different definitions emanate from the different perspectives that deal with the subject of domestic violence. According to Buzawa *et al.,* (2017) there are basically three types of definitions, namely, societal definitions, legal definitions and research definitions. These different definitions have a different understanding of what acts can be described as domestic violence. Buzawa *et al.,* (2017) define domestic violence as a maltreatment by intimates that includes physical violence, threats of physical violence, sexual violence, severe emotional or psychological abuse, economic violence, controlling behaviour, stalking and many more.

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Burrill, Roberts, Thornberry (2010) define domestic violence as; physical violence, psychological, verbal abuse and neglect. The above stated descriptions of domestic violence are in accordance with the study that was conducted by the World Health Organization (WHO: 2005) in relation to Intimate Partner Violence (IPV). Making an extensive reference to the WHO study, Burrill *et al.,* (2010) assert that IPV can be divided into four categories:

(1) Physical violence which involves, for an example, slapping, pulling woman's hair, pushing, hitting, choking, clubbing, kicking, dragging and

shoving, burning, throwing acid or boiling water, threatening, using a weapon (Burrill 2010).

(2) Sexual violence involving being forced to engage in acts of sexual intercourse when the female partner did not want to because she was afraid of what her partner might do, etcetera (etc) (Burrill 2010). Watt, Sikkema, Abler, Velloza, Eaton, Kalichman, Skinner, and Pietersse (2015) cite the World Health Organization (WHO) which defines forced sex "as an act of unwanted sex against a person's consent, compelled by physical force or threats of force''. Watt *et al.,* (2015) further cite a detailed definition of the South African Police Service (S.A.P.S) which defines forced sex to include "vaginal, oral, and/ or anal penetration of a sexual nature by whatever means and without consent (S.A.P.S., 2011; Stanton, 1993)''.

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(3) Emotional violence which involves being made to feel bad about yourself, insulted, being belittled or humiliated in front of others, being scared by the way the male perpetrator the way he looked at her, by yelling, smashing things, etcetera, (Burrill 2010)

(4) Controlling behaviour which involves being kept from seeing friends, being restricted from seeing her family of birth by the male partner, insisting knowing where she is at all times, ignoring her, being angry if she spoke to other men, being suspicious that she was unfaithful etc. (Burrill 2010)

Cheldeline and Mutisi (2016) make an important point in this regard when they argue that “in the context of an intimate partnership it is primarily a problem of men using violence to maintain control over their women to which they feel they are entitled’’.

2.2.3 CAUSES OF DOMESTIC VIOLENCE/WOMEN ABUSE

2.2.3.1 HISTORY OF OPPOSITION AGAINST DOMESTIC VIOLENCE

Tracing the history of opposition against domestic violence Diduck and Kaganas (2012) cite Smith (1989) who points out that “violence against women was taken up as an issue by both British and American suffragists, ‘it visually disappeared from the agenda of “social” problems between 1920 and 1970’’, but re-emerged due to the activities of women’s movement in the 1960s and 1970s. Feminist campaigners and researchers took it upon themselves and brought domestic violence to the attention of the public eye through awareness campaigns and other means.

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Feminist writers, through their efforts sought to change the perceptions that domestic violence was a private family matter that did not require public attention. Their endeavors helped demonstrate that a significantly large number of women were affected by the scourge of domestic violence. From an African perspective, Mukanangana, Moyo, Zvoushe and Rusinga (2014) state that “Zimbabwe has made strides in addressing gender based violence through the enactment of various pieces of legislation like the 1987 Matrimonial Cause Act, the 1989 Maintenance Act, the 1997 Administration of Estate Act, the 2001 Amended Sexual Offences Act, etcetera (etc)”. Mukanangana *et, al.,* (2014) further say that “regardless of all above mentioned policies, Gender Base Violence (GBV) continues to be a thorn in flesh among women globally.”

2.2.3.2 EXPLANATION OF THE CAUSES OF DOMESTIC VIOLENCE

In an attempt to explain the causes of domestic violence, Diduck *et al.,* (2012) assert that a number of theories have emerged. Some of the theories explained the causes as being biological in nature. In other words, the structure of one's chromosomes (testosterone) determines one's behavioural patterns. Some of the theorists explained the causes of domestic violence from the perspective of women who are victims of the violence.

Those theorists argue that women themselves can be the cause of their own predicament, for example, by nagging their partners to the extent that their partners become provoked and violence towards them ensues. Diduck *et al.,* (2012) further claim that there are theorists who see the onset of violence from the family members themselves. They argue that in the family where violence occurs, women like men can be aggressors.

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Researchers who use a feminist perspective see domestic violence differently. Diduck *et al.,* (2012) citing Dobash and Dobash (1979) correctly state that domestic violence is ''an extension of male power and control, control that is historically and socially constructed and that domestic violence against women is different to other forms of violence. Different forms or types of domestic violence against women are named and one of those is called intimate terrorism. A distinguishing feature of intimate terrorism is its use of control ''which can include isolating the victim, demeaning and humiliating her, depriving her of control over economic resources and intimidating her''. For Diduck *et al.,* (2012) this type of domestic violence is perpetrated by men only.

Unequal power relations between men and women play a pivotal role in maintaining such relations where women are dominated and men use the power to control. In executing their power men will sometimes go to an extent of being physical. “Feminist theories focusing on patriarchy as a form of domination locate the causes of domestic violence at the level of whole societies whose institutions and culture reinforce the power of men over women’’ (Burrill, Roberts and Thormberry 2010).

The idea of the power struggle between men and women as the cause of abuse or domestic violence is further articulated by Graaff (Daily Dispatch,2017) who states that “the most common depiction of IPV involved a female victim and an abusive male partner’’. To further illustrate the seriousness of domestic violence, Graaff (2017) argues that it is the most common form of violence suffered by women in South Africa and constitutes about 30% of all violence related cases. Graaff (2017) warns that the 30% referred to above does not include some of the unreported incidents by the victims of intimate partner violence.

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There are extreme cases in South Africa where women are subjected to forced marriages and *ukuthwala* custom. According to Jokani (2018) there are different dimensions of *ukuthwala* practice. *Ukuthwala* by mutual consent whereby the girl agrees to the practice but her parents do not consent. *Ukuthwala kobulawu* occurs where the families agree but the girl is not aware of the arrangement. Lastly, *ukuthwala* without consent refers to a situation in which neither the girl nor the parents of the girl consent to the *thwala*. Jokani (2018) further asserts that this form of *ukuthwala* is a human rights violation. The above cited examples show the extent to which some aspects of culture can be a fertile ground of abuse against women. Some women face

situations where they are strangled to death by their husbands and partners, but that is beyond the scope of the current study. The researcher seeks to shine the spotlight only on how abuse affects mentally ill women especially those with repeated admissions.

2.3 WOMEN ABUSE AND ITS IMPACT ON WOMEN'S MENTAL HEALTH

Before going into the causes of repeated admissions of the abused mentally ill women, the researcher would like to look into the extent to which abuse of mentally fit women can be a cause of mental disorders. In other words, can women who have no history of mental illness become mentally ill on account of them being subjected to constant abuse?

To answer this question, the researcher will begin by defining what mental health is. What makes a definition of mental health necessary is the fact that the current research entirely revolves around abuse and how it affects abused mentally ill women relating to repeated admissions in a psychiatric institution. Steyn (2008), in discussing the origins of the definitions of mental health gives an interesting historical background.

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According to Steyn (2008) mental health and mental illness were traditionally used as synonyms by some theorists. Recent definitions have made a distinction between these two terms, namely, mental illness and mental health. Steyn (2008) cites Snyders and Lopez (2005) who assert that when defining mental health, only positive characteristics are mentioned, like, ''resilience and an inner sense of coherence; the ability to make relationships, to attach to others and to love; the ability to think clearly including about emotional matters; the ability to manage emotions successfully and appropriately; the ability to be sensitive to one's own and others emotions; and the capacity to have an

accurate self-concept and high self-esteem''. Individuals who possess the above - mentioned characteristics are said to be in good mental health, minor and moderate daily experiences do not overwhelm them (Steyn 2008).

On the contrary those individuals who experience negative and stressful life events over prolonged periods can in the long run loose their coping ability and eventually have mental health problems.

Mental health comprises of two states, namely, emotional problems and mental illness, the latter is the most serious of the two. Steyn (2008) cites the United States Department of Health & Human Services (1999) which claims that individuals who suffer from mental illness often display the following symptoms; Pronounced/prolonged alterations in,

- Thinking
- Mood
- Behavior.

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Among the disorders found in individuals with mental illness, anxiety and depression are the most common, and schizophrenia is only found to a lesser degree. Cases, Aguado, Girones, Usaola, Trincado, and Liria (2013) assert that Intimate Partner Violence(IPV) against women is a serious phenomenon the world-over due to its consequences on women's physical and mental health. Cases *et al.,* (2013) further say that there is an abundance of literature that shows extreme cases where abused women die due to IPV.

According to the study cited above some of the abused women will present with both physical and psychological symptoms. This argument is supported by Dillon, Hussain, Loxton, and Rahman (2012) who argue that association between IPV and poor physical and mental health have been demonstrated in the international and national literature across numerous studies. Dillon *et al.,* (2012) citing the review research papers published in 2006 to 2012 from Western and developing countries argue that IPV was associated with a range of mental health issues including depression, PTSD, anxiety, self -harm and sleep disorders.

Trevillion, Oram, Feder, Howard (2012) argue that generally individuals who are, over an extended period of time, find themselves subjected to threatening life experiences, domestic violence included, will experience an onset, duration and recurrence of mental disorders. This argument is of significance for this research because it shows that a constant exposure to abuse by women has a potential to cause or make it possible for mental disorders to recur. What it means is that even if a woman recovers from the mental illness after a psychiatric intervention, there is a huge probability of relapsing once she goes back to the abusive situation at home. This situation renders her vulnerable to mental sickness.

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In an attempt to understand the relationship between poverty, partner abuse and women's mental health Gilroy, Nava, Maddoux, McFarlane, Symes, Koci, Fredland (2015) conducted a study where a sample of 300 women was used. The study was designated to look into the long-term effects of abuse on female participants over a period of seven years, in other words it was an ongoing study that was started in 2010 and was completed in 2018.

The preliminary result of their study has thus far revealed that to some extent poverty had no direct effect on the women's mental health. However, what is of interest for this research is the fact that severity of abuse had an impact on the mental health of the women regardless of their income. According to their findings the women who lived above poverty line were also, in the same way as those who lived below poverty line, negatively impacted upon by the abuse of their partners, in that they too reported with the highest levels of depression. They also alluded to a study by Gilboe *et al*., (2009) that came to a conclusion that the mental health of female survivors of partner violence is negatively affected and the impact lasts a long time even after they left the relationship.

These findings about the relationship between women abuse and women's mental health are further corroborated by Orzeck, Rokach, Chin (2010) who have conducted a study on The Effects of Traumatic and Abusive Relationships. Orzeck *et al.,* (2010) point out that individuals who have been subjected to abuse will usually present with various mental health issues. The following are specifically mentioned as the most common;

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- Depression
- Anxiety
- Posttraumatic stress disorder (PTSD)
- Substance abuse
- Suicide attempts
- Suicide ideation

- Eating disorder pathology
- Mood liability
- Self-destructive behaviour.

Orzeck *et al*., (2010:168) cite Allen, (2001); Herman, (1977) who say that ''traumas that are of human design and especially those perpetrated by a loved a one, appear to have the longest lasting psychological effects''. Orzeck *et al.,* (2010), define psychological trauma ''as a state of psychological crisis that exceeds an individual's mental capacity to handle the stress placed upon it' 'This definition attests to the extent to which the negative effects of abuse can have on the victim's mental health if the abuse goes unchecked and unchallenged.

A study by Cuevas and Rennison (2016) quoting Coker, Smith and Fadden, (2005) lists a number of health consequences of intimate partner violence that include "respiratory, circulatory, and nervous system disorders such as asthma, and emphysema, circulatory disease, heart problems, nerve damage, and chronic back or joint pain".

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It is also important to mention that the mental disorders mentioned in the study cited above increased with the intensity of the violence. An escalation of the violence means an increase of the mental disorders, clearly demonstrating how dangerous partner violence can be on the state of mental health of the domestic violence victim.

Steyn (2008) states that women who are exposed to gender-based violence within their home environment may negatively influence their mental health. Steyn (2008) further asserts that women who suffer from anxiety disorder could result in severe psychological distress that affects their mental state.

These finding are further supported by Cuevas *et al.,* (2016) who state that "women who experience domestic violence suffer from chronic conditions, for example, difficulty in sleeping and mental health conditions including depression and anxiety''.

Steyn (2008) citing Patel (2003) asserts that gender-based violence, patriarchal oppression could be associated with higher prevalence of psychiatric morbidity in South African women. This shows that women who are oppressed and abused by their partners by virtue of being women are both physically and mentally negatively affected by the abuse.

Citing the study that was conducted by Wisner *et al*., (1999) Alhabib, Nur and Jones (2009:370), argue that "abused women have more than double the number of medical visits, an 8-fold greater mental health care usage, and an increased hospitalization rate compared to non-abused women''.

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Burrill *et al.,* (2010) allude to a global survey that was conducted in 2005 by the WHO where it is reported that between 15% and 71% of the ever-partnered women respondents had experienced some form of physical or sexual violence in their life time. Cuevas *et al., (*2016) make an important contribution in their study of depression and anxiety in which they cite a meta –analysis of 37 studies spanning 30 years that was conducted in 2012 by Beydoun, Beydoun, Kauman, LO, and Zonderman.

The study just mentioned above puts everything into perspective when it says that ''women who experienced IPV were two to three times more likely to meet criteria for major depressive disorder compared with those who did not experience IPV". In an endeavor to study the effects of IPV on women, Cuevas *et al.,* (2016) cite another

research that was conducted by Garcia- Moreno and colleagues (2013) whose findings claim that depression was nearly double among women who experienced victimization by their partners.

Common to all the research studies that the researcher has consulted, including Cuevas *et al.,* (2016) it is has become explicitly clear to the researcher that domestic violence has a negative effect on women's mental health. It can cause mental health problems on abused women. The following illnesses run like a golden thread throughout these studies;

- Depression
- Anxiety
- Posttraumatic Stress Disorder
- Eating Disorders
- Suicide Ideation.

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Thus far the current research study has demonstrated that there is factual evidence to suggest that there is a link between mental disorders and IPV, and the question that needs to be answered is, if IPV affects the mental health of women the way it does, how much more will it affect the mental health of those women who are discharged from a psychiatric institution to their abusive partners. Why do some of the abused mentally ill women have numerous admissions compared to those who come from non-abusive homes? This is the question upon which the current study hangs. It is a question that the current study will try and give an answer to. The researcher will solidify her argument by also reflecting on biological factors, for an example, do biological factors

influence repeated admissions or does IPV trigger repeated admissions? The current study will attempt to make a humble contribution towards finding causes and reasons behind relapsing.

Trevillion *et al.,* (2012) in their research on the Experiences of Domestic Violence and Mental Disorders come very close to giving an answer to the problem. According to the above mentioned study, Trevillion *et al.,* (2012) argue that men and women with different types of mental disorders report high prevalence and increased odds of domestic violence compared to people without mental disorder, with women more likely to experience abuse than men.

In support of these findings, Trevillion *et al.,* (2012) go further and allude to the data from Wave II of the large US National Epidemiologic Survey on Alcohol and related conditions where it is said that ''men and women with bipolar affective disorder were more than eight times more likely to report ever having been a victim of partner violence than people with no mental health disorder".Trevillion *et al.,* (2012) are quick to add that although there seems to be a causal relationship between domestic violence and mental disorder, the available data is not sufficient and therefore cannot be used to draw conclusions on the causal relationship between domestic violence and mental disorder.

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2.4 A BRIEF EXPLANATION OF THE PROMINENT MENTAL DISORDERS MENTIONED IN THE STUDY

2.4.1 ANXIETY

There is a consensus amongst most of the scholars' data which the researcher has consulted, that anxiety is one of the most common mental disorders found in victims of abuse, regardless their gender. Steyn (2008) citing Carson, Butcher, and Mineka (2000) state that anxiety disorders characterized by either internal or external stressors activating an alarm response which is either adaptive or maladaptive

Buhrmann (2016) cites Sadock & Sadock (2011) who say that anxiety as ''a warning signal of impending threat, however, it is not always clear to the individual what the danger may be as the threat can be unknown, internal, vague, conflictual, and insidious''. Buhrmann (2016) further asserts that one's response to anxiety is largely dependent on the cause, and generally anxiety, when in moderate form is performance-enhancing; which means that there is a positive side to anxiety. Whereas, on the flip side anxiety in its extreme form has a potential to change an individual's quality of life, meaning that a fully functional and healthy individual can, due to anxiety, be rendered mentally impaired.

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2.4.2 DEPRESSION

As the researcher has already stated above, apart from anxiety depression is one of the common mental disorders suffered by the victims of domestic violence. According to Buhrmann (2016) citing Sadock & Sadock, (2011) ''symptoms of depression can be described as a range of emotional responses which are less pervasive than mood and represents the immediate, fluctuating experience and behavioral manifestation of emotion''.

These symptoms are both cognitive and emotional as well as physical. On one hand cognitive symptoms include slowness of thought, recurring negative thought patterns, obsessive worrying, loss of self-esteem et cetera, while on the other hand emotional symptoms show signs of deep despair, hopelessness, irritability and social withdrawal. Physical symptoms often show by changes in energy levels, weight, libido and sleep patterns.

It is also important to point out that among the AmaXhosa mental illness is in some instances associated with a calling to become a traditional healer *(ukuthwasa*). Lombo (2010) cites Swartz (1998) who describes *ukuthwasa* "as the state of emotional turmoil a person goes through on the path to becoming a traditional healer".

2.4.3 POST TRAUMATIC STRESS DISORDER(PTSD)

PTSD is one of the common mental disorders suffered by the victims of IPV. Dillon *et al*., (2012) citing the reviewed research papers published in 2006 to 2012 from western and developing countries assert that IPV was associated with a number of mental health disorders. These disorders include, among others, depression, PTSD, anxiety, self-harm and sleep disorders.

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Dillion (2012) further state that in 14 studies related to the incidence of posttraumatic stress disorder, all studies agreed on the fact that a history of IPV was positively associated with the increased incidence of PTSD symptoms and PTSD diagnoses. Dillon *et al.,* (2012) citing O'Campo *et al.,* (36) estimated that women with a history of IPV were 2.3 times more likely to develop PTSD compared to never- abused women after controlling for race, marital status, and income.

If abuse can have such a devastating effect on healthy victims, it remains to be seen how much damage it will have on women who are already mentally ill, particularly those women who are discharged from a psychiatric institution to the care of their abusive partners. Although the foregoing discussion is not directly linked to abused mentally ill women who are discharged to their families, it has helped the researcher to understand the seriousness and the extent of abuse on women's mental health. It is the researcher's hope that the answer to the causes of repeated admissions of mentally ill women, as the aim of the study will be found after data analysis in chapter four.

2.4.4 AN AFRICAN PERSPECTIVE ON WOMEN ABUSE

As it can be noted, up to this point in the discussion, the researcher relied heavily on the literature from the western world in order to have a global understanding of women abuse and how it impacts on women's mental health. It is the researcher's opinion that the current study will be incomplete without a voice from the African continent. It is important to understand how Africans view women abuse and how it impacts on women's mental health. This needs a special mentioning to see whether there are any of the African practices that can be considered as being abusive.

