FACTORS INFLUENCING RELAPSE OF PSYCHIATRIC OUTPATIENTS IN THE RURAL COMMUNITIES OF THE EASTERN CAPE PROVINCE

by

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UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF TR MAVUNDLA

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Student number: 34396276

DECLARATION

I declare that FACTORS INFLUENCING RELAPSE OF PSYCHIATRIC OUTPATIENTS IN THE RURAL COMMUNITIES OF THE EASTERN CAPE PROVINCE is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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

SIGNATURE             DATE

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Abstract

A descriptive survey to identify factors influencing relapse of psychiatric outpatients in the rural communities of the Eastern Cape was undertaken. A questionnaire was used to collect data from family caregivers who were relatives of psychiatric patients receiving their monthly medications from two rural clinics. Data were analysed using the Statistical Package for Social Sciences (SPSS) version 17. A total number of 92 family caregivers participated. Respondents reported side effects of psychotropic drugs, poor family role, poor referral system, lack of home visits, non-compliance and stigmatization as major factors contributing to relapse of psychiatric outpatients. Active involvement of caregivers in follow up care of their relatives is effective in fostering collaboration between the psychiatric hospitals and patients with the common goal of relapse avoidance. It is recommended that adequate provision of resources in conjunction with health education is effective in enhancing collaboration towards prevention of relapse in psychiatric patients. This would promote team work among patients, caregivers and health care providers.

Key words: Psychiatric relapse, stigma, caregivers, rural communities, Eastern Cape Province, descriptive survey, community psychiatric services.
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Success is not measured by where you are in life, but by the obstacles you have overcome. Now that the dust has settled, I feel it is proper for me to express my sincere gratitude to the following individuals for their support:

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# CHAPTER 1

## Orientation to the study

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## CHAPTER 2

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

In the health profession, a relapse means to “become ill again after apparent recovery; the return of ill health after an apparent or partial recovery” (Collins English Dictionary 1991:1307). Mwaba and Molamu (1998:56) define relapse as “a worsening condition of a psychiatric outpatient”. Often, this is due to patients stopping medication on their own against the advice of a multi-disciplinary team. Martenyl, Brown, Zhang, Koke and Prakash (2002:316) state that a nurse or any member of the multidisciplinary team can observe that relapse clinically.

Psychiatric issues, including relapse, impose a burden on the economy. For example, schizophrenic patients are hospitalised for long periods, which is expensive (Launer 1997:16).

In the Eastern Cape Province, South Africa, the researcher observed that factors that contributed to relapse included lack of transport to conduct home visits, the stigma attached to mental illness, side effects of psychotropic drugs, and non-compliance with and unavailability of psychotropic drugs. The present study wished to identify factors that contributed to relapse among mentally ill patients located in the rural areas of the Eastern Cape. The study was conducted in the Nkonkobe Local Service Area at Debe Nek and Zihlahleni clinics (see annexure 3).

1.2 BACKGROUND TO THE PROBLEM

Craig and Boardman (1997:1609) found that the most common mental disorders among patients in primary health care (PHC) were depression (10%), anxiety disorders (8%) and alcohol abuse (3%). A major contributing factor in the relapse of psychiatric patients is non-compliance with treatment (Mwaba & Molamu 1998:56).
Manamela (2001:163) found that the stigma attached to mental illness is a problem that psychiatric patients experience daily. Stress can result from stigma and cause psychiatric patients to feel neglected by the community and their families (Mwaba & Molamu 1998:56). Sokhela (1997:76) emphasised that stress leads to health or illness behaviours; that is, unbecoming behaviours. When psychiatric patients are stressed as a result of unacceptable behaviours within the family, such as neglecting the patient, they are likely to relapse. According to Mbanga, Niehaus, Mzamo, Wessels, Allen, Emsley and Stein (2002:70), stressful life events, like the loss of a loved one, are contributory factors in relapse. Solombela and Uys (1994:27) identified alcohol abuse and dagga smoking as factors associated with relapse. Nkonzo-Mthembu (1996:58) found that factors such as a poor educational environment, poor infrastructure, high crime rates, stress, and violence contributed to alcohol abuse in the community.

In addition, poor referral systems are an ongoing problem. In dealing with the problem of relapse, Solombela and Uys (1994:27) recommended that the referral systems be improved between psychiatric institutions and the clinics, where discharged patients will attend for follow-up care.

In Austria, Herbert, Meltzer and Fleischhacker (2001:3) found that some patients refuse treatment because of a resultant weight gain. According to Laurence and Kirkmayer (2001:126), in South East Asia, patients with psychiatric disorders (e.g. depression or post traumatic stress) reported taking treatment as instructed, but had no detectable blood levels in the therapeutic range. This could be due to the unwillingness to take treatment because the drugs are very strong, physiological and psychological side effects, and stigma attached to psychiatric treatment. Patients’ cultural attitudes towards authorities, such as clinicians, could cause them to appear compliant merely to please the clinician. Treatment compliance is regarded as implying that the patient's responsibility is solely to conform.

Culture conformity could have negative connotations of weakness and subservience by patients to clinicians (Laurence & Kirkmayer 2001:26). Clinicians instruct patients to take their treatment properly, but do not guide them. For the treatment regimen to be successful it requires a joint effort by clinician and client.
Substance abuse, major life changes and defaulting treatment influence relapse. Factors such as boredom, patients’ lacking routine or something to do in their daily life, isolating themselves, not taking part in anything in the community and anger resulting from unresolved conflicts could lead to relapse (Dual Recovery Anonymous, Relapse Prevention 2003:1). The present researcher personally found a lack of home visits by psychiatric nurses, due to transport problems leading to psychiatric patients’ relapse, especially in the rural Eastern Province. Besides uncoordinated after-care, inconsistent diagnosis can also influence relapse.

Hospitalisation of mentally ill people may be very costly to the state or country concerned. Scott, Palmer, Paykel, Teasdale and Hayhurst (2003:224-225) pointed out that the morbidity and economic burden of depression are equal to or more than major disorders such as Acquired Immunodeficiency Syndrome (AIDS), cancer, and coronary heart disease. Cooper (2003:2) states that psychiatric issues contribute to the overall burden of the world economy.

Over and above the cost associated with relapse to the state or government, Louner (1997:16) found that schizophrenic patients are hospitalised for up to six years. Knott (1997:26) emphasises that standards of community care are lowered by government’s obsession with general practice costs instead of total care costs. For example, some practitioners ask local hospitals to use less efficacious cheaper rather than more efficacious expensive drugs. In spite of the existing findings of relapse in psychiatric patients in general, this researcher wants to know specifically, what are the factors that contribute to relapse in psychiatric outpatients in the Nkonkobe Local Service Area.

1.3 PROBLEM STATEMENT

In South Africa, registered nurses are in charge of many community health services. Most Black South African patients depend solely on these services for follow-up care after discharge from the local psychiatric institutions (Uys 1991:1). The researcher is in charge of a community psychiatric service at Nkonkobe Local Service Area, Region C at Debe Nek Clinic, in the Eastern Cape Province. Approximately 40% of the psychiatric patients attending the clinic for follow-up care are regularly readmitted to psychiatric institutions each year.
Various reasons lead to mentally ill patients’ relapse. For example, between the late 1990’s and 2005 Uys noted a serious unavailability of psychotropic drugs in the rural clinics of the Eastern Cape (Uys 1991:1). Community services were run without transport allocated specifically for that department. Home visits, one of the vital functions of a community psychiatric nurse, were poorly done due to lack of transport. In the researcher’s experience, during home visits, a community nurse could identify clients’ problems that could be overcome in advance, thus preventing relapse.

As a strategy for continuity of care, a psychiatric patient discharged from a psychiatric institution is given a referral letter to take to the nearest clinic for follow-up care. Some patients keep the letters with them and never attend follow-up care. The psychiatric nurse at the designated clinic never learns about the patient, as in some cases, relatives take such clients, in case of relapse, directly to the general hospital where they are admitted for seven days and transferred to psychiatric institutions if needed.

The patient on improvement is discharged after one or two months with a referral letter to the nearest clinic to continue with follow-up care. The referral letter either reaches the clinic late or does not even reach the clinic. This becomes a vicious cycle, because the psychiatric institution where the patient was initially admitted, sends a referral letter which was never received at the chosen clinic, whilst the patient is on the second admission to another psychiatric institution.

The prevailing referral system imposes a problem because there are two referral letters: the first is given to the patient and the second is sent to the nearest clinic by the psychiatric institution where the patient was admitted from. The psychiatric nurse only becomes aware of the patient when the family brings him/her to the clinic because of relapse symptoms, such as violence and destructiveness. The psychiatric nurse is then informed that the patient was admitted to a psychiatric institution but never attended a clinic for follow-up care. In the researcher’s view, this shows the families lack of commitment to follow up care to their patients.

In the Eastern Cape, the researcher also found that community abuse of the mentally ill was escalating. For example, some members of the community such as shebeen owners, send them to the alcohol stores to buy alcohol in large amounts for retailing. In
return, they are given liquor and dagga as a gesture of appreciation. This practice results in alcohol and dagga abuse.

In order to investigate the research problem, therefore, the researcher formulated two research questions.

1.4 RESEARCH QUESTIONS

The researcher wished to answer the following research questions:

- What are the factors that influence relapse of outpatients in rural communities of the Eastern Cape Province?
- What can psychiatric nurses do to prevent relapse of psychiatric patients in these communities?

1.5 PURPOSE OF THE STUDY

The purpose of this study was to

- identify and describe factors influencing relapse among psychiatric outpatients in rural communities of the Eastern Cape Province
- make recommendations for the role of psychiatric nurses in dealing with this problem in these communities

1.6 DEFINITION OF TERMS

For the purposes of this study, the following terms are used as defined below:

1.6.1 Relapse

Relapse means to “become ill again after apparent recovery; the return of ill health after an apparent or partial recovery” (Collins English Dictionary 1991:1307). Solombela et al (1994:24) define relapse, as referring to the worsening of the condition of a discharged patient, which is shown by one of the following:
• The patient stops medication against the advice of medical professionals.
• At the clinic the patient hallucinates, which is a sign and symptom of relapse.
• The patient is hospitalised at a psychiatric institution.

1.6.2 Psychiatric nurse

A psychiatric nurse is an individual that is professionally educated and equipped with skills to be able to interact with a patient in a goal-directed way. Psychiatric nurses help clients to use their environmental resources to facilitate mental health (Poggenpoel 1994:54).

1.6.3 Psychiatric outpatient

Psychiatric outpatients are individuals who play a vital role in maintaining their optimal functioning in the community and preventing relapse (Blott 2000:15). They receive treatment as out-patients and reside in their communities in the rural areas. They are referred to as clients, patients and persons interchangeably.

1.7 CONCEPTUAL FRAMEWORK OF THE STUDY

This study was based on concepts that emanated from the literature review and the theoretical framework proposed for psychiatric rehabilitation by Uys (1991:2). In this theoretical framework, a patient and his or her family are seen as members of the psychiatric team through their active participation. Whatever information is presented to them on the condition of the patient and treatment, should be the latest information in a simple and understandable form (Uys 1991:2). A patient is “a person who is receiving medical care (Collins English Dictionary 1991:1143). The community should not be left out, but should be educated on how to take care of the mentally ill to reduce the rate of relapse. A community is “the people living in one locality; a group of people having cultural, religious, and ethnic or other characteristics” (Collins English Dictionary 1991:327). The family as part of the community can play a major role in the prevention of relapse.
1.8 RESEARCH DESIGN AND METHODOLOGY

1.8.1 Research design

Brink and Wood (1998:94) define a research design as “a blueprint or a plan for research. The purpose of a research design is to plan and structure the study, to maximise the validity of the findings. The choice of the design is determined by the research problem or the research question.” Babbie and Mouton (2002:75) state that the research design focuses on the end product; the point of departure is the research problem or question.

1.8.1.1 Quantitative approach

In this study, the researcher selected a quantitative non-experimental descriptive design, using a questionnaire. This type of research design was considered appropriate as the researcher was interested in determining factors influencing the relapse of psychiatric patients in the rural communities of the Eastern Cape Province. Information was analysed statistically and collected under controlled conditions. Structured procedures and formal instruments were used to collect data. Brink (1996:13) points out that this approach develops specific predictions from general principles.

1.8.1.2 Quantitative (non-experimental) descriptive design

Brink (1996:109) defines the descriptive design as “providing a description of the variables in order to answer the research question. The descriptive design encompasses a wide variety of quantitative methods.” A survey was used because the researcher wanted to describe the incidence, prevalence and characteristics of the phenomenon under study (Brink & Wood 1998:103). The researcher selected a descriptive design to describe the incidence of relapse in the context of rural clinics of the Eastern Cape Province.

