PSYCHOSOCIAL IMPACTS OF CARING FOR PATIENTS WITH MENTAL ILLNESS ON FAMILIES AT TEMEKE MUNICIPALITY, DAR ES SALAAM, TANZANIA

Masunga Iseselo Kidula

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BY

Masunga Iseselo Kidula

A dissertation Submitted in partial Fulfilment of the Requirement for the Degree of Master of Science in Nursing (MSc Nursing Mental Health) of Muhimbili University of Health and Allied Sciences

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November, 2010

CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance of dissertation entitled ***Psychosocial Impacts of Caring for Patients with Mental Illness Families at Temeke Municipality, Dar es Salaam, Tanzania,*** in fulfilment of the requirement for the degree of Masters of Science in Nursing (MSc Nursing Mental Health) of Muhimbili University of Health and Allied Sciences.

.....

Khadija I. Yahya Malima, PhD

(Supervisor)

Date 24-11-2010

.....

Lusajo J. Kajula, MPhil

(Co-supervisor)

Date 24/11/2010

DECLARATION AND COPYRIGHT

I, **Masunga Iseselo Kidula,** declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature ..... Date 16/11/2010

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ABSTRACT

Introduction: Mental illness is the condition affecting more than 450 million people worldwide. People with mental disorders often cause distress among their family members and mostly are overwhelmed by the patients' symptoms. Many studies in developed countries have focused on burden encountered by family members with small attention to psychosocial impacts and coping skills when caring the patient, and few of these studies have been done in developing countries. It is expected that this burden is more severe in low-income countries as it aggravated by poverty consequently families suffer psychologically and socially due to living with or caring for their relative or family member afflicted by mental illness. This study explored the psychosocial impacts of family caring a mentally ill patient and the way they coped with caring situation.

Objectives: The aim of the study was to determine the psychosocial impacts and coping strategies of mental illness on the family members caring a person with psychiatric disorders in Temeke Municipality, Dar es Salaam.

Method: The study was a descriptive qualitative study where purposive sampling procedure was used to enrol 14 participants and data was collected by focused group discussion and in-depth interviews. Ethical clearance was granted from MUHAS Ethical Committee. Data analysis was done by content analysis whereby seven different themes emerged

Results: Seven main themes emerged from this study: Financial constraints, disruption of family functioning, problems in managing patient's symptom, lack of social support, conflicts with neighbours, stigma and discrimination and coping and adaptation. These findings revealed social and psychological problems incurred by families caring patients with mental illness in Temeke municipal council and thereby has suggested several interventions.

Conclusion: Family caring for person with mental illness has its advantages, yet it has multiple social and psychological problems and challenges for both family carers and the mental health professionals. This study has attempted to explore psychosocial problems in family caring patient with mental illness. The findings offer a direction for family intervention that acknowledges the need of both the carers and their mentally ill relatives.

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ABBREVIATIONS

MBD	Mental and Behavioural Disorders
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
MoH & SW	Ministry of Health and Social Welfare
RA	Research Assistant
WHO	World Health Organization
WPA	World Psychiatric Association
UBS	Uganda Bureau of Statistics
UNHS	Uganda National Health Services
MUHAS	Muhimbili University of Health and Allied Sciences
MNH	Muhimbili National Hospital
PI	Principal Investigator
CPN	Community Psychiatric Nurses
UNAIDS	The Joint United Nation Programme for HIV/AIDS

DEFINITION OF TERMS

Coping: Is defined as a cognitive, affective or behavioural effort made by the individual family to offset the impact of harm, threat or stress when an automatic response is not readily available.

Caregiving: is the amount and extent of help provided by a family member to the care recipient. This includes supervisory, instrumental, preventive, emotional and interpersonal responsibilities.

Family: members in the household consists of the husband, the wife, children and other relatives who are living in that household

Mental illness: mean a brain disorder that causes mild to severe disturbances in thinking, perception, and behaviour. These disorders include anxiety disorders, mood disorders, schizophrenia, dementia and eating disorders. "Mental disorders" is used interchangeably with mental illness

Severe mental illness: debilitating mental illness such as schizophrenia, affective disorders and dementia and /or the patient suffers from the condition continuously or intermittently for a period of 3 years and /or the condition results to low level of function to the patient.

Common mental illness: mental illness which causes mild disturbance in thought and perception such as anxiety disorders and eating disorders

Psychosocial impact: a strong effect on emotional and social aspects of family behaviour resulting from one of the relatives' mental illness.

Relative: means a grandparent, grandmother, brother, sister, cousin, uncle, aunt or any other member of the extended family;

Key carer: means a person who provides the most support of patient, often devoting substantial numbers of hours each day towards taking care of the patient.

CHAPTER ONE: INTRODUCTION

Background

It is estimated about 450 million people worldwide, are affected by mental disorders at any one time. These disorders include 121 million people with depression, 24 million with schizophrenia and 37 million with dementia (WHO, 2001). Mental illness accounted for about 12.3% of the global burden of disease in 2001 (WHO, 2001) and by 2020 unipolar depressive diseases will be the second most important cause of disability (Mathers, 2006). For disability alone, without the effects of premature mortality, neuropsychiatric conditions account for 31% of all years lived with disability. Such averages conceal substantial global variations. In Europe and the Americas, for example, these conditions made up 43% of the total burden of disability in 2001 (WHO, 2001).

In low and middle income countries, the burden of mental illness constitutes to about 11.1% of all diseases (Patel, 2007) and are closely associated with other public health concerns such as maternal and child health and HIV/AIDS (Myer et al., 2008). The HIV/AIDS pandemic increases the burden and psychosocial impacts to families already inflicted by mental illness because they are both associated with stigma and low self-esteem of a person or the affected family. Freeman et al (2005) who studied integrating mental health in global initiatives for HIV/AIDS reported several factors which demonstrate that mental health is integral to HIV/AIDS care programmes. For example, mental disorders such as substance abuse are risk factors for HIV/AIDS, and mental disorders such as dementias and depression are consequences of HIV/AIDS. Thus, Mental illness may be a major impediment to HIV preventive behaviours and adherence with anti-retroviral drugs, a key requirement for successful management of HIV/AIDS.

In Tanzania, about 5.7% of people are living with HIV/AIDS (MoH&SW, 2008). This has detrimental effect to women whose prevalence has remained higher at 50% since 1990s compared to that of men (UNAIDS, 2008). A prospective study conducted in Dar es Salaam to determine the association between depressive symptoms, the risk of HIV progression and mortality among women found that 57% of women living with HIV experienced depression at least once during the study period and that depression was associated with disease progression

and mortality (Antelman et al., 2007). This suggests that some families care for dual afflicted patients with mental illness as well as HIV/AIDS.

This tremendous burden of mental disability falls on the family who care for the chronically ill patient. Evidence show variation in prevalence of psychiatric patients who are cared in the families in different countries. In US, for example, between 50% and 90% of people with mental illness are cared within the family (Ward-Griffin et al, 2005) while in Australia; between 21% and 23% of children in households have at least one parent with a mental illness who lives in the family (Maybery et al, 2005). However, in the People's Republic of China, over 90% of persons with schizophrenia live with and are taken care by their family members (Yip, 2005) which is high compared to the western countries probably due to its unique social, cultural and legal contexts.

Although evidences in the developing countries are scarce, some countries show higher prevalence of psychiatric patients living with families. In Uganda, for example, the Uganda National Health Statistics (UNHS) of 2005/06 (UBS, 2006) reports that of all households with disabled members, 58% had at least one person with a mental disorder. To date Tanzania lacks established statistics of families affected with mental illness nevertheless, a considerable number of families are impacted by the expectation of having to care for a relative with a mental illness often with little or no supports (BasicNeed, 2009).