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Another reason for looking into women abuse from an African perspective is that this research study is conducted in an African context and specifically South Africa. Therefore, understanding some of the cultural dynamics will make an invaluable contribution in understanding the behavioural patterns of some of the male perpetrators.

Olawande, Jegede, Edewor and Fasasi (2018), in a study conducted in Nigeria, concisely express the importance of culture in understanding mental illness. The above

stated researchers argue that ''holistically, what one culture may consider as a mental disease or abnormal behaviour may be seen as normal in another culture''. Olawande *et al.,* (2018) claim that in most Yoruba communities in Nigeria gender plays a significant role in explaining mental illness. For an example when a male is mentally ill the reason for his situation will be attributed to someone in his extended family who does not want to see him successful in life. In the case of a mentally ill woman still be accused of having committed witchcraft or of being promiscuous.

The gender-based explanation of mental illness always favours males; his mental illness is always seen to be due to external factors, in other words mental illness is not in his control. While on other hand when females suffer from mental illness the understanding is that their illness is self-imposed because it is caused by their acts of promiscuity or witchcraft. What this belief means is that, if women can refrain from committing such acts, namely, promiscuity and witchcraft their chances of becoming mentally ill can be reduced to a minimum.

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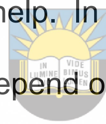
Mukanangana *et al.,* (2014) in dealing with gender-based violence (GBV) in Harare, Zimbabwe, argue that forced marriages is another form of violence against women and it is prominent in Zimbabwe. The purpose of the forced marriages is to secure a better future for the girls and in these marriages GBV has negative reproductive health effects on women and has been attributed to a power struggle between men and women. "A study in Zimbabwe for Musasa project revealed that 32% of women reported physical abuse by marital partners since the age of 16 years''. (Mukanangana *et al.,* 2014). Hilde Jakobsen (2014) has conducted an interesting study on the social meanings of wife beating in Tanzania that shows how the phenomenon of wife beating is supported by

social norms. The above cited study mentions two types of wife beating, namely, a bad beating and a good beating. A bad beating occurs when a woman is innocent and therefore does not deserve the beating, for an example, when a man beats a woman to cover his own fault or beat her out of anger or drunkenness.

A good beating occurs when a husband beats his wife to make her ''comply with the husband's commands and preferences'', (Jakobsen 2014). The cultural practice alluded to above, namely, wife beating is meant to enforce inequality between male and female as an acceptable way of life. The purpose of this practice is to make the insubordination of women look natural and 'normal'.

To further complicate a woman's dire situation, McGovern (2013) explains that in the event where there is a problem between a woman and her husband, she is expected to approach her husband's family for help. In this way a woman is discouraged from seeking help outside the family thus depend on the family of her husband for a solution.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It is the researcher's view that some in-laws are biased when it comes to solving a marital related situation that involves their sons and daughters-in-law. They, most of the time, take their son's side in solving the problem.

Bower (2014) in the study about the plight of women and children, gives us an interesting back ground about South Africa after 1994. Bower (2014) correctly states that ''South Africa has made serious commitments to protecting and enhancing the rights of women and children, placing obligations on the country to ensure the realization of these rights''. Of concern for Bower (2014) is the fact that notwithstanding having a progressive constitution that is admired all over the world and after two

decades of democracy women of South Africa still continue to face gender-based violence (GBV).

Bower (2014) is of the opinion that South Africa is a deeply conservative and patriarchal society as far as women treatment by men is concerned. Women are still being viewed as inferior to men and women are more prone to violence perpetrated by men. The researcher fully agrees with Bower (2014) that as long as there is no demarcation between femininity and motherhood and dependence on a man the end to women's challenges is still a pipe dream.

The evidence we have just cited shows that, like in the rest of the world and despite the good intentions of the constitution, inequality is still a common experience for women in South Africa. Flowing from the human rights culture espoused in the constitution, since the advent of democracy in South Africa a number of initiatives against women abuse have seen the light of the day. According to Makota (2014) one of the initiatives was the introduction of the Domestic Violence Act (DVA) which was designed as an intervention measure against domestic violence. In a nut shell the DVA contains the following;

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a) Recognizes a wide range of GBV.
b) Acknowledges that violence against women can occur in a variety of familial and domestic relationships.
c) Gives magistrates power to serve abusers with court orders and extend this to even the workplace of the survivors.
d) Compels the perpetrator to maintain the victim's finances while not staying in the same house or accommodation.

e) Disarms the respondent who is the perpetrator and offers police protection to the victim.

f) Outlines the obligatory duties of the police and

g) Lays down penalties for failure to execute such duties, (Makota 2014).

Makota (2014) cites Mogale *et al.,* (2012), the critics of the DVA, who argue that despite the availability of the policies that seek to address the plight of women, “traditional practices of men’s rights, have negated the social status of women in South Africa. Traditional practices to some extent continue to regard women as inferior in society and continue to violate women’s rights which have deterred progress in the attaining of gender equality’’. In order to expose the inadequacy of the policies that seek to address violence against women Makota (2014) points out that the aforementioned critics, namely, Mogale *et al.,* (2012) have identified four areas in which the DVA needs some improvement in order for it to be effective:

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a) Governance and legal responsibilities – a weakness in the management of the act.

b) Public agenda and considerations – need for more public education in the areas of sex and preventative practices, gender inequalities, physical violence and mental abuse.

c) Prevailing culture and attitudes – unfair biases and prejudices in convicting and sentencing of violence against women.

d) Ethical issues concerning impact or effectiveness evaluations or research – safety of both the research participants and researchers involved in sensitive studies that could identify controversial issues.

The question that begs an answer is but why, despite having such an admirable constitution in South Africa, do our women still undergo such suffering at the hands of their husbands and partners. If the constitution and other initiatives cannot save the women from male violence, then surely the problem lies deeper that we have always imagined.

Olawande (2018) contends that ''the society socialized a Nigerian woman into a culture of female subordination as in most other patriarchal (male controlled) cultures of the world''. The researcher would like to quickly add that the statement just mentioned above about Nigeria, socializing women into a culture of female insubordination, is also true of most societies, South Africa included.

Researchers from the University of the Witwatersrand cited by Bower (2014) correctly state that as long as ''the patriarchal status quo remains relatively unchanged, and unless the mind set behind gender discriminatory practices is unchallenged through debate, media campaigns, education, etc. nothing much is going to change (Skillsportal 2012)''.

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Bower (2014) goes to the heart of the problem and points in the right direction in arguing that women are abused by their husbands and partners by virtue of being women and men treat women as their subordinates. This shows that violence against women and children in South Africa is endemic (Bower 2014).

Bower (2014) cites the Medical Research Council (MRC) which argues that violence against women in the South African society “can also be attributed to a sense of male entitlement''. It is the researcher’s considered opinion that the inequality between men

and women and the culture of male entitlement which Bower (2014) is making reference to, is premised on patriarchy.

Some of the traditional practices indeed contribute to the abuse of women by men. A victim of abuse in the area of Johannesburg confirmed this when she said that she “was raised to believe that being hurt is normal and just part of life, when men have the right to do as they please with our bodies’’, (Makota 2014).

The words of the victim cited above, that ‘hurt is normal’, lay bare the collusion that exists between some of the cultural norms and values and how these cultural norms and values contribute towards GBV. Some of the male perpetrators of GBV even go to the extreme and make statements like, for example, lobola is a price they pay to own their wives.

Jakobsen (2014) states that in Tanzania most of the work in the agricultural fields is done by women but some men believe that the proceeds from the harvest belong to the husband. This is based on the belief that a husband is the head of the family therefore wealth belongs to him. To illustrate the point just mentioned above, Jakobsen (2014) cites one of the participants who says ‘’The way I see it, I’m the one who married her. I proposed to her. So, I’m the one who deserves to take the wealth. I take it from the house to me. In short, I’m the head. It comes to me’’.

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This is how some of these perpetrators of violence against women misconstrue the whole purpose of lobola to give substance to their belief of ownership of their wives.

Phiri, Mulaudzi and Heyns (2015) state that some indigenous proverbs are used to promote the supremacy of men over women. One such proverbs are, ‘’lebitla la

mosadikebogadi'' which, when translated, means ''a woman's grave is at her husband's place or home''. Phiri *et al.,* (2015) argue that this proverb is used to discourage a wife from leaving his husband when marital problems occur between them.

A woman is expected to soldier on irrespective of the problems she may be facing in her marital relationship or she may be killed by her spouse if she wants out of the marriage. ''Women often suffer as a result of harmful cultural practices and beliefs that subject them to gender inequality under the disguise of cultural and so-called expectations (United Nations Children's Fund [Unicef], 2000)'', (Phiri *et al.,* 2015). Women ''are not expected to complain about what is happening to them, and sometimes have to persevere in a depressing situation which may result in stress related conditions such as anxiety and depression'', (Phiri *et al.,* 2015)

The situation described above does not only apply to South African women but expatriate women are also negatively affected.

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Makota (2014) explains that other factors like ''the social, economic and political instability play a role in increasing vulnerability of women and girls from other countries as they illegally seek employment in South Africa''. Male perpetrators of GBV take advantage of such women.

To further illustrate how foreign women become subjected to GBV in South Africa,

> Makota (2014) quotes Becky who says, ''Almost every day Max would bring other men to the house. Men of all walks of life, businessmen, lawyers, truck drivers, old and young men, ugly men and handsome men. Max would bring and they would be free to do whatever they wanted with her. Others lacked the basic

sense of humanity and dignity to treat Angelique well. They gave her rough sex, hit her, abused her and swore at her. Each week it was always the same''.

Bower (2014) provide statistics in order to demonstrate and paint a picture of how women suffer in South Africa. Bower (2014) says that according to the statistics supplied by the Medical Research Council there are more than 4000 rapes of women per day ''at a rate of roughly 180 an hour. If the police are correct, the figures are even more horrific, with around 265 rapes an hour taking places''. Of concern is that these rapes include those perpetrated by intimate partners.

According to the statistics on Crimes against Women supplied by Statistics South Africa (2018) household crimes ''despite being out of the spot light, these crimes have a great impact on women. For example, apart from the psychological trauma that comes with robbery, women sometimes get raped or murdered during a home robbery''.

Bower (2014), further cites Mathews *et al.*, (2004) who argue that according to the People Opposing Women Abuse (POWA), (a Gauteng based advocacy and service organization dealing with gender-based violence), in South Africa one in six women who die in Gauteng Province is killed by an intimate partner.

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“It is estimated that a woman in South Africa is killed by her intimate partner every six hours. (Mathews *et al.,* 2004)”. Arguably “South Africa has the highest rates of sexual violence in the world, approximately 200,000 adult women are reported as being attacked in South Africa every year''; (Bower 2014).

So far, what has not been mentioned in the current study is the fact that gender disparities have a racial dimension as well. McGovern (2013) correctly points out that

''Black African women faced disadvantages and discrimination, entrenched patriarchy and lack of basic social services as part of apartheid's legacy''. McGovern (2013) further says that ''racial and social inequalities compound gender inequality in South Africa''.

According to Timse (2016) the media also plays a role ''in perpetuating dominant patriarchal values''. Timse (2016) argues that ''most rape cases against women are not reported due to the fact that many people in South African society subscribe to myth about rape''. The overarching myth associated with rape of women, puts the blame for the crime on the victim, and further suggests that the victim's behavior is the reason why the rapist carries out the assault (Rape Crisis, 2014)''.

Timse (2016) further says that ''violence against women was normalized under apartheid and many argue that this continues today, making it difficult to combat sexual violence in the country (Gabbidon, 2009)''. Timse (2016) is of the view that Zwelinzima Vavi's rape case illustrates media bias against women in ''the portrayal of the rape complainant in the media and the use of media space is often attributed to men''.

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Sometimes the terminology used in cases of rape in the media also shows a bias against women, for example, in the Vavi rape case, Phooko the woman involved is referred to as an ''accuser'' instead of being called a ''complainant'', (Timse 2016). This kind of reporting rape is dangerous where by women are viewed and characterized differently to men, it can have a devastating effect on women.

Yemeke, Sikkema, Watt, Ciya, Robertson, and Joska (2017) who conducted a study on screening for traumatic experiences and mental health distress among women in HIV Care in Cape Town. Yemeke *et al*., (2017) state that ''among the participants, 51 %

reported a history of sexual abuse and 75% reported physical intimate partner violence (physical IPV)''. Further state that among all the participants, 36% met screening criteria for depression, among those with traumatic experiences (n = 57), 70% met screening criteria for posttraumatic stress disorder (PTSD)''.

Yemeke *et al.,* (2017) alluded to the fact that ''women in South Africa also suffer from high prevalence of traumatic experiences, including childhood abuse and physical and sexual abuse in childhood''.Yemeke *et al.,* (2017) further elaborates on the effects of abuse of women by citing Abrahams *et al*., (2004), Jewkes *et al.,* (2002) and Jewkes *et al*., (2001) who state that abuse and violence in South African women is rooted in gender inequality, patriarchal and normative use of violence in affirming power.''

Yemeke *et al.,* (2017) and Bower (2014) belong to the same school of thought in saying that physical and sexual abuse affect women emotionally and financially within intimate relationships and these forms of abuse are often co-occurring.''Yemeke *et al.,* (2017) further points out that ''a history of trauma can negatively affect clinical outcomes among women living with HIV, particularly when those lifetime events result in ongoing psychological distress and poor mental health''.

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Nkosi and Van der Wath (2012), in corroboration with Yemeke *et al.,* (2017) contend that ''regardless of whether the violence is physical, sexual or psychological, it increases the incidents of mental illness, which can cause additional health care problems and over utilization of health care resources (Campbell, 2002; Moultrie & Kleintjies, 2006) ''. Nkosi *et al.,* (2012) base their argument on the statistics taken from Pillay and Kriel (2006) which claim that ''422 women attending a district level clinic in

South Africa, 50% had relationship problems, 48% reported violent partners while 37 % viewed their partners as beings oppressive''.

The assertion by Nkosi *et al.,* (2012) that a ''failure to identify a woman exposed to domestic violence implies a lost opportunity to intervene in the cycle of violence'' cannot be overemphasized. It is a sad thing that, as shown by Nkosi *et al.,* (2012) that domestic violence is not addressed as part of the health care programme for women who are exposed to home based violence, until health care professionals have a sharp eye for abused women and have the necessary skills to probe the affected women the scourge of violence against women will continue to haunt our society.

Although the picture painted above about the implications of violence on women's mental health is not directed to abused mentally ill women per se, it is the researcher's view that continued abuse will make mentally ill women more vulnerable due to their mental state. This situation, that is, continued exposure to violence has a potential to make abused mentally ill women prone to relapsing or would make a mentally healthy woman more vulnerable to mental illness or repeated admissions.

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The review of the relevant literature relating to women abuse shows the negative effects on women's mental health. More importantly for this study literature review has demonstrated that there is a link between women abuse and mental illness.

There is no literature available on the causes of repeated admissions of abused mentally ill women in the South African context hence this is a ground breaking study.

However, hopefully when doing data collection in Chapter 3 the researcher will be able to demonstrate conclusively the link between abuse and repeated admissions of mentally ill women admitted in a psychiatric institution.

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CHAPTER THREE

RESEARCH PARADIGM AND RESEARCH DESIGN

3.1. INTRODUCTION

“It is the task of methodology to uncover and justify research assumptions, as far and as practicably as possible, and in so doing, locate claims which the researcher makes within the traditions of enquiry that use it’’ (Clough & Nutbrown, 2012).

In line with the above statement, the researcher discusses the research design and the methodology used in this study. The problem statement and objectives are also described. Lastly, ethical considerations regarding the study are also explained.

3.2RESEARCH PARADIGM

De Vos *et al.,* (2012) point out that there are two basic and recognized approaches to research, namely, the qualitative and the quantitative paradigms”. Holliday (2016) draws a distinction between the two approaches, namely, the qualitative and quantitative approaches. The quantitative approach has a tendency to count occurrences across a large population. It uses statistics and replicability to validate generalization from survey samples and experiments and attempts to reduce contaminating social variables (ibid).

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The qualitative approach looks deep into the quality of social life and locates the study within particular settings to explore all possible social variables and set manageable boundaries. An initial foray into the social setting leads to further, more informed exploration, as themes and focuses emerge.

In articulating the difference between the two paradigms, Saldana and Omasta (2018) correctly argue that the quantitative approach is experimental in its approach and works on a proposed hypothesis. This makes it possible for researchers who utilize this approach to predict the outcome of the research. The qualitative paradigm examines natural life as it is lived in the world and what people say, do, feel and create.

Of the two paradigms the researcher used the qualitative approach for the following reasons. Firstly, research on repeated admissions of mentally ill women is a new area of research. Secondly, since this is a new research area, there is a dearth of literature on the subject. Therefore, on the strength of the reasons stated above, the researcher holds the view that the qualitative approach was the most appropriate of the two research approaches, as it allowed the researcher to have face-to-face encounters with the participants.

De Vos *et.al.,* (2012) correctly argue that the qualitative researcher is concerned with understanding (verstehen) rather than explanation, with naturalistic observation rather than controlled measurement, with the subjective exploration of reality from the perspective of an insider, as opposed to that of an outsider predominant in the quantitative paradigm.

Mertens (2015) underscores the above statement in asserting that qualitative researchers study things in their natural settings, attempting to make sense of or to interpret phenomena in terms of the meanings people bring to them. The researcher must adopt an open mind when doing research, especially when collecting data and listen to the participants sharing their knowledge.

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This is precisely the route the researcher took with the current study. The researcher wanted to understand the natural setting from the perspective of the caregivers or families when mentally ill women are at home after discharge. The researcher could only achieve this through entering their natural habitat, which is their homes. This approach helped the researcher to avoid working on the basis of presupposed ideas but allowed caregivers and families to speak for themselves.

3.3 RESEARCH DESIGN

Saldana *et al.,* (2018) define a research design as the overall framework and provisional plan for initiating and conducting the study. The use of a qualitative design enabled the researcher to understand causes of repeated admissions of abused mentally ill women admitted in a psychiatric institution, which is the focus of this study. The reason for the choice of this method was that the researcher wanted to view and understand the

participants in their natural setting. Maxwell (2013) states that the qualitative method helps in understanding the meaning for participants in the study, of the events, situations, experiences and actions they are engaged in.

Rungano-Hokonya (2015) mentions two important aspects of a research design. One aspect is that qualitative research is exploratory and descriptive in nature as it aims to explore the phenomenon under investigation. Another aspect is that the design chosen must be appropriate to the subject and the intention of the study.

3.3.1 EXPLORATORY RESEARCH

De Vos *et.al.,* (2012) explain that exploratory research is useful to gain new insights about a situation, phenomenon, community or individual. Exploratory research helped in the realization of the following objectives of this research study:

- To investigate possible causes of readmissions of mentally ill women;
- To explore the nature and extent of abuse meted on mentally ill women; and
- To explore intervention strategies that can be applied to reduce repeated admission of mentally ill women into a psychiatric institution.