1.8.2 Research methodology

This section briefly describes the research methods used by the researcher during the planning and implementation of this research project.
1.8.2.1 Population

Polit and Hungler (1997:223) define a population as “the entire aggregation of cases that meets a designated set of criteria. Sampling refers to the process of selecting a portion of the population to represent the entire population.”

1.8.2.2 Sample

A sample refers to “the sum of individuals within a specific territory or a small portion of a population or a smaller representation of a larger whole, intended to reflect and represent the character, style or content of a population from which it is drawn” (Brink 1996:133).

1.9 DATA COLLECTION

A structured approach was used to collect data, using a formal instrument (a questionnaire) that obtained the same information from every respondent. A structured approach uses data that are qualified easily. The data collected were statistically analysed and therefore needed to be qualified (Polit & Hungler 1996:254-255) (see chapter 3 for research methods).

1.10 DATA ANALYSIS

For data analysis the researcher used the Statistical Package for Social Sciences (SPSS) computer program.

1.11 ETHICAL CONSIDERATIONS

Nursing is an ethical profession and upholds certain ethical principles. In this study, the researcher acknowledged the rights of the respondents by explaining the purpose of the study and informing them of their willingness to exercise their rights regarding their participation in the study. The researcher discussed the study with the respondents in their own language at their level of understanding. They were given the opportunity to decide voluntarily whether to participate in the study or not. Anonymity was ensured by not using their names, but code names. The respondents’ understanding was weighed
or assessed by asking questions on the information presented to them. Confidentiality and privacy were maintained by not availing information to an outsider or any other person (Brink 1996:42).

1.11.1 Rights of the institution

The researcher applied to the district manager in writing for permission to conduct the study at Debe Nek and Zihlahleni Clinics.

1.11.2 Scientific honesty

The researcher maintained honesty by not making up information that did not exist. The researcher did not present someone else's work as her own work, but other people’s work used was appropriately referenced. The researcher did not manipulate data by choosing information that supported her views.

1.12 SCOPE AND LIMITATION OF THE STUDY

The study was conducted in the Eastern Cape Province at Debe Nek and Zihlahleni clinics, Nkonkobe Local Service Area, Region C.

1.13 OUTLINE OF THE STUDY

Chapter 1 outlines the problem, context, research design and methodology as well as ethical considerations of the study and definition of the key terms.

Chapter 2 explored the literature for psychiatric patient relapse and the roles of family and community to help prevent the phenomenon.

Chapter 3 describes the research design and methodology, study population and sample, process of data collection and analysis and ethical consideration.

Chapter 4 presents the findings, the data analysis and the interpretation. A discussion of findings in relation to existing information in the literature was considered.
Chapter 5 presents the conclusions and limitations of the study and makes recommendations for practice and further research.

1.14 CONCLUSION

This chapter presented the statement of the problem, the research setting which is the rural area of the Eastern Cape Province, and the purpose of the study. This chapter also gave a synopsis of the factors influencing the relapse of psychiatric outpatients, and also offered the entire organisation plan of the project. Chapter 2 explores the literature review for the study.
CHAPTER 2

Literature review

2.1 INTRODUCTION

This chapter examines the literature reviewed on the various factors that could contribute to psychiatric patients’ relapse. These include non-adherence to the medication regime, substance abuse, mental illness stigmatisation and the shortages of anti-psychotic drugs.

This study was based on Uys’s (1991:2) theoretical framework for psychiatric rehabilitation. The underlying assumption is that patients and their families are members of a psychiatric health team through their active participation in the maintenance of mental health as an integral part of wholeness. Information presented to them should be up to date, in a simple and understandable form. The information given to both parties should be about the illness and treatment.

Mental illness can be successfully managed in the community since it is long-term illness also, persons who suffer from it, after the acute phase are discharged from mental institutions, and they return back to the community. The success of managing mental illness in the community relies on the rehabilitation approach and adequate availability of resources (Uys 1991:2). The researcher conducted a detailed literature review on factors that impacted on relapse of psychiatric outpatients.

2.2 PURPOSE OF THE LITERATURE REVIEW

The researcher conducted a literature review to

- validate the information about relapse in order to gain further insight into the topic of the study
- compare the research findings
- clarify the problem statement, the conceptual framework, and the design for the study
2.3 SCOPE OF THE LITERATURE REVIEW

Brink (1996:76) emphasises that it is essential that researchers make an in-depth and intensive investigation into the relevant literature. Literature review is a process that involves finding, reading, understanding and making conclusions about the published research and theory on a particular topic. In this study the review dealt with the topics outlined below:

- Family care giving
- Guidelines for families with mentally ill members
- Managing disturbing behaviour successfully
- Rehabilitation of mentally ill people in the community
- Factors contributing to the relapse
- Mental illness stigma
- Duration of untreated psychosis
- Treatment resistance in schizophrenia
- Substance abuse

2.3.1 Family care giving

Family care giving involves care of immediate family members by their relatives. A primary informal care giver is the person that provides the most unpaid support to an individual and helps with physical care or emotional or psychological support (Foster 2005); (Hileman, Lackey & Hassanein 1992). The term applies to anyone caring for a person with an acute, chronic, or terminal condition and not only to caregivers of individuals with mental illness (Mavundla, Toth & Mphelane 2009). In this section of the literature review the researcher discusses the following: (1) role of family in care giving, (2) family interventions and (3) guidelines to be followed by families of mentally ill people.

2.3.1.1 The role of the family in caring for the mentally ill

Clark (1992:396) defines a family as “a social system consisting of two or more people living together who may be related by blood, marriage or adoption”. Furthermore, family
members also share obligations, goals, a sense of belonging, and love. Spradely and Allender (1996:366) note that the health of each family member affects the health of other family members and contributes to the total family's level of health. The family, more than any other societal institution moulds and shapes a member of society.

In line with the contributory factors to families’ wellbeing is urbanisation. Kgositintsi (1996:39) is of the opinion that urbanisation causes reduction of the family's ability to care for the mentally ill. This is due to the fact that productive age groups migrate to urban areas to seek employment and this reduces family structure. Wilson (1989), as cited in Kgositintsi (1996:36), emphasises that the ability of the family to support a dependent member varied with the progress of its development. He or she further argues that in order to promote mental health and prevent mental illness, the family needs services like social welfare, rehabilitation, and health provided for the patient (Kgositintsi 1996:42). This is believed to lessen emotional and physical burden from caring for the client. To support this view Spradely and Allender (1996:354) further argue that a family gives emotional support and acceptance, and also provides support and fosters care during illness of its family members.

Apart from the role of the family at home, their involvement during the rehabilitation process of a mentally ill patient is necessary to facilitate recovery. Sokhela and Uys (1998:9) emphasise the involvement of the family in the rehabilitation of a psychiatrically ill patient, because the family takes care of the patient in the absence of a nurse or a health professional. They claim that the family should be educated on the outcome of the illness on the day-to-day functioning of the mentally ill patient and the nature and cause of illness. Sokhela and Uys (1998:9) further refer to Sullivan’s (1994) view that the family should be educated on the side effects of the medication such as drooling, tremors, and stiffness, and what to do when the family observes these symptoms.

In addition to the involvement of families during the rehabilitation process, the possession of the appropriate skills is required to manage the patient in the absence of the health care team. Uys (1991:3) contends that a family needs to have the necessary skills to deal with the problems caused by the patient’s illness. She recommends two types of skills as being necessary, namely, social and coping skills. She continues to
explain that family’s social skills include healthy communication and coping skills deals with the family’s ability to handle both the patient’s treatment and the illness.

Though family caregivers may have necessary skills to take care of the patient within a home environment, research shows that expressed emotions may influence patient’s recovery negatively. Kuipers, Bebbington, Dunn, Fowler, Freeman, Watson, Hardy and Garety (2006:173) found that highly expressed emotion in caregivers predicts an increased relapse rate in schizophrenia patients. Patients whose caregivers showed highly expressed emotions had higher levels of anxiety and depression. Patients who are continually exposed to families who criticise in a manner that will traumatisate them emotionally, frequently relapse (Lewis, Tarrier & Drake 2005:65). Das and Kulahara (1997:56) emphasise that family stress expressed emotionally is directly related to psychiatric patient’s relapse.

In a study on the effect of integrated treatment versus standard treatment on subjective burden of illness, expressed emotion (EE), knowledge of illness and satisfaction with treatment in key relatives of patients with a first episode of schizophrenia-spectrum disorder, Jeppesen, Peterson, Thorup, Maj-Britt, Oehlenshlager, Christensen, Krurup, Hemmingsen, Jorgensen and Nordetof (2005:85) found that the course of illness in schizophrenia depends on how the family members relate to and deal with the patient. Jeppesen et al (2005:65) describe the integrated treatment, as a “rich assertive community treatment model including protocols for medication, social skills training and psycho-educational family treatment” and standard treatment as “medication, and consultation with psychiatrists”. Relatives consulted psychiatrists and were informed about the treatment, and also gave background information. Some relatives took part in workshops. Integrated treatment reduced positive and negative symptoms; that is, it reduced the burden on relatives, increased patients satisfaction with treatment regime, shortened their hospital stay, and improved the continuity of care. The background of a study conducted by Slade, Pinfold, Rapaport, Bellringer, Banerjee, Kuipers and Huxley (2007:148) show that psychiatric patients may not consent to sharing information with caregivers, meanwhile caregivers require access to relevant information to support them in their role. Slade et al (2007:148) conducted a study showing the importance of psychiatric patients giving consent for sharing information with their caregivers. Psychiatric patients withhold personal information to carers. A questionnaire was
distributed to healthcare professionals, carers and psychiatric patients. Psychiatric patients highlighted confidentiality being guaranteed by consent processes, caregivers suggested a shift in culture was required, in addition to professional training to work with carers, professionals emphasised the mental capacity of the carers and their professional judgement.

### 2.3.1.2 Family interventions

Apart from the family role in supporting people with mental illness, family interventions are crucial during patient care. Lewis, Tarrier and Drake (2005:65) recommended the following effective family interventions to reduce estranged relations between the patient and the family:

- Educate the family about the illness, symptoms and the effects of symptoms such as inactivity.
- Promote a problem-solving approach whereby problems, their causes and outcomes are identified by the patient jointly with their family. Encourage families and patients to develop strategies to deal with the problems.
- Problems should be solved: This means that the family and the patient should come together and discuss the problems.
- The family should include the patient in identifying sources of stress within the family and seek ways to alleviate them.
- Include the patient more often and have sessions, that is, meetings with the patient perhaps two-monthly or twice in a month for six to nine months.

According to Lewis et al (2005:65), the positive outcome of family interventions is a reduction in relapse rate.

### 2.3.1.3 Guidelines for families with mentally ill members

During the care giving role of families of the mentally ill persons/patients/clients it is important to follow scientific guidelines in the care giving role. In this subsection of the review, the researcher presents guidelines to be followed by family caregivers in their
care giving role within a home environment. These guidelines were proposed by Uys and Middleton (1997:83-85) and they are as follows:

**Create an environment with low stress**

*Plan for stressful situations*

Try to avoid stressful situations although that is not always practical and possible. A family can reduce stress by preparing the patient for the situation. Psychiatric patients should be told in advance what to expect and be prepared for their role in the upcoming event.

*Avoid over involvement*

Psychiatric patients cope better if the family manages to keep some distance between them. The more the family approaches the patient, the more the patient withdraws. Repeatedly asking questions causes more stress. The family should try to limit face-to-face contact and develop interest externally; that is, outside the family structure so as to keep their minds occupied with something else and provide the patients time by themselves.

*Develop appropriate expectations*

The family should not have high expectations of psychiatric patients as high expectations cause stress if they are not met. Expectations should be kept low. Sometimes patients may have high expectations of themselves, and the family should wisely encourage the patient not to be in a hurry and take unmanageable steps; that is, big steps towards achieving the goal.

*Speak simply and clearly*

It is difficult for psychiatric patients to follow long, loud, rapid mixed sentences. The family should speak slowly, using short and simple sentences.

*Deal actively with their stress*

The family should find positive ways of decreasing their own stress and not project negative feelings to the patients.
Managing disturbing behaviour successfully

Dealing with inactivity
The family can draw a schedule or programme of easily understandable activities and add others, as the patient copes with the schedule. For example, if the patient is taught self-care activities, household chores can be included later if the patient handles them well. The family should ensure that the patient comprehends what is required of him or her.

Refusal of treatment
Should psychiatric patients refuse treatment, the family should meet with the treatment team and discuss the problem. Home visits by a treatment team can assist in maintaining medication compliance. If the need arises, routes of administration can be changed from oral to intramuscular medication for compliance purposes.