All regions of Tanzania are affected with mental illness but the prevalence varies from region to region. The National Mental Health Statistics of the Ministry of Health & Social Welfare of 2007/08 estimated regional prevalence of mental disorders in 2008 as: Morogoro 4.7%, Kilimanjaro 7.5% while Dar es Salaam 17.5% of the total mental disorders (MoHSW, 2008). The prevalence in Dar es Salaam was higher compared to other regions and was exacerbated by high prevalence of drug abusers (McCurdy et al, 2007). The increased drug use in Dar es Salaam is explained by high number of youths coming from rural areas with high expectations of getting jobs and upon failure; they usually turn into drug users (McCurdy et al, 2007). The groups affected by drug abuse are mostly youths who are expected to be productive in the family but on the contrary become a burden to the family and hence increase psychosocial effects. However, these data may present a gross underestimation since very few mentally ill patients in Tanzania do attend the health facilities, other than that records are unavailable. It is known that most mentally ill clients consult traditional healers, in such cases

written data on such visits is normally not kept. Ngoma et al (2003) found that 48% of mentally ill patients in Dar es Salaam, attended traditional healers where as only half of those, i.e 24% attended health facilities.

To date, reasons to explain this pattern of health seeking behaviour is still obscure, though there are several considerations; The belief of the cause of mental illness may be one - most family members view mental illness not as disease but as a curse, or a product of both witchcraft and evil spirits of which the patient himself is counted as the main contributor (MoHSW, 2008). There are numerous unreported cases of mentally ill persons while most are left unattended. However, in all cases, family members bear the burden caused by the patient since family members are always a close together in these societies. Caring for relatives including extended family members is the norm and when a family has a relative with any illness it affects all. Mental illness (and currently HIV/AIDS) bears a greater burden due to its nature and thus, it affects all members psychologically and socially (Alejandra et al, 2006). Furthermore, many families have different coping skills when confronted with distressing situations such as use of cognitive coping strategies, behavioural coping and avoidance coping styles (Boschi et al, 2000). However, in mental illness perspectives, it is uncertain what coping styles do the family caring for patient with mental illness employ. This study examined the psychosocial impacts and coping skills of families caring for the mentally ill patients within Temeke Municipality, Dar es Salaam.

Statement of the problem

There are about 2.5 million people affected with mental illness in Tanzania of whom only a fifth receive professional treatment and the rest seek traditional treatment (Basic Need report, 2005). Despite the Government's effort to ensure easy access to mental health care such as free diagnostics and medication costs for known mentally ill patients, the burden of this illness is still raising. Latest data from the MoH SW (2007) show that, mentally ill patients in Temeke district had increased from 1374 in 2003 to 8344 in 2007 while Kinondoni had increased from 5,559 to 7,272 in the same period. In the given trend, this means that one fifth of 7,272 psychiatric clients from Kinondoni get professional care while majority of individuals do not receive appropriate care. This is common to find such individuals roaming unkempt in

the streets. This situation is highly suggestive of failure of the current health system in taking care of psychiatric ailments. The exact reason of this failure is not clear. Culturally, in Tanzania, families are closely linked institutions and incidentally, caring for the sick members of the family is a shared responsibility of all. It has been suggested that stigma attached to mental illness, managing finance when caring the patient, worrying about the future and dealing with excessive demand of the patient (Larson et al 2008; William & M'O-Carthy, 2006) may be one of the reasons for neglect at family level leading to failure of the health system to cater for clients with mental illness. Other reasons may be to the general health system deficits such as lack of psychosocial support contributed by inadequate human and non-human resources such as psychiatrists, psychiatric nurses, social workers and other team members especially in low income countries like Tanzania. The lack of supportive institutions that would actually care and house displaced persons due to psychiatric illness may be a fundamental reason for poor prognosis of mentally ill patients and may likely contribute to failure of preventive strategies.

Little is known on psychosocial impact of the families caring patient with mental illness and the way they cope with abnormal behaviour in Tanzania. In the promotion of mental health and achieving good prognosis of psychiatric patients evidence on how families cope socially and psychologically when caring for a relative with mental health illness is prerequisite and has yet to be documented. This study was expected to explore the social and psychological consequences of family caregivers and provide insight for appropriate intervention so as to alleviate the impact and hence to promote mental well-being of the family.

Rationale of the study

This study is expected to reveal the psychosocial problem in families affected with mental illness and coping mechanisms when caring for such clients. Information on how families can be supported was explored by families' experiences and identification of such needs through their coping mechanisms. Strengthening and supporting families who care for a member with mental illness, either living at home or in the community, are crucial in promoting family health. Unique opportunities can be obtained in primary health care practice,

where nurses provide unique opportunities for support directly to families or indirectly by assisting them in supporting their own members (Wright & Bell, 2004). Researches in few countries have shown that family carers show a high degree of burden. Age, education, employment and gender seemed to be key determinants for family burden and knowledge had indirect impacts to the burden through negative coping strategies (Alejandra et al, 2006; Lim & Ahn, 2003). However, these studies did not specifically determine the social and psychological consequences for caring mentally ill patients at family level and therefore this study explored psychosocial burden in the Tanzania context.

Broad objective

This study aimed to describe the psychosocial effects and coping skills of family members caring for a person with psychiatric disorders in Temeke Municipality

Specific objective:

The specific objectives of this study was

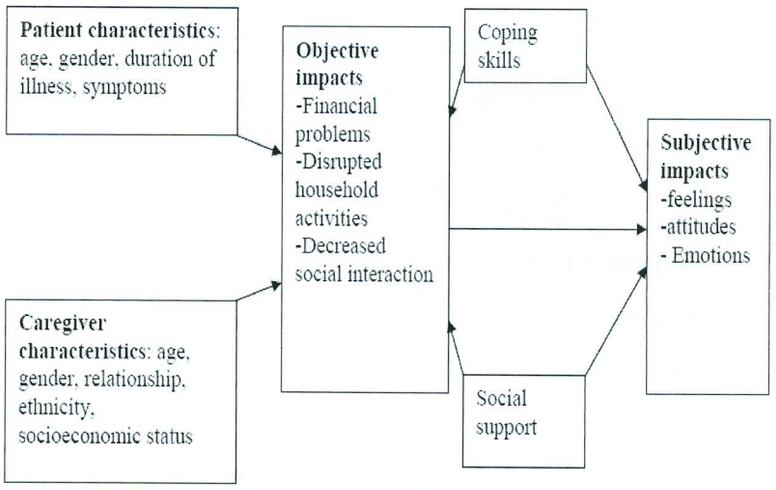
1. To explore the psychological problems of the family members caring for a psychiatric patient
2. To determine the social problems of the family caring for a patient with mental illness
3. To explore coping skills of family members when caring for a person with mental illness.

Conceptual framework of a family caring for a patient with mental illness

Using the adapted conceptual framework known as the Family Caregiver Impact Framework from Rungreangkulkij & Gilliss, 2000; a burden is substituted by impacts in my study (See the Figure below). The model is made up of the following components or concepts. Caregiver characteristics, patient characteristics, objective and subjective impacts, that are influenced by coping skills and social support. Taking care of a mentally ill person is assumed to have a negative impact on the family and is perceived as a family burden (Reinhard, 1994;

Solomon & Draine, 1995). Based on empirical findings, the family caregiving burden framework can be illustrated as in Figure 1 below.

FIGURE I: Family caregiver impact framework



Source: Modified from Rungreangkulkij & Gilliss, 2000

Objective impacts in this study is defined as the observable concrete costs to the family resulting from the mental illness, such as disruption to everyday life in the household, financial problems, limitations on personal activities, and social interactions and

Subjective impacts are defined as the individual personal appraisal of the situation and the extent to which caregivers perceive they are carrying burden (problems). Subjective impacts results from the caregiving experience and includes feelings, attitudes, and emotions. Many predictors of caregiver impacts have been identified. These include the ill relative's characteristics, such as age, gender, duration of illness, number of previous admissions, functional status, and symptoms and caregiver characteristics, such as gender, age, socioeconomic status, ethnicity, health status, kin relationship, and living situation. Reported mediating factors include social support and coping skills (Solomon & Draine, 1995).