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Exploratory research further helped the researcher gain a clear picture and a better understanding of the home circumstances of abused mentally ill women. The researcher enjoyed an informed view of the natural setting of the abused mentally ill women and their families or caregivers when the abused mentally ill women are at home after discharge from a psychiatric institution.

Exploratory research assisted the researcher to understand how the caregivers or family members become affected by the home environment when the mentally ill women are at home after discharge from a psychiatric institution and how the families or caregivers themselves cope with taking care of mentally ill women.

3.3.2 DESCRIPTIVE RESEARCH

According to De Vos *et.al.,* (2012), citing Kreuger and Neuman (2006), say that descriptive research presents a picture of specific details of a situation, social setting or relationship, and focuses on how and why questions.

Both the exploratory research and the descriptive research were used because they complement each other perfectly for the purpose of helping the researcher to have a clear picture and better understanding of home circumstances of the abused mentally ill women.

3.4 RESEARCH METHODOLOGY

3.4.1 METHODS EMPLOYED FOR DATA COLLECTION

3.4.1.1 FOCUS GROUPS

Maruyama and Ryan (2014) state that focus groups are structured group interviews. They bring together a small group of interacting individuals who discuss, under the guidance of a moderator, the topic of interest to the researcher.

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Jackson, McDowal, Mackenzie-Davey and Whiting 2016), citing Clark (2009), point out that the purpose of focus groups is to build conversation among participants rather than conversations between the interviewer (or focus group facilitator) and individual participants, which would be akin to doing a round robin exercise.

Like any other method, the focus group method of data collection has its advantages and disadvantages. The researcher discusses the disadvantages and then moves on to the advantages.

- **Disadvantages of focus groups**

Aurini, Heath and Howells (2016) outline the following disadvantages of a focus group:

- Individual participants changing their answers after hearing someone else's response;
- Control may be limited during the conversation;

- Bias of the researcher in favour of certain answers; and
- Risk of overlooking individual over group responses exists.

Although the danger exists for the above-mentioned disadvantages that may compromise the purpose of the focus group, the researcher is of the opinion that under the supervision of a well-trained researcher, this situation can be controlled, if not averted. It is for this reason that training of the facilitator is emphasized. Further, the researcher believes that the advantages far outweigh the disadvantages.

- **Advantages of focus groups**

Jackson *et al.*, (2016) have the following to say about the advantages:

- When managed well, they can produce a broader as well as more in-depth understanding of an issue or topic because the interaction process stimulates memories, discussion, debate and disclosure in a way that is less likely in a one-on-one interview;
- Saldana *et.al.,* (2018) assert that it is beneficial to interview a group of participants at the same time in a setting where they can hear others' responses and engage in conversation, rather than strictly responding to questions posed by the interviewer;
- Aurini *et.al.,* (2016) argue that in a group focus setting, participants have an opportunity to question one another; and
- Questions help to achieve clarification and misunderstandings.

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Arthur, Waring, Coe and Hedges (2012) assert that one of the strengths of focus groups is that participants in a focus group may feel able to talk about sensitive topics in a way in which they would not do in an individual interview, and they may gain strength from the energy of a group setting.

Also key to the focus group method is the size of the group. De Vos *et al.,* (2012) citing Morgan and Krueger (1998: Vol.2: 71) point out that having "a right number of

participants means striking a balance between having enough people to generate a discussion and not having so many people that some feel crowded out". De Vos *et al.,* (2012) further correctly state that smaller groups of about four to six participants are preferable especially when participants have a lot to share about the topic at hand. In keeping with the above statement and due to the nature of the study, the researcher took a conscious decision to work with a small group of participants in order to give each of the participants enough time to make a contribution.

As the researcher has already stated above, in the current study a focus group was used to access information and evidence pertaining to the home circumstances of mentally ill women, particularly events that contributed to repeated admissions in a psychiatric institution. The focus group comprised seven (7) caregivers or family members of the mentally ill women and two professionals, a doctor and a social worker. The mentally ill women were not active participants in the focus group due to the compromised nature of their mental state. The focus group was homogenous in that it included only those who had the requisite experience, namely, caregivers or families of mentally ill women. The professionals, a doctor and a social worker, shared their professional knowledge and experience as they had a working experience with mentally ill women. Above all, the doctor and the social worker provided an objective view in the focus group. The focus group consisted of 3 males and 4 females, aged from 30 years upwards. The researcher, participants, and professionals had not met before the focus group sessions.

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In order to commence with a study of this nature, the correct procedure was followed. The researcher sought permission from the Ethical Clearance Committee of the University Fort Hare and the Provincial Ethical Research Committee at Bhisho. The researcher further obtained permission from the Chief Executive Officer of Dora Nginza Hospital and the clinical Head of Department of Psychiatry Unit at Dora Nginza Hospital to conduct focus group sessions in one of their rooms.

The researcher worked together with the Hospital Psychiatric department to access a list of names of people who fitted the profile of women with repeated admissions in a psychiatric institution. The list contained contact details of caregivers or family

members. The researcher negotiated with the gatekeepers to visit the site before interviewing potential participants to ensure that the venue was suitable for the purpose of the focus group. The venue was central, reachable, suitable and comfortable to be used for group sessions.

The researcher used contact details of potential participants to make telephonic appointments to visit them to explain the purpose of the study. The venue where the focus group sessions were held was discussed with the participants. The commencement times of sessions and length of each session were also discussed in advance with the caregivers and families.

Before the start of the first session, the researcher introduced herself to the participants and refreshed their memory about the purpose of the study. The researcher further explained what was expected of the participants.

Freedom to use one's own language was articulated to make them comfortable and allow them to express their feelings freely to afford the researcher maximum benefit from the information. Most participants expressed themselves in *IsiXhosa* throughout the interviews, while two individuals opted to communicate in English. The researcher did not have a problem in the foresaid languages as she speaks vernacular and understands both languages well. The participants agreed to both the recording of the conversations and taking of notes. The interview schedule was used. After each session, the researcher would offer participants refreshments.

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Due to the sensitivity of the study, some participants requested to be interviewed at their homes. The researcher granted their request and utilized the snowball sampling technique to identify other participants as replacements in the focus group. The researcher visited the individuals in the comfort of their homes and utelised the interview guide that was used in the focus group to conduct interviews with them.

A study of this nature has a potential of opening old wounds and for that reason, the participants were informed about the availability of counselling services in the event that a need arose.

3.4.1.2 IN-DEPTH OR UNSRUCTURED INTERVIEWS

Since not much is known about causes of repeated admissions, the researcher used intensive interviewing for data collection. Saldana *et al.,* (2018:92) argue that unstructured interviews are very useful when collecting information on a topic where there is limited knowledge.

The interview guide was used to elicit more information from participants. Unstructured interviews also provided the researcher with the opportunity to ask probing questions for clarity when that became necessary. Probing questions were based on personal experiences of living with mentally ill women with repeated admissions. This also made it possible for the researcher to understand daily experiences of participants and the meaning they attach to their experiences. The researcher used verbal and non-verbal cues, such as nodding the head; 'mh', "yes" were used to encourage participants to express themselves and hear their views and understanding about repeated admissions.

Participants provided the researcher with a complete picture of home circumstances of the mentally ill women. They shed light on the events leading to repeated admissions. The professionals, that is, the psychiatric social worker and the psychiatric doctor were asked a general question first (an ice breaker) about their understanding of working with mentally ill people. These professionals (psychiatric social worker and the psychiatric doctor), who have a wealth of experience in working with mentally ill women with repeated admissions, also provided the researcher with a professional opinion and understanding of the causes of repeated admissions.

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The researcher utilized the interview guide, and the focus group members explained their understanding of the causes of repeated admissions.

3.5 POPULATION UNDER STUDY

Maruyama *et.al., (*2014) define a population as an aggregate of all the cases that conform to some designated set of specifications. The population of this study

comprised caregivers or families of abused, mentally ill women with repeated admissions in a psychiatric institution.

3.6 SAMPLING

Maruyama *et.al.,* (2014) state that a *sample* refers to a group of elements that have been taken from a population, with the intention of finding out something about the population from which they are taken. An inference that can be made from this definition is that a sample is useful since it is not possible to study each and every member of the population.

3.6.1 NON-PROBABILITY SAMPLING

There are broadly two categories of sampling, namely, probability sampling and non-probability sampling.

Probability sampling refers to those in which every element of the sampled population has a known probability of being included, while in non-probability sampling, the inclusion of each element of the population cannot be guaranteed (Maruyama *et al.,* 2014).

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Since the extent of the phenomenon of abused mentally ill women with repeated admissions in a psychiatric institution is not known and probably dispersed, the non-probability sampling method was used in the present research study.

3.6.2 TYPES OF NON-PROBABILITY SAMPLES

Under non-probability sampling, Maruyama *et al.,* (2014) names four different types as:

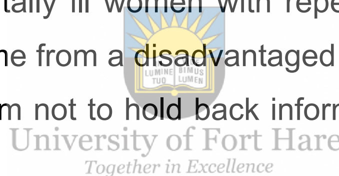
- Haphazard Samples: taking cases at hand until the sample reaches a designated size;
- Quota Samples: the inclusion of diverse elements of the population to ensure that they are taken into account of, in proportions in which they occur in the population;

- Purposive samples: handpicking to form samples that researchers deem satisfactory for their needs; and
- Snowball samples: apply to situations where it is difficult to locate members of the population. A small initial sample snowballs into a sample large enough to meet the requirements of research design and data analysis.

For the current research study, snowball sampling was utilized as it was the most appropriate. Gatekeepers and members of the initial sample of the target population assisted by enlisting other members who shared the characteristics of the population under study.

Another important consideration of a sample is homogeneity, which means that members of the sample should, by all means, have the same characteristics (e.g. same socio-economic class, same age group) to facilitate disclosure because of the rapport it creates among people who are otherwise unknown to each other (Jackson *et al.,* 2016).

The sample of this research study comprised members whose common characteristic was the care of abused mentally ill women with repeated admissions in a psychiatric institution. All participants came from a disadvantaged background, which helped create a relaxed atmosphere for them not to hold back information but to express themselves freely.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3.7 RESEARCH DOMAIN

The study was conducted in the Nelson Mandela Bay Municipality (NMBM), which comprises Port Elizabeth, Uitenhage and Despatch. The focus group and mentally ill women are residents of the above-mentioned metropolitan municipality. The population of the Nelson Mandela Bay Municipality stood at 1 263 051 during the time of the research.

3.8 ETHICAL CONSIDERATIONS

Du Plooy-Cilliers, Davis and Bezuidenhout (2014) state that a researcher who acts with integrity adheres to ethical principles and professional standards essential for practicing

research in a responsible way. The purpose of ethical considerations is to achieve certain objectives outlined below.

3.8.1 CONSENT

Participants must be informed about what the study is about and what is expected of them. When they have understood the purpose of the research and the process that will be followed, they must be allowed to give their consent.

In this study, after the researcher had explained the purpose of the study and how the study was going to be conducted, consent forms were made available.

3.8.2 VOLUNTARY PARTICIPATION

Another objective of the research ethics that needs to be explained to participants is that they are taking part in the research out of their own free will; therefore, they are free to withdraw at any stage of the study.

In this study, participants were made aware about the fact that they were not obligated in any way to continue participating if they wished to withdraw and could stop participating without any consequences.

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3.8.3 CONFIDENTIALITY

Participants are always concerned about their identities for their own protection. It is for that reason that the researcher must explain to participants and ensure them that their identities will be protected.

Due to the sensitivity of the current study, the researcher explained to participants that their identities would not be compromised in any way. Pseudo-names were used and whatever information they shared remained between them and the researcher.

According to the South African Council for Social Service Professions policy guidelines for course of conduct, code of ethics and rules for social workers, social workers are expected to respect rights of individuals to privacy, confidentiality, self-determination and autonomy.

3.8.4 DECEPTION

Deception should be avoided at all costs. Du Plooy-Cilliers *et al.,* (2014) assert that *deception* means not telling participants the truth about the study.

The researcher explained to the participants that there would not be monetary or material benefits for participating in the study.

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CHAPTER 4

DATA ANALYSIS AND PRESENTATION OF RESEARCH FINDINGS

4.1 INTRODUCTION

In this chapter, the researcher presents the collected data from 9 participants of the focus group plus 5 individual participants. The 5 individual participants were, as mentioned above, interviewed in their homes. The data presentation is preceded by the biographical profile of the focus group participants and the biographical profile of the 5 individual participants will follow. Data collection analysis is presented in the form of themes and sub-themes that emerged from the data analysis process.

The exact words of the participants are used (verbatim) to support the identified themes and the sub themes. After each interview, the researcher read through the data, coded and organized it into themes and sub-themes.

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Creswell (2013) describes data analysis as a process that involves organizing the data, conducting a preliminary read-through of the database, coding and organizing themes, representing the data and forming an interpretation of these. De Vos *et al.,* (1998) state that “there are two ways to manage the coding system, namely by computer software programmes or manually”. The researcher analysed the data manually by listening to recorded information and by identifying trends and parttens in the field notes.

According to Grbich (2013), data analysis is preceded by preliminary data analysis that involves analyzing data every time data is collected. This practice gives the researcher enough time to thoroughly read through notes and note areas that need more information for clarity purposes.

4.2 THE BIOGRAPHICAL PROFILE OF PARTICIPANTS

Hesse-Biber (2017) asserts that a researcher might provide a demographic table that shows characteristics of the researcher's research sample that depicts the age and gender, depending on the research topic.

The following table constitutes biographical details of participants who were selected from families or caregivers of the mentally ill women with repeated admissions in a psychiatric institution. The psychiatric doctor and the psychiatric social worker were part of the participants. Some of the participants' details, such as their age, have been transformed into numbers (Hesse-Biber, 349).

Table 4.1 Biographical characteristics of the focus grpoup participants

	Pseudo name	**Gender**	**Marital status**	**Age range (in years)**	**Relationship to patient**	**Employment**	**Resident**
1	Emihle	Female	Single	30-39	Daughter	Unemployed	Port Elizabeth
2	Babalo	Male	Married	40-49	Brother	Odd jobs	Port Elizabeth
3	Sipho	Male	Single	40-49	Son	Unemployed	Port Elizabeth
4	Social worker	Female	Single	50-59	Health worker	Employed	Port Elizabeth
5	Thabo	Male	Married	50-59	Husband	Unemployed	Port Elizabeth
6	Doctor	Female	Married	60-69	Health worker	Employed	Port Elizabeth

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7	Fezile	Male	Married	60-69	Father	Old age pensioner	Port Elizabet
8	Nobuntu	Female	Widow	60-69	Aunt	Old age pensioner	Port Elizabet
9	Celiwe	Female	Widow	70-79	Sister	Retired nurse	Port Elizabeth

All the 9 participants came from the Nelson Mandela Bay Municipality, which includes Port Elizabeth, Uitenhage and Despatch. The majority of participants were Xhosa speaking and had the experience of caring for mentally ill women with repeated admissions in a psychiatric institution. Two of the participants expressed themselves in English. The professionals had the experience of approximately thirty years, dealing with psychiatric mental health care service users admitted in a psychiatric institution in the Metro. The researcher, out of respect for participants, used the age range instead of asking them their exact ages. The participants' ages ranged from 30 to 70 years.

The participants' ages, as shown in the table above are as follows:

One participant in the 30 to 39year range; two in the 40 to 49year range; two in the 50 to 59year range; three in the 60-69year range, and one in the 70-79year range. There were five female participants and four male participants.

Four of the participants were married, three were single, and two were widowed. In line with the qualitative data collection method, all participants took part in unstructured interviews.

The researcher concurs with Mertens (2015) who correctly states that when conducting interviews, "yes" and "no" questions must be avoided because they may stifle the conversation between the researcher and participants, thus defeating the intended purpose of the study. Instead, open-ended questions should be used.

4.3 PRESENTATION OF THE THEMES AND LITERATURE CONTROL

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After the analysis of the transcribed data, four themes and sub-themes emerged. The themes and sub-themes are presented in the following table:

Table 4.2 Themes and sub themes

.4 DESCRIPTION OF THE THEMES AND SUB-THEMES

THEME ONE: BEFORE BECOMING MENTALLY ILL
Sub-theme 1.1: Education
Sub-theme 1.2: Employment status
Sub-theme 1.3: Relationship with family
Sub-theme 1.4: Relationship with partner or husband
Sub-theme 1.5: Relationship with friends/concerned others
THEME TWO: HISTORY OF MENTAL ILLNESS
Sub-theme 2.1: Mental illness in the family
Sub-theme 2.2: Environmental factors
THEME THREE: CAUSES OF REPEATED ADMISSIONS
Sub-theme 3.1 Neglect and lack of supervision by family
Sub-theme 3.2 Neglect and lack of supervision by partner or husband
Sub-theme 3.3 Default of medication
Sub-theme 3.4 Alcohol and substance abuse
Sub-theme 3.5 Lack of understanding of mental illness by family, partner and husband
Sub-theme 3.6 Abuse of state grant by families
Sub-theme 3.7 Lack of financial support from the partner or husband
Sub-theme 3.8 Stigmatization by family, partner and community
THEME FOUR: INTERVENTION STRATEGIES SUGGESTED BY PARTICIPANTS
Sub-theme 4.1: Provision of community supportive resources

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Based on the qualitative character of the current study, the researcher made a choice of thematic analysis, as it allowed the researcher to code and identify themes and sub-themes that emerged from the interviews with participants.

Saldana *et al.*, (2018) define a theme as an extended phrase or sentence that identifies and functions as a way to categorize a set of data into a topic that emerges from a pattern of ideas.

In the section that follows, themes and sub-themes are discussed, followed by direct quotations from participants, taken from the transcripts of the participants' interviews in the context of the knowledge available. The link to reviewed literature is also provided.

Theme One: Before becoming mentally ill: during the discussion with the participants regarding the welfare of mentally ill women before they became mentally ill, the following five sub-themes emerged:

- **Sub theme 1.1**: Education.

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This sub-theme relates to the educational background of the mentally ill women with a view to understand their mental state prior the onset of the mental illness when in a school setting.

The researcher asked Emihle about her family member's level of education prior to getting sick, and she answered as follows:

"*Before she became mentally ill, she had dropped out of her training as a teacher, she was brilliant, educated"* (Emihle)

"*She trained at Lovedale as a nurse but unfortunately, in her first year, she sustained a backache after falling on steps. She came back from Lovedale with the assistance of friends because I had already completed my midwifery. When she came back, she could not do anything, she could not walk after slipping on the steps, (pause) it is said. She could not wash herself. I had to wash her and prepare her meals. Mentally she was okay. She passed the Junior Certificate* (Celiwe)

"She went up to standard 10" (Babalo)

"She passed standard 10, as we used to call it back in the day, ha ha ha ha (laughing). She was a brilliant person I am not going to lie. She went to Fort Hare (university) to do communication but dropped out…. shame. I can say, I think because of her illness. She further enrolled at UNISA to do something like management administration, I cannot remember the year. Shame she dropped out due to this condition. Shame I am not jealous of her, she could study independently but when it was time to write exams, she got sick and she dropped out. She was brilliant shame, but the illness…(paused) shame cost her" (Thabo)

"*She liked her books; I think may be...(paused) if I am not mistaken, she went up to standard 8"* (Fezile)

"My mother stopped schooling in Standard 5" (Sipho)

The above stated excerpts are a clear illustration of the fact that symptoms of mental illness can, in certain cases, show later in life. The case of the two women cited above is a classic example of how environmental factors impact one's mental health later in life.