Aggressive behaviour
Psychiatric patients do get angry, and may have sound reasons for their anger and complaints. The family should listen and pay attention to what psychiatric patients say. The family should identify signs of relapse and seek help, take the patient for hospitalisation or give medication.

Psychiatric patients can be aggressive just because they demand for what they want. The demands can intensify or worsen if the family fears the patients and may have to give in to them. If such behaviour occurs, the family members and health workers should hold a meeting when the patient is calm and collectively decide what requests will be allowed or refused. The family and the team should inform the patients of the consequences if they behave aggressively again. Mentally ill patients can behave destructively when they lose control over themselves.

2.3.4 Rehabilitation in the community

While family care giving entails rehabilitative strategies within a home environment there is also care of the mentally ill people within the community. Clark (1992:8) defines rehabilitation as the “level of health-care taking place in the community. It involves
efforts that seek to reduce disability and restore function.” Spradley and Allender (1996:17) state that persons whose disability results from illness, such as mental illness, they can be helped to regain some measure of their lost function or acquire new counterbalance skills. Clark (1992:60) defines a community as “a system of formal groups, characterised by interdependence, and whose function is to meet the collective needs of group members”. Charltee, Patel and Weiss (2003:60) maintain that community-based rehabilitation, depends on the efforts made by communities, in the management of disability. As a result, patients and their families should be equipped with information, to become partners in the planning and implementation of rehabilitation strategies. To facilitate recovery, a positive social milieu should be created.

- **Psycho education**

Uys and Middleton (1997:52) recommend psycho education where the patient and the family are taught about mental illness and its management in order to cope better with community-based rehabilitation. Psycho education equips the patient and family to produce effective and appropriate outcomes for the patient.

- **Social intervention**

Social intervention “includes increasing contact between people with schizophrenia and supportive others, often through self-help support groups” (Susan Nolen-Hoeksema 1998:241). The groups meet together to discuss the impact of their illness on their lives, efforts of trying to make people understand their disorder, fears of relapse, experiences with various medications, and so on. Group members learn skills, such as leatherwork, and sports. Family and patients can be encouraged to join spiritual or cultural groups. A well-functioning and supportive network of a person with mental disorder reduces relapse (Otsman & Kjellin 2002:494). Social networks fulfil two functions, namely, practical and emotional support. Living with a spouse or family member provides direct social support. Manamela (2001:159) cites Palmer-Erbs and Anthony’s (1995) findings that persons suffering from mental illness need friends to go to, when a crisis situation arises.
2.3.5 Factors contributing to relapse of mentally ill patients

Relapse means the recurrence or marked increase in the severity of the symptoms of the disease, especially following a period of apparent improvement or stability (Austin & Boyd 2008:952). In this study the researcher reviewed the literature on factors influencing relapse of psychiatric patients in the rural contexts of South Africa (SA). She identified: transportation, non-adherence to psychotropic drugs, mental illness stigma, gender and socio-economic factors contributing to the relapse of psychiatric outpatients. These factors are dealt with in detail in sub-headings bellow:

2.3.5.1 Lack of transport to conduct home visits

Clark (1992:156) describes home visits as a traditional health nursing approach to caring for individuals and families. During home visits, the nurse has an opportunity to experience the client's situation and factors that could affect the client’s health. In this section of the review, the researcher identified only one study conducted in SA’s primary health care system dealing with transportation as a problem to the care of mentally ill people in the community. The study was conducted by Thipanyana and Mavundla (1998:31). The aim of this study was to evaluate the provision of primary health care in the rural Eastern Cape Province. The findings revealed that unavailability of transport for nurses to conduct home visits, negatively affected the provision of primary health care (PHC). These findings are supported by Kgosidintsi (1996:41), who describes that lack of the transport as a problem, obstructs health care givers in performing their duties effectively. Lack of transport hinders psychiatric nurses from observing the factors in the home environment that could negatively affect the health of psychiatric patients, which, in turn, could lead to relapse.

2.3.5.2 Non-adherence to psychotropic drugs

Csernansky and Schruchart (2002:474) contend that the most essential component of a successful long-term treatment programme is adherence to treatment. In a study on the effect of patient and family education, in a sample of Chinese patients with schizophrenia, Li and Arthur (2005:343) compared the relapse and adherence after discharge amongst patients who adhered to medication and those who did not adhere.
Nine months after discharge, the relapse rate among the patients who did not adhere to medication was 37% and 16% among those who did adhere. This indicates that lack of adherence to medication may be a profound problem that hinders recovery.

In addition to non adherence to medication, Csernasky and Schruchart (2002:474) found that a previous history of non-adherence, combined with a history of substance abuse, poor insight into the nature of the illness and poor relationships between patients, family and care providers precipitated the non-adherence with treatment. Adverse effects of psychotropic drugs such as weight gain, risk of heart disease, vascular disease, and diabetes cited as some factors that led to psychiatric patients’ non-adherence to treatment. The risk of non-adherence leads to a risk of relapse.

Apart from the effects of non-adherence to medication is the issue of the gender of patients. Beebe (2002:40) points out that psychiatric medication can cause uncomfortable side effects. Treatment non-adherence in males can be related to the absence of therapeutic response and positive relationship with health care givers. Beebe (2002:40) adds that a poor relationship between patients and staff while in hospital is another factor precipitating non-adherence which results in relapse. Beebe (2002:41) refers to Castle and Murray (1991) who maintain that generally men have a more severe and a relapsing form of schizophrenia, male patients with paranoid hallucinatory symptoms were more likely to develop complications characterised by severe impairments. Hospitalisation reduces social skills and functioning due to. Men are hospitalised more often than women, which could account for social difficulties encountered by men in various social services.

In addition to gender is the maintenance of therapeutic levels of medication in patients. Kirkmayer (2001:24) found that 53% of South East Asian patients with depression and post-traumatic stress disorders claimed to be taking medication, but had no detectable blood levels of drugs taken, and only 16% had blood levels within the therapeutic levels. Low blood levels are frequently the outcome of refusal to take medication due to its potency or the stigma attached to psychiatric treatment. Mwaba and Molamu (1998:56) associated the default of psychiatric treatment to side effects experienced due to taking drugs. In this study, patients further reported the lack of family commitment at home and the lack of supervision.
In an effort to elaborate on side effects suffered by patients Ntongana (1996:68) explored non-compliance with treatment schedules in chronic psychiatric patients, with two previous admissions. He found that 70% of the respondents experienced dry mouth; 65% experienced tremors; 50% experienced stiffness, and 52% had increased salivation. The patients refused to comply with medication because of the experience of the side effects. Moreover, 65% of the respondents’ non-adherence to treatment because their parents did not allow them to attend clinic or their employers refused their request for permission for time off to attend the out-patient’s clinic. Kniesel (1988:343) (cited in Ntongana 1996:69) found that side effects caused by psychotropic drugs frustrate the psychiatric patients, leading to non-compliance and resulting in relapse. Gray, Leese, Bindman, Becker, Burti, David, Gournay, Kikkert, Koeter, Puschner, Schene, Thornicroft, and Tansella (2006:508) (cite Nose et al 2003) stating that non-adherence rates for prescribed anti-psychotic medication are estimated at 50%. Robison et al 1999 (cited by Gray et al 2006:508) state that relapse rates have been shown to be five times higher in people with schizophrenia who are non-adherent to medication compared with adherent persons resulting in a significant economic burden.

In an effort to address problems associated with non-adherence to medication among patients with chronic mental disorders, Li and Arthur (2005:339) studied the effect of patient and family psycho education in a sample of Chinese people with schizophrenia. The education programme was designed to educate families and patients about schizophrenia and its treatment and to teach skills to help patients and families cope more effectively with the disruptive results of the illness. They found that the shorter the duration of illness, the less the families knew and the more they longed to acquire information. The longer the patient's illness, relatives gained more time to formulate their own way of dealing with it. Patient and family education in addition to hospital treatment was found to be effective in the early admission period. Moreover, there was a significant correlation between medication adherence and relapse. Muller and Fisher (2005:148) categorised standards for the mental health care of people with severe psychiatric disorders into core standards, standards for service delivery, and standards for specific settings. Patient and caregiver participation is categorised under core standards, which indicates the importance of involvement of both parties in achieving positive results or the intended goal, namely a well-maintained mental health user. Caregivers can achieve this by supervising psychiatric patients when taking medication.
and reminding them of follow-up dates. Rathbone, Zhang, Zhang, Xia, Lui, Yang and Adams (2007:379) conducted a study on evaluating Chinese herbal medicine for schizophrenia and the results suggested that combining Chinese herbal medicine with anti-psychotic drugs was beneficial to the patients.

2.3.5.3 Mental illness stigma

Otsman and Kjellin (2002:494) describe the stigma of mental illness as undesirable characteristics that causes loss of reputation. The stigmatisation of mentally ill people leads to prohibition of full acceptance by others e.g. friends or public. There are various theories that describe the existence of stigma in people with mental illness. Corrigan (2000:48), in explaining social cognitive paradigms of stigma, is of the opinion that people with mental illness, portray symptoms that provoke stereotypes on the part of public and such stereotypes lead to discriminatory practices. Corrigan (1998:210), Crocker and Lutsky (1986:97) mention two paradigms that explain the stigma of mental illness as socio-cultural perspectives – defined as stigmas that develop to justify existing social injustices and motivational biases – stigma that develops to meet basic psychological needs. Corrigan (2000:49) conceptualises stigma as a set of prejudicial attitudes, stereotypes, discriminatory behaviours and biased social structures endorsed by a sizeable group about a discredited subgroup.

2.3.6 Stigma by association

Stigma affects not only the persons with mental illness, but their families as well. Associate stigma is a process whereby a person or a relative is stigmatised because of being associated with or related to the stigmatised individual (Otsman & Kjellin 2002:494). It is important to note that such stigma may also be termed affiliate stigma (Mak & Cheung 2008:532). They further define affiliate stigma as the extent of self-stigmatisation amongst the associates of the targeted minorities.

In their study of stigma by association and psychological factors in relatives of people with mental illness, Otsman and Kjellin (2002:494-498) found that 83% of relatives are burdened by one of the psychological factors; 72% of women thought the sick relative would have been better off dead; 33% wished that the patient or they themselves had
never been born; spouses did not believe that the patient would be better off dead; 51% of relatives and 47% of the spouses reported that the patient's mental illness had affected them negatively and they could not have company of their own. It also affected the mental health of relatives.

Phillips, Pearson, Li, Xu and Yang (2002:490) state that the Chinese believe that mental illness is a punishment for unbecoming behaviour or the family's misconduct. The Chinese people also believe that mental illness is genetically transmitted and leads the to discrimination of the patient's family members (Phillip, Pearson, Li, Xu & Yang 2002:490-491). Solombela and Uys (1994:25) cite Bengu (1985) who found that in the Black culture in South African mental illness is not taken as punishment but as an affliction that necessitates the intervention of a traditional healer.

Stuart and Sudeen (1987:326) found that some families keep the person's illness a secret. This causes additional stress because they fear that the truth will be discovered at some time. An act of this nature shows that the family is shameful about the illness and shares the prejudice of the community. Lee, Lee, Chiu and Kleinman (2005:153) conducted a study aiming at comparing interpersonal experiences of stigma in patients with schizophrenia and patients with diabetes mellitus in Hong Kong. Results from data collected from outpatients with schizophrenia (n=320) and diabetes (n=160) were as follows: more patients with schizophrenia (>50%) than diabetes (average 15%) experienced stigma from family members, partners, friends and colleagues. Over 40% anticipated stigma and about 55% concealed their illness, dysphoria occurred in over half.

2.3.7 Social exclusion and social income

With regard to social inclusion, social quality and mental illness, Huxley and Thornicroft (2003:289) found that people's level of income enabled them to participate in community leisure (recreational) activities. Huxley and Thornicroft (2003:290) pointed out that the nature of mental illness, health problems and discrimination against them could cause interpersonal relationships to deteriorate, leading to reduced social contacts. They are unlikely to have any close friends and many may have no one to turn to for help. Mwaba and Molamu (1998:5) found that the stigma attached to mental
illness made psychiatric patients feel rejected by their families and the community. Consequently, they had few friends or relatives who cared for them and they felt lonely and isolated.

2.3.8 Employment

Discrimination against the mentally ill makes it difficult for a psychiatric patient to be productive in a work situation. Stromwall (2002:77) cites Orlin (1995) who holds that social agencies as employers should have law or legislations prohibiting discrimination of the mentally ill persons at work. Mwaba and Molamu (1998:58) found that employers discriminated against the mentally ill because they were labelled as unstable and dangerous even though they could function well in a job situation.