CHAPTER TWO: LITERATURE REVIEW

Psychosocial impacts

Mental illness may cause varieties of psychosocial impacts such as sleeping problems, feeling guilty, inappropriate behaviours leading to a decreased quality of life on the patient's family members. Psychosocial impact is enhanced by stigma attached to mental illness which is a big problem affecting not only the patient but also the family as whole. The family members who help care for people with mental illness report feeling stigmatized as a result of their association with the loved one having mental illness (Ssebunnya et al., 2009).

Caring for a relative with mental illness can be burdensome in different ways. Family members are often concerned and worried about the health and well-being of their relative with mental illness. Many family members provide financial assistance, shelter, and assistance in performing everyday tasks. Persons with serious mental illnesses often engage in behaviours that are frightening, troublesome, disruptive, or at least annoying, and many relatives are obliged to control, manage, or at least tolerate these behaviours. Thus, psychiatric professionals often view the family members of a patient as people of support; family members can act as informants regarding the patient and they can act as co therapists at home (Hasui et al., 2002). Family members of the patient with mental illness can also be a good support to Community Psychiatric Nurses as they work shoulder to shoulder to improve the condition of the patient. Therefore, family members need to be at optimal social and psychological state. However, the family members themselves are facing difficulties due the patient's behaviours and symptoms. Reduced function of one family member contributes to the burden of other members and this in turn leads to other family members assuming a critical attitude towards the patient. Such criticism can perhaps lead in some cases to a relapse of the patient's illness or the family to be overwhelmed by the patient's disruptive behaviour which leads the family to abandon the patient and make him/her roam in the street (Ssebunnya et al, 2009; Larson et al, 2008).

Social support is important for the prosperity of the family affected with mental illness. Friends and other close relative of the mentally ill person can be a big booster of the welfare

and unity of the family. This unity forms the so called "social network" and eventually helps to prevent stigma to mentally ill patient in the family and the community at large. Larson et al (2008) added that families should assume major roles in supporting relatives with mental illness; service plans should prominently feature family members when so indicated by relatives with mental illness and collaborative plans should include strategies to assist family members and consumers in dealing with stigma. In a study conducted in Morocco showed that stigma is one of the social contexts of mental illness that increases psychological disturbance as family lacks support (Kadiri et al, 2004). In this study it was shown that stigma impacts on families of patients with schizophrenia and that 86.6% of families reported psychological suffering and disturbance in their quality of life that was directly related to their mental illness. Furthermore, a complexity exists for family carers' reception of social support in respect to the stigma associated with mental illness. In a study investigating the links between stigmas, depressive symptoms and coping amongst caregivers, Perlick et al (2007) found that stigma may erode the morale of family carers and result in withdrawal from potential supporters. This argument tries to substantiate the situation of families affected with mental illness in Tanzania as many families with mental illness hide the patient to avoid stigma being social ostracism.

Beliefs about the causes of mental illness amongst some communities and families, such as mental illness being a result of bad deeds, criminal behaviour or bad karma, witchcraft, or that mental illness is contagious, can seriously impact on the acceptance of those with the illness (Bakshi et al, 1999). However, this view has not very much changed for about a decade as Adewuya et al (2008) in Nigeria found similar beliefs although supernatural power and misuse of psychoactive substances had higher correlation with cause of mental illness in rural areas than in urban areas. Similar belief is also encountered in most of the Tanzanians who believe that mental illness is not a disease but a result of curse and witchcraft (MoHSW, 2008). In other African countries it has shown that social relationship of people with mental illness decreases as family members dissociates from the person with mental illness. This leads to a person affected with mental illness to seek support from non family members such as religious services and to some extent to friends (Wintersteen et al, 1995). With respect to report from the Ministry of Health and Social Welfare in 2006, it was estimated that more than 80% families with mentally ill persons sought treatment from traditional healers. However,

three years before, Ngoma et al (2003) found that about 48% of people with mental illness sought traditional treatment at some times before seeking professional health services. This practice result to chronicity of the mental illness and therefore life-long psychosocial burden to the family members who take responsibilities to care the patient.

Mental illness in married couples co-occurs at a level far greater than expected, that is, mental illness in one spouse is associated with mental illness in their partner due to the fact that mental health problems in one spouse impact on the mental health of their partner, due to difficulties in their relationship, through any consequences on their economic or living conditions, or as a direct consequence of one spouse having to care for the other (Connell & Goodman, 2002). This effect may impact also on children. According to Burke (2003) children may be affected in terms of their own direct care, or indirectly through impacts on their social and emotional health and wellbeing. Core attachment needs such as love, physical and emotional nurturing and security may be at risk. For example, depressed mothers may provide less stimulation, support and responsiveness to children, which can affect children's physical and psychological health, attachment and social problems. Mental illness is associated with other physical illness as well as poverty in some families (Ward-Griffin et al, 2005; WHO, 2009). It is a big problem in the low and middle income countries including East Africa.

The World Bank (2002) ranks Kenya–Uganda–Tanzania among the poorest countries in the world. Data from cross-national surveys show that common mental disorders are about twice as frequent among the poor as among the rich with depression more common in the poor than in the rich (Njenga, 2002). In Uganda, Ssebunnya et al (2009) commented that poverty and mental illness are in a vicious cycle and that poverty is a contributory factor to mental illness and poverty can be the result of mental illness. Poverty is an alarming factor in Tanzania as most of the people are living below standard of poverty line (Mkenda et al, 2004) which facilitates young people to abuse drugs and alcohol as a result increases mental problems in the families.

Mental health of the family carer is associated with caring activities. This was revealed in some studies in Australia which specifically examined the mental health impacts of caregiving on the carer and focused on a specific disabling condition or types of condition and different groups of carers and found that there was poor mental health of carer compared to those who do not provide care (Edwards et al, 2008; Cummins et al, 2007). This can be linked with a number of factors associated to this mental health problem such as unemployment, lack of social support, financial difficulties, and physical health issues. This is because people with mental illness are often unable to generate income they often have to rely on the financial support of family members to meet basic living needs and to pay for any health expenditure associated with mental illness. Thus, family members may have to set aside a significant amount of their time to care for an ill family member. This can diminish caregivers' chances to get or keep a job or earn income, which in turn affect the source of income of that carer thus further increasing the risk of poverty and poor mental health.

Family coping and adaptation

Family coping and adaptation to caring a person with mental illness is another issue which the family faces. Coping differs from one family to another. This is due different factors associated with family system and the types of coping mechanism. In developed countries, some researchers (Kartalova 2008; Doornbos, 1996) have emphasised coping as a key concept for the study of adaptation and mental health. However, the effects of age, duration of illness, living arrangements and other contextual factors on the coping styles of family caregivers, and on the recovery or rehabilitation of persons with mental illness were important factors in the well being of the carer (Kartalova, 2008).

Family caregivers have to learn and understand the patient's characteristics and behaviour. Symptoms such as delusions, hallucinations, and inappropriate sexual behaviours, disturbances during the night, threats of suicide and alcohol or drug abuse have to be appreciated by the family carer (Tedman-Jones et al, 2003). Coping with these symptoms and behaviours may often require lengthy, complex, and distressing negotiations. Perlick et al (2008) found that burdened caregivers who appraise higher levels of caregiving stress in

relation to the patient's problem behaviours employ less effective coping strategies, report more frequent health and mental health problems and use services more often.