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The above-mentioned women were well-functioning and mentally sound before they lost "an integral part of an individual's capacity to live a life of fulfillment, including the ability to maintain social relationships and to make day-to-day decisions", Olawande *et al.,* (2018) citing the World Health Organization (2005).

Lombo (2010) concurs with the above in arguing that "the environment plays a major role in determining mental illness. Unsatisfactory environmental conditions may result in mental illness if left untreated".

- **Sub-theme 1.2**: Employment: The current sub-theme looks at how the mentally ill women were functioning in their work environment before they became mentally ill. The sentiments of the focus group were also articulated by the individual participants. The following excerpts serve to illustrate how well the

mentally ill women functioned in their work environment before mental illness set in:

"*Before she became mentally ill, she used to work at a restaurant. She was financially independent. She liked to support her boyfriend. She gave love all out. I am not sure whether she was using the money to buy love"* (Babalo)

"*She was a lady. She worked for Shoprite in Greenacres. One day, she was brought home by her supervisor while staying at Walmer in 2006. She was confused while assisting a client as a cashier, she was admitted at Dora. Ever since, she has been in and out of the hospital"* (Nobuntu)

"She went to Cape Town where she worked as a domestic worker. Wow…, she was lo…ved by her employer who used to give her clothes. She used to share the clothes with us" (Celiwe)

"*Her life was full of fun. She was a seasonal worker at the harbor, sorting oranges for exportation. She was not yet married to me at the time. She was my girlfriend. I did not receive any (negative) report from her work"* (Thabo)

"My mother used to work in PE (Port Elizabeth) *as a petrol attendant. After her husband left her, she had to work hard and became a breadwinner. Her children were still small and attending school. She worked there for +-10 years or so. There was nothing peculiar about her behaviour at her place of work. She stopped due to old age"* (Sipho)

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The above excerpts, like the previous sub-theme on education, support the fact that negative external factors can have adverse effects on mental health. The mentally ill women were coping at work until they were incapacitated by mental illness, and the work environment became too much to bear for them.

- **Sub-theme 1.3:** Relationship with family: This sub-theme comes from the process of data collection and data analysis. The following excerpts show how the mentally ill women related with their families before becoming mentally ill:

"*My mother is 55 years old and she was born in Port Elizabeth. Mother is still married but is separated. They lost their house in 2006 and had to move to stay with my mother's family. My mother's parents died. Her sisters are still alive. They chased my father away from the house he was staying in with my mother. My father and mother bought an RDP house without a title deed and they were evicted from that house by lawyers*. My aunts chased my mother away from their parents' house. *The situation stressed my mother and she started drinking alcohol. My father was also drinking alcohol not supporting my mother financially and otherwise"* (Emihle)

"*She loves her siblings. She does not hold grudges against those who used to punish her. From her adolescence they would be punished with friends for attending discos. She stayed with her aunts without a problem, Queenstown and Port Elizabeth with our young aunt. Our sister used to complain about the step mother. She was negative towards the step mother"* (Babalo)

"My sister gave her child (patient) to the care of a certain woman in the Transkei, known to us. She was married to my brother. We heard that the child was illtreated, locked alone in the house, cooked for herself at the age of three. I spoke to my sister to go and fetch the child…ohm…in 2000 there about… She started school here in Port Elizabeth" (Nobuntu)

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"What I remember about my sister is that she was sick and was subsequently admitted at Glen Grey Hospital. It was such a traumatic thing for our sibling to be kept there by the nuns claiming that she was their own child. She grew up as a likeable person" (Celiwe).

"*Before she was raped, she was right…eheee, this child was a sweet child, a quiet child, she would clean the house, she would cook. She was not a talkative child, she was a sweet child, and she liked children, ja"* (Fezile)

"*What is happening, she is a product of a polygamous marriage. I found out she did not appreciate anything. I found out she had a recycling anger and had a defensive anger, always angry as if she was not treated well (by husband). She did not see that she was*

at a place where she was loved. This polygamy…...yes…yes, I mean her mother was left by her father for another woman. She was raised by her mother without her father. Her father stayed with another woman. So, after that she had anger, especially with men. So, she had that anger. She would not be satisfied with anything I did. She was always talking about witchcraft and always angry. When she could not love her own family (of birth) which used to visit us, I realized that she was getting worse. When her extended family visited us, she would laugh during the conversation with them pretending all was well, but when they left, she would talk bad about them. We did not like that because we did not want to make enemies. We saw that they were nice to us. I realized that she had a problem (nodding his head repeatedly) because if she could not love her own family, how can she love us?" (Thabo)

According to the above cited excerpts, with the exception of Thabo's wife who comes from a polygamous marriage, the mentally ill women had sound and healthy relationships with their families before the onset of mental illness.

Mokgothu, *et al*., (2015), citing Njue *et al*., (2007), point out one of the salient aspects of the family system when saying that *family cohesion* is defined as the emotional bond that family members feel toward other family members.

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This is expressed through commitment and spending time together, especially during family events such as weddings, births, deaths and illnesses. The sentiments that emerged from the focus group and individual participants testify to the fact that some of the mentally ill women had good emotional bonds with their families. However, other mentally ill women experienced rejection from their families.

- **Sub-theme 1.4:** Relationship with the partner or husband

Upon analysis of collected data, a sub-theme on the relationship between the mentally ill woman and her partner or husband emerged. During the focus group sessions, it transpired that some of the mentally ill women suffered neglect at the hands of their partners or husbands even before they became mentally ill.

The following excerpts provide evidence on the plight of the mentally ill women relating to neglect by their partners or husbands;

"My sister used to look after her husband's child from another woman. My sister liked her husband's child more than her own, I don't know whether she was forced to do so. There is a story to the effect that one day, my sister's child did not sleep at home because she did not get along with her (step) *dad, maybe the child realized that her mother was not treated well by her husband. The child said that she was neglected"* (Babalo)

"*Her pensioner husband takes loans, and they do not have enough to buy groceries. No-o-o-o, he seldom abuses her physically or emotionally. He is not supportive, but I see them sometimes sitting together and chatting. He is a quiet person and is not violent. They are not staying together. There is no support from dad, and the only support is from her family"* (Emihle).

"Her husband was promiscuous and had a lot of extra marital affairs. He left my mother for another woman and that was the end of her marriage. I think this is one of the things which affected her life negatively. She felt so small that her husband left her for another woman. This is how her problems began. She was about 34 years when this happened. It was in the 1980s" (Sipho)

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During the focus group session, the researcher sensed that the participant (Emihle) was reluctant to speak openly about the relationship between her parents. She was holding back to the extent that even probing questions could not elicit the desired explanation.

Theme Two: History of mental illness.

During the focus group sessions, the following sub-themes emerged;

- Sub-theme 2.1: Mental illness in the family: When analyzing data, the researcher realized that there were cases where the patient was not the only one in the family suffering from mental illness. There are family members who were or who are still mentally ill, which means that mental illness can be genetic.

The psychiatric doctor explained that sometimes, people delay to seek professional assistance because in some cultures, people do not believe in the existence of mental illness but attribute symptoms of mental illness to being called by ancestors to be a

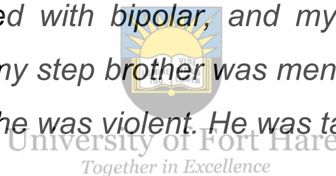
healer. Families' failure to understand symptoms of mental illness delays the diagnosis. The person remains sick for a long time before going to the hospital.

In support of the above statement, the psychiatric social worker argues that the first port of call for other people, when they encounter mental illness, is the traditional healer or the church. Lombo (2010), citing Hicks (2005), argues that vulnerability plays a role in many mental illnesses since the risk of becoming ill is greater if you have a closer relative who suffers from the same illness, but no specific gene has been isolated that causes any illnesses.

"*From my mother's side, it was my grand-mother, from my father's side, the last born was on psychiatric treatment"* (Babalo)

"*I do not know her mother's family well because the patient was born out of wedlock. On my side, my mother was mentally ill and was on treatment for years. My mother was confused, talkative, at times she was right when on medication. When she died, she had stopped taking her medication due to her age. She was 87 when she died* (Fezile).

"Later on, she was diagnosed with bipolar, and my sister was also diagnosed with bipolar. On my father's side, my step brother was mentally ill. I won't know, but when he came back from Cape Town, he was violent. He was taken to Komani Hospital" (Celiwe)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The above excerpts concur with the focus group discussions which revealed that there were cases where patients inherited the mental illness from either their parents or close family members. However, in our study, out of 9 participants, only 3 of the participants inherited the mental illness.

The psychiatric doctor's opinion was that family history can influence the patient's condition, a family with bipolar also influences the patient's condition. The psychiatric doctor's opinion confirms the view that mental illness can be inherited.

- **Sub-theme 2.2:** Environmental factors.

During data analysis, it transpired that there are cases where the onset of mental illness can be attributed to environmental factors. Lombo (2010) argues that the environment

plays a major role in determining mental illness. Unsatisfactory environmental conditions may result in mental illness if left untreated.

"At the place where my mother used to stay, she used to fight with her neighbours but I do not know what they fought about. The neighbors did not want my mother to stay in that neighborhood. My mother decided to sell that house, and they (mother and father) *bought an RDP house without a title deed* (they did not possess a title deed)*. The lawyers evicted them from that house after staying for ten years. My mother went back to her home. Her parents passed away. In the family, they have issues, and there were times when her sisters would not dish up for her. Her sisters chased her away from home, and she had to fend for herself. My mother was not employed and did not receive a social grant. Her husband was not financially supportive towards her.*

I do not know. It is said that her problem had something to do with alcohol tempering. It is the belief of amaXhosa. A portion was put into the glass with which she was drinking alcohol. She started seeing things we did not see. She was hearing voices. She would break things at home" (Emihle)

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The following excerpt from a participant who tells a story about her sister (patient) who was forcefully taken by white nuns to stay with them shows the severity of the environmental factors on mental illness.

"*The child was traumatized. That is what I remember about her illness, and in hindsight, as a learned person now, you hear about the impact and effects that this could have had later in the person's life. Can you understand how it feels to lose someone close, by force to some people who abused their authority? She used to cry when my mother visited her. Thereafter, the nuns refused my mother to visit her. I blame the nuns for her sickness. She was traumatized"* (Celiwe)

"The child was given to the care of a certain woman (known to us) in the Transkei. We heard that the child was ill-treated, locked alone in the house and have to cook for herself at the age of three" (Nobuntu)

"She became sick at the age 59 because there were things that affected her, and one of those was that her husband had left her. She had a burden of being a breadwinner and

had to start her life all over again. Because of the hardship, she had to take her children to her husband, but the children were ill-treated by her husband's wife and went back to their mother (patient)" (Sipho)

"What is happening, she is a product of a polygamous marriage. This polygamy…I mean her mother was left by her father for another woman. She was raised by her mother without her father. So, after that she had an anger especially to men. She had that recycle of anger...understand the way she was raised. I am sure her mother had an influence in her thinking that she was bewitched" (Thabo).

Another participant whose child was repeatedly raped by her cousin in his house, in their absence (parents), said the following to describe the trauma caused by the incident of rape to her daughter:

"After the first rape, she became forgetful, not right…. not right. After giving birth to the child, she became mentally ill and was transferred from the hospital (general) *to a* (psychiatric) *hospital. She would say things we did not understand and would cry now and again saying that these people were going to kill her. We took her to the hospital. I remember she was given psychiatric medication and HIV treatment. She was less than 30 then, maybe she was 19. She was still attending school doing standard 8.* (Fezile)

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The excerpts cited above clearly confirm the negative impact of environmental factors. According to the participants, all the women cited above never showed signs of mental illness previously, until they went through the traumatic experiences. The sentiments from the individual participants were articulated during the discussions in the focus group sessions.

Theme Three. Causes of repeated admissions.

On further analysis of the data the following sub themes emerged:

- Sub-theme 3.1: Neglect and lack of supervision by the family.

During the analysis of the data, it became evident that neglect is one of the outstanding challenges in relation to the causes of repeated admissions. It also became evident that

there is a variety of reasons why families neglect patients. The researcher identified three reasons as outlined below.

Firstly, some families neglect patients for no apparent reason. Sometimes, some families neglect their mentally ill patients so that the grant is not stopped by the government. Secondly, others neglect them because they cannot cope with the responsibility of supervising a mentally ill person, and it becomes too much for them. Thirdly, there are cases where families neglect the patient due to lack of knowledge about mental illness.

Mokgothu *et al*., (2015) assert that in cases where families' coping skills are challenged, in terms of looking after their mentally ill member, the mentally ill member relapses, which eventually leads to repeated admissions. Therefore, the role of families in supervising a mentally ill member cannot be overemphasized, and its absence contributes towards repeated admissions of the mentally ill member, as the following examples show.

> *"My mother's family does not support her"* (Emihle)
>
> *"My other sisters do not support me. I am all by myself"* (Nobuntu). As the participant was saying this, she started crying.
>
> *"My mother's family does not support her. She fends for herself"* (Sipho)

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During the focus group sessions, it became evident that some families do play their role of supervising their mentally ill members; however, sometimes it is the sick members themselves who refuse to cooperate. As mentioned above, some of the patients are in denial of mental illness, like Thabo and Babalo.

The following excerpts from the participants are a case in point:

"Her sisters sometimes punish us (including the patient) and tell us that we are not working and that we don't buy food, so they refuse to dish up for us. My sister is the one who wants my mother to stay permanently at Tower (Psychiatric Hospital). *The family wants her to be away for good. She is currently at Tower since 2018 and the family is not visiting her"* (Emihle)

"Her father and uncle (patient's uncle) *abuse her verbally. They claim that the patient has never done anything for them while she worked for Shoprite. They even insult her about her mental illness. While the patient was in hospital, I asked her father whether she had visited her. He told me that he did not have the money, and he never visited during all the patient's admissions"* (Nobuntu)

To further articulate the neglect and the lack of support for the patient from her family, Nobuntu expressed the following:

"They just phone to ask about her. I am alone, no support from family. I am taking care of the patient and her three-year old child. *It is an uphill, Social Worker* (referring to the researcher, she shed tears and the pain was visible in her face).

The psychiatric doctor had the following to say regarding neglect: *"The families blame the patient for the illness or her actions especially if she uses substances. Ja, sometimes they say substances cause the illness and neglect the patient"*

Commenting on some of the reasons for neglect, the psychiatric social worker stated that most of the time, some families' neglect of the patient is as a result of the family not knowing what to do with a mentally ill member. The psychiatric social worker further went on to say that the only form of abuse she could identify was that some families neglect patients and fail to follow up on medication.

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Mokguthu *et al*., (2015), citing Hughes (2005), say that families who take care of mentally ill family members might experience huge difficulties. Therefore, it is the researcher's view that the difficulties families contend with can, in some cases, be the cause of neglect.

- **Sub-theme 3.2:** Neglect and lack of supervision by partner or husband.

During data analysis, the following excerpts emerged, which show how some partners or husbands respond when their partners or wives are mentally ill.

"Maybe the child realized that her mother was not being treated well by her husband. The child says she (mother) *was neglected. In Cape Town, the patient depended on her husband for financial support. The husband continued with her love affair with her*

girlfriend. He would leave her behind to look after the girlfriend's child (who was staying with them) (Babalo)

"He is not supportive, but sometimes I see them sitting together chatting. There is no support from dad" (Emihle)

Another participant shared with the focus group the manner in which the boyfriend of the patient neglected her and the extent to which his failure to supervise her medication could have contributed to her relapsing.

"When back from the hospital she is calm. I do not think the boyfriend cares about her. If he cared, he would have visited her in hospital, never…never. He loved her only when she was back from the hospital. He would ask her to cook for him and clean the house. He goes and drink alcohol with his friends, leaving the patient behind. When back from his friends, he would offer her alcohol. There is no support from him; instead, he makes her worse" (Nobuntu)

"Her husband neglected her and the children. Since my father had these extra-marital affairs, he would come home drunk and assault my mother now and again. These fights affected us as children. Her husband left my mother to stay with his family, together with his new wife. My mother did not know whether she was divorced or not because my father never said anything. This was the beginning of suffering and hardship for my mother. We saw all these fights between our parents, but there was nothing we could do since we were still small" (Sipho)

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The psychiatric doctor explained that sometimes, the partner or husband becomes abusive because to him, the partner or wife does not function normally as a partner; this leads to a strained relationship in the family.

The partner becomes abusive and neglects the patient. Now and again, the partner makes sexual demands and poses adverse behaviour to the patient. More often, this results from a lack of understanding of the partner's illness.

Melrose, Dusome, Simpson, Croker and Athens (2015) argue that when people are mentally ill, they cannot manage activities of daily living, working effectively or

maintaining relationships. This is consistent with the psychiatric doctor’s view cited above, that lack of understanding of the patient’s illness may lead to strained relations between the partners.

- **Sub-theme 3.3:** Defaulting on medication

As the researcher analyzed data, it became evident that defaulting on medication was also a contributing factor towards relapsing, which eventually leads to repeated admissions.

“She defaults on her treatment because she believes she is not sick. To her, I am the one who is sick, or my wife is sick. She claims that she is a god and she is the water. She wants to go back to her husband. Her mind is fixated in the years she had been staying with her husband. On one occasion, my aunt (paternal) took her from the hospital before she was rehabilitated. When at home, she relapsed” When she is at home, after discharge, she stays for two to three weeks and defaults on her medication again. When she is in a relapsed state, the police get involved and the way they handle her really hurts” (Babalo)

“I do not think she takes medication when she is with her boyfriend (Nobuntu)

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“Sometimes she reflects on the negative experiences she went through. She thinks about her future, and you can see that she is losing her mind. She will start talking to herself. When this happens, we take her to Dora (Nginza hospital) *where they give her treatment. She does not want to be reminded by us when she forgets to take her medication. She is never wrong. She is always right* (according to her opinion). *She has three admissions. This is what we endure”* (Sipho)

To illustrate how sometimes defaulting on medication comes about, during the focus group sessions, one of the participants told a similar story of denial of mental illness.

“There are times when my wife refuses to take her medication. She will tell me that she is not sick but I am the one who is sick. She also talks about witchcraft in the house. She is getting worse and one day, set my church clothes on fire claiming that I am sick.

She shouted at my children and the neighbours. I took her to Dora (Nginza Hospital)" (Thabo)

Another participant told the focus group a traumatic story of her daughter's rape which took place after her discharge from the psychiatric institution.

"After the first rape, she became mentally ill and was put on medication. Sometimes she would refuse to take her treatment claiming that there were just too many tablets and that she could not swallow all of them. She would tell us that she had taken the treatment whereas she had not done so. When we forced her to take the treatment she would vomit. Even my wife would talk to her but in vain. Thereafter, she would relapse and we would take her to the clinic. On a certain day after her discharge from the hospital, she was raped again in the neighborhood. This incident brought back memories of the previous rape. She became forgetful and was not (al)*right. She relapsed and we took her to the hospital where she is still admitted"* (Fezile)

- **Sub-theme 3.4:** Alcohol and substance abuse.