The employment level of psychiatric patients rarely reaches more than 10% and they work more than four hours and earn only two-thirds of the average national hourly rate (Huxley & Thornicroft 2003:289-290). Stromwall (2002:78) states that mental health consumers face numerous hindrances at work; for example, harassment from co-workers and stigmatising attitudes. According to Beebe (2002:41), psychiatric patients’ job-related problems encompass conflicts with co-workers or supervisors and the inability to be productive according to stipulated time.

2.3.9 Cost-effectiveness of relapse prevention

Lam, McCrone, Wright and Kerr (2005:186) refer to Rice and Miller (1995), Gupta (2002) and Patel (2003), who state that bipolar disorders evidenced by relapses often cause a high economic burden on society. Lam, Hayward, Watkins, Wright and Kerr (2005:325) conducted a 30-month study on cost effectiveness of relapse prevention cognitive therapy for bipolar disorder. The primary measure of cost effectiveness was the number of days without a bipolar episode. The standard care treatment comprised mood stabilisers, psychiatric follow-up and psychiatric in patient care. Cognitive therapy was combined with mood stabilisers. The group receiving cognitive therapy during the first 12 months and the whole period of 30 months had lower service costs compared to the comparison group. The most expensive care was the in-patient. The findings indicated that in bipolar disorder, adding cognitive therapy to mood stabilisers could
prevent relapse at a lesser cost. Combination of cognitive therapy and mood stabilisers was superior to mood stabilisers alone in terms of clinical outcome and cost effectiveness for those with frequent relapses of bipolar disorders.

2.4 DURATION OF UNTREATED PSYCHOSIS

Norman, Lewis and Marshall (2005:19) found a relationship between longer duration of untreated psychosis (DUP) and poorer outcome of treatment. Norman et al (2005:20) refer to Altamura et al (2001) who discovered that patients with short DUP were less likely to have a multi episode course. Norman et al (2005:20) refer to Loebel et al (1992) and Larsen et al (1996), who report that males have a longer DUP than females. Moreover, longer DUP is related to a younger age of onset. Duration of untreated psychosis is not related to substance abuse or adherence to medication. Longer periods of “untreated illness could lead to disruption in social support and it is certainly conceivable that DUP have effects mediated through reduced self-confidence, increased hopelessness, engulfment and pre-treatment disruption of education or vocation, all of which could have an impact on treatment outcome” (Norman et al 2005:20).

2.5 TREATMENT RESISTANCE IN SCHIZOPHRENIA

Treatment resistance has major health, economic and social consequences. Homelessness, itinerancy and incarceration follow, leading to further difficulties with inadequate treatment access and response. There are factors with poorer outcomes in people with schizophrenia, that may be relevant when considering treatment resistance, namely, increased number of episodes of psychosis, poor treatment adherence, side effects of medication, and substance abuse (Jones & Castle 2006:18).

According to Jones and Castle (2006:18), Clozapine is the best antipsychotic medication for treating schizophrenia. Second-generation anti-psychotic drugs, namely, Clozapine and Risperidone, have fewer side effects and both drugs work on spatial working memory, a neuropsychological function of interest in schizophrenia. Other potential benefits of Clozapine include a reduction in aggressive and suicidal behaviours (McGurk, Carter, Goldman, Green, Marder, Xie, Schooler & Kane 2005:1013).
In a study on management of violent behaviour in acutely relapsed schizophrenia, Koen, Lategan, Jordan, Niehaus and Emsley (2004:74) found that aggression occurs in several psychiatric disorders including agitated depression, mania, panic disorders, general anxiety disorders, dementia, delirium, substance-induced agitation, acute psychosis and akathisia. Schizophrenic patients show higher rates of assault than other categories of mental disorders. Persecutory delusions and command hallucination are symptoms related to relapse. Measures are needed to prevent the potential risk of violence. McGurk et al (2004:74) cite Allen’s (2000:3) finding that little has changed in the treatment of aggressive patients and up to now there is no agent approved for the overall management of aggressive behaviour.

Hospitals usually do not have clear protocols regarding the management of violent behaviour. Benzodiazepines and second-generation anti-psychotics are still regarded as the first choice for management of aggression. Second-generation anti-psychotics are usually unavailable in South African psychiatric hospitals therefore they cannot be used in treatment practices.

2.6 SUBSTANCE ABUSE

Brink, Oosthuizen, Emsley, Mbanga and Keyter (2003:7) point out that there is a high prevalence of substance abuse in patients with psychotic disorders. Brink et al (2003:7) found that substance abuse by patients with schizophrenia is a rule not an exception. The prevalence rate among young psychiatric patients with schizophrenia ranges from 25% to 60%.

The link between the two disorders, raises the question of whether substance abuse precipitates schizophrenia or is an outcome of schizophrenia.

Cantwell (2003:327) found increased symptoms and relapse in those patients who abused substances. In a study investigating the association between cannabis-use and mental health among Dutch adolescents, Monshouwer, van Dorselaer, Verdurmen, Bogt, Graaf and Vollenberg (2006:148) found that the use of cannabis rises with increasing age; more boys than girls used cannabis, and cannabis use is related to mental health problems associated with delinquent and aggressive behaviour. This
resulted in poor school performance and early school leaving. Psychotic symptoms in young people using cannabis were found, while psychosis and depression were disorders noticed among those adolescents.

Cannabis triggers the onset or relapse of schizophrenia in predisposed persons as well as aggressive symptoms. The use of cannabis during adolescence can lead to schizophrenia, depending on the dose-response relation (Cannabis and psychiatric illness 2002:1183). Substance abuse, even in small quantities, may have an effect on the onset of psychotic illness on certain individuals (Brink et al 2003:7).

2.7 TOBACCO USE

Aguilar, Gurpegui, Diaz and De Leon (2005:215) state that schizophrenia is associated worldwide with a higher rate of smoking compared to other severe mental illnesses. Aguilar et al (2005:215) conducted a study on the effects of smoking on schizophrenic patients. Smokers were classified as dependent smokers, mildly dependent smokers and non-smokers. Results showed that highly dependent smokers had the highest proportion of hospital admissions, compared with mildly dependent smokers and non-smokers. Disorganised residual symptoms were associated with heavy smoking. Schizophrenic patients who smoke tend to receive consistently higher doses of antipsychotics than non-smokers. McCreadie (2002:121) studied the use of drugs, alcohol and tobacco by schizophrenia patients from rural and urban areas compared to the general population. Tobacco use outnumbered the use of alcohol or drugs in these patients. Brown et al (2000) (cited by McCreadie 2002:121) found that patients with schizophrenia dies earlier from smoking-related diseases. Williams and Foulds (2007:222) state that in the United States individuals with schizophrenia smoke at rates three times higher rate than the general population, with smoking prevalence rates of at least 60%. Schizophrenia is associated with a 20% reduced life expectancy, and increased rates of smoking related to respiratory and cardiovascular diseases.

2.8 POOR REFERRAL SYSTEM

With regard to factors influencing the relapse of outpatients with schizophrenia in the Kentani area of Transkei in 1989, Solombela and Uys (1994:25) found that out of 175
patients discharged from Umzimkulu Hospital, 35 were not documented on the records of the Kentani district. This implied that 20% of these patients did not attend the clinic services for follow-up care. The major reason for patients’ not attending follow-up care was the poor referral system between the Umzimkulu Hospital and the clinics.

2.9 UNAVAILABILITY OF DRUGS

In her study of problems encountered by people with schizophrenia in the community, Beebe (2001:40) mentions the shortage of medications as a contributory factor in relapse.

In a study in the Transkei on factors that affect the provision of PHC, Thipanyana and Mavundla (1998:30) found that the shortage of medication in the clinics was a problem in delivering health care services. Since the late 1990s to date the present researcher has found the shortage of psychotropic drugs a problem and a contributory factor in relapse in the rural communities of the Eastern Cape.

2.10 LENGTH OF HOSPITAL STAY

Behr, Christie, Soderlund and Lee (2002:71) examined patterns and determinants of acute psychiatric readmissions, using a retrospective design. The length of hospital stay was approximately 37 days for all admissions. Behr et al (2002:73) found that only 21% of patients discharged attended the follow up clinic, and of those readmitted, 52% had been readmitted within 3 months of discharge, indicating that the risk of readmission is higher after discharge. Behr et al (2002:76) maintain that patients are discharged before they are ready for the community or before medication has played its role of stabilising the patient.

2.11 CONCEPTUAL FRAMEWORK

This study was based on the concepts that emanated during the literature review, conducted by the researcher. These concepts were then used for the construction of the survey instrument, used by the researcher to collect data from her respondents.
The researcher also used Uys’s (1991:2) theoretical framework for psychiatric rehabilitation to enrich the survey instrument. According to Uys (1991:2), patients and their families should be seen as members of the psychiatric health team through their active participation. Whatever information is presented to them on the patient’s condition and treatment should be simple and in an understandable form. The researcher is also of the opinion that the community should not be left out, but be educated on how to care for the mentally ill to reduce the rate of relapse.

2.12 CONCLUSION

This chapter dealt with a review of the literature relevant for this study. The literature review covered the main concepts responsible for the relapse in people with mental illness. The most important concepts studied are family-care-giving, mental illness stigma, readmission, relapse and factors contributing to relapse. Chapter 3 describes the research design and methodology followed by the researcher in conducting this study.
CHAPTER 3

Research design and methodology

3.1 INTRODUCTION

This chapter covers the design and methodology that addresses the research question of the study. The researcher adopted a quantitative approach, using a non-experimental descriptive design. The researcher selected a survey to describe the incidence of relapse. A questionnaire was developed to collect data (see annexure 4); probability sampling was used; and the sample consisted of relatives of psychiatric patients. The accuracy of the instrument was tested by means of validity and reliability, and a pilot study pre-tested the questionnaire.

3.2 RESEARCH DESIGN

Brink and Wood (1998:94) define a research design as “a blueprint or plan for research. The purpose of a research design is to plan and structure the study to maximise the validity of the findings. The choice of design is determined by the research problem or research question.” Babbie and Mouton (2002:75) state that the research design focuses on the end product; the point of departure is the research problem or question.

A quantitative, non-experimental, descriptive design using a questionnaire was used in this study. This type of design was considered appropriate as the researcher was interested in determining and exploring factors influencing the relapse of psychiatric outpatients. Quantitative research deals with the systematic collection of numerical information. It is analysed statistically and collected under controlled conditions. Structured procedures and a formal instrument were used to collect data. The researcher did not take part in the events that were investigated. This approach develops specific predictions from general principles (Brink 1996:13). The researcher remained objective.

Descriptive designs provide descriptions of the variables in order to answer research questions. Descriptive research encompasses different designs that utilise quantitative
methods. A survey was used as the researcher wanted to describe the incidence, prevalence and characteristics present in a specific population (Brink & Wood 1998:103). Survey studies are concerned with gathering information from a sample of the population (Brink 1996:109). Surveys are used to collect original data to describe a population that is too large to observe (Babbie & Mouton 2002:232). The researcher did not manipulate any variables.

3.3 RESEARCH METHODOLOGY

Babbie and Mouton (2002:75) state that research methodology focuses on the research process and the kind of tools and the procedures used. The point of departure are specific tasks, that is, data collection or sampling. Research methodology includes individual steps in the research process and the objective procedures to be used.

3.3.1 Population

Polit and Hungler (1996:223) define a population as “the entire aggregation of cases that meets a designated set of criteria. It is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned with. The accessible population is the population of subjects or objects who are available to the researcher.”

3.3.2 Sample

A sample refers to the sum of individuals within a specific territory or a small portion of a population or a smaller representation of a larger whole, intended to reflect and represent the character, style or content of a population from which it is drawn (Brink 1996:133).

3.3.3 Sampling

Sampling refers to the process of selecting the sample from a population in order to obtain information regarding a phenomenon in a way that represents the population of interest (Brink 1996:133).
3.3.3.1 **Sampling criteria**

The respondents were selected in accordance with the selection or inclusion criteria. To participate in the study, the respondents

- had to be relatives, spouse, or guardian of psychiatric outpatients between the ages of 18 and 70 years
- could be male or female
- had to have lived with the clients for more than 5 years in the same house

3.3.3.2 **Representativeness**

In order to be representative, the sample should have approximately the characteristics of the population relevant to the research in question (De Vos 1998:193). Hence, if gender and socio-economic class are variables (characteristics) relevant to the research, a representative sample would have approximately the same proportion of men and women, and middle- and working-class individuals as the population.

3.3.3.3 **Sampling approach**

There are two sampling approaches, namely probability and non-probability sampling. The probability sampling approach permits researchers to estimate the sampling error, reduces bias in the sample and makes it possible for researchers to use inferential statistics for data collection and analysis (Brink 1996:134).