In Tanzanian context, however, it is unclear how family members cope with mental illness of their patients. In Australia, Wynaden (2007) found that when family member tried to care for mentally ill relative, they were consumed by the loss of things that they had before such as established pattern of family life, ability to work and financial support. However, they coped by using different skills such as seeking knowledge concerning the mental condition, involving in religious activities, physical exercise and other recreations. In Thailand (Sethabouppha & Kane, 2005) family caregivers used distraction, withdrawal, tolerance, religious practices, positive thinking and seeking help as the way of controlling stress caused by mental illness. However, the study in Thailand involved Budhistic belief which may not reflect the coping strategies in Tanzanian context where people have different religious beliefs.

Some descriptions of coping style as a personality characteristic pertain to how a person approaches a problem, i.e. making an active effort to solve it or trying to avoid it. Boschi et al (2000) categorized coping strategies by response to a stressor as cognitive or behavioural. Active cognitive style involves such internal processes as acceptance, positive reassessment or finding inner strength in religious beliefs. 'Avoidance' style includes such strategies as trying to ignore the problem, resorting to legal or illegal drugs, and keeping fears or worries to oneself without discussing them with others. According to Kartalova et al (2008) strategies such as exercising would fall under the of active behavioural coping style, trying to look at the positive side of things would be classified as active cognitive coping, whereas avoiding contact with the ill relative would fall into avoidance style.

Several studies show that active behavioural and active cognitive strategies may be more effective for alleviating distress than passive strategies, such as avoidance. A broader range of coping strategies may be acquired with age (Martin et al, 2001) and a higher number and range of coping mechanisms may be used in response to higher levels of perceived stress or complexity of mental health problems. It is important to know how the family struggles to cope with the stressful situation so as to be able to help the family with mental illness. Mental health professional are more likely to give support to the family. Gavois et al (2006) proposed

mental health professional support model which could help a family with mental illness to cope with the situation. According to her, the strategies interact and have different dimensions such dimension includes being present, empowering, sharing and listening. In Tanzania little is known about family strengths and coping skills when caring patient with mental illness. This study aimed at determining the psychosocial impact and coping of mental illness on families living with a person with mental illness so that to provide appropriate, cost effective intervention which would benefit the patient, the family members and community at large

CHAPTER THREE: METHODOLOGY

Study design

The study used the qualitative descriptive design. Information from individual families living with mentally ill person regarding the impacts and experience on mental illness was obtained. Exploration, description of the social and psychological effect when caring for a mentally ill relative is described. It is acknowledged that subjective experience and observable data could be obtained from the family in their settings by interviewing them. The theoretical underpinnings of qualitative research assume a personal view or way of perceiving and interpreting a phenomenon (Polit & Beck, 2004). In relation to this perspective, it was easier to enter in the respondents' world of understanding and gain her/his articulation (verbal description) in order to gain a deeper and clearer understanding of how the family is affected when caring for a patient with mental illness.

Sampling

Purposive sampling technique was used. This is described as the method of sampling based on appropriate selecting a sample on the basis of knowledge of a population, its elements and the purpose of the study (Polit & Beck, 2004). Purposive sampling in this study is based on the assumption that the researcher wanted to discover, understand, and gain insight on the impacts of families caring for and living with a relative with mental illness.

Sampling of participants took place at Temeke Municipal Hospital in the Outpatient Clinic of Mental Health and Drug Abuse. Purposeful sampling was done on the clinic days of Monday, Wednesday and Friday. Family members escorting the patient at clinic and who met the criteria were asked to participate in the study. The identification of participant was done by asking the escorting family member if he/she live with the patient in the same household and that if he/she provides most of the necessary support to that patient. He/she was explained briefly the nature of the study before asked to participate. Those who agreed were asked to provide names and phone number for subsequent informing them for the appropriate day of

the interview and focused group discussion. Two days before the interview participants were informed by the investigator and the interview took place at the hospital premises due to the fact that it was the place which was known by everyone and at their homes in case of in-depth interviews. A total of fourteen family carers (informants), whose age ranged from 35 to 60 years, were interviewed. Five informants were men and nine were female whereas Christians were four compared to ten Islams. Most of the informants had primary education level with few of them who had attained a secondary education. Five informants were housewives, that is, they were married with no so source of incomes except that of their husbands while five participants were petty traders. Some were farmers and one participant was a photographer as shown in the Table 1.

Table 1: Characteristics of informants

Informants	Kinship	Age (years)	Sex	Religion	Duration of illness (years)	Education level	Occupation
1	Father	42	Male	Islam	10	Primary	Petty trade
2	Sister	46	Female	Christian	3	Primary	House wife
3	Mother	38	Female	Islam	3	Primary	House wife
4	Mother	60	Female	Christian	5	Primary	Petty trade
5	Mother	45	Female	Islam	4	None	House wife
6	Father	46	Male	Islam	4	Primary	Petty trade
7	Mother	50	Female	Christian	7	None	House wife
8	Brother	58	Male	Islam	21	Primary	Photographer
9	Father	58	Male	Islam	27	Primary	Watchmen
10	Mother	53	Female	Islam	4	Secondary	House wife
11	Mother	51	Female	Christian	4	Secondary	Petty trade
12	Brother	35	Male	Islam	7 months	Secondary	Farmer
13	Mother	40	Female	Islam	1	Primary	Farmer
14	Mother	59	Female	Islam	16	Primary	Petty trade

Participants were selected according to the following criteria

1. Caregiver living with relative, who had been suffering from mental illness for more than 6 months.
2. The caregiver should be 18 years old and above
3. The caregiver should be the key carer.

The key carer here means a person who provides the most support of patient, often devoting substantial numbers of hours each day towards taking care of the patient.

The informants who participated were caring for ill relatives with different types of mental illness including schizophrenia, bipolar disorders, autistic disorders and epilepsy. The duration of relatives' illness ranged from 7 months to 27 years, the period being considered before and after diagnosis of illness in the health service because number ill relatives were brought to the attention of mental health services and confirmed to be mentally ill after months or even years of the onset of illness. All the carers were living with the patient in the same household and most of them were parents

Ethical clearance

Before data collection, ethical clearance was obtained from Muhimbili University of Health and Allied Sciences Ethical and Publication Committee. Further permission and approval was obtained from the Temeke Municipal Medical Officer and thereby to Medical Officer in Charge of Temeke Municipal Hospital.

Before the interview started, the informants were given full explanation of data collection procedure. That is the written consent form was read and understood and signed by the participants. Each participant was fully informed and that information given could be handled processed confidentially. To ensure confidentiality, code numbers were used for each participant instead of names. Each participant understood the nature of the study and voluntarily agreed to participate. All agreed and participated except who did not attend on that particular day of the interview even though he/she agreed to attend. However, they were informed that they could continue to use the health service as usual.

Data collection and procedures

Focus group discussion (FGD) and in-depth interview was chosen because it is considered to be effective in complimenting the data. FGD is an effective technique for exploring people's views about particular issues and examining why they hold such views (Morgan, 1997). FGD encourages sharing of general information and problem which one participant may have during the discussion whereas in-depth interview is effective for obtaining in-depth knowledge about the individual family problems during caring patient with mental illness. In this study both method were used due to the fact that more detailed and rich information was needed which could give a complete picture of social and psychological problems in family caring the patient with mental illness.

In the study, data were collected through audio taped interviews which lasted to about 55 to 60 minutes for focused groups discussions and 30 to 45 for in-depth interviews. The three focused discussion were conducted at the hospital premises in a room which comfortably accommodated around 4-8 people. The four in-depth interviews were conducted in their respective home environments. This provided opportunity for the researcher to observe the living situation of the carer and the patient.