Lombo (2010) contends that people who use alcohol and drugs may find themselves mentally ill in the passage of time. Lombo (2010) re-enforces the above statement by citing Bauman (1998), who argues that abuse of harmful substances can be understood at the level of brain physiology.

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There are patients who indulge in alcohol and other substances knowing fully well what the consequences of such practices are relating to their health. One of the participants said:

"She goes to her boyfriend who drinks alcohol, and they drink together" (Nobuntu)

"There is poverty at home, there is no support. When there is a traditional ceremony in our area, she will start by saying that she is going there for the meat only, but we notice that she had taken alcohol when she mumbles things. It is then that we realize that she is sick. Yes, it is alcohol, after discharge, she continues with her treatment but within a month, she starts drinking alcohol again. She had about 4 to 5 admissions in a psychiatric institution" (Emihle)

Another participant said *“Maybe alcohol should not be near her”* (Nobuntu)

The psychiatric doctor explained that some patients abuse substances as a coping mechanism. These substances can also delay the patient’s rehabilitation because, the psychiatric doctor argues, they cause neuro imbalances in the brain. Another important fact the psychiatric doctor mentioned was that the substances interfere with the medication in the blood stream, which eventually leads to a relapse. The psychiatric social worker concurs with the above statement and specifically mentions dagga as one of the triggers for most mental illnesses.

- **Sub-theme 3.5:** Lack of understanding of mental illness by family.

Lombo (2010) asserts that mental illness is difficult to understand due to the fact that interpretation of a strange behaviour varies from person to person and from culture to culture. Mental illness manifests in a variety of ways from person to person.

Olawande *et al*., (2018), in agreement with the above statement, argue, “What one culture may consider as a mental disease or abnormal behaviour may be seen as normal in another culture”. In other words, families are sometimes tempted to give up on the psychiatric treatment and consult traditional healers, especially when they are of the view that the mentally ill member needs to be initiated as an *ithwasa (*process to be followed to be a traditional healer).

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To confirm the above statement, one of the participants said:

“My mother was told by the family to observe a traditional ritual because they believed that she was going to be a traditional healer. She observed the ritual, and stopped her psychiatric medication because when she had started with the ritual, she was not allowed to use other medication. When she saw that the ritual was not helping, she stopped and went back to her church and eventually to the hospital psychiatric treatment. We did not know her diagnosis because the psychologist at Dora (Nginza Hospital) told us in English. I am not going to lie to you I did not understand it, and I did not know her treatment too” (Sipho)

"She was taken to a general hospital but my aunt took her from the hospital without a discharge. It was when they noticed that she was not right mentally. She was violent, threatening to assault people. She wanted to go back to Cape Town. They returned her to Komani hospital" (Babalo)

"Before she came to stay with me, she was staying with my sister. My sister could not take it anymore because the patient would swear at her in front of her husband. She would fight with her cousins. They thought that she was being silly. The family took her to a faith healer for prayer but there was no improvement. Then (when this failed) *her mother's family appealed to her father's family to observe a traditional ritual for her. The patient bought a goat which was slaughtered for the ritual, but still there was no improvement"* (Nobuntu)

"*I am not psychiatric trained so I can't remember the treatment"* (Celiwe)

The psychiatric doctor explained that some of the families take mentally ill members to *sangomas* (traditional healers) for help. This articulates what has been said above regarding families' lack of understanding of mental illness, which contributes to repeated admissions.

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The foresaid was reiterated by the psychiatric social worker who claims that some families take their mentally ill people to traditional healers when they are in a relapsed state. This course of action that is, consulting of traditional healers when the patient is in a relapsed state, confirms lack of knowledge on the part the families, which leads relapsing and repeated admissions.

- **Sub-theme 3.6:** Abuse of state grant by families

Gunhidzirai, Makoni and Tanga (2017) refer extensively to Chapter 2 of the Constitution of the Republic of South Africa where it is stated that "the government is responsible for providing welfare services to all citizens in non-discriminatory and no racial tendency (Constitution of South Africa 1996). Gunhidzirai *et al*., (2017) add that "the White Paper for Social Welfare is a strategy to alleviate poverty through offering cash grants as relief to vulnerable individuals. It states that every South African should have a minimum

income sufficient to meet basic needs and should not live below minimum acceptable standards (Department of Social Welfare 1997)".

The above-mentioned statement was underpinned by 5 participants who stated that their mentally ill members were recipients of the disability grant. Only 2 participants reported that their mentally ill members were not recipients of the afore-mentioned grant.

"My mother was assisted by the social worker in applying for a disability grant but I am not sure whether she received it or not. My mother is now at Tower (Hospital) (Emihle).

"*My wife is not getting a grant. I want to assist her in applying for it"*. (Thabo)

"My sister administers her grant on her own, she does not want my involvement in her financial affairs. All I do is to supervise her medication and to see that her house is kept clean" (Celiwe).

"My sister is in Fort Beaufort. I administer her grant well by paying her funeral policies and I buy things when I visit her in Tower Hospital" (Babalo).

"I use her grant to buy necessities for her and her child. I never misused it" (Nobuntu).

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"My mother is doing her own things with her grant. I am also getting a grant for nerves. She is protecting her grant and is very strict about it. When she is hospitalized at Dora (Dora Nginza Hospital) *she will make sure that her Sassa card is with her* (Sipho).

"My daughter is currently admitted at Dora (Dora Nginza Hospital)*. I make sure that her money is kept safe and I pay her funeral policies"* (Fezile).

Not one of the participants admitted to the abuse of the state grant of the mentally ill family members, however, the following excerpts suggest that the psychiatric social worker and the psychiatric doctor hold a different view on the matter, based on their experience;

"*What I see, is financial abuse (grant)*" (Psychiatric Social Worker).

In other words, the psychiatric social worker has a wealth of knowledge where relations between families and their mentally ill members are concerned. The psychiatric social

worker is also aware of the dynamics regarding financial matters of the affected families.

"*Yep, families also abuse their disability grant, patients do not get pocket money, families do not visit them in hospital, if they visit at all, it is because of the grant. They take the grant money or keep their (bank) cards and withdraw the money. They don't even buy them basic needs like clothes, they often...eh… ja*" (Psychiatric doctor)

The psychiatric doctor confirms what the psychiatric social worker said above, namely, that families do indeed abuse the grants that their mentally ill members receive from the state. In some cases, this causes conflicts between families and mentally ill members. These conflicts sometimes escalate to a point where the mentally ill member relapses, becoming extremely violent due to extreme anger.

- **Sub-theme 3.7:** Lack of financial support from the partner or husband

Van der Heijden, Abrahams and Harries (2016) in their study on violence experiences of women with physical disabilities in South Africa, claim that many women had limited education and skills to be fully employed, and most were reliant on the disability grant. Van der Heijden *et al*., (2016) further cite an example of one of the participants (in their study) whose husband demanded half of her grant to spend on alcohol.

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"While in Cape Town, she was not employed but dependent on her husband. Her husband did not give here financial support; instead, he would leave her and visit his girlfriend for about three days" (Babalo).

"Her boyfriend did not support her financially; instead, he used to drink alcohol with her. I tried to report this to the social worker at Dora (hospital), *but the patient attempted to assault me in the presence of her boyfriend"* (Nobuntu).

"*I heard that my daughter met with her boyfriend while they were still schooling together. He never visited her in my house. I am not sure whether he visited her at Dora Nginza Hospital. He stays in New-Brighton, in Port Elizabeth" (*Fezile).

"My father did not support my mother financially, at all. Instead he bought alcohol for himself" (Emihle).

"*My dad failed to give financial support to my mother, instead he left her for another woman. My mother was battling to make ends meet"* (Sipho).

"When my wife lost her job, I used to financially support her but now that I am retrenched, I cannot help her. I will assist her to apply for her grant as the doctor at the clinic recommended" (Thabo).

"My sister was unmarried; she separated with her boy-friend a long time ago. We, as family did not even know her boyfriend and the reason for their separation is unknown to the family" (Celiwe).

- **Sub-theme 3.8:** Stigmatization by family, partner and community

Dusome *et al*., (2015) assert that the stigma associated with mental illness makes most people reluctant to talk about their experiences of having strange thoughts or deep sadness. Sehoana and Laher (2015) cite Kakuma *et al*., (2010) who infer that mental illness leads to unfair discrimination and victimization of those with mental illness.

The following excerpts from data analysis confirm the reality of challenges pertaining to the stigma issues, which mentally ill people contend with in their daily lives.

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*"They do not treat her well, they laugh; they sometimes talk bad about her, silly… saying that she does not have a husband and so… on… Sister (*referring to the researcher*) they heard that she is not mentally well and they talk about her mental illness, I do not hope that they will ever change their attitude"* (Sipho).

"*Her sisters should refrain from insulting her about her past and her choice of a husband*". (Emihle).

"*They would even insult her about her mental illness*" (Nobuntu).

"At times communities lack insight when it comes to mentally ill people, they do not understand how we, as families feel" (Celiwe).

"*When my wife is sick, she becomes violent and shouts at me and my children without provocation. Our neighbours never help us by calling the police. Instead, they stare at*

us. They do not even visit our house because of my wife's mental status. We live in isolation" (Thabo).

"*Some community members do not want to have any-thing to do with my family but yes, some individuals are supportive. I remember they called the police when my daughter was raped on her way to a nearby shop"* (Fezile).

"My sister used to run away from my house when in a relapsed state. She would say that my wife and I had chased her away, whereas there was no such thing. I had to run after her. The way people in the neighbourhood look at me when running after my sister, makes me feel a deep pain (deep pause*). They even stop their children from coming to my house to play with my children"* (Babalo).

The psychiatric doctor's observation is that families isolate mentally ill members because of the stigma attached to the illness. In former disadvantaged areas, derogatory names such as "*igeza***",** "*unqwakunqwaku",* are used to name the mentally ill. The stigmatization further makes the patients not to function properly and develop a low self-esteem. Some families do not talk about the illness of their family member to other family members. They hide the illness or hide the fact that the member is mentally ill.

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Theme Four. INTERVENTION STRATEGIES SUGGESTED BY PARTICIPANTS.

The following sub-themes came forth during further analysis of the data.

Sub-theme 4.1: Need for community supportive resources

"On one occasion, social workers took my mother's ID and promised to apply for a grant for her but nothing came of it. When I tried calling them, their phones were always on voice mail. She is currently at Tower, and I do not know what happened to the grant application (Emihle).

"We need a place in the community where we, as caregivers can run to for protection when the mentally ill member is aggressive towards us. This child has a lot of energy when she is in a relapsed state" (Nobuntu).

"When my wife turns violent, shouting at us and the neighbours, we do not know where to go. We call the police to assist us but they delay, it hurts me" (Thabo).

"*The police take long to assist us when my sister is in a relapsed and violent state"* (Babalo).

"More psychiatric nurses are needed in our clinic for quick service because my sister becomes agitated easily at times" (Celiwe).

"When I take my daughter to the clinic, most of the time we spend the whole day because the clinic is always full with few nurses on duty" (Fezile).

The psychiatric doctor's observation was that there are not enough local psychiatric clinics in the Nelson Mandela Municipality. The psychiatric doctor also emphasized the need for rehabilitation resources in the community.

- **Sub-theme 4.2:** Need for professionals trained in psychiatry

"We need to see psychiatric trained nurses at the clinics. I wish they could have a separate section at the clinic for quick service" (Celiwe).

"I wish she can be treated well when she is in the hospital. I will be glad if knowledgeable people like nurses and social workers can visit when she is at home. (Babalo).

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The psychiatric social worker reiterated the need for psychiatric trained people. The social worker said that more people trained in mental health are needed in the community, as psychiatrists that work in the clinics are currently non-existent. There are only 10 to 12 social workers who serve the entire Nelson Mandela Municipality. The social worker further suggested that it would be helpful if the Department of Social Development can train psychiatric social workers in the community to service the broader area.

4.5 BIOGRAPHICAL CHARACTERISTICS OF INDIVIDUAL PARTICIPANTS.

The following table constitutes the biographical details of the individual interviews participants. All the individuals fit the required characteristics of the participants in that

they are family or caregivers of the mentally ill women with repeated admission in a psychiatric institution. As correctly stated by Hesse-Biber (2017) some of the participants' details such as age will be transformed into numbers.

Table 4.3 Biographical characteristics of the participants

	Pseudo name	**Gender**	**Marital status**	**Age range (in years)**	**Relationship to patient**	**Employment**	**Resident**
1	Themba	Male	Single	40-49	Brother	Casual jobs	Uitenhage
2	Laetitia	Female	Married	50-59	Mother	Unemployed	Port Elizabeth
3	Amanda	Female	Single	50-59	Mother	Unemployed	Uitenhage
4	Nozibele	Female	Widow	60-70	Grand Mother	Pensioner	Port Elizabeth
5	Mzamo	Male	Married	60-70	Uncle	Pensioner	Uitenhage

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All the 5 participants came from the Nelson Mandela Bay Municipality comprising Port Elizabeth, Uitenhage and Despatch. They all speak IsiXhosa and had the experience of caring for mentally ill women with repeated admissions in a psychiatric institution.

The researcher, used the age range instead of asking them their exact ages. The participants' ages range from 40 to 70 years.

The participants' ages as shown in the table above;

There was 1 participant in the 40 to 49year category, 2 in the 50 to 59year category and 2 in the 60 to 70year category.

Of the 5 participants 3 were females and 2 were males. Two of the participants were married, 2 were single and 1 widowed. In line with the qualitative data collection method, all the participants took part in the unstructured interviews.

The researcher relies heavily on De Vos et al, (2012) who states that open ended questions must be used "to allow participants to express themselves freely".

4.6 PRESENTATION OF THE THEMES AND LITERATURE CONTROL

After the analysis of the transcribed data, four themes and sub themes emerged. The themes and sub themes are presented in the following table;

Table 4.4 Themes and sub themes

THEME ONE: BEFORE BECOMING MENTALLY ILL
Sub-theme 1.1: Education
Sub-theme 1.2: Employment status
Sub-theme 1.3: Relationship with family
Sub-theme 1.4: Relationship with partner or husband
Sub-theme 1.5: Relationship with friends/concerned others
THEME TWO: HISTORY OF MENTAL ILLNESS
Sub-theme 2.1: Personal factors Sub-theme 2.2: Mental illness in the family
Sub-theme 2.3: Environmental factors
THEME THREE: CAUSES OF REPEATED ADMISSIONS
Sub-theme 3.1 Neglect and lack of supervision by family
Sub-theme 3.2 Neglect and lack of supervision by partner or husband
Sub-theme 3.3 Default of medication

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Sub-theme 3.4 Alcohol and substance abuse
Sub-theme 3.5 Lack of understanding of mental illness by family, partner and husband
Sub-theme 3.6 Abuse of state grant by families
Sub-theme 3.7 Lack of financial support from the partner or husband
Sub-theme 3.8 Stigmatization by family, partner and community
THEME FOUR: INTERVENTIONSTRUTEGIES SUGGESTED BY PARTICIPANTS
Sub-theme 4.1: Provision of community support resources
Sub-theme 4.2: Provision of professionals trained in psychiatry

4.7 DESCRIPTION OF THE THEMES AND SUB THEMES

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As mentioned above and based on the qualitative nature of the current study, the researcher used thematic analysis to code and identify themes and sub themes that emerged during interviews with participants. Saldana *et al.*, (2018) define a theme as a phrase or sentence that "identifies and functions as a way to categorize a set of data into a topic that emerges from a parten of ideas". In the following section themes and sub themes will be discussed followed by direct quotations from the participants taken from the transcripts of the participants' interviews. Literature control will be provided.

Theme One: Before becoming mentally ill: During the discussion with the participants about the welfare of the mentally ill women, before they became mentally ill, the following five sub themes emerged;

- **Sub theme 1.1:** Education.

The purpose of this sub theme is to understand the mental state of the mentally ill women when in a school setting before they became mentally incapacitated.

The researcher asked the participants about the mental state of the mentally ill women when in a school setting.

"*Before she became mentally ill she was well behaved and I never received any bad report about her from her teachers. Sometimes she would do her homework with her friends. She met her first boyfriend while she was still at school doing grade 8*" (Laetitia)

"*She was afraid of doing bad things at home and in the location. When she was in primary school she was clean and I bought expensive school shoes and an expensive school bag because she loved her books. I did not want her to feel neglected since her mother passed away when she was only 2 years old. She never disappointed me. At school she socialized well with her peers, even in high she did so well"* (Nozibele)

"I am not going to sit here and lie to you. I did everything possible to raise her well like any other child, because she is my late sister's child. Her father deserted her to stay with another woman after the death of her mother. I sent her to school and she did well, she socialized well until she passed her grade 12" (Mzamo)

"*At school she made good progress and socialized well with her peers. There were no signs of mental distabance"* (Amanda)

"*Ja she went up to grade 10 at school and I can tell you she was a hard worke but due to financial problems she could not finish school*" (Themba)

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The bove excerpts show that the mentally ill women were high functioning while in a school setting.

- **Sub theme 1.2:** Employment status.

The current theme looks at how mentally ill women functioned before they became mentally ill in the work place. The following excerpts demonstrate how well the mentally ill women functioned in the work environment before the mental illness set in.

The researcher asked the participants how the mentally ill women functioned in a work setting.

"After dropping out of school due to financial constraints my sister worked as a domestic worker here in Uitenhage. She was very supportive and would buy groceries and other needs. As I depended mostly on odd jobs, my sister would assist with my needs without complaining. Our

parents died some time ago and we were left to fend for ourselves. She was never dismissed for wrong doing at her place of work" (Themba)

"*After finishing her matric my child was employed as security guard at Brister House in PE. She took her job seriously. Her work kept her busy, sometimes she worked night shifts but she never misbehaved"* (Amanda)

"*She worked for a butchery in Despatch as a general assistant. At work she used to have outbursts and misunderstandings with her colleagues and her supervisor. All along I was not aware that she was HIV positive because she hid it from me. In a particular day she became sick and I accompanied her to the clinic. Back home from the clinic she disclosed her status and told me that she was infected by her first boyfriend while she was still at shool. Mhhh I was shocked but there was nothing I could. Only God knows"* (sobbing) (Laetitia)

The above excerpts show that the mentally ill women were mentally sound until environmental factors took their tall on their mental state making it difficult for them to cope at work.

- **Sub theme 1.3:** Relationship with family.

This sub theme emerged from the process of data collection and data analysis. The following excerpts show how the mentally ill women related with their families before they became mentally ill.

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"*Hey my sister was a good person, she never held a grudge against anyone. She was peaceful. Although my aunt never supported us but when she visited my sister would make her tea and offer her a plate of food. She was loved by her friends and neighbors because of her personality. Sometimes some people took advantage of her* (Themba)

"*My grand child was very sweet in her childhood. She liked cleanliness and after school she would help me with home chores. She had a very good relationship with her uncle with whom we stayed. Yes! Mam* (showing respect to the researcher) *we stayed together under the same roof. Her uncle opened her a bank account so that she could learn to save while still young. I was pleased because I would not like to see my grand child suffering after I am gone. She used to appreciate this and she was very close to all of us, even to my sister who stays in Motherwell* (Nozibele)

"*Tjo…… social worker* (nodding his head), *I played a role of a father to her and she respected me. She listened when I reprimanded her. She was very close to my wife. She would even*

confide in her when she was upset with anything. We had a very good relationship as a family (Mzamo)

"*She was a quiet child by nature and she seldom had quarrels with the family. I think her love for the gospel music had something to do with the way she related to us as her family. When at home she liked to sing to us some of the songs they rehersed. We really enjoyed our time together. I had always hoped that she was going to be a professional gospel artist* (Amanda)

"*Oh! My heart is sore because of the way in which my mother treated my child. You know what, this child was born out of wedlock and when I got married I took her to stay with my mother in Uitengage. Before I took her to my mother we had a good relationship. Her step father and* (step) *siblings loved her but I took her away to avoid complications with my husband. Yes, you will never know but now she is back with me"* (Laetitia)

According to the above excerpts, the relationships between families and the mentally ill women were cordial except for Letitia's daughter who was illtreated by her maternal grand mother. The relations were good before the mental illness and the mentally ill women bonded very well with their families.