3.4 **RESEARCH METHODS**

Research respondents have rights that have to be protected, whilst participating in a research project. Participation must be voluntary. Respondents have the following rights.

3.4.1 **Ethical rigour**

Respondents must be protected by informing them of the nature and purpose of the research, their rights, and that participation is voluntary. Permission to conduct the
study at the various clinics was sought from the district manager in writing (see annexure 1). In addition, the following ethical principles were followed.

3.4.1.1 Right to informed consent

Respondents should never be forced or pressurised to participate in a study. Brink (1996:44) emphasises that respondents should participate voluntarily in a study. Accordingly, the researcher explained the nature and purpose of the study with the respondents in their own language and at their level of understanding. The researcher informed the respondents of the following:

- Purpose of the study
- Objectives of the study
- Methods to be used
- Duration of the study
- The type of participation expected from the respondents
- How the results would be used and published
- How confidentiality, anonymity and privacy would be safeguarded

3.4.1.2 Informed consent

Burns and Grove (1997:354) stress that respondents can withdraw from a study at any time. In this study, the respondents’ completion of the questionnaire served as consent. The questionnaire contained the following statement at the beginning: Your completion of the questionnaire indicates your consent to participate in the study (see annexure 2).

3.4.1.3 Right to self-determination

The right to self-determination is based on the principle of respect for persons. It means individuals have the right to decide on their own whether to participate in a study or not, without being penalised. Individuals have the right to withdraw from a study at any time (Brink 1996:39-40). In this study, the respondents were treated as autonomous agents, and were at liberty to do as they wished without external control from the researcher. The respondents were told about the proposed study and were allowed to choose to
participate in the study voluntarily. They were free to withdraw from the study at any
time without being penalised. No pressure was exerted on them to participate.

3.4.1.4 Right to privacy

Burns and Grove (1997:342) define privacy as the “freedom an individual has to
determine the time, extent and general circumstances under which private information
will be shared with or withheld from others”. Manamela (2001:342) points out that the
South African Nursing Association refers to privacy as a person’s behaving and thinking
without interference or the possibility of private behaviour or thoughts being used to
embarrass or demean that person at a later stage. In this study, the respondents used a
quiet room to complete the questionnaire without interference. The researcher
completed the questionnaire for respondents who could not read or write after
explanation to them.

3.4.1.5 Right to confidentiality and anonymity

Brink (1996:41) describes anonymity as “keeping individuals nameless in relation to
their participation in the research”. No information related to the participation of the
respondents in the study should be made available to anyone except the research
team. Anonymity prevails if the respondents’ identity cannot be linked to any individual
responses.

3.4.1.6 Right to fair treatment

The right to fair treatment is based on the ethical principle of justice. According to Brink
(1996:40), this principle includes the respondents’ right to fair selection and treatment
and their right to privacy. Respondents should be selected for reasons directly related to
their problems. Researchers should not select respondents according to their own
interest.

3.4.1.7 Right to protection from discomfort and harm

The right to protection from discomfort and harm is based on the ethical principle of
beneficence, which is concerned with protecting the well being of persons, doing good
to others, and doing no harm. Discomfort and harm can be physical, emotional, spiritual, economic, social or legal (Brink 1996:40). Manamela (2003:100) points out that the research should benefit the participating subjects and society in general.

3.5 DATA-COLLECTION INSTRUMENT

The researcher developed a questionnaire for data collection in order to obtain information that was valid, and could be generalised to the whole population. The questionnaire ensured that the respondents would be asked the same questions and that the information would indicate factors influencing relapse.

3.5.1 Tool construction

Spradley and Allender (1996:604) define a research instrument as either an instrument, specific tool, a questionnaire or interview guide used in a study to measure the variables. In this study, the respondents were required to write their answers in response to the questions asked. The researcher selected a questionnaire as a data-collection instrument for the following reasons (Polit & Hungler 1997:259):

- Questionnaires help researchers obtain data.
- They are economical to use, in terms of money and time.
- The format used is standardised for all respondents.
- They are the easiest research instrument to test for reliability and validity.

3.5.2 Format

The questionnaire contained forty-seven (47) questions. The questionnaire was subdivided into two sections. Some questions had to be further discussed with the respondents in order to ensure that they understood their meaning. Valuable information obtained would not have been obtained if the questionnaire was distributed for the respondents to complete.

Section A dealt with demographic information and Section B dealt with the factors influencing relapse.
The researcher attempted to ensure that the questionnaire was free from bias and constructed to facilitate administration as well as computer-coding requirements in preparation for data analysis and interpretation.

3.5.3 Reliability and validity

To assess and evaluate the accuracy of the instrument it was tested for validity and reliability. Polit and Hungler (1996:467) emphasise that “an ideal instrument is the one that results in measures that are relevant, accurate, unbiased, sensitive and efficient”. After the questionnaire was developed, it was tested for validity and reliability before the data collection.

3.5.3.1 Validity

De Vos (1998:83) cites Hudson’s (1981:104-105) definition of a valid instrument as one "doing what it is intended to do, measuring what it is supposed to measure and yielding scores whose differences reflect the true differences of the variable being measured rather than random or constant errors". The definition of validity has two dimensions: the instrument actually measures the concept in question and the concept is measured accurately (De Vos 1998:83). In this study, the questionnaire’s content, face and external validity were tested.

• Content validity

Babbie and Mouton (2002:123) describe content validity as “how much a measurement covers meanings included within the concept.” Brink (1997:168) points out that if the instrument neglects one or more components meant to be measured, researchers cannot be certain that they are measuring what they intended to measure. Content validity deals with how accurately the questions asked tend to elicit the information sought (Manamela 2003:95).

De Vos (1998:84) states that only experts in the field can assist researchers to evaluate the content validity of the instrument. In the study, the researcher gave the questionnaire to the supervisor of the research project to evaluate.
• **Face validity**

Face validity refers to whether the instrument appears to measure what it is supposed to measure (Brink 1996:168). In this study, the questionnaire was considered to meet the requirements of face validity because all the questions in the instrument focused on the factors influencing relapse of outpatients in the rural communities of the Eastern Cape.

• **External validity**

Polit and Hungler (1996:221) define external validity as “the degree to which the findings of the study can be generalised to settings or samples other than the one studied”. The present researcher provided a detailed database and description for others to determine whether the findings of the study were applicable in other settings (Brink 1996:124).

3.5.3.2 **Threats to external validity**

• **Selection of respondents**

The respondents were relatives of psychiatric outpatients receiving monthly treatment at the clinic. These respondents lived with the clients, that is, the research population. Manamela (2001:96) cites Talbot’s (1995:214) statement which states that respondents should be selected with the study and its purpose in mind to ensure a correct representation of the population.

• **Setting**

Talbot (1995:214) (cited in Manamela 2001:97) points out that the correct setting in which to collect data is of utmost importance to eliminate threats to external validity. In this study, the researcher used the natural setting of two clinics to collect data.
• **Experimenter effect**

Experimenter effect is a threat to study results when researcher characteristics have an influence on respondents’ behaviour (Brink 1996:108). The researcher tried to avoid such behaviours by not talking about anything not related to the study, and not using facial expressions or wearing clothes that would disturb the respondents’ concentration.

3.5.3.3 **Reliability**

Brink (1996:124) and Polit and Hungler (1996:367) describe reliability as “the degree to which the instrument measures the attributes it is supposed to be measuring. Reliability encompasses stability, consistency, accuracy and dependability of a measuring instrument.” Manamela (2001:97) refers to Muller’s (1996:54) guidelines to control the reliability of validation results:

- Ensure the respondents’ anonymity in order to encourage objectivity and honest debate.
- Give clearly written and/or verbal instructions to participants.

3.6 **PILOT STUDY**

Brink (1996:174) describes a pilot study as “a small-scale study carried out before the major study”. De Vos (2000:85) cites Huysman’s (1993:205) description of the purpose of a pilot study as an investigation of the feasibility of the planned project to point out possible deficiencies in the measurement procedure before the major study.

Niewiadomy (1993:200) (cited in Manamela 2001:102) points out that a pilot study should be conducted to

- establish the instrument’s content validity
- reduce ambiguity in the wording of the items and ascertain clarity
- find out how long it would take for the researcher and the subjects to complete the questionnaire
- determine the weaknesses in the administration and organisation of the questionnaire
• enable the researcher to make improvements and corrections prior to embarking on the actual data-collection phase

The researcher conducted a pilot study (pre-test) with ten respondents who were relatives of psychiatric outpatients attending Debe Nek Clinic, Zihlahleni Clinic and Middledrift Health Centre. The last two clinics were not included in the main study. The purpose of the study was explained to the respondents. Some questions were not clear to them and the researcher had to rephrase and explain them. The respondents took 40 to 45 minutes to complete the questionnaire, which was considered too long for their concentration span. A second pilot study was conducted with other respondents who were not included in the first pre-test and would not be included in the main study. The questionnaires were completed within 25 to 30 minutes, which was regarded as feasible and acceptable.

3.7 DATA ANALYSIS

Data was analysed with the assistance of a statistician using the Statistical Package for Social Science 16.0 Version for Windows. The results from the data analysis and interpretation are presented in the form of graphs, tables and diagrams (see chapter 4).

3.8 CONCLUSION

This chapter dealt with the methodology adopted to complete the study. A quantitative, exploratory, descriptive research design was chosen and a questionnaire was used for collecting data. The instrument was tested for validity and reliability. The respondents were relatives of psychiatric outpatients living with the clients. The respondents’ rights were respected throughout the study.
CHAPTER 4

Research findings

4.1 INTRODUCTION

Chapter 3 dealt with a description of research design and methods. Chapter four presents research findings based on a self-report questionnaire administered by the researcher to family care givers of patients with mental illness who collect their medication from clinics in the rural Eastern Cape Province. Data for this study were analysed using Statistical Package for Social Science (SPSS) 17.0 version for Windows. All (52) variables were entered numerically on SPSS spread sheet. The findings are presented according to the sections of the survey questionnaire used by the researcher to collect data, starting with the demographic variables of research respondents. This chapter uses descriptive statistics and inferential statistics to explain the findings. Examples of descriptive statistics are frequencies and percentages while chi square test and cross tabs are examples of inferential statistics. Not all demographic factors had a significant difference for relapse except a few. Correlations were also done among variables to give a better picture of research findings and to draw conclusions from the data.

4.2 SAMPLE DESCRIPTION

In this study, the researcher was the primary data collector with assistance received from her colleagues in the clinics where data were collected. The sample consisted of 92 respondents. Respondents in this study were family care givers of people suffering from mental illness who collect their medication on a monthly basis from rural clinics in the Eastern Cape Province. The researcher collected data from two clinics, namely, Debe Nek and Zihlahleni clinics. The sample is described according to various variables used in the survey questionnaire including gender, age, language, home location, marital status, income of client. The demographic data also presents the relationship of the person interviewed to the client, their education level, and type of dwelling. The description of the sample begins with the gender of respondents.
4.2.1 Gender

Based on the questionnaires that were completed by the researcher during the time of data collection, findings comprised 43.5% (n=40) females whereas 56.5% (n=52) were males. Figure 4.1 below, shows the distribution of research respondents according to their gender:

![Figure 4.1: Gender of respondents](image)
4.2.2 Age of respondents

The majority of the study respondents 34.8% (n=32) were under the age range 41-59 years, followed by 60 years and above who represented 25% (n=23) of the sample. The lowest but not the least were those respondents who were in the age range 36-40 years who represented about 18.5% (n=17) and the least was the age range 15-18 years who represented 2.2% (n=2) of the entire sample. Figure 4.2 below depicts the age distribution of respondents:

Figure 4.2: Age distribution of respondents
4.2.3 Home of respondents

Apart from the age the tool also assessed the locality where respondents stayed in the Eastern Cape Province. It became clear from the analysis of data that the majority of research respondents were based in the rural areas 73% (n=67) whilst 27% (n=25) were living in the informal settlements areas. Figure 4.3 below shows the distribution of respondents based on their place of residents.

![Figure 4.3: Home of respondents](image)

**Figure 4.3: Home of respondents**
4.2.4 Language spoken by respondents

The survey instrument also assessed the home language spoken by the users of mental health services in the rural Eastern Cape Province. It became clear from the data analysed that of 95.7% (n=88) of respondents spoke isiXhosa whilst only 4.3% (n=4) were speaking isiZulu at home. The explanation given for the availability of people speaking isiZulu in the rural Eastern Cape Province was that some of them were married to Xhosa people and some were working in these rural areas. See figure 4.2 for the distribution of respondents according to the spoken language.