The discussions and interviews were conducted in Kiswahili language due to the fact that it was easily understood by all informants. During focused discussions, the principal investigator moderated the discussion while the competent research assistant was mainly controlling the environment including note taking, operating the audio recorders and taking care of any interruptions. Critical observations of non-verbal reactions were noted during and after the discussion making sure that most important information is collected. Field notes were taken of which were blended with the recorded data during analysis.

During the discussion some informants responded with brief answers to the preliminary questions and the moderator had to probe for further information.

Data analysis

Audiotaped focussed group discussion and in-depth interview were transcribed verbatim in the original Kiswahili language. The researcher himself transcribed the audiotaped data by typing directly to the computer in Microsoft word program. This helped the researcher to correlate

the tone of the informants in the sentence with the feeling and emotions which was of importance in analysis. In the process of transcription, the informants' words were captured as closely as possible. To make sure that the data is transcribed correctly, the transcripts were checked against the tape and then reviewed by an experienced person who was also proficiency in Kiswahili language. After transcription the bulk of interview transcripts were printed to get the hard copy of which the analysis based.

The stages in analysing the interview transcripts were generally guided by the work of Graneheim and Lundman (2004). Interview notes and ideas were jotted down and the transcripts were read several times so that the researcher could be immersed in the data so that different ideas said by the participants are captured.

The unit of analysis was the whole interview text about social and psychological problems found in families caring person with mental illness. Iterative reading of the interview transcripts was done. Pens, highlighters and memos were used during analysis. Different colours were used to highlight the important ideas (patterns) in the text which corresponded to the preconceived category derived from the study objectives. In the both margin of the hard copies of the transcripts, the patterns were jotted in a crystallised meaning (condensed meaning) which were then transferred in a different sheet of paper for further analysis. Memos were used to summarize the patterns of the condensed meaning before transferring to the master paper sheet. To identify the source of data in the memo and in the text, identification (ID) numbers of informants were used when transferring the condensed meaning to the master paper sheet, so that the source could be easily traced and accessed. In this sheet of paper, coding schemes were developed with the abstracted categories and themes. Different categories, condensed meaning units or codes were compared for underlying meaning and relationship at the interpretation level which formed the themes. Field notes were also analysed separately whereby the patterns and categories were compared to that from the focused discussion and in-depth interview.

Some excerpts of relationships between these categories which formed the themes as shown in table 2 below;

Table 2: Some excerpts of coding scheme resulted in theme formation

Meaning unit	Condensed meaning unit	Code	Category	Theme
The problem which I get is that I can't even chop onions in public, I always do that in the locked room, and all knives and everything are hidden in the cupboard	Doing thing in hidden places to avoid physical attack	Fearing physical attack	Fear of being attacked	Problems in Managing patient's symptoms
There is a day he can really succeed to kill, if not him to kill, himself may be killed, because I can prevent when attempting to hurt me, unfortunately hurts himself.	Expressing fear of patient to kill or to be killed	Unpredictable patient's behaviour	Patient's safety	

Some categories in the coding scheme were straightforward and could be easily identified on the manifest contents. Others were harder to identify because they were partially based on the content meaning of the text. The categories were expected to be mutually exclusive (distinct from each other) and exhaustive. Before identifying the themes, an experience research nurse was invited to generate categories without seeing the researcher's list to enhance credibility of the categorization. The two lists of categories were compared, adjustment were made to the words used in the labelling of the categories. Transcripts were read again alongside with the list of the categories to ensure that the interviews had been covered thoroughly. All the transcripts were then coded according to list of the categories and the coded section of the transcripts were collected and then sorted. This increased trustworthiness of the study. Verbatim examples were used as evidence for each theme and categories.

CHAPTER FOUR: FINDINGS

After analysis, seven main themes emerged from the data as described below:

Financial constraints

Financial strain was a concern for almost all participants. They said they had limited time to work for earning money because most of the time spent caring the patient. Even that little amount of money earned from limited working time was said to be used for the care of patient including bus fare to the hospital and purchasing medications and other activities for the patient;

Lack of bus fare

Most informants expressed concerns on financial strains caused by increased cost for patient treatment services which was coupled by decreased working time. Since most of the participants were living a considerable distance from the hospital, they had to travel either by taxi or by public transport for patient follow up. This caused most carers to have multiple financial crises with the meagre amount of money they had. For psychotic patients, some used to take taxi but the easiest and accessible transport was public bus transport (daladala). However, some passengers felt distressed to have person with abnormal behaviour in the bus making the carer uncomfortable due to stigmatized nature of mental illness. The most important concern was how to get the money for bus fare as most of them had poor income due to limited time of working as most of the time used caring the patient. For this reason, some failed completely to come to the hospital for more than two or more months and other carers sometimes used their other relatives to collect the medication. One woman aged forty-six years old cares for her schizophrenic elder sister who also had unilateral paralysis of the left side commented:

"Like that day I sent my bother-in-law, and told him; take this patient's register book because you are going there, I don't have the bus fare for going to the hospital just to collect the medicine."

Inability to buy psychotropic drugs

In addition to the bus fare problems, it was revealed that shortage of medicine in the hospital compromised the treatment system of the patient which was expressed as a major contributor of patient's improvement. Those informants whose ill relative used more than two medicines were hardly getting the second medication especially of the type of antipsychotics and therefore were advised to go and purchase in private pharmacy. As a result of lack of money, patient used only one type of medicine due to the carer's inability to buy the second drug. A man aged 58 years old caring for his son with epileptic psychosis commented as follows:

"……and when you come the next month, you are told; again, we don't have this type of drug, so you are given the only one, okay! Then the patient uses the one type of drug because no money to buy the second drug."

Some drugs are expensive that those who managed to buy had to withhold other household needs so that the patient can get the drug to prevent his/ her disruptive behaviour. A fifty one years old woman caring her son with bipolar disorders remarked:

"My main problem is money to buy the medicine. They (doctors) have changed the medication, just imagine, a single monthly dose now costs forty thousands shillings (40,000/=) and she uses three different types of drugs……we ought to abandon other household issues to buy the medicine because if she does not use the drugs for two or three consecutive days, you find that no peace at home".

Not only those with multiple drugs, some expressed that even if the patient had one type of drug which is not available at the hospital, the patient had to wait until they get the money to buy it which was expressed as the causative risk factor for frequent relapse of patients' symptoms as a result of inappropriate dosage regimen.

Most of them showed concern that their patient's disruptive behaviour need to be prevented by regular use of medicine. So, lack of money for bus fare and inability to buy drugs for the patients was the main drawback of the patient's improvement.

Disruption of family functioning

Family functioning is the family's resilience despite of internal or external threat. Most participants expressed disturbances in their normal family routine as a result of having a mentally ill person in the household as explained below;

Disrupted household chores

Disruption of household tasks and other responsibilities were important aspects revealed by many carers. Unpredictable patient's symptoms seemed to be of distressing factor which made them to have limited time for the other family responsibilities especially who were the parents of the patient. Parents of patient with mental illness had multiple roles of caring the patient as well as making sure that other family members are getting their daily bread. One carer whose ill relative was totally dependent said that she had devoted most of the time doing activities for the patient. This made her to fail to do other activities at home for other members who in turn had little or no contribution to the care of the patient. Some informants explained that they had to remain at home keeping an eye on the patient so that to prevent the injury to others or to self due to disruptive behaviour of the patient whenever occurred. This affected tremendously the earning capacity of the family carer and hence making the life to be difficulty as expressed by a fifty-one years old woman caring her daughter with schizophrenia:

"So far, I am no longer doing any work, all of my work are compromised by always staying at home caring that one(the ill daughter); no any more work to do. I have to give medication, making sure she is safe and my properties are safe"

Another one added:

"Really affected .....you ought to remain at home to protect him probably unanticipated catastrophe may occur. If you attempt go out to do your work, you become anxious because he (the patient) may be violent."