The researcher is in complete agreement with Njue *et al.* (2007) in Mokgothu *et al.* (2015) who states that family cohesion is the emotional bond felt by families for one another.

- **Sub theme 1.4:** Relationship with partner or husband.

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After analyzing the collected data, a sub theme of the relationship between the mentally ill women and husband or partner emerged. During the individual interviews, it transpired that some of the mentally ill women were abused and neglected by their husbands or partners before they became mentally ill.

The excerpts that follow are evidence of the plight women suffered in the hands of their husbands or partners. Some of the mentally ill women suffered neglect even before they were diagnosed as mentally ill.

"*You know what sister* (referring to the researcher)*, this is a long story, but I am not going to waste your time. My child was sexually abused by her boyfriend at a tender age, while doing Grade 8. Following that imcident she started doing strange things. You know one day she set the principal's office alight and ran away. This boyfriend is the one who infected my child with HIV. My child was still too young and new nothing about these things. Oh! My heart is bleeding to this day. My child child was left by that boy emotionally messed up. After breaking up with*

him she met another one who fathered her a child. After the birth of the child she started behaving strange even neglecting the child. Her boyfriend chased her away because they were staying together" (Laetitia)

"*To speak the truth, this child was unfortunate, because her first boyfriend was doing drugs and he forcefully introduced her to drugs. He abused her and always demanded to sleep with her. If she refused, he would force himself on her. This went on and on until my child discovered that this boy was cheating on her. She was so devastated that she made an attempt on her life. Since she was staying with this boyfriend she smashed the windows and broke the door of his house. We were called because she was very aggressive* (Amanda)

"*My sister left me to stay with her partner. I soon realized that her partner was abusing alcohol and dagga. My sister was not a drinking person but she, like her partner eventually started to drink and smoke dagga. I did not like their relationship, as a result I called her to come back home but she refused, may be she was scared of her partner, I don't know. In 2016 I was told by her friends that she was admitted here in Cayler Hospital after showing signs of aggression. She also pelted the house they were staying in with stones. What makes me angry is that the nurses at Cuyler told me that her partner never visited her in hospital"* (raised his voice and was visibly angry) (Themba)

"*Mhhh (*taking a deep breath) *I am really so disappointed after everything I have done for her. I wanted her to be something in life but look at her now. This is what happened, I am a strict person and my grand daughter would sometimes visit her maternal aunt in Motherwell and this when the problem started. She mixed with bad friends and eventually met with his partner who was abusing drugs. She developed a tendency of disappearing from home until she disappeared for three months without trace. I involved the police to look for her. When police found her at her partner's house they dropped her back home. While at home she appeared to be mentally unstable. She claimed to see things we could not see. She was also scared of things we did not know. I took her to Dora Hospital where blood samples were taken and traces of drugs were found in her blood. She was put on psychiatric medication and discharged back home. She took her medication and everything went well. After some time, she went back to her partner and they started abusing drugs again. When her partner realized that she had savings, he forced her to spend the money I had saved for her on drugs. What really got into me was that her partner assaulted her"* (Nozibele)

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"*After passing matric my niece got married to her husband and everything went well. They stayed together without problems until their second child was born. I don't know what went wrong, because they would have constant fights and she would report to me. She always told me that her husband did not support her financially. He spent all his money on other women and on alcohol. Her husband would stay away from home for days on end leaving her without food and other necessities. She would visit me and my wife and ask for food. This situation stressed her so much that she ended up in hospital where she was diagnosed with depression. She was also put on medication mhmm* (with a deep breath). *What also worries me is that my niece's father does not want to have anything to do with her. I want her to come back home, the doors are open, but she is reluctant" (*Mzamo)

The excerpts discussed above clearly demonstrate the manner in which the extremely strained relationships of the mentally ill women with their partners or husbands impacted on their mental health.

- **Sub theme 1.5**: Relationship with friends/concerned others.

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On analysis of the collected data a sub theme on the relationship with friends/concerned others came to the fore. It transpired during the interviews that some of the relationships between mentally ill women and their friends/concerned were good while others were not so good.

The following excerpt shows that one of the mentally ill women was in a toxic friendship.

"*She mixed with bad friends and eventually met with his partner who was abusing drugs"* (Nozibele)

During the interviews the researcher realized that the choice of friends is of paramount importance because it can negatively impact one's health. For example, Nozibele's grand child, when visiting her maternal aunt in Motherwell got mixed with wrong friends who introduced her to alcohol and drugs. Their relationship impacted negatively on her mental state.

Theme Two: History of mental illness.

During individual interviews the following sub themes emerged;

- **Sub theme 2.1:** Personal factors.

During data analysis the researcher noted that personal factors also played a critical role in causing mental illness. For example, Lombo (2010) asserts that substance abuse was mentioned by one of the participants in the study on Mental illness within the IsiXhosa cultural context as the cause and consequence of mental illness. People who continue using drugs consequently develop dependence and addiction if the addicted person does not receive treatment.

The following extracts from the individual interviews attest to the above statement.

"*Her boyfriend coerced her into using drugs until she displayed signs of mental illness"* Amanda

"*She was taken to Dora Hospital where blood samples were taken from her. Traces of drugs were found"* (Nozibele)

"*My sister would tell me that her partner would force her to drink alcohol and smoke dagga even when she refused. In 2016 we heard from her friends that she admitted in hospital because she displayed an odd behavior. After spending time in the hospital she was diagnosed with mental illness and was put on medication"* (Sesethu)

The extracts cited above confirm severity of alcohol and drugs on mental illness. The mentally ill women mentioned in the above exerpts were mentally fit until they were introduced to alcohol and drugs.

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- **Sub theme 2.2:** Mental illness in the family.

When analyzing the data, the researcher realized that the mentally ill women were not the only ones affected by the mentall illness, but in some cases there were some in their own families who suffered the same fate. These family members may not have been subjected to abusive situations like the mentally ill women with repeated admission in a psychiatric institution. Therefore, the researcher is of the view that this can only point in one direction, namely, genetic determination of mental illness.

Of the 5 individuals interviewed, only one had family members who are also mentally ill and on psychiatric medication.

The following excerpt taken from the individual interviews shows that mental illness can in some cases be genetic.

"*My brother and my sister are both mentally ill and they are on psychiatric medication but I do not know their diagnosis. All I know is that they are mentally ill. I always accampany my sister to the Day Clinic for her medication"* (Leatitia)

Heekin and Polivka (2015) argue in favour of genetic disposition to mental illness. According to the authors mentioned above, "genetic risk factors have been indicated as important in the causation of many mental disorders, including schizophrenia, bipolar disorder, major depressive disorder, and generalized anxiety disorder.

- **Sub theme 2.3**: Enviromental factors.

Upon thorough analysis of the collected data from individual interviews, the researcher became fully aware that environmental factors play a crucial role in causing and perpetuating mental illness. The afore mentioned statement is corroborated by Olawande *et al.,* (2018) when he argues that constant subjection of women to sexual violence results in a high rate of Post Traumatic Stress Disorder.

The following extracts from the individual interviews attest to the major role played by unsatisfactory environmental factors in mental illness.

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"*My niece stayed harmoniously with her husband here in Uitenhage, Ja, as I said before, there were no problems between them. Things changed for the worse after the birth of their second child. There was a lot of fighting between them and my niece would call me to intervene. Her husband abused her because he spent his money on other women. My niece would come to us crying without food for her children. This stressed her to such an extent she was admitted in hospital and was diagnosed with depression. As I am talking to you now she is still on medication"* (Mzamo)

"*Eish things were bad for my child because after breaking up with her abusive boyfriend she met another one and they stayed together. Now this young man made her pregnant. After that he chased her away with the child. I could see that she was frustrated and she started behaving funny. She neglected her personal hygiene and*

sometimes would even undress in public. Tjo I feel so embarrassed when she does that, I don't want to think about it. Eish you know how the people of this place can be" (Amanda)

"*My grand child, while visiting my sister in Motherwell would disappear with her friends, loose friends. On one occasion she was brought home by the police. I took her to Dora because she appeared to be mentally disturbed. Blood samples were taken and drug traces were found in her blood. It became clear to me that in Motherwell she was visiting all the wrong places because in that place there are many shebeens and taverns. Drugs are all over the place"* (Nozibele)

Heekin *et al.,* (2015) mention among other environmental factors associated with mental illness the following examples; death of a loved one, job loss, financial hardships, and excessive intake of alcohol and drugs. The above excerpts from the individual interviews confirm the afore mentioned statement that environmental factors like too much consumption of alcohol and drugs has adverse effects of mental health.

Theme Three: CAUSES OF REPEATED ADMISSIONS.

On further analysis of the data the following sub themes emerged;

- **Sub theme 3.1:** Neglect and lack of supervision by the family.

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During data analysis it became apparent to the researcher that neglect of the mentally ill plays a part in their repeated admission in a psychiatric institution. Mokgothu *et al***.** (2015) correctly argue that where families fail to look after their mentally ill members, the mentally ill members relapse which eventually leads to repeated admissions.

The following extracts will demonstrate this point.

"*My mother illtreated my child very much while she was staying with her in Uitenhage. She over worked her and deprived her food. She never supervised her medication, which is why my child ran away to stay with her boyfriend. For that reason, I took a decision to take her to stay with me"* (Leatitia)

"*I am always at work during the day and leave my daughter with my brother and my other two children, what I have noticed is that after each discharge she relapses quickly. Sometimes she relapses after a month of her discharge from the hospital. I suspect that when I am away at*

work they do not bother about her. I am the bread winner and I can't stop working, who is going to support us. That is the pro blem I am faced with. At some stage I asked the hospital to take her to Tower Hospital for rehabilitation so that she can learn to take responsibility for her medication, but that did not help. She continues defaulting *her medication because no one cares about her*" (Amanda)

Three of the individual participants stay with their partners or husbands hence only the two mentioned above have been cited. The two extracts cited show that there are cases where the mentally ill women are not taken care of by their own families, which in turn causes them to relapse.

- **Sub Theme 3.2**: Neglect or lack of supervision by partner or husband.

This sub theme relates to the neglect by partner or husband. The following excerpts display how partners or husbands of the mentally ill women respond when their mentally ill wives or partners fall ill.

"*Her boyfriend never visited her in hospital and he failed to supervise her medication, as a result my grand daughter relapsed now and again*" (Nozibele)

"*After her discharge I begged her to come and stay with me so that I could supervise her medication, but she refused and went back to stay with her boyfriend. They continued with their dagga abuse until she relapsed. This did not happen once but several times caused her to relapse now and again*" (Themba)

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"*I think lack of support from her partner is the reason behind her admissions, I don't know I may be wrong but this is what I think, because eversince started to staying together with him she has been in and out of the hospital*" (Mzamo)

"*Her second boyfriend left her for another woman. He neglected her and never ever supported her at al*l" (the participant was tearful when saying this) (Amanda)

"*After each discharge from the hospital she would go back to her boyfriend who is the father of her child. When she is there she is not supervised which causes her to relapse and go back to the hospital*" (Laetitia)

The above extracts are consistant with Melrose *et al.*, (2015) who argue that when people are mentally ill they cannot cope with their daily duties and they cannot work

effectively. Therefore, the researcher fully concurs that the mentally ill need all the support they can get from the people close to them

- **Sub Theme 3.3:** Default of medication.

On combing the data collected the researcher realized that default of medication was a common thread throughout almost all the different cases. As a consequence of defaulting of medication the patients relapsed and were admitted to a psychiatric institution.

The following extracts from the individual participants attest to the above statement.

"*After each discharge from the hospital she would go to her boyfriend* (father of her child) *and would default her medication and relapse"* (Laetitia)

"*She went to stay with her partner and after some time we heard from their neighbours that she was in a relapsed state. They called us because she was very aggressive, smashing windows and braking anything in front of her. We took her to the hospital*" (Amanda)

"*Oh that boy did not care about her medication. He did not support her in any way. When she stayed with him I knew she would relapse"* (Nozibele)

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"*When she was discharged from the hospital, I begged her to come home so that I could help with her medication, but she refused and went back to her abusive boyfriend. When there, they continued with dagga abuse until she relapsed"* (Themba)

"*Mam* (referring to the researcher) *I can tell you without any doubt, the lack of support from her partner made her not to take her medication. I am saying this because after her discharges from the hospital she is always fine but when they are together the problem starts. You see, ja!"* (Mzamo)

- **Sub Theme 3.4:** Alcohol and substance abuse

Heekin *et at.,* (2015) mention excessive alcohol abuse as one of the factors with dire consenquences for mental illness.

Lombo (2010) corroborates the above statement by citing Bauman (1998) who correctly indicates that “abuse of harmful substances can be understood at the level of brain psychology”.

The extracts from the individual interviews, cited below, underline the consequences of excessive indulgence on alcohol and other substances.

“*Her boyfried forced her to drink alcohol and smoke dagga even when she refused”* (Themba)

“*She cohabitated with her boyfriend who was hooked on drugs. Her boyfriend introduced her to substances, including alcohol until she displayed signs of mental illness”* (Amanda)

“*She mixed with bad friends who abused alcohol and it was during this time that she met her boyfriend who also abused drugs. On one occasion, while in hospital, her blood samples showed traces of drugs. She was in a relapsed state then”* (Nozibele)

The above excerpts clearly show the extent to which drugs and alcohol negatively connect to mental illness.

- **Sub Theme 3.5:** Lack of understanding of mental illness by family, Partner and husband.

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Olawande *et al.,* (2018) argue that mental illness or abnormal behavior may be seen as normal in another culture, in other words culture plays a huge role in the understanding abnormal behavior.

The researcher, while analyzing collected data, realized that some families consulted traditional healers when the patients displayed signs of mental illness in the initial stages. This is so because in some cultures mental illness is associated with witchcraft or ukuthwasa, i.e, a calling to be a traditional healer.

The following excepts demonstrate and confirm that there is no uniformity in the understanding of mental illness. Cultures look at mental illness differently.

“*In 2017 she was taken to a traditional healer but she refused to take the medication. She continued with her behavior until we took her to the hospital where she was diagnosed with Bipolar Mood Disorder. She was put on medication and things improved, but unfortunately she defaulted”* (Amanda)

"*When my mother noticed that my child's behavior was odd she chased her away. She ran to her boyfriend who also chased her away. I took her to stay with me, mhmmm* (she started sobbing). *What saddens me a lot is that I did not know that all along my child was ill"* (Laetitia)

"*My son suspected that she was bewitched and suggested that we take her to a traditional healer, but I refused, instead I took her to Dora"* (Nozibele)

"*After discharge from the hospital, they always continued with their dagga and alcohol abuse which made her to be admitted in hospital on many occasions"* (Themba)

"*His husband left her with her children to stay with other women"* (Mzamo)

Lack of understanding of mental illness by families, partners or husbands contributes to repeated admissions, as can be seen in the above extracts.

- **Sub Theme 3.6:** Abuse of state grant by family.

According to Gunhidzirai *et al*., (2017) the White Paper was produced as a strategy of the government to alleviate porverty through offering grants as a relief to vulnerable individuals. During the analysis of the individual interviews, the researcher realized that one of the patients was a state grant recipient.

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"*My mother used to abuse my child's disability grant, and when she demanded her money she would chase her away. This would make my child extremely angry"* (Laetitia)

- **Sub Theme 3.7:** Lack of financial support from the partner or husband.

Jewkes *et al.,* (2001) in Yemeke *et al.,* (2017) assert that apart from physical and sexual abuse, "women also suffer from emotional and financial abuse within intimate relationships, and other foms of abuse are often co-occuring".

"*Her husband abused her financially. He would leave her starving with her children and he would spend his mother on other women. She eventually ended up in hospital where she was diagnosed with depression*" (Mzamo)

“*Her boyfriend does not support her but instead spent the money I had saved for her on drugs and alcohol. I am really hurting”* (Nozibele)

“*I never heard that her boyfriend had ever supported her financially except abusing drugs with her*” (Themba)

“*Her boyfriend did not give her financial support. He even failed to take care of his own child. Instead he chased her away from his house”* (Leatitia)

The above excerpts are a further indication that withholding of financial support can also have dire consequences on mentally ill women.

- **Sub Theme 3.8:** Stigmatisation by family, partner and community.

Sehoana and Laher (2015) cite Kakuma *et al.,* (2010) who infer that mentally ill people suffer unfair discrimination and victimization.

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The following excerpts that emerged during data analysis show that the discrimination and victimization does not only occur in the communities where they stay, but unfortunately the families themselves engage in such practices.

“My child was treated differently. My mother did not treat her like her other grand children she stayed with. She overworked her and deprived her food. She neglected her. I really do not know who would do that to her own blood” (There was a long pause, and the researcher noticed that her eyes were welling) (Laetitia)

“*What worries me is that I am all by myself, because my aunt does not care for my sister. Eversince my sister became mentally ill my aunt distanced herself”* (Themba)

"*Sometimes when she is a relapsed state she goes around nude and I feel humiliated. When chasing after her the on lookers would make fun of me. It is so humiliating"* (Mzamo)

"*My neighbours did not like my grand child. They even stopped their children from playing with her. My neighbours also isolated me because they were of the view that I had spoiled her hence her behavior*" (Nozibele)

"*When I leave her with my brother and her siblings they do not assist her until I come back from work. This makes her to default her medication. Whe she is sick the neighbours laugh at her"* (Amanda)

The researcher believes that the stigmatization of the mental illness makes the patients feel ashamed of themselves and develop a low self esteem.

THEME FOUR: INTERVENTION STRATEGIES SUGGESTED BY PARTIPANTS.

On further analysis of the collected data, the following sub themes emerged.

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Sub Theme 4.1: Lack of community supportive resources.

"*My child is most of the time, board. I wish she can attend a community project during the day because she gets tired of sitting at home doing nothing. Another thing I wish my child can get a grant because I cannot meet all her requirements as I am the only working here. Every one depends on me"* (Amanda)

"*The government must build places where the mentally ill people can go to during the day and be trained on how to take their treatment and how to look after themselves*" (Nozibele)

"*Mentally ill people like my sister must be sent to a place, if there is any around here, where they can be rehabilitated from abusing alcohol and dagga. It is always my hope that my sister can be rehabilitated to be who she was before because she is not stubborn person by nature"* (Themba)

"*Oh I am not coping because I am advanced in age. I so wish my child's sister can be taken to another hospital or place so that she can be far away from this abusive husband. I am prepared to look after her children*" (Mzamo)

"*I don't know, may be if there is a place where she can go and keep herself busy, like for instance sowing, I don't know. Because she gets tired and I am not coping, so if she keeps busy then it gives me some relief. She once applied to Siyaya Skills Training Centre in the beginning of 2018, if I am not mistaken but she was not taken. I don't know why she was rejected*" (Laetitia)

Sub Theme 4.2: Need for professionals trained in psychiatry.