![Figure 4.4: Language of respondents](image)
4.2.5 Marital status

The analysis of data revealed that the majority of research respondents were married 45.7% (n=42) followed by those single who represented 38% (n=35). The data revealed that respondents that were divorced were 7.6% (n=7), the widowed accounted for 5.4% (n=5) and only 3.3% (n=3) indicated that they were co-habiting. Figure 4.5 depicts the distribution of respondents according to marital status.

![Figure 4.5: Marital status of respondents](image)

**Figure 4.5: Marital status of respondents**
4.2.6 Relationship status to the client

Apart from the marital status of respondents, the survey instrument also assessed the relationship between the family members who were interviewed and their relatives who were suffering from mental illness. It became clear that 35.9% (n=33) were living with parents, 21.7% (n=20) were living with relatives, 10.9% (n=10) were living with guardians, another 10.9% (n=10) were living with children, 8.7% (n=8) lived with their spouses and 12% (n=11) lived with others not specified during the time of the survey. Figure 4.6 shows the distribution of respondents according to relationship with the mentally ill clients.

![Figure 4.6: Relationship to mentally ill clients](image_url)

Figure 4.6: Relationship to mentally ill clients
4.2.7 Home location of client

Regarding the home location of the mentally ill clients, the study revealed that 73% (n=67) of the respondents were living in the rural areas whilst 27% (n=25) were living in the informal settlements of the Eastern Cape Province. Figure 4.7 below shows the distribution of respondents according to the location of their home in the province.

![Figure 4.7: Home location of client](image)

4.2.8 Income of clients

It became necessary to assess the income of clients during data collection. The data analysis revealed that 54.3% (n=50) were depending on disability grant as the source of income whilst 25% (n=23) were employed, 10.9% (n=10) were under sheltered employment 8.7% (n=8) were selling and only 1.1% (n=1) was planting. Figure 4.8 below shows the distribution of respondents per income.

![Figure 4.8: Income of clients](image)
4.2.9 Type of dwelling

Coupled with income, it’s necessary for the researcher to know the living conditions of clients in rural areas because some of them are poor it might be difficult to afford accommodation. The findings of this study revealed that 59.8% (n=55) were living in four-roomed houses which are accepted living size for accommodation in South Africa. About 29.3% (n=27) of subjects were living in two-roomed houses and only 10.9% (n=10) were living in the six-roomed houses. Figure 4.9 represents the type of dwelling of respondents.

![Figure 4.9: Type of dwelling](chart)

Figure 4.9: Type of dwelling
4.2.10 Educational level

Following the type of dwelling, it became necessary to assess the level of education of each respondent. The analysis of data revealed that 40.2% (n=37) went to school as far as grades 6-9, 26.1% (n=24) went as far as grades 1-5, 19.6% (n=18) attained grades 10-12 while 8.7% (n=8) had tertiary education and only 5.4% (n=5) indicated that they had never been to school. Figure 4.10 represents the level of education of study respondents.

Figure 4.10: Educational level of respondents
4.2.11 Religious affiliation

Apart from the level of education, the survey tool also assessed religious affiliation of subjects. The majority of research respondents 30% (n=27) were affiliated to Methodist Church, 26% (n=20) were members of African Religious Beliefs, 16% (n=15) were affiliated to Pentecostal churches, whilst 15% (n=14) indicated that they were affiliated to Zionist churches which is a popular movement among African people in South Africa. The outstanding four respondents were members to other religious groups not specified 4% (n=4) to the researcher. Figure 4.11 depicts the distribution of respondents according to religion.

![Figure 4.11: Religious affiliation of respondents]

4.3 FACTORS INFLUENCING RELAPSE

Once the demographic variables are described, it is necessary to describe the factors influencing relapse among people suffering from mental disorders and residing in the rural communities of the Eastern Cape Province. The survey tool assessed these factors with regard to the following important sub-headings, namely: (1) factors affecting the client e.g. adherence to psychotropic drugs, (2) individual factors, (3) social factors, (4) family perceptions of access issues, (5) Gender, (6) social stigma, and (7) rehabilitation of the mentally ill in the community.
4.3.1 Factors influencing the client

4.3.1.1 Adherence factors

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>He/she smokes dagga</td>
<td>10.9</td>
<td>28.3</td>
<td>13</td>
<td>42.4</td>
<td>5.4</td>
</tr>
<tr>
<td>I think dagga influence treatment</td>
<td>--</td>
<td>45.7</td>
<td>13</td>
<td>39.1</td>
<td>2.2</td>
</tr>
<tr>
<td>Availability of treatment at the clinic</td>
<td>8.7</td>
<td>53.3</td>
<td>25</td>
<td>13</td>
<td>--</td>
</tr>
<tr>
<td>How often does he/she have signs and symptoms of the following side effects in a month?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Dry mouth</td>
<td>---</td>
<td>19.6</td>
<td>13</td>
<td>65.2</td>
<td>2.2</td>
</tr>
<tr>
<td>- Tremors</td>
<td>---</td>
<td>38</td>
<td>4.3</td>
<td>56.5</td>
<td>1.1</td>
</tr>
<tr>
<td>- Increased weight</td>
<td>31.5</td>
<td>50</td>
<td>2.2</td>
<td>15.2</td>
<td>1.1</td>
</tr>
<tr>
<td>- Stiffness</td>
<td>51.1</td>
<td>40.2</td>
<td>1.1</td>
<td>6.5</td>
<td>1.1</td>
</tr>
<tr>
<td>We are afraid to give him treatment when we notice signs of side-effects</td>
<td>--</td>
<td>38</td>
<td>9.8</td>
<td>52.2</td>
<td>--</td>
</tr>
<tr>
<td>I know what to do when he/she presents with signs and symptoms of side-effects</td>
<td>--</td>
<td>47.8</td>
<td>4.3</td>
<td>47.8</td>
<td>--</td>
</tr>
<tr>
<td>He/she refuses to take treatment at times</td>
<td>2.2</td>
<td>68.5</td>
<td>1.1</td>
<td>23.9</td>
<td>4.3</td>
</tr>
<tr>
<td>At times and forget to remind him/her to take treatment</td>
<td>--</td>
<td>78.3</td>
<td>2.2</td>
<td>18.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>

According to the results, 48% of the respondents do not smoke dagga, 39% agreed that they are smoking dagga. Around 41% disagree that dagga does not influence treatment while 46% agree that dagga do influence treatment. Sixty two percent of the respondents agree that availability of treatment at the clinic influences relapse while only 13% disagree that the availability of treatment at clinic does not influence treatment.

Sixty seven percent of the respondents do not experience dry mouth as the side effects in a month while around 20% experience dry mouth as the side effects in a month. Thirty eight percent of the respondents have tremors as the side effects in a month and 57% do not have tremors as side effects in a month. Eighty one percent of the respondents have increased weight as the side effects while only 15% do not experience increased weight as the side effects. Ninety one percent of the respondents do have stiffness as a side effect in a month and only 7% do not have stiffness as a side effect.

Fifty percent of the respondents disagree that they are afraid to give treatment when they notice signs and symptoms. Forty eight percent of the respondents indicate that they know what to do when the client present with signs and symptoms of the side effects while another 48% do not know what to do when the client present with signs and symptoms. Seventy percent of the respondents agree that the client refuses to take
treatment sometimes while 30% disagree with the statement. Seventy eight percent at times forget to remind the client to take treatment while only 20% reported never forgetting to remind the client to take treatment.

Of the respondents 19.6% (n=14) mentally ill do experience dry mouth in a month while 67.4% (n=49) do not experience dry mouth. There is significant difference regarding the side effect. The chi square test results (.037) shows that a number of clients do experience dry mouth. Regarding weight gain 81.5% (n=58) do experience weight gain while 16.3% (n=12) do not. There is significant difference; chi-square test results (.012) show that quite a number of clients experience weight gain. According to respondents 91.3% (n=85) experience stiffness in a mouth while 7.6% (n=7) do not. Chi-square test results (.019) show a significant difference.

### 4.3.1.2 Individual factors

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentally ill people do not have communication skills, i.e. do not communicate effectively</td>
<td>2.2</td>
<td>66.3</td>
<td>1.1</td>
<td>29.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Mentally ill people have no work skills, for example, cannot wash themselves</td>
<td>2.2</td>
<td>51.1</td>
<td>---</td>
<td>46.1</td>
<td>---</td>
</tr>
<tr>
<td>Mentally ill people reason well</td>
<td>2.2</td>
<td>31.5</td>
<td>7.6</td>
<td>56.5</td>
<td>2.2</td>
</tr>
<tr>
<td>He/she has a good manner of approach when talking to others</td>
<td>1.1</td>
<td>47.8</td>
<td>5.4</td>
<td>45.7</td>
<td>---</td>
</tr>
<tr>
<td>He/she needs accompaniment when going to the clinic</td>
<td>1.1</td>
<td>58.7</td>
<td>1.1</td>
<td>39.1</td>
<td>---</td>
</tr>
</tbody>
</table>

Sixty eight percent of the respondents agree that the mentally ill have poor communication skills while 30% disagree that mentally ill have poor communication skills. Fifty three percent of the respondents agree that mentally ill people have no work skills and forty seven disagree that mentally have no work skills. Around 59% of the respondents disagree that the mentally ill people reason well, 33% agree that the mentally ill people reason well and 8% are not certain if the mentally people reason well. Forty nine percent of the respondents agree that the client has good manner of approach, 46% of the respondents do not agree that the client has good manner of approach and 5% of the respondents are uncertain if the client has good manner of approach. Sixty percent of the respondents agree that the client need accompaniment when going to the clinic while 40% of the respondents do not see accompaniment of the client to clinic as a factor influencing relapse.
4.3.1.3 Social factors

4.3.1.3.1 Family role

Forty eight percent of the respondents agree what mentally ill people should be allocated tasks to perform at home while 47% disagree with allocating tasks to perform at home to mentally ill people, only 5% are uncertain about allocating tasks to perform to at home to mentally ill people. Sixty two percent of the respondents agree that the mentally ill people should not be left alone because they will hurt themselves; 33% disagree with the statement while 4% are uncertain about leaving the mentally ill people alone as they will hurt themselves. Fifty nine percent of the respondents agree that the clients are discharged with letters from psychiatric institutions; 21% disagree that the clients are not discharged with letters from the psychiatric institutions while 21% of the respondents are uncertain about the clients having discharge letters from the psychiatric institutions.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think mentally ill should be allocated tasks to</td>
<td>2.2</td>
<td>45.7</td>
<td>5.4</td>
<td>45.7</td>
<td>1.1</td>
</tr>
<tr>
<td>perform at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think he/she should not be left alone because he/</td>
<td>1.1</td>
<td>60.9</td>
<td>4.3</td>
<td>31.5</td>
<td>2.2</td>
</tr>
<tr>
<td>she will hurt him/-herself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>He/she is discharged with a letter from psychiatric</td>
<td>--</td>
<td>58.7</td>
<td>20.7</td>
<td>19.6</td>
<td>1.1</td>
</tr>
<tr>
<td>institution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know the contents of the letter</td>
<td>--</td>
<td>21.7</td>
<td>22.8</td>
<td>55.4</td>
<td>--</td>
</tr>
<tr>
<td>I do not know what to do with the letter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I sometimes forget to remind him/her about follow</td>
<td>--</td>
<td>57.6</td>
<td>13</td>
<td>29.3</td>
<td>--</td>
</tr>
<tr>
<td>up dates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Twenty two percent of the respondents agreed that they know the contents of the discharged letters, 55% disagreed that they do not know the contents of the discharged letters while 29% of the respondents are uncertain about the content of the discharged letters. Fifty seven percent of the respondents agree that they sometimes forget to remind the client about his/her follow up dates, 29% of the respondents disagree that they sometimes forget to remind the client about his/her follow up dates while 13% of the respondents are uncertain if they sometimes forget to remind the client about his/her follow-up dates.
Of the respondents who have been to school 57.65% (n=49) agree that clients did have manner of approach when talking to others, 40.3% (n=76) disagree. Of the respondents who have never been to school 5.5% (n=5) only 1% (n=1) agrees that clients have manner of approach when talking to others. There is a significant difference in perception regarding the good manner of approach when clients are talking to others. The chi-square test result (0.05) (.023) show that those who have been to school agree and those who have never been to school disagree 4.4% (n=4) disagree.

**Task performance**

Of the respondents that are married 45.6% (n=42), 32.6%( n=30) do agree that clients should be allocated task to perform while 13% (n=12) disagree. Of the single respondents 38% (n=35), 19% (n=18) agree that clients should be give allocated task to perform, 17.4% (n=16) disagree. Of the respondents that are divorcees 3.3% (n=3) is uncertain whether clients should be given task to perform or not. There is a significant difference. Chi-square test results (.005) show that married respondents agree, while single respondents disagree and divorcees uncertain.