Most parent carers stated that it is their responsibilities that they ought to do it because it is their children who are suffering and they cannot give any one else. So they had to plan the activities for the patients appropriately. Because they have to work, some used to lock in the patient when they need to go out for daily activities. One carer aged 59 years old caring her son with autistic disorders expressed that, "even this time I am here; I have locked in my son in his room until I come back." She insisted that patient is totally dependent that cannot express his needs. Basic needs such eating, drinking, elimination should be initiated by the carers as the patient cannot talk a word. Although some said that they have other family members living in the same household, they had little or no contribution to care of the patient.

Lack of harmony in the family

Harmony in the family was also affected by the patient's behaviour sometimes losing their tempers or by family members disagreeing about the management of the mentally ill relative's affair. One carer expressed concern on her husband saying that his husband was treating the patient badly compared to the other children because of mental illness. This caused misunderstanding on issues related to the patient welfare. Others raised the source of misunderstanding on how to find the solution of the patient's problems. It was revealed that one parent/ member could resort to traditional healer for treatment while the other may need spiritual treatment. However, most carers resolved by seeking professional treatment.

Problems in managing patients' symptoms

It was reported by many participants the difficulties of managing the disruptive patients' symptoms. Most of them expressed in the way that there was no anyone else who could be able to handle the unpredictable behaviour of the patient. They reported that it needs skills and high psychology of carers and that they were the only one who had learned how to handle the patients' behaviour; therefore, they had to remain at home to protect the patient and other

people from patient's uncontrolled behaviour. The majority expressed fear of being attacked by patient as well as safety of the patient as elaborated below:

Fear of being attacked

Violence and patient safety was another aspect which expressed by many carers. They reported that their lives were always in danger due to unpredictable aggressive and violent behaviour. Some patient physically attacked the family members or the carer with intention of killing or hurting them. This made most of carers to live with lots of uncertainties. One carer aged 51 caring her son with bipolar disorder expressed lack of freedom of doing anything using a tool which she affirmed would otherwise be a weapon in the hand of the patient:

"I have got many problems with my patient because, he is very strong and fat and his intention is to kill me and his father. The problem which I get is that I can't even chop onions in public, I always do that in the locked room, and all knives and everything are hidden in the cupboard."

Some others informants expressed that they had to be modest and humble when talking with the patients. They revealed that some family members do not bother to learn the patients' behaviour and how to handle him or her when aroused. They just left for the carers even though it was also difficult for them as some times the patient could verbally abuse and attempt to harm them.

Fear of patients' safety

A good number of carers expressed concern on safety of the patient whose violence aimed to attack and kill others. So, they were worried that sometimes can be its opposite as echoed by a thirty-five year old man caring his young brother with paranoid schizophrenia:

"……there is a day he can really succeed to kill, if not him to kill, himself may be killed, because I can prevent when attempting to hurt me, unfortunately hurts himself."

This situation made the family members to be full of anxieties and worries especially when the patients get lost in the street or when had become disruptive and violent. Parents caring epileptic patients stressed that when their ill children get out, they did not remember to return home. The carers had to take time and effort to look for the patient everywhere. Some patients were reported to get lost for several of weeks either due to their memory deficit or due to being influenced by falsified imagination of their mind. In this situation the carers showed concern on the safety of patient because one carer said he lost his son for about a month and finally was found him in most risky places:

"That day I told him to go home alone, but he was lost for about a month, I mean he did not return home. After looking for him for two weeks, I found him in the social beach near a deep water level"

Most of them reported that, patients were more aggressive and violent when they do not take their medication and this was a common problem provided that some medications had to be bought. Furthermore, family resilience was also disrupted when the patient interfered with normal social life in the family including prohibiting some basic activities such eating and watching television. This brought fear and anxiety to the family members.

Social support

Social supported seemed to be a concern by many informants. Lack of social support from either within the family members or outside the family was revealed by several carers as described below:

Lack of social support

In this study, many informants expressed lack of support from other relatives in or outside the family. It was revealed that distance between other relatives and the carers increase as the patient's symptoms increases. Ignorance of family member on the nature of mental illness was said to be a contributory factors as most of them thought that the illness was of short duration. For this case if the patient's symptoms delays for more than they expected, they give up and withdrawal their support. Others reported that the patient's symptoms are caused by the parent

himself/herself to get wealth by stupefying the patient. One carer pleaded that 'no relative will come to give you anything rather than advising you to go to the traditional healers.' Financial or material assistance was mentioned to be very important but this was not a case in most families provided that they are very close relatives with good financial position. A forty-six years old woman caring her sister with schizophrenia said:

"She (the patient) has many siblings here in Dar es Salaam, her brother, sister; both are workers but no even phoning to know how you are progressing there. .....they are educated with cars, oh, no even phoning."

Some participant acknowledged the current family life system that people are changing from extended family system to nuclear family where a parent is responsible for the welfare of his/her children. They contributed that families in the past were living as a single unit. When one parent gets a child, this child could go and live with other relatives such as aunt or uncle, and then could come to his / her parents. But this trend has changed tremendously especially in the urban areas where people are more practicing nuclear families. No one may take part in taking care of ones' child in health or in illness. a man aged 58 years old caring his son with epileptic psychosis reported:

"When you get such problems bear in mind that it is yours; neither uncle, cousin nor whoever, according to the current situation will assist you in any how."

It appeared clearly that feeling of helplessness described by carers gave perception that nobody could help them out of care giving situation and that they had to persevere with caring problems as living with such patients need cooperation with other members of the families

Self-help groups

Some carers reported to have a need for social support groups which could help their mentally ill relatives to improve their conditions. These social groups could be of any type including educational, religious or any group which could help their ill relatives to socialize and relieve tension caused by sense of perceived loneliness. Also they concerned on the deteriorating

cognitive functioning of their patient that if they could find an educational group could help to improve the mental functioning and hence could not lose considerably their skill.

"*If we get such group which can help to socialize and assist such children and intermingle with those who are mentally stable, could greatly help them. .....because we toil to go here and there as a result we become weary in vain.*"

Furthermore, it was also revealed that there is a need of support from social or individual groups for caregivers. This is because they had physical and psychological problems due to unresolved patient's mental health problems. Professional or social support was an important aspect expressed by carers for ventilating their emotional tension:

"You become tired of everything; you long to have new ideas or people to help or group to mix with for getting new challenges.....you find that we are also tired of thinking, tired of strength, at the same time running short of money."

May of them suggested having this social group so that they can boost the welfare of the patient at the same time improving their well-being. This is because some reached a point to look for permanent admission to the mental health institution so as to have at least adequate time for other activities. Others suggested having schools of mentally disabled people with qualified teachers because some patients who had improved their mental status but unable or afraid of joining the normal schools with mentally stable students could be enrolled in.

Supportive family members

Despite of lack of social support, some informants expressed some extent of support from their family members. Some caregivers expressed to have had provided some sort support such as financial support, emotional and psychological support. But the support they get usually limited and was given when they carer was obviously overwhelmed by the caring situation. One carer aged 35 years old caring his young brother with paranoid schizophrenia remarked:

"I am really thankful since when I was in the village, the neighbours were helpful and they usually came to sleep at home in case he (the patient) became violent, we often caught and fasten him with a rope. ……..if they see him wanting to escape, they call me and then we altogether return him back."

Presence of social support was reported to help the caregiver and the patient to improve their social and psychological status. The need for professional support at home was emphasized so as to know how the patient condition and the family are experienced the situation. Self help group was said to improve the patient condition and hence family resilience.

Conflict with neighbours

The carers revealed that their patients' uncontrolled behaviour such as temper tantrum, shouting in public places, insulting people and neighbours and hitting people had caused them deprivation of good social relationship. Some carers had been accused of their patient's behaviour in force of law causing endless misunderstanding between the two families. One informant reported that:

"When you make jokes of him several times, then, he becomes aggressive suddenly attacks you even stubbing you if in access with a knife; I have been arrested by police about two times to answer cases."