"*If we can have nurses who can teach us about mental illness because we do not know what to do when we are confronted with a mentally ill person especially where violence is concerned*" (Laetitia)

"*I so wish the social workers can visit our homes to see whether we are coping, because it is so difficult to live with a mentally ill person*" (Nozibele)

"*I can be pleased if there can be more doctors in the clinics so that we do not have to go to the hospitals because we do not have money for travelling, these hospitals are very far*" (Themba)

"*I wish the police can respond quickly when we call them, to save us the humiliation of having to chase after a mentally ill person. That is my plea to the police*" (Mzamo)

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"*I am struggling because I do not know much about Bipolar Mood Disorder, I wish the doctors and nurses can tell me more about this illness. All I know is that my child is mentally ill, besides that I am ignorant*' (Amanda)

4.8 SUMMARY

This chapter dealt with data analysis. Four themes from the data were identified and a number of sub-themes emerged out of those themes. All the themes were in line with the objectives of this study. Excerpts from the focus group discussions and from the individual interviews' participants were used to substantiate the themes and the sub-themes. The discussions were supported by theory, namely, the thematic analytical

approach used for data analysis. Therefore, Chapter 5 will focus on summary, conclusions and recommendations of this study.

CHAPTER FIVE

SUMMARY, CONCLUSSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Grbich (2013), on conclusions and recommendations, asserts that at this point, the researcher presents a final summary of what has been found, together with what needs to be done.

Du Plooy-Cilliers, Davies and Bezuidenhout (2014) concur with the above stated view say that the conclusions and recommendations section is used to discuss the most important points related to the analysis of the research findings and merge final arguments.

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In the previous chapter, data was analyzed, and excerpts from both the focus group sessions and interviews with individual participants were presented. A variety of revealing arguments emerged, relating to causes of repeated admissions. In conclusion, the researcher present findings that have been arrived at after a rigorous process of data analysis.

5.2 CONCLUSIONS

5.2.1 CONCLUSIONS RELATING TO LITERATURE REVIEW AND THEORETICAL FRAMEWORK

An investigation into causes of repeated admissions was not done in isolation from abuse of women in general. Literature review provided evidence about adverse implications of abuse on the mental health of women.

While reviewing literature, the researcher came across a variety of terms, relevant to the study, which describe abuse, for example, gender-based violence, intimate partner violence and sexual violence. These terms helped the researcher in understanding the behavioural patterns of women who are survivors of abuse. The terminology further helped the researcher in understanding dynamics of a relationship which is characterized by abuse and violence.

The review of literature also described different dimensions of abuse, namely, emotional abuse, psychological abuse, physical abuse, to mention but a few. Consistant with the above statement, one of the participants told a story of his sister who was subjected to emotional abuse by her partner. Her partner would leave her to look after his girlfriend's child while he went to stay with his other girlfriends. Her sister financially dependent on her partner for financial survival.

Of cardinal importance for this study is the significance consulted literature places on consequences of abuse to the mental health of abused women. Several authors mention some of the mental diseases that result from constant exposure to abuse, particularly in the context of partner abuse like post-traumatic stress disorder and depression.

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One of the participants related a story of how their father neglected their mother. Their father had numerous extra marital affairs and would now and again come home drunk and assault their mother in their presence. These fightls affected their mother badly and this was the beginning of suffering and hardship for their mother.

Buzawa *et al*., (2017) argue that women exposed to partner violence experience high levels of depression and Post Traumatic Disorder. In agreement with the above statement, Laviolette and Barnett (2014) cite an example of earlier research by Houskamp and Foy, where 60% from two samples of abused women in need of treatment presented PTSD symptoms.

Use of the radical feminist approach helped highlight the skewed gender power relations between men and women, which results in the abuse of women by men. Gender inequality puts men in a position of advantage and makes women subservient to their male counter parts. For example, women become financially dependent on their male partners for their survival. This situation makes women vulnerable and abuseable to men.

Shamase (2017) asserts that feminism is a movement that seeks to transform society and challenges the patriarchal conception of male and female roles in society. Payne (2014) indicates that it is feminism's position that the very social structures and relationships in society put men in privileged positions and devalue women. Women with little economic power become the most affected.

In order to complement the feminist theory, the researcher also used the empowerment and advocacy theory. Payne (2014) defines the empowerment and advocacy theory as a theory that "seeks to represent the interests of powerless clients to powerful individuals and social structures". According to the findings of this study, mentally ill women were vulnerable because they were neglected by their partners and families. The study found that there is a need for psychiatric social workers and other professionals who can intervene on behalf of the mentally ill women after discharge.

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5.2.2 CONCLUSIONS RELATING TO THE QUALITATIVE RESEARCH PROCESS

As affirmed by Creswell (2013), in this study, the qualitative method was used to explore causes of repeated admissions of abused mentally ill women in a psychiatric institution. The explorative and descriptive research design was used to explore experiences of participants regarding causes of repeated admissions of abused mentally ill women in a psychiatric institution.

All participants had first-hand information of the home circumstances of abused mentally ill women with repeated admissions in a psychiatric institution. In-depth interviews helped the researcher gain in-depth knowledge of causes of repeated admissions of abused mentally ill women.

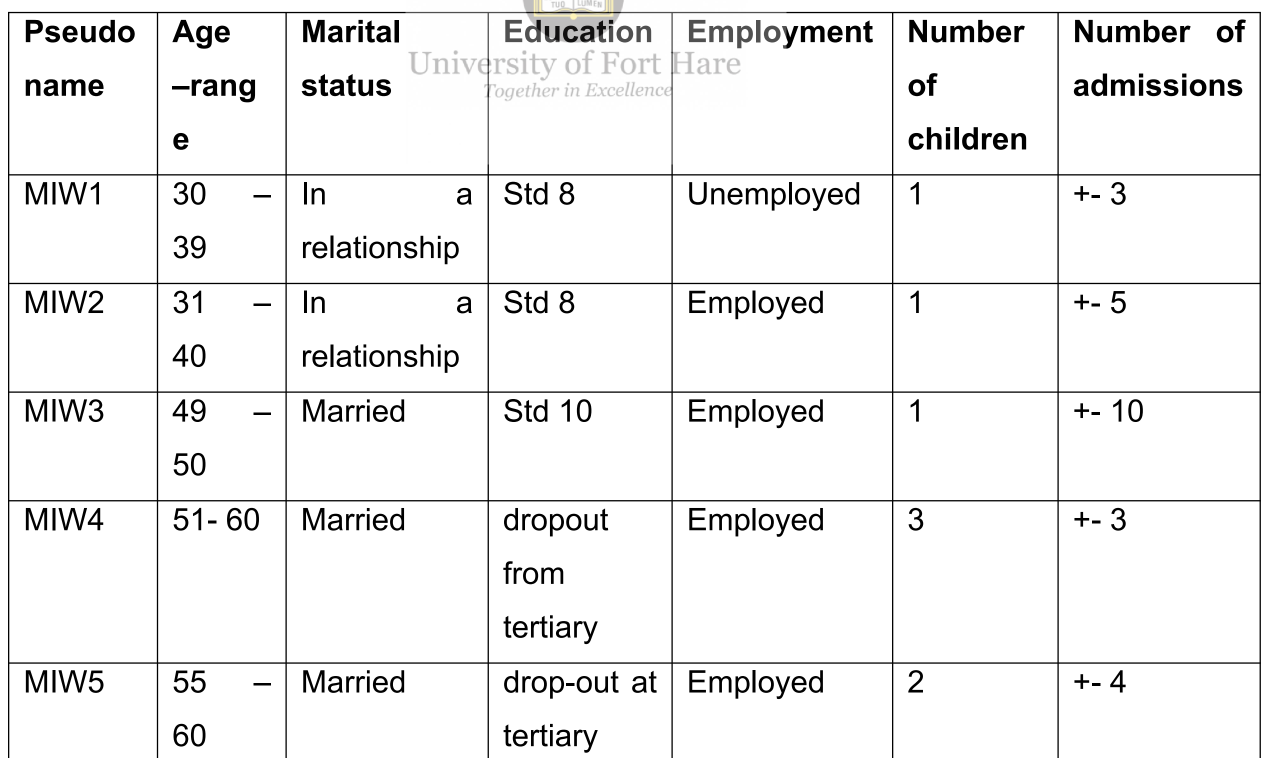
Therefore, the researcher can conclude that methods of data collected from participants and data analysis were appropriate for this study as they add a coherent, logical and systematic approach to data analysis. Ethical considerations employed in this study enhanced accountability of the research process.

5.2.3 CONCLUSIONS RELATING TO THE RESEARCH FINDINGS

As aluded to above, in the current study two methods of data collection were used, namely, the focus group and the individual interviews methods. Two tables of the biographical characteristics of the mentally ill women will follow. The first table comprises a list of the mentally ill women who were represented by their caregivers or families in the focus group. Subsequently a table consisting of the list of mentally ill women that were represented by individual participants will follow.

Table 5.1 Biographical charactaristics of mentally ill women

*The abbreviation (MIW) that appears under pseudo-name stands for Mentally Ill Woman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Pseudo name	Age –range	Marital status	Education	Employment	Number of children	Number of admissions
MIW1	30 – 39	In a relationship	Std 8	Unemployed	1	+- 3
MIW2	31 – 40	In a relationship	Std 8	Employed	1	+- 5
MIW3	49 – 50	Married	Std 10	Employed	1	+- 10
MIW4	51- 60	Married	dropout from tertiary	Employed	3	+- 3
MIW5	55 – 60	Married	drop-out at tertiary	Employed	2	+- 4

MIW6	60 – 69	Married	std 5	Employed	3	+- 3
MIW7	60 – 69	Separated with boyfriend	dropout from tertiary	Employed	2 but 1 passed on	+- 10

The focus group members who took part in the study shared with the researcher that the mentally ill women were mentally fit before they became mentally ill. As illustrated in the above table, all of the mentally ill women were once active in education and the work environment. There is only one member who has never worked. They all went through school. The least educated being a mentally ill member who went up to standard 5. Three have a secondary education. Three had to stop while attending training, one at a university and another one while training as a nurse and the last one while training as a teacher.

Table 5.2 Biographical characteristics of mentally ill women

The abbreviation (MIW) that appears under pseudo-name stands for Mentally Ill Woman

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Pseudo name	**Age –range**	**Marital status**	**Education**	**Employment**	**Number of children**	**Number of admissions**
MIW1	30-39	married	Std 10	Domestic worker	2	+- 7
MIW2	30-39	In a relationship	Std 10	Security guard	1	+- 4
MIW3	30 - 39	In a relationship	Std 10	General assistant	1	+- 5
MIW4	30- 39	In a relationship	Std 9	Disability grant receipient	1	+- 4

MIW5	40-49	In a relationship	Std 9	Unemployed	Nil	+- 7

5.2.3.1 CAUSES OF ABUSE ON MENTALLY ILL WOMEN

The first research question was about the causes of repeated admissions on mentally ill women. Under this section excepts from both the focus group and the individual interviews will be discussed.

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One of the participants (Sipho) said that his mother was constantly assaulted by his father because his father had extra marital affairs. Eventually his father left his mother for another woman. The following excerpt from sub theme 3.2 demonstrates the abuse Sipho's mother had to endure at the hands of Sipho's father.

"Since my father had these extra marital affairs, he would come home drunk and assault my mother now and again. This was the beginning of suffering and hardship for my mother. Mental illness showed when she was about 59 years, that was the onset of her mental illness. She was affected sister when her husband left her. She did not know sister what she was going to do with her children" (Sipho)

The following excerpt from sub theme 2.2, shows how Thabo's wife who grew up in a polygamous marriage was affected by the treatment which her mother endured at the hands of her father. It goes on to show how it affected his wife long after she had left

her home where her mother was ill-treated. According to Thabo, his wife's mental illness cannot be separated from the polygamous situation in which his wife was raised and grew up in. In other words, the environment his wife grew up in, traumatized her to the extent that she has since been on psychiatric medication for the past +- 3 years.

"She is the product of a polygamous marriage. I found out she had a recycling anger and a defensive anger, always angry as if she was not treated well. This polygamy…yes…yes, I mean her mother was left by her father for another woman. She was raised by her mother without a father" (Thabo).

The following extracts show the extent of abuse the mentally ill women endure due to their compromised mental state. They became vulnerable to abuse by their partners.

"*Sexually abused by boyfriend while doing standard 6. After each discharge from hospital she would go to her boyfriend* (father of the child) *and would default medication and relapse"* (Laetitia)

'*Her boyfriend introduced her to drugs until she displayed signs of mental illness. He abused her sexually and emotionally"* (Amanda)

"*After some time she would go back back to her abusive boyfriend. When intoxicated with drugs her boyfriend developed a tendency of assaulting her"* (Nozibele)

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The following is another example of a woman who was mentally sound but due to adverse circumstances ended up on psychiatric medication. The participant's sister who was mentally sound then would be left by her husband to look after his girlfriend's child. During his time away from home he would be having a good time with his girlfriend while the participant's sister would be slaving away in their house with the child.

"My aunts even said that he is the one who made her ill" (Babalo)

The husband's behaviour regarding him leaving the participant's sister with his child underpins the aunts' view that the husband was responsible for their niece's mental illness. The participant's aunts, whenever they visited their mentally ill niece, they will always find her alone.

In can be concluded on the basis of the above stated excerpts that it is evident that a link exists between abuse and mental illness. Below the researcher will deal with the excerpts from the interviews with the participants which will show that abuse can lead to repeated admissions.

From the findings relating to the causes of repeated admissions of abused mentally ill women in a psychiatric institution, the following sub themes from the interviews with individual participants and the focus group stood out.

5.2.3.2 NATURE AND EXTENT OF ABUSE METED ON MENTALLY ILL WOMEN

The second research question was about the nature and the extent of abuse meted out on mentally ill women. From the research findings it can be concluded that the following sub themes stood out as the causes of repeated admissions of abused mentally ill women in a psychiatric institution.

The participants from both the focus group and the individual participants identified neglect by partner or husband or family as the most outstanding form of abuse. Their partners or husbands fail to support them financially especially if the partner is the breadwinner. Abuse of the state grant is a huge challenge. The grant is meant for the welfare of the ill individual but the partners and families of the ill members use it for their own benefit.

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The state grant is in the majority of cases a source of conflicts between the partners, families and the mentally ill members.

Neglect also results in defaulting the medication as it goes together with the lack of supervision.

Some of the participants expressed their concern about the excessive use of alcohol and substances by the mentally ill women and their partners when they are at home.

Lack of understanding of mental illness was said to be another reason for the manner in which partners and families dealt with the mentally ill women after discharge. The lack of knowledge calls for more education on mental illness and how partners and families can deal with the mentally ill women.

Stigmatization of mental illness was noted as one the main problem areas that need attention, if repeated admissions were to be reduced significantly.

Egbe, Brooke-Summer, Kathree, Selohilwe, Thornicroft and Peterson (2014) state that the mentally ill take time to seek help due to the fear of being stigmatized by families, friends, employers, communities and health care providers themselves. Melrose *et al.,* (2015) concur with the above stated and say that the stigma associated with mental illness makes most people reluctant to talk about their experiences of having strange thoughts or deep sadness.

The psychiatric social worker and the psychiatric doctor emphasized the dire shortage of trained professionals who can deal with the scourge of stigmatization at a local level and the shortage of resources in the community. Most of the clinics do not have a section for mentally ill patients where their needs are catered for. The mentally ill have to travel long distances to access their medication which can be a contributing factor in them defaulting medication.

The psychiatric social worker and psychiatric doctor mentioned the consultation of the traditional healers and faith healers as one the reasons for the defaulting of medication. In some cases, after consulting the traditional healers and faith healers, the mentally ill women are encouraged to discontinue with their mediation which eventually causes them to relapse resulting in repeated admissions.

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In reflecting on the findings, the study concludes that all of the above cited situations, for example, neglect, defaulting medication, stigma, abuse of alcohol and substances and abuse of the state grant, are the core of the causes for repeated admissions of mentally ill women in a psychiatric institution. In addition, the lack of understanding of the illness, continued abuse, lack of support, poverty and the unavailability of community resources to provide access to medication also complicated the situation of the mentally ill women.

According to Heekin and Polivka (2015) mental illness is associated with a variety of factors, namely, genetic or biological, environmental and psychological. Genetic factors are closely associated with mental disorders such as schizophrenia, bipolar disorder,

major depressive disorder, generalized anxiety disorder and obsessive compulsive disorder.

Closely associated with genetic factors are psychological factors. Heekin *et al.,* (2015) argue that psychological trauma which results from physical, or sexual abuse is responsible for the development of mental illness in childhood and adulthood.

As mentioned above, environmental factors also play a role in the causation and development of mental illness. Heekin *et al*., (2015) say that stressors have the potential to create strain that can lead to a diagnosable mental disorder, for example,

- Stressors such as the death of loved one,
- Separation or divorce,
- Changing schools,
- Job loss,
- Financial hard ships,
- Cultural and social variables,
- Excessive alcohol and drug use.

Trained psychiatric social workers, working together with families, clinics, Government structures, Non-Governmental Organizations (NGO) and other relevant community structures need to develop a long term preventative strategy that will benefit the mentally ill women and their families or caregivers to alleviate the fore-mentioned situations.

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5.3 RECOMMENDATIONS

5.3.1 RECOMMENDATIONS PERTAINING TO QUALITATIVE RESEARCH PROCESS

This study explored the causes of repeated admissions of mentally ill women in a psychiatric institution. Based on this study it is recommended that qualitative approach should be used to get an in-depth understanding of the causes of repeated admissions of mentally ill women.

The use of in-depth interviews as a method of qualitative data collection is recommended as it allows the researcher to enter the world of the participants and provide insights as to how they make sense of their context.

According to Creswell (2013) in "qualitative inquiry a researcher faces many ethical issues" particularly during data collection phase and data analysis.

The ethical considerations of informed consent, confidentiality regarding the information of the participants, anonymity of the participants and voluntary participation must be adhered to in-order to allow the participants to voluntarily withdraw at any time during the study. To protect the information gathered from the participants and their identity by using pseudo-names.

5.3.2 RECOMMENDATIONS PERTAINING TO RESEARCH FINDINGS

In the light of the findings on the causes of repeated admissions of the abused mentally ill women in a psychiatric institution the following recommendations can be made;

5.3.2.1 PSYCHO SOCIAL EDUCATION AND EMPOWERMENT OF THE FAMILIES

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Psycho social education and empowerment of the families about mental illness and how to interact with the mentally ill women. The responsibility should be undertaken by psychiatric trained social workers who will visit their homes after discharge.

In relation to educating the families Mokgothu *et al.,* (2015) underline the following aspects;

- Calming the mentally ill member by using kind words when talking to them. This helps in making them manageable and better.
- Explaining the importance of treatment to the mentally ill member.
- Keeping the mentally ill member busy as this help to reinforce positive behavior on the member.