Of the respondents with grade (6-9) 25% (n=23) agree that clients should be given task to perform while respondents with grade (10-12) 5.4% (n=5) disagree. Of the tertiary education 7.6% (n=8) disagree. Chi-square test result (.023) indicates that there is a significant difference; respondents with (6-9) differ with those at the tertiary level.

According to the results married respondents 45.7% (n=42), 43.8% (n=32) do agree that clients can be left alone at home, 10.9% (n=10) disagree. Of the respondents that are single 38% (n=35), 32.6% (n=30) agree that clients can be left alone, 5.4% (n=5) disagree. Of the respondent that are cohabiting 3.3% (n=3) do agree that the clients can be left alone. There is significant difference, chi-square test results (.045) show that married respondents 34.8% (n=32) do agree while single 5.4% disagree.

**4.3.1.3.2 Family perceptions regarding issues of access**

Seventy one percent of the respondents agree that it is difficult to go to the clinic for consultation because of the distance; 28% of the respondents disagree with the statement about being difficult to go to the clinic for consultation because of the
Sixty three percent of the respondents agree that public transport cost about R10.00 to visit the clinic, 34% of the respondents disagree that the public transport cost about R10.00 to visit the clinic while only 3% of the respondents are uncertain about public transport costing about R10.00 to visit the clinic. Sixty three percent of the respondents agree that the clinic should be open over weekends and public holidays, 14% of the respondents disagree with the clinic opening over the weekends and public holidays and 22% of the respondents are uncertain about the clinic opening over the weekends and public holidays.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is difficult to go to the clinic for consultation because of distance</td>
<td>1.1</td>
<td>70.7</td>
<td>---</td>
<td>27.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Public transport cost about R10.00 to visit the clinic</td>
<td>2.2</td>
<td>60.9</td>
<td>3.3</td>
<td>31.5</td>
<td>2.2</td>
</tr>
<tr>
<td>I think the clinic should be open over weekends and public holidays</td>
<td>4.3</td>
<td>59.8</td>
<td>21.7</td>
<td>14.1</td>
<td>---</td>
</tr>
</tbody>
</table>

4.3.1.3.3 Home visits

Ninety two percent of the respondents agree that the mental health nurses seldom visit the homes of the mentally ill; 6% disagree with the statement while 2% are uncertain about mental health nurses visiting the homes of the mentally ill.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health nurses seldom visit the homes of the mentally ill</td>
<td>22.8</td>
<td>69.6</td>
<td>2.2</td>
<td>2.2</td>
<td>3.3</td>
</tr>
<tr>
<td>I think poor road conditions prohibits the mental health nurse from visiting homes</td>
<td>---</td>
<td>18.5</td>
<td>2.2</td>
<td>62</td>
<td>17.4</td>
</tr>
<tr>
<td>Lack of transport lead to poor home visit</td>
<td>4.3</td>
<td>37</td>
<td>35.9</td>
<td>22.8</td>
<td>---</td>
</tr>
</tbody>
</table>

4.3.1.3.4 Societal stigma

Fifty two percent of the respondents agree that it is not good to be related to the a mentally ill person, 14% of the respondents disagree with the statement about not being good to be related to a mentally ill while 34% of the respondents are uncertain about being good to be related to a mentally ill patients. Fifty four percent of the respondents agree that it is better to institutionalise the mentally ill so that they stay away; 32% of the
respondents disagree with the statement about institutionalising the mentally ill so that they stay away and 13% of the respondents are uncertain about institutionalisation of the mentally ill so that they stay away.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is not good to be related to a mentally ill person</td>
<td>8.7</td>
<td>43.5</td>
<td>33.7</td>
<td>13</td>
<td>1.1</td>
</tr>
<tr>
<td>It is better to institutionalise him/her so that he/she is away</td>
<td>7.6</td>
<td>46.7</td>
<td>13</td>
<td>31.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Community members do not want to associate with a mentally ill person</td>
<td>2.2</td>
<td>45.7</td>
<td>13</td>
<td>37</td>
<td>2.2</td>
</tr>
<tr>
<td>Community leisure activities are for normal people, not for mentally ill people</td>
<td>2.2</td>
<td>65.2</td>
<td>7.6</td>
<td>25</td>
<td>---</td>
</tr>
<tr>
<td>I do respect mentally ill persons as individuals</td>
<td>2.2</td>
<td>59.8</td>
<td>7.6</td>
<td>29.3</td>
<td>1.1</td>
</tr>
</tbody>
</table>

4.3.1.3.5 Gender

Seventy five percent of the respondents agree that it is normal for men to be hospitalised more frequently than women for psychiatric conditions, seventeen disagree with the statement and around 8% of the respondents are uncertain about it being normal to hospitalised men frequently than women with psychiatric conditions. Seventy eight percent of the respondents agree that male mentally ill person does not deserve to have a girlfriend or boyfriend, around 9% of the respondents disagree with that while 13% of the respondents are uncertain about male mentally ill people having a girlfriend or boyfriend. Thirty six percent of the respondents agree that female mentally ill persons care a lot about their appearance, 55% of the respondents disagree with that, the female mentally ill persons care a lot about their appearance while around 9% of the respondents are uncertain about the female mentally ill persons caring a lot about their appearance.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is normal for men to be hospitalised more frequently than women for psychiatric conditions</td>
<td>2.2</td>
<td>72.8</td>
<td>7.6</td>
<td>17.4</td>
<td>---</td>
</tr>
<tr>
<td>I think a male mentally ill person does not deserve a girlfriend or boyfriend</td>
<td>1.1</td>
<td>77.2</td>
<td>13</td>
<td>8.7</td>
<td>---</td>
</tr>
<tr>
<td>Male mentally ill people do not care about their lives because they abuse substances</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Female mentally ill persons care a lot about their appearance</td>
<td>2.2</td>
<td>33.7</td>
<td>8.7</td>
<td>55.4</td>
<td>---</td>
</tr>
</tbody>
</table>
Men hospitalised more frequently

Of the respondents that are married 45.7% (n=42), 34% do agree that men are hospitalised more frequently than women. Of the respondents that are single 38% (n=35) 41.3% (n=38) disagree that men are hospitalised more frequently. Of the divorcees respondents 7.6% (n=7) agree to the perception. There is marginal difference regarding frequency of admission between men and women. The chi-square test result (.070) shows that there is slight difference among those that are married, single and divorced.

Mentally ill males do not deserve girl friends

Of the respondents that are real parents to the clients 35.9% (n=33), 19.6% (n=18) do agree that mentally ill males do not deserve girl friends 16.3% (n=15) disagree. According to report 21.7% (n=20) who are relatives to clients 15.2% (n=14) disagree. Of the respondents that ate married to the clients (spouse) 8.7% (n=8) disagree that male mentally ill should have girlfriends. Regarding the perception there is marginal significance. Chi-square tests results (.071) show that relatives-spouse and spouse differ slightly.

According to results of the respondents with grade 1-9 52% (n=48) agree that they forget to remind clients to take the treatment. Of the same the respondents 13.1% (n=12) disagree to forgetting to remind clients about taking treatment. Of the respondents with grade 12 to tertiary education 12.7% (n=20) do agree to forgetting to remind clients to take treatment. Regarding the perspective there is significant difference, chi-square test result (.019) show that a number of respondents with different educational levels do forget while few disagree to forgetting to remind the clients.

Of the respondents who are parents to the clients 8.7% (n=8) agree that client are discharged with a letter, 8.7% (n=8) is uncertain about the letter while 18.5% (n=17) disagree that the clients are discharges with a letter from the psychiatric institution. Of the respondents who are relatives 13.0% (n=12) disagrees that the clients is discharged with a letter from the psychiatric institution, 3.3% (n=3) is uncertain about the presence
of the letter. Only 2.2% (n=2) of the spouses agree to knowing about the letter of referral.

4.3.1.3.6 Rehabilitation of clients in the community

Seventy eight percent of the respondents agree that resources are available in the community where mentally ill people can work, only 17% of the respondents disagree with that and 5% of the respondents are uncertain about resources being available in the community where mentally ill people can work. Eight nine percent of the respondents agree that mentally ill people are able to comprehend a thing when they are told, 7% of the respondents disagree with the ability of the mentally ill people in comprehending a thing when they are told and only 4% of the respondents are uncertain about mentally ill people being able to comprehend a thing when they are told. Only 4% of the respondents agree that community people accept and love mentally ill while around 90% of the respondents disagree with the community members accepting and loving mentally ill.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources are available in the community where mentally ill people can work</td>
<td>4.3</td>
<td>73.9</td>
<td>5.4</td>
<td>15.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Mentally ill people are able to comprehend a thing when they are told</td>
<td>2.2</td>
<td>87</td>
<td>4.3</td>
<td>6.5</td>
<td>---</td>
</tr>
<tr>
<td>Community members accept and love mentally ill</td>
<td>1.1</td>
<td>3.3</td>
<td>---</td>
<td>58.7</td>
<td>37</td>
</tr>
</tbody>
</table>

The descriptive statistics for the demographic data, indicated a positively skewed distribution on gender (-267), age range (-394), source of income (-337), as a negative values of skewness indicate positive skew of the data. The values of skew statistics for home language (4.55), marital status (1.402) for relationship (.526), for home (1.403) for educational level (.193), type of dwelling (.116) and (.326) indicate a negative skewed data. The notions above on not normally distribution demographics are reaffirmed by the values of kurtosis statistics, as for both home language (19.13) and marital status (1.99) indicating a pointy distribution whereas for gender (-1.972), age range (-.913), relationship (-.996), home (-.932), for source of income (-.757), educational level (-.351), type of dwelling (-.414) while for religion (-.670) the distribution is flat.
4.4 CONCLUSION

This chapter presented the findings of the data collected from family care givers of people with mental illness. The presentation was done using tables, graphs, and pie charts. The relationship among variables was explored using chi squares with significant results reported in the text. The findings were discussed in agreement or disagreements with reviewed literature. Significant findings include impact of gender on mental illness admissions to the hospital. Men are admitted more often than women. It was also revealed that the income of the clients was affected by the mental illness which had a rippling effect on job skills, communication skills as well as with their social network. Their mental illness also had a relationship with the type of housing accommodation, which was determined by their income and their family status.

The findings in regards to family support reflect the sympathy and the concern that family members accorded each other in times of illness, although this support is affected by age group. In other words, the energised youth who may be more supportive leave home for greener pastures to work in the cities, leaving the older or younger family members to provide support to the mentally ill in times of need.

In addition, the mentally ill were perceived by some family members as being loved by the community whereas others disagreed. It therefore signals to custodians of health care to find ways and means to educate both family members and society in general, as to the orientation of mental illness and how victims can be supported positively to cope with their illness and avoid relapse.
CHAPTER 5

Conclusion, limitations and recommendations

5.1 INTRODUCTION

This chapter covers the conclusions from this study, acknowledges the limitations, and offers recommendations. This study was conducted in two clinics in the Eastern Cape Province and only two clinics were used by the researcher as research sites for the data collection. These clinics were used by the researcher due to their accessibility and as they are her sites of work. The study comprised 92 subjects who were family caregivers to people with chronic mental disorders who received their monthly medications in these clinics. Data was collected using an instrument that was constructed by the researcher assessing factors influencing relapse among people with chronic mental disorders, in rural communities in the Eastern Cape. The instrument was implemented by the researcher with assistance from other community mental health nurses at the chosen clinics for the data collection. Data was entered into SPSS version 17 spread sheet for the purpose of its analysis. All 52 variables that were assessing relapse were manually entered by a data coding expert. Data was then presented in descriptive and inferential statistics. According to the results from the study, relapse leading to re-admissions is influenced by several factors, which included side effects of drugs, problems with adherence, lack of family commitment or role, and gender. These are addressed further in the following subheading.

5.2 DISCUSSIONS

As indicated in the conclusion above, various factors contributed to the relapse of clients with mental disorders and residing in the rural communities of Eastern Cape Province. Side effects of psychiatric drugs may lead to non adherence to treatment by clients. According to the results of this study 92.3 % (n=85) experienced stiffness of jaws amongst other factors. Beebe (2002:40) points out that psychiatric medication can cause uncomfortable side effects. Ntongana (1996:68) concurs with these findings and describes drug side effects as dry mouth, tremors, and stiffness as well as increased salivation. It is not surprising to realise that patients would choose to stop medication without consulting their psychiatric nurses or their psychiatrists. Such behaviours lead to
increased relapse rates among such patients. To counteract such effects of medication on patients with mental disorders, family caregivers play a major role. Adherence is encouraged by family caregivers through support in reminding clients with mental illness to take their medications regularly. It is therefore assumed that clients depend heavily on family caregivers to adhere to their treatment. This is supported by the work of Mwaba and Molamu (1998:56) who found that patients who default treatment were not supervised by their family members. This lack of family support or commitment can lead to relapse.