This was said to be due to the fact that most people do not know the nature of the mental illness and think that the person was pretending or otherwise was the family's conspiracy so they were using the patients as 'bait' to disguise it. Most of the family members tried to illuminate that their ill relative is not pretending rather he is suffering from mental illness.

Stigma and discrimination

This issue was described by several carers that most people around them had negative attitude toward their mentally ill relative. Most of them said that the patient was more stigmatized than

the carers and when they hear or see their ill relative ostracized in that way they felt guilty and were psychologically disturbed. However this circumstance is escalated by some close relatives who in one way showed negative attitudes towards the carers and creates an increased distance among them and the community at large. It was explained to occur at different occasions such as in the public transport and other social gatherings. Sometimes was said to occur in the family and other close relatives of the patient. One participant whose ill relative had cannabis induced psychosis complained of his neighbours who used to shun his son from socialization:

"Because even if he sees them sitting and chatting, and if he decides to go there to sit with them, you find that they all stand up and start leaving away. They perceive him as insane and can't chat with them."

Some highlighted that stigma was present among the family members. This was apparent after the onset of illness. This seemed to be unbearable burden to the carer and as everything is left to him/her. One informant aged 38 years old caring her daughter with epilepsy remarked:

"Stigma is present even among us, because, you find that initially, you will be with your family and the society in general, but when the problem happens, none of your relative will come to know your progress with the patient."

Stigma was said to be caused by lack of knowledge about the nature of mental illness. The carers expressed concern on the education program to the people to know mental illness so that to reduce stigma and discrimination. Most caregivers had shown interest in knowing the origin of mental illness and some had got brochure from some mental health services with respect to their patient's condition. They reported to be aware of nature of mental illness but none of the non-carers had interested to know how mental illness is caused and treated. This was said to increase stigma in the society. Patients were said to be more stigmatized than the caregiver probably due to ostensible awkward behaviour. However, caregivers (parents) were blamed of causing the ill relative to be in that situation.

Coping and adaptation

Coping and adaptation are one of the aspects of caring a patient with chronic mental illness. Different ranges of coping and adaptation had been reported by the participants as described below.

Adaptive coping

Most family carers described some range of strategies to cope with long term caring situations. Acceptance and praying was one of the most important cited strategies of coping. Carers had learned to accept and reconcile the disability or deviant behaviour in the mentally ill relative and so to avoid the dissatisfaction and disappointment that would have resulted from patient's bizarre behaviour. One caregiver aged 58 heard saying:

"You need to accept, no way, that is your child, whether your relative, your family member. .....where would you ask help? That is you gift from Almighty God, you have to accept."

Some family carer took positive action by undertaking problems solving to cater for their relatives' psychological, emotional and practical needs to help overcome the illness. This is because most family members brought their ill relative to the hospital after consulting different areas especially from traditional healers. After a going here and there seeking for relief without success, they come to the mental health service which they reported to be satisfied and giving hope for their imminent desperation.

"So, it is the hospital services we are continuing with until now.. It gives me hope and satisfaction I and the patient have will never go to the traditional healer again"

Other family caregivers sought religious support as the only way of hope and encouragement. They said that their religious practice gave them peace of mind and helped to endure the care giving situation. They believed that praying was likely to reduce the suffering for their ill relative as well. So their faith seemed to be a cornerstone for continuing caring the patients irrespective of their distressing behaviour. A woman aged fifty years old caring for her schizophrenic son said:

"Whenever the aggressive behaviour of my son begins, I immediately enter into my room, lock the door, kneel down and pray for Almighty God; Oh God! Help me to touch the Cross until my time of death!"

Maladaptive coping

Some carers showed signs of desperation due to difficult life situation caused by the patient's critical demands and attention coupled with unrealistic daily income. They had no means of coping or adapting to manage their situation either due to persistent patient's bizarre behaviour or their own lack of endurance to the patient's overt behaviour. However, they still had hopes due to their faith as described by a 46 years old lady caring her sister paralysed schizophrenic sister:

"That's why sometimes you speak rudely to me, and I answer rudely to you as well. What respect do I expect from you I wonder! I always provide care for you so what! It is merely my faith which makes me to be here."

Love, patience and knowledge of the problem were other aspects mentioned by the family carers which were one of the enduring strategies for care giving situations. However, none of the caregiver had abandoned his/her patient but most showed signs of desperation.

CHAPTER FIVE: DISCUSSION

This study has offered an insight on social and psychological impacts of caring for patients with mental illness on families. Feelings and coping strategies experienced by family carers were revealed in the study. Furthermore, lack of social support, stigma and conflict caused by the patients had been the main themes in this research. The focussed discussion encouraged participants to share experience of the problems which they were facing and this was complimented by in-depth interview.

The result of this research depended on the accuracy of respondents and upon one carer only in the family whereas in the family there may be variation in perception and experiences of caregiving situation by other relative. However, the small sample size could make the result to be applicable in the local setting.

Financial constraints

The financial constraints found in this study conform to other studies which explored the relationship between mental illness and poverty (Njenga, 2002; Ssebunnya, 2009; Edward et al, 2008). In this study, it has been found that people with mental illness are often unable to generate income they often have to rely on the financial support of family members to meet basic living needs and to pay for any health expenditure associated with mental illness. Thus, family members may have to set aside a significant amount of their time to care for an ill family member. This can diminish caregivers' chances to get or keep a job or earn income, which in turn affects the source of income of that carer thus further increasing the risk of poverty and poor mental health of the patient. In Mtwara region, Basic Needs (2009) had reported that shortage of psychotropic drugs resulted in substitution of their usual medicine with alternative ones which were not effective. In this research, the shortage of drugs was reported to decrease the credibility of the health facilities which is the main pillar of many families with mental illness. So there is a need to improve mental health services including adequate antipsychotic supply so that carers could continue getting them at the hospital free of charge as the policy stipulates.

Social support

This study found that there is a need for social support for the prosperity of the family affected with mental illness. Friends and other close relative of the mentally ill person had been found to be important for the welfare and unity of the family. This unity helps to prevent stigma to mentally ill patient in the family and the community at large. Larson et al (2008) in United State (US) reported that families should assume major roles in supporting relatives with mental illness. His report is inconsistent with these findings probably because of different cultural background of Tanzania and USA. However, education on the nature of mental illness can also be the problem which calls for more emphasis on community awareness of mental illness in Tanzania. A qualitative study conducted in Thailand to explore the lived experience of Thai family caregivers (Sethabouppha et al, 2005) found that extended family was a major support to carers physically, financially and emotionally. This is not the case in this study because the family system was described to be more nucleated which results to decreased support to the family carers may be due to the fact that the study was conducted in urban setting. In rural areas, most families are believed to be extended than in urban areas. In essence neighbours and the community are important component of support. This research suggests that social support system is the mainstay and streamline for the improvement of mentally ill patient. However, shortage of this important component has hampered the improvement of the patient, family and is the drawback to the psychosocial rehabilitation of chronic mentally ill patient. This argument is supported by Sheth (2005) who gave several reasons for difficulties encountered by patients cared at home. The most important way to improve the social support system in Tanzania is to integrate mental health into primary heath care system (WHO, 2008). Although mental health is stipulated in the National Health policy (2007), the pace is too slow to cater the increasing burden and demand of mental health care in the local setting. The government support is essential not only in improving primary mental health care but also in ensuring adequate provision of free treatment and free medication, nevertheless, effort is needed by the government to increase the mental health professional by increasing training institutions and deployment of available human resources.