- Protecting the mentally ill member from negative outside influences like strong beverages and alcohol as these tend to trigger the symptoms of mental illness.
- Positive and clear communication with the mentally ill member helps where a member needs to adapt to new situations.
- Praising the mentally ill member when he or she had done something positive.
- Creating a supportive and accepting environment so that the member can see that he or she is being sympathized with. Mokgothu *et al.,* (2015) cite Lawska *et al.* (2006) who correctly states that an accepting environment is indispensable for the rehabilitation and socio-professional therapy of the ill.

5.3.2.2 PSYCHO SOCIAL EDUCATION OF THE PARTNER OR HUSBAND ABOUT MENTAL ILLNESS

Psycho social education of the partner or husband about mental illness and how to deal with a mentally ill spouse. This will help in rehabilitating the partner's behaviour towards the mentally ill spouse or partner. Briginshaw, Clarke, Masa, Van Der Merwe, Meredith and Yared-West (2015) articulate a very important point in saying that when abused mothers are accommodated into shelters their older boys are not allowed to stay at the shelter with their mothers. They are therefore separated from their families or left unattended or in some instances made to stay with the abusive perpetrator. The researcher is of the view that the continued stay of the older boy with the abusive perpetrators can impact negatively on the boy's future behavior and he may develop anger issues. This situation may also make it difficult to break the cycle of abuse.

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The responsibility should be undertaken by a trained psychiatric social worker who will have psycho-social education sessions with families.

5.3.2.3 PSYCHO-SOCIAL EDUCATION OF COMMUNITIES ABOUT MENTAL ILLNESS

Psycho-social education of communities about mental illness especially the disadvantaged communities. To protect the mentally ill women from further abuse to reduce repeated admissions. Primary schools, secondary schools, and all other community structures, including faith-based organizations need to be targeted.

5.3.2.4 PROVISION OF MORE PSYCHIATRISTS AT THE COMMUNITY CLINICS

Provision of more psychiatrists at the community clinics. This will assist the mentally ill women not to travel long distances to the hospital to consult with psychiatrists, thus prevent defaulting of medication which results in relapsing and eventually in readmission.

5.3.2.5 TRAINING OF SOCIAL WORKERS IN PSYCHIATRY

Training of social workers in psychiatry. A module in psychiatry should be introduced at the institutions where social workers are trained. Most of the social work graduates lack the basic knowledge about psychiatry which makes them inadequate when they have to work in psychiatric institutions. Their role in these institutions is critical in helping the mentally ill women and their families towards rehabilitation. They also help in reconstructing broken relations between families and the mentally ill.

5.3.2.6 PROVISION OF HOMES FOR MENTALLY ILL WOMEN IN THE COMMUNITY

Provision of homes for mentally ill women in the community, particularly in disadvantaged communities. Places where mentally ill women can be accommodated when home circumstances are not conducive for them to stay. The government can assist in the realization of this recommendation because, according to the researcher's experience, these facilities are scarce in the Nelson Mandela Bay Municipality and the pricing is beyond the reach of the mentally ill women from the disadvantaged section of the municipality.

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5.3.3 RECOMMENDATIONS PERTAINING TO FURTHER AND FUTURE RESEARCH

In view of the study concluded, the participants of the current study recommended that further research should focus on the empowerment of both the survivours and the perpetrators of abuse on the mentally ill women. The participants' motivation was that the lack of knowledge about mental illness results in the abuse of the mentally ill women which in turn leads to defaulting of medication and relapse

5.4 PROBLEMS, CHALLENGES AND LIMITATIONS FOR THE RESEARCH METHODOLOGY

Du Plooy-Cilliers *et al*., (2014) correctly state that “limitations of the study refer to “any potential problems you foresee for conducting your study”.

In this context it is of paramount importance to say that the findings of this study are not suffient to draw causation with a note of finality as there are a host of other factors that can explain frequent repeated admission of patients. The researcher would also wish to explain that the participants of the focus group are relatively illiterate except the two professionals. Therefore, the reader will be cautioned not to generalize the findings of the study because of the potential issues around the level of illiteracy of the participants.

The researcher would also like to highlight the use of family members or caregivers as participants as a challenge of subjective bias that might have impacted the study findings.

Also, of importance Du Plooy-Cilliers *et al*., (2014) argue that under the limitations of the study, “the scope, logistical and resource limitations” should be noted. In line with the above explanation the following limitations of the current research study have been noted;

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- The study was conducted within the Nelson Mandela Bay Municipality which includes Port Elizabeth, Uitenhage and Despatch, and therefore the results of this study cannot be applicable to other areas beyond the jurisdiction of this municipality.
- The participants came from different locations around the geographical area of the municipality. The researcher identified a central reachable place for the focus group sessions.
- It was not easy for the researcher to find a venue. Some of the institutions which the researcher approached did not respond to the request to conduct the sessions and others refused. This was a time-consuming exercise, but after several attempts the researcher managed to find a place at Dora Nginza Hospital Psychiatric Unit in Port Elizabeth.

- It was also a challenge for the researcher to find participants, there was a long delay, but through perseverance the researcher managed to find them.
- Some of the potential participants withdrew without giving reasons and the researcher had to try and identify others through the snowball sampling method.
- Other participants were not comfortable with the group setting and preferred to be interviewed individually in their homes. They cited the sensitivity of the study as the reason for their reluctance to be part of the group.
- A male doctor who had agreed to participate in the study withdrew in the last minute without an explanation to the researcher. The researcher had to identify another one using the snowball method.
- Financial constraints on the part of the researcher, without a sponsor was one of the serious challenges, given the vast geographical area of the municipality.
- The focus group participants made sacrifices by travelling long distances, some from the outskirts of the municipality to attend the focus group sessions.
- The interview guide was in the English language and the researcher had to translate it into isiXhosa for IsiXhosa speaking participants. As the interviews were conducted in IsiXhosa the audio interviews were translated and transcribed into the English language and was time consuming.

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5.5 CONCLUSION OF THE CHAPTER

Emanating from the study with title; Narratives of caregivers on repeated admissions of abused mentally ill women in a psychiatric institution, the final chapter of this research study presented conclusions which are consistent with the research process and the research findings.

Recommendations were formulated based on the conclusions in relation to the research process and findings.

Finally, a recommendation for further and future research was made.

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APPENDIX A: Ethics Research Confidentiality and Informed Consent Form

I hereby declare that I am aware of potential conflicts of interest which should be considered by the UREC:

Signature: ______________________________ Date: 5 December 2017

Ethics Research Confidentiality and Informed Consent Form

Please note:

This form is to be completed by the researcher(s) as well as by the interviewee before the commencement of the research. Copies of the signed form must be filed and kept on record

(To be adapted for individual circumstances/needs)

Monica Priscilla Swelindawo is asking people from your community / sample / group to answer some questions, which we hope will benefit your community and possibly other communities in the future.

Monica Priscilla Swelindawo is conducting research regarding repeated admissions of abused mentally ill women in psychiatric institution. We are interested in finding out more about the causes of repeated admissions. We are carrying out this research to help abused mentally ill women, their families and policy makers.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you don't want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

The interview will last around (1 hour) *(this is to be tested through a pilot).* I will be asking you questions and ask that be are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before, and which also involve thinking about the past or the future. We know that you cannot be absolutely certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions there are no right and wrong answers. When we ask questions about the future, we are not interested in what you think the best thing would be to do, but what you think would actually happen (*adapt for individual circumstances*)

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If possible, our organisation would like to come back to this area once we have completed our study to inform you and your community what the results are and discuss our findings and proposals around the research and what this means for people in this area.

INFORMED CONSENT

I hereby agree to participate in research regarding caregiver's narrative on causes of repeated admissions of abused mentally ill women in a psychiatric institution: A Port Elizabeth study. I understand that I am participating freely and without being forced in

any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

……………………………..
Signature of participant **Date**:…………………..

I hereby agree to the tape recording of my participation in the study

……………………………..
Signature of participant **Date**:…………………..

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APPENDIX B: **Letter for assistance to form Focus Group / Gate Keepers**

137 Cetu Street

Kwa-Magxeki

Port Elizabeth

6201

12 March 2019

The Chief Executive Officer

Dora Nginza Hospital

Port Elizabeth

6200.

Dear Sir/madam

Re: Assistance to form a Focus Group / Gate keepers

My name is Monica Priscilla Swelindawo a Masters student with the University of Fort Hare.

As part of my masters requirements I need to form a focus group for data collection.

The aim /focus of my research is to investigate the causes of repeated admissions of abused mentally ill women in a psychiatric institution.

I am humbly writing this letter to request your permission to allow me to utilize the Mbulawa Ward (B - Block) facilities to hold focus group sessions for data collection. I am also appealing to you to allow the Mbulawa Ward social workers to be my gate keepers, that is, to assist me with the recruitment of families or care givers of the abused mentally ill women with repeated admissions in a psychiatric institution.

As stipulated in my study I will use nine participants, that is, 7 families or care givers and two (2) professionals (preferably a social worker being one of the professionals). Please note that I will be interviewing the families or care -givers of the abused mentally ill women without interacting directly with the mentally ill women themselves. The participants must be 30 years old and above. The participants must also be willing to participate in the study.

As a trained social worker, I undertake to uphold the ethical guidelines of my profession as well as the ethical guidelines stipulated by University of Fort Hare. See attached ethical clearance certificate from the University of Fort Hare.

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I am willing to share the findings of my study with your institution.

Your cooperation in this regard will be highly appreciated.

Should you require more information, please do not hesitate to contact me on the following number or email address; 073 354 8759 or swelindawomp@gmail.com.

Regards

Mrs. Priscilla Swelindawo

APPENDIX C: Letter to the Psychiatric Clinical Head

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137 Cetu Street

Kwa Magxaki

Port Elizabeth

6201

19 March 2019

Ref. Focus Group/Swelindawo

Dr. Bronkhorst

Dora Nginza Hospital

Mbulawa Psychiatric Ward

Zwide, Port Elizabeth

Dear Doctor

Re: Focus group permission

Your correspondence dated 19 March 2019 refers.

I want to express my sincere appreciation for your prompt response to my request.

I wish to highlight the following for clarification as per your request;

1. I am going to have one focus group. My choice for Dora Nginza Hospital is based on the fact that I am not familiar with the mental health care service users and their families that you take care of in your institution. This will help me remain objective as much as is possible when conducting my research. Ethically, working with the mental health care service users and their families from Elizabeth Donkin Hospital with whom I interact almost daily, will compromise the objectiveness, which is so critical in a study of this nature. I am so familiar with their situation and circumstances that it will be difficult for me to remain unbiased. I would further like to emphasize that the identities of the mental health service users and all the participants will need to be protected.
2. I want to assure you that when the research has been completed, probably towards the end of 2019, the results will be shared with you as this may have helped in identifying the causes of repeated admissions of abused mentally ill women in a psychiatric institution which the aim of my research.

Looking forward to hearing from you.

Regards

Monica Priscilla Swelindawo.

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APPENDIX D: Interview Guide for the Care Taker

My name is Monica Priscilla Swelindawo and I am conducting a research study towards the completion of my Master's degree in social work at the University of Fort Hare, Alice campus. My research study is about the causes of repeated admissions of abused mentally ill women in a psychiatric institution in the Nelson Mandela Metropolitan Municipality, Port Elizabeth.

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The study is premised on the following objectives:

- To investigate the possible causes of repeated admissions of mentally ill women.
- To explore the nature and extent of abuse meted on mentally ill women.
- To explore intervention strategies that can be applied to reduce repeated admissions of mentally ill women into a psychiatric institution.

It is also important for you to know that your participation in the research is voluntary and you have a right to withdraw at anytime during the study.

Please be aware of the fact that there will be no monetary or any other material benefit associated with participating in this study, but your participation will assist you and your community to have a better insight about the negative effect of abuse on mentally ill women.

The interview will be recorded using an audio recorder and whatever information you provide will be strictly confidential and your identity will not be revealed. There will be no right or wrong answers, therefore I am appealing to you to answer the questions with honesty as your answers are important towards finding the possible causes of repeated admissions of mentally ill women.

I also wish to inform you that a consent statement for you to sign has been prepared in compliance with current statutory guidelines. This will have to be signed before the commencement of the interview.

If you feel the need to talk to the researcher about the study you are welcome to contact:

Researcher

Monica Priscilla Swelindawo (Mrs)

Cell Number: 0733548759

Email Address: swelindawo@gmail.com

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Thank you

Interview guide

Section A

Participant's demographical profile

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Age	30-39	40-49	50-59	60-69	>70

- Gender: Male Female
- Marital: Single Married Divorced Widowed
- Are you related to the patient?

Yes	
No	

- If yes, how are you related?
- How old is the patient?

Age	<30	30-39	40-49	50-59	60-69	>70

- How many children does the patient have?

1	2	3	4	5	>5

- Where was the patient born?

Section B:

Unstructured interview

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SUB SECTION 1- General questions

1. Can you please give me the family background information of the patient, for example:
    - Where was she born and grew up?
    - Her parents
    - Her siblings

2. How was she before she came to stay with you?
    - While staying with her family/ background
    - While staying with extended family
    - While staying with friends / concerned other

3. Before she became mentally sick, can you explain to me the kind of person she was?
    - Was she employed?
    - Was she "mentally fit", functioning well and independently? Please explain.
4. Can you explain how the patien ended up staying with you?
    - What did you notice that made you suspect that she was mentally sick?
5. How long has the patient been displaying this behaviour ie, being mentally unstable?
    - Was there professional or traditional intervention / diagnosis?

Yes	
No	

- I f yes, please explain the medication she was put on.
- What were the traditional rituals that were conducted?
- How did she respond to the medication / traditional ritual?
- At what age did she start with medication?
- Can you remember the year when she was put on medication?
- Was she already staying with you then?

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<u>SUB SECTION 2:</u> Causes of repeated admissions of mentally ill women

1. Is there a history of mental health in her family?

Yes	
No	

- If yes, which of her family members were diagnosed as suffering from mental illness?
- How did they present the ailment?

- Did any of them experience repeated admissions?

Yes	
No	

- If yes, how do you think could have led to those admissions?

2. In your understanding, what do you think led to the patient's mental illness?
3. In your opinion, what do you think could have led to repeated admissions?
4. After her discharge from hospital, can you describe how her partner treated her?
5. Was her partner supportive towards her?

Yes	
No	

- Can you explain, what kind of help did her partner give to her?
- (If her partner did not support her) What do you think could have been the reason for her partner not supporting her, can you explain?
- (If her partner did not support her) Did you report this to the clinic where she takes her medication or community agencies for support?

6. In your opinion, do you think the lack of support from her partner is the reason for her repeated admissions?
   - In your understanding, did you suspect any form of abuse meted upon her by her partner?

<u>SUB SECTION 3:</u> The nature and extent of abuse

1. From your experience, how are mentally ill people abused by their families?
2. How has the patient been abused by her partner?
3. What about the other members of the family, how did they abuse her?

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4. Can you describe how her family and partner perceived her after she became mentally ill?
    - How did they react to the condition?
    - What kind of support did she receive from her partner and family?
5. Can you remember how often she has been hospitalised ever since she became mentally ill?
    - Did she take her medication while at home after discharge from the hospital?

Yes	
No	

- If yes, how diligently did she take her medication?
- Who was supervising her?
- What do you think could have been the cause of her repeated admissions to hospital?

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6. Can you please explain how the repeated admissions affect each of the following?
    - Her partner
    - Children
    - Significant others
7. In your understanding, did you suspect any form of abuse meted to her by her partner? Please elaborate.

<u>SUB SECTION 4:</u> Intervention strategies

1. What intervention strategies can be applied to minimise repeated admissions of mentally ill women into a psychiatric institution?
2. If her partner can get support in the form of professional advice on how to relate to the patient, do you think the relationship can improve?

Yes	

No	

- If yes, how?
- If no, why?

3. When she gets discharged from the hospital, what kind of assistance does her partner get from the following:

- The social worker
- The nurses
- Community agencies

4. How are you coping with the situation when she is at home?
5. What do you think can be done to reduce repeated admissions?
6. I think we have said it all, is there perhaps anything you would like to say?

Thank you for your time and participation!

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APPENDIX E: Interview Guide for the Focus Group

My name is Monica Priscilla Swelindawo and I am conducting a research study towards the completion of my Master's degree in social work at the University of Fort Hare, Alice campus. My research study is about the causes of repeated admissions of mentally ill women in a psychiatric institution in the Nelson Mandela Metropolitan Municipality, Port Elizabeth.

The study is premised on the following objectives:

- To investigate the possible causes of repeated admissions of mentally ill wom en.
- To explore the nature and extent of abuse meted on mentally ill women.

- To explore intervention strategies that can be applied to reduce repeated admissions of mentally ill women into a psychiatric institution.

It is also important for you to know that your participation in the research is voluntary and you have a right to withdraw at anytime during the study.

Please be aware about the fact that there will be no monetary or any other material benefit associated with participating in this sudy, but your participation will assist you and your community to have a better insight about the negative effect of abuse on mentally ill women.

The interview will be recorded using an audio recorder and whatever information you provide will be kept strictly confidential and your identity will not be revealed. There will be no right or wrong answers, therefore I am appealing to you to answer the questions honestly as your answers are important towards finding the possible causes of repeated admissions of mentally ill women.

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INTERVIEW GUDE: FOCUS GROUP

Unstructured interview

SECTION 1 – General questions

1. Could you explain what you understand about mentally ill people? (An ice breaker to ensure that each member is familiar with mentally ill patients).
2. In your line of work, how do you work with mentally ill people?
3. From your understanding, what do families usually do when a member shows signs of mental incapacity?
4. How do members feel when such a thing happens?

- What is the usual port of call for assistance?
- And why is this their usual first port of call?

<u>SECTION 2:</u> Causes of abuse on mentally ill women

1. What could make spouse to be abusive on their mentally ill partners?
2. How do abused patients present?
    - How does family history influence the patient's condition?
3. Generally speaking, what do think led to the patient's mental illness?
4. In your understanding, what do you think could have could have led to the repeated admissions?
5. Upon discharge from hospital, how do partners treat the patients?
6. Can we talk about the support patients receive from their partners upon discharge?

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- What kind of help do patients get at home?
- How does lack of support from partners or family affect the patient?
- In your interaction with the patient, what symptoms made you suspect that the patient was abused at home?
- How do other family members play a role in offering support?

<u>SUB SECTION 3:</u> The nature and extent of abuse

1. Based on your experience, how are mentally ill people abused by their families?
2. Can you explain how the patient had been abused by her partner?
3. Can you describe how her family and partner perceived her after she became mentally ill?
    - How did they react to the condition?
    - What kind of support did she receivefrom her partner and family?
4. What might have caused the repeated admissions to hospital?

5. Can you please explain how the repeated admissions affected each of the following?
    - Her partner
    - Children
    - Significant others
6. In your understanding, did you suspect any form of abuse meted to her by her partner? Please elaborate.

SUB SECTION 4: Intervention strategies

1. How do patients cope at home upon discharge from hospital?
2. Let us talk about intervention strategies. What do you think can be done to minimize repeated admissions of mentally ill women into a psychiatric institution?
3. Do you think professional intervention can improve the patients' situation in any way?
4. What do you think can be done to reduce repeated admissions?
5. I think we have said all, is there perhaps anything you would like to add?

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Thank you for your time and participation!