In view of the role played by family caregivers in supporting their relatives with mental illness to adhere to medication, the work of Li and Arthur (2005:339) showed the importance of family education about schizophrenia and treatment, as this helped the relatives to acquire skills to help patients and their families to cope more effectively with the disruptive results of their illness. Kirkmayer (2001:24) reveals that due to strong stigma attached to psychiatric treatment, patients refused their medication. He concurs with previous authors in arguing that the family role or commitment is key to the prevention of relapse.

Regarding the family role, it was identified that family caregivers did not take referral issues into serious consideration. For example the letters that accompanied patients after discharge were not taken seriously by families. This showed that there was an element of lack of commitment to patients’ wellbeing by the family members. Otsman and Kjellin (2002:498) state that a well functioning and supporting network includes families of the persons with mental disorders in reducing relapse.

It was found that men were hospitalised more frequently than women. Beebe (2002:41) refers to Castle and Murray who maintain that generally men have schizophrenia, something that makes them prone to more relapse. Based on these views about men, the researcher is of the opinion that as men do not report frequently to health services when they experience health problems, this exposes them to serious health problems.

5.3 LIMITATIONS

For a quantitative study to be successful 100 or more respondents should participate to make it representative enough for generalisation. Representative samples are required
to generalise research results to the entire population. This is the extent to which the sample characteristics actually represent the population characteristics, and determines whether and to what extent the research results can be generalised. This is called generalisability or external validity. Generalisability is a major issue with quantitative research designs (Fawcett & Garity, 2009). In the current study 92 respondents participated and the focus was on clients with connected families which made it difficult to generalise. The study also took place in two clinics in the Eastern Cape Province and as such, this limits the ability of the researcher to generalise her findings to the rest of the population with mental illness in rural communities of the Eastern Cape. Other factors used to determine universality of research findings such as determining the sample power were not taken into consideration during the data collection phase. The collection of data in the clinics in which the researcher works may have added to the limitations of this study.

5.4 RECOMMENDATIONS

Based on the findings of the study the researcher makes the following recommendations for practice and further research.

5.4.1 Improve referral system

Psychiatric institutions from where the patients were discharged should devise a strategy to improve the referral system. One letter should be given to the patient and the other letter can be emailed or faxed to the nearest clinic where the patient will attend for follow up care. Such a letter will help the clinic staff to know about the patient and to make a follow up even before the date of clinic appointment. The limitation in this approach might be the lack of computers in the clinics and the nurses’ lack of knowledge to utilise such equipment. Posting the letter to community psychiatric clinic can be done as a last resort since some of those letters do not even reach the clinic. Some clinic nurses end up not knowing about the patient because it’s rare that they bring the letter to the clinic.
5.4.2 Family role

To prevent relapse, caused by side effects, the family should play a vital role by way of commitment to the treatment regime. Educating the family about the importance of caring for their mentally ill and showing them love is very important. This includes supervising clients when taking treatment and educating them about the importance of regular visits to the clinic for their appointments. It is also important for families to take care of all the matters relating to clients health.

5.4.3 Future research

The researcher is of the view that future research with regard to relapse rates of men with severe mentally disorders should be investigated further. Taking into consideration the fact that research into men’s health issues are lacking when compared to women, it is necessary to explore factors predisposing men to relapse.

Apart from research into men’s mental health issues, it is necessary to explore strategies that could be used by health care professionals, in promoting adherence to psychotropic drugs. Research into such strategies should be conducted and used to support health care professionals in their fight with relapse.

5.6 CONCLUSION

The study examined factors influencing relapse among rural patients with mental disorders. The findings and recommendations should serve to improve the role of the family in caring for the clients, and in all respects and new strategies should be developed to improve the referral system between the psychiatric institutions where clients were admitted and the clinic where follow up will take place.
List of references


Beebe, HI. 2002. Problems in community living identified by people with schizophrenia. *Psychosocial Nursing and Mental Health Services, the Official Publication of the Alliance for Psychosocial Nursing* 16(2):40-42.


Unisa see University of South Africa.


ANNEXURE 1

Request for permission to conduct a research study
ANNEXURE 2

Permission granted to conduct research
ANNEXURE 3

Consent letter
ANNEXURE 4

Questionnaire
REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

I am currently an MA student majoring in Public Health at the University of South Africa exploring “Factors influencing relapse of psychiatric outpatients in the rural communities of the Eastern Cape” as my thesis topic.

The main purpose of this study is to identify factors influencing relapse of psychiatric outpatients. This information will help (and to) equip nurses and families with knowledge and skill when dealing with these patients.

To complete this study I need to conduct survey using questionnaire, asking relatives, patients, and guardians of patients who have been admitted twice or thrice in a year. The names of the patients appear on clinic registers hence permission is asked to use the registers.

The direct benefit of this study to the local service area is that a summary of the research findings will be made available to the department. The long term benefits are that the research findings will be used to formulate guidelines for the paper management of psychiatric outpatients to prevent relapse. I hope this request receive your favorable consideration.

Thank you in advance.

Yours sincerely

…………………………

Mrs ND Mahamba
Chief Professional Nurse
DEBE Nek Clinic
Student

…………………………

Prof TR Mavundla RN, PhD
Supervisor
ANNEXURE 3

CONSENT LETTER FOR PARTICIPANTS

College of Humanities and Social Sciences
Department of Health Studies
PO Box 392
UNISA
0003

Dear Research Participants

REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

I am currently enrolled for MA studies in Public Health at the University of South Africa. I am engaged in a research project entitled “Factors influencing relapse of psychiatric outpatients in the rural communities of the Eastern Province” The objective of this study is to identify and describe factors influencing relapse of psychiatric outpatients and to develop guideline for the management and prevention of relapse.

To complete this study I need to conduct survey using questionnaire for approximately 45 to 60 minutes duration. In this study I undertake to safeguard your anonymity by omitting the use of names and places. Confidentiality will be ensured by making use of codes instead of names and by not availing information to outside or any other person. It is understood that you are under no obligation to participate in this study. You are free to terminate your participation even when the interview has begun. The direct benefit to you of participating in this study is that you will have an opportunity in this answer questions pertaining to patients that are lining with you concerning matters which lead to relapse and how relapse can be prevented.

Should you wish to contact the researcher for any enquiries feel free to do so at the following postal address:

MRS ND MAHAMBA
PO BOX 3236
KING WILLIAMS TOWN
5600
Cell: 0833570385
Tel: 040 6577274 (work)

Thank you.

........................................... ...........................................
Signature of participant    Date

........................................... ...........................................
Mrs ND Mahamba            Date
Chief Professional Nurse

........................................... ...........................................
Prof TR Mavundla RN, PhD  Date
Supervisor

........................................... ...........................................
Supervisor
Dear Mrs ND Mahamba

Re: Factors Influencing Relapse of Psychiatric Outpatients in the Rural Communities of the Eastern Cape Province

The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants. You will not impose or force individuals or possible research participants to participate in your study. Research participants have a right to withdraw anytime they want to. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

3. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.

4. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

[Signature]

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT
Survey Instrument to Measuring Relapse in the Rural Eastern Cape Province

SECTION 1

Your completion of questionnaire indicates that you have agreed to partake in the study. Kindly respond to the following by marking X over the appropriate boxes.

1 DEMOGRAPHIC DATA

1.1 Gender

☐ Male

☐ Female

1.2 Age range

☐ R-18

☐ 19-35

☐ 36-40

☐ 41-59

☐ 60

1.3 Home language

☐ Xhosa

☐ Zulu

☐ Sotho

☐ English

☐ Afrikaans

Other (specify): .............................................................................................................................................................................................................

1.4 Marital status

☐ Single

☐ Married

☐ Divorced

☐ Widowed

☐ Co-habitation
1.5 **Relationship to client**
- [ ] Parent
- [ ] Guardian
- [ ] Relative
- [ ] Child
- [ ] Spouse

Other (specify): …………………………………………………………………………………………………………………………..

1.6 **Home**
- [ ] Rural
- [ ] Urban
- [ ] Informal settlement

1.7 **Source of income**
- [ ] Employment
- [ ] Sheltered employment
- [ ] Disability grant
- [ ] Selling
- [ ] Ploughing

1.8 **Type of dwelling**
- [ ] Two-roomed house
- [ ] Four-roomed house
- [ ] Six-roomed house

Other (specify): …………………………………………………………………………………………………………………………..

1.9 **Educational level**
- [ ] Never been to school
- [ ] Grade 1-5
- [ ] Grade 6-9
- [ ] Grade 10-12
- [ ] Tertiary education
1.10 Religious affiliations

☐ Seventh Day Adventist

☐ African Religious Belief

☐ Methodist

☐ Pentecostal

☐ Zionist

Other (specify): ………………………………………………………………………………………………………………………………………..
### SECTION 2

The statements below refer to factors influencing relapse. Please evaluate each statement by using the following keys:

1 = SA  (Strongly agree)  
2 = AG  (Agree)  
3 = UC  (Uncertain)  
4 = DA  (Disagree)  
5 = SD  (Strongly disagree)

Place a cross under the relevant answer.

2 FACTORS INFLUENCING THE CLIENT

2.1 Adherence

2.1.1 He/she smokes dagga

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2.1.2 I think dagga smoking influences treatment

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2.1.3 There is always treatment at the clinic

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2.1.4 He/she always has signs and symptoms of side-effects, namely:

- Dry mouth
  |   |   |   |   |   |
  | 1 | 2 | 3 | 4 | 5 |

- Tremors
  |   |   |   |   |   |
  | 1 | 2 | 3 | 4 | 5 |

- Fatness
  |   |   |   |   |   |
  | 1 | 2 | 3 | 4 | 5 |

- Stiffness
  |   |   |   |   |   |
  | 1 | 2 | 3 | 4 | 5 |

2.1.5 We are afraid to give him/her treatment when we notice signs and symptoms of side-effects

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2.1.6 I know what to do when he/she presents with signs and symptoms of side-effects

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2.1.7 He always refuses to take treatment on regular basis

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2.1.8  At times I forget to remind him/her to take treatment

2.2  Individual factors

2.2.1  Mentally ill do not have communication skills, ie do not communicate effectively

2.2.2  Mentally ill do not have work skills, for example, cannot wash themselves

2.2.3  Mentally ill do not reason

2.2.4  He/she lacks manner of approach

2.2.5  He/she does not need accompaniment when going to the clinic

2.3  Social factors

2.3.1  Family role in caring for the client

2.3.1.1  I think mentally ill should be allocated tasks to perform at home

2.3.1.2  I think he/she should not be left alone because he/she will hurt him-/herself

2.3.1.3  He/she is always discharged with a letter from psychiatric institution

2.3.1.4  I know the contents of the letter

2.3.1.5  I do not know what to do with the letter

2.3.1.6  I sometimes forget to remind him/her about follow-up dates
### Family perception regarding issues of access

#### 2.3.2.1 Sometimes it is difficult to go for consultation because of distance

#### 2.3.2.2 Public transport costs about R10,00 to visit the clinic

#### 2.3.2.3 I think the clinic should not be closed over weekends and public holidays

### Home visits

#### 2.3.3.1 Mental health nurse seldom visits homes of the mentally ill because of distance from the clinic to their homes

#### 2.3.3.2 I think poor road conditions prohibits the mental health nurse from visiting homes

#### 2.3.3.3 Unavailability of transport will always lead to poor home visits

### Societal stigma

#### 2.3.4.1 It is not good to be related to mental ill person

#### 2.3.4.2 It is better to institutionalise him/her so that is away

#### 2.3.4.3 Community members do not want to associate with her because he is mentally ill

#### 2.3.4.4 Community leisure activities are for normal people, not for mentally ill

#### 2.3.4.5 I do respect mentally ill as individuals
2.3.5 Gender

2.3.5.1 It is normal for men to be hospitalized frequently

2.3.5.2 I think a male mentally ill person does not deserve a girlfriend

2.3.5.3 Male mentally ill people do not care about their lives because they abuse substances

2.3.5.4 Female mentally ill persons care a lot about their appearance

2.3.6 Rehabilitation of clients in the community

2.3.6.1 No resources are available in the community where mentally ill can work

2.3.6.2 Mentally ill will never be able to comprehend a thing when they are taught

2.3.6.3 Community members accept and love mentally ill

THANK YOU FOR COMPLETING THE QUESTIONNAIRE