Stigma and discrimination

This study had reported that stigma as one of the important aspects of social problems which impacted on the families caring patient with mental illness. Several studies have shown that stigma may erode the morale of family carers and results in withdrawal from potential supporters (Perlick et al, 2007; Perlick et al, 2004; Dicky et al, 1999 ;). This argument substantiates the findings in this study as some families with a person with mental illness reported to have lost their close relatives and other social supporter after the onset of mental illness of the their relative. However, a longitudinal study is required to establish the causal relationship between the social supporter and stigma of families caring patient with mental illness. As participants were concerned to their caring obligations in this research, there is a significant need for education of the general population about the causes, presentation, and treatment of mental disorders. Although stigma and discrimination is socially and culturally influenced phenomenon (Griffith et al, (2006), general population's increased education and understanding may decrease the stigma experienced by people who have a mental illness, their carers, and their families. Stigma is acknowledged globally as one of the major problems to the success of community mental health care (Sartorius 1998) and it prevents a person from being fully accepted in society. Mwape et al (2010) in Zambia reported that stigma will be reduced if people with mental health problems would be treated in primary health care rather in mental or district hospitals. In Tanzania, the health care facilities in the local setting have not incorporated mental health in their basic health care packages which would aid in reducing stigma. Current research suggests that the media plays a pivotal role in the stigmatization of mental illness and therefore could also play a role in the de-stigmatization process. Governments should aim to use the media effectively to improve the preparation of the general population's understanding of mental disorders.

Coping and adaptation

Coping strategies is an important aspects in caring a patient with mental illness. In this study carers have shown some limited ranges of coping with patients' disruptive behaviours. Acceptance and praying are ones of the most cited. Some researches have revealed different ways of coping with distressing situations including cognitive, behavioural and avoidance the

strategies. (Kartalova-O'Doherty & Doherty, 2008; Martin et al, 2001; Bosch et al, 2000; Doornbos, 1996).

Martin et al (2001) specifically examined the difference in coping strategies in different age, ethnic, gender, and education and found some evidence that older people are more religious than younger adults. In his study, religious coping seems to focus more on informal activities, especially religious beliefs, rather than on more formal religious activities. This is consistent with the findings in this study although did not consider gender, age, ethnic and education background. Praying as one of the coping mechanism in this study has been similar to the findings from studies in Thai family carers (Sethabuppha, 2005). However, there is a difference in religious beliefs as in Thai families had Bhudhistic beliefs compared religious base of Tanzanians. In this research, both Christians and Islams had developed habit of praying as the way to confront with caregiving situation that they described to be relieving the symptoms. Practically, findings suggest that different consultation is sought as the way of finding solution or treatment to their loved one. Some were advised to seek treatment to traditional healers but when they find no relief, they turned back to God and sought hospital services. Most were satisfied with the hospital treatment after individual effort to seek information concerning the illness of their loved ones (cognitive coping). Maladaptive coping strategies had not apparently described even though some shown sign of desperation in caring their ill relatives as they were tired and did not now what to do so that they can make their ill relative feel better.

Disruption of family functioning

Family functioning has been affected by caring patients with mental illness. There is change in role of family members as the parents were involved or more consumed by patient's demand. The patient has many things which need to be fulfilled by the carers while also doing his / her daily activities to gain their daily living. This increases the objective burden to the carers. A large quantitative study in Australia (Edward, 2008) reported that higher levels of the objective burden of care were associated with lower levels of family functioning, which in turn were associated with higher levels of anxiety, depression and perceptions of poorer health. In these findings, it has similar outlook due to the fact that there was a low level of family functioning that associated with patient's uncontrolled behaviour. The results of this

research would further suggest that families affected with mental illness feel less cohesive and perceive themselves to be less connected to one another and less bonded as a unit than the normative family. In addition the families of the mentally ill felt dissatisfied with the functioning of their family. This gives a strong desire that individual families should maintain their roles and relationships, thereby enabling the family system to maintain equilibrium because any occurrence of mental illness of a family member which needs caring at home results in psychological and emotional disturbances for the whole family (Chien W-T et al, 2007). In relation to the conceptual approach of family caregiving suggested by Rungreangkulkij and Gilliss (2000), these family beliefs and relationships can be of great importance in understanding caregiving problems and any socio-cultural factors influencing family care of people with mental illness. However, it is also important to examine further and distinguish between the availability of social supporting resource and the actual use of that resource to strengthen the family functioning.

Problems in managing patient's symptoms

Violence and menacing behaviour displayed by patient in this study would seem to be the results of insufficient symptom management. Proper management is of important phenomenon to not only the family carer but to all people who come in contacts with the patient. This research has found that families are perplexed by violent patients. This is because many violent patients fail to see their behaviours as threatening and may actually perceive the family as threatening. Similar research has been suggested the same findings in United State (Estroff et al, 1994). This threatening behaviour of patients cost family carers a lot as most of them had been fined due to paying back of things which has been dismantled by the patient or compensation for injury caused by the patient. This phenomenon demoralizes the carers and enhances stigma of mental illness. Information of nature and strategic approaches are required when interacting with the mentally ill person.

Conclusion

Family caring for person with mental illness has its advantages, yet it has multiple social and psychological problems and challenges for both family carers and the mental health professionals. This study has attempted to explore psychosocial problems in family caring patient with mental illness.

The findings offer a direction for family intervention that acknowledges the need of both the carers and their mentally ill relatives. Tackling of these problems needs a collaborative approach so that the needs of the carer and the family in general could be resolved. The policy makers are in good position to intervene at the family level by developing mechanism that would enable the mental health professional to provide care at the family setting and also provides an insight to intervene at the facility level by improving the provision of psychotropic drugs to the patients. Community mental health nurses need to extend their care at the family level at least be able to provide other services such as emotional support.

Limitation of the study

There are several limitations in this research. Firstly, all of the participants were volunteers and the sample might not include those caregivers with the highest level of caregiving problems, which may have caused a selection bias in the results. Secondly, only one primary caregiver from each family who was the primary caregiver and spent most of the time with the patient was recruited. There would be variations in levels of caregiving problems among family caregivers, due to their differences in family roles and perceptions of caregiving. Finally, this study relied upon the accuracy of the respondent to report their true feelings on the impacts of caring for mentally ill persons and personal observation of the nonverbal cues that would depend on the accuracy of interpretation of the observable non-verbal cues.

Implication for practice and future research

Findings of this study serve to provide a foundation of better understanding of the family carers for relative with mental illness in the local setting. The study calls for psychiatric nurses, especially community psychiatric nurses who have the advantageous position in meeting with families in the health care delivery process, to gain a better understanding of social and psychological problems of caregiving as well as the policy makers. The implication for this study can described according to the area of practicum as follows:

For mental health professionals

Psychiatric nurses need to extend care provided to include the whole family. Reducing the negative impacts of caregiving on families by employing various interventions appropriately can be effective. For instance, educational programs can be developed to satisfy the needs of family carers. Family counselling should be provided to the families to help them to cope with the emotional and interpersonal aspects of caregiving.

The study also provides insight to other mental health practitioners or policy makers.

For policy makers

The carers expressed concern on shortage of psychotropic drugs in mental health services. This calls for government and other stakeholders to ensure adequate supply of these medications. There is also an urgent call for family oriented mental health services to be developed to assist families in the care of mentally ill relatives at home.

Recommendation for future research

Replication of the study with larger sample will be useful in further enriching the knowledge base of the phenomenon and in proving the foundation for the future research in clinical practice.

This study gained information from the experience of family carers as a whole without differentiating the relationship between carers and the ill relatives. Age, gender, education background, occupation and were also not considered in this study.

Therefore specific research addressing the following topics is encouraged;

1. Are there differences in the caregiving across group of carers, e.g mothers, spouse, siblings, age and sex?
2. How effective are the specific nursing interventions in helping family carers cope with the caregiving?

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