

FAMILY CENTRED CARE:
VIEWS OF MENTALLY ILL PATIENTS'
RELATIVES ON HOSPITAL MANAGEMENT
OF THESE PATIENTS.

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DECLARATION

I hereby declare that the work presented in this study for the Diploma in Nursing Education has not been presented for any other Diploma and is not being currently submitted for any other Diploma.

SIGNED BY: _____

[Handwritten Signature]

Candidate

APPROVED BY: _____

Supervising Lecturer

S T A T E M E N T

I hereby certify that this research is entirely the result of my own independent study. The various sources to whom I am indebted are clearly indicated in the text and in the references.

SIGNED: _____

Amn.

Candidate

DEDICATION

Dedicated to my husband Mr M. S. Banda for his encouragement and prayers, to my son Sifiso, whom I deprived of maternal love and to my mother and late father Mr & Mrs Z. Phiri for educating me.

A B S T R A C T

The study looked at views of mentally ill patients' relatives on hospital management of these patients.

A review of literature on involvement of the family in nursing care has been included. The instrument used to obtain information from fifty relatives was a structured interview schedule. The respondents were randomly chosen during their visits. The interview gathered data about number of times that the patients had been admitted in Chainama Hospital, family's knowledge about the patients' illness and how often the family visited the patients. Relatives were asked if it was the duty of the hospital personnel alone to care for the hospitalised patients.

It was discovered that more than fifty percent of the relatives did not know what the patients suffered from. This ignorance therefore increased the family's anxiety. Most relatives visited the patients every day and this was done because they loved the patients. Most ^{relatives} patients felt that they had a major role to play in the management of the patients. They said that they knew the patients better. Some respondents were even willing to spend 24 hours with the patient so that together with the hospital personnel they could monitor the patient's progress.

The findings of the study could mean that the families of mentally ill patients are ready to fully participate in the nursing management of mental patients. They realize that they must work hand in hand with the hospital personnel. This then implies that the hospital personnel have denied the patients' relatives the direction and encouragement to actively assist in the nursing management of these patients.

To fail to involve the family is equivalent to a physician deciding not to carry out a full examination in the case of an organic disorder (Bruggen & Davies, 1977).

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CHAPTER I

INTRODUCTION

Family centred care means rendering nursing care involving or focused on the family. This means care and intervention given to all family members whether in health or illness. Rankin & Duffy (1983) say that assistance is also given when the family is going through a crisis which could be due to a chronic illness, or a terminal illness leading to death of a family member. There is a give and take type of interaction between the nurse and the family. The family can help while the patient is in hospital. This can be achieved if the nurse gives the relatives information regarding the patient's condition so that the relative can understand the need for the participation. It must be remembered that the relative knows the patient better than the nurse therefore he or she is in a better position to assist the patient. The practice in fact maintains the patient's privacy (Mtonga, 1985). However, the nurse must assess the patient's condition and see what help can be done by the relative.

Deep down in each individual's heart there is a longing for affection and a feeling of belonging, whether in health or illness. Involving the family in the management of mental patients creates a learning opportunity for the family, the nurse and the patient. The family members benefit in that they get to know the patient's illness better. The relatives are also afforded the chance to know the effects and side effects of the drugs given, and the nursing care due to the patient thereby becoming knowledgeable in caring for the patient while in hospital and at home after discharge.

This could ultimately reduce the number of neglected mental patients who roam the streets. The nurse on the other hand becomes more knowledgeable in the field and this will enable her to recognise the potential the family has in rendering help for the quick recovery of the patient. The patient too benefits in that he or she will feel loved, cared for and will appreciate the combined effort of the nursing personnel and the family in enhancing his or her well being. All patients suffering from mental illness need kindness, consideration, to be loved and above all to be accepted by others and particularly to be accepted as one of the members of the family and society as a whole (Rankin & Duffy, 1983). The family is indispensable for the totality of the patient and any human being. Rankin & Duffy (1983) say that as human beings, all have common needs that must be satisfied. The ability of patients and their families to survive depends on their effectiveness in meeting these basic needs.

Finally, family members's participation in caring for mental patients is a gateway to family centred care. Therefore nurses should encourage family participation in order to achieve comprehensive nursing care. Relatives like to feel that they too care for the patient and as such this is recognized by others, it helps erase any guilty feelings that they may harbour and if the patient were to die, this would not be on their conscience. Mtonga (1985) says that rehabilitation becomes more effective if the patient and relatives are encouraged to participate in the delivery of care and in case of a relapse the relatives should be in a position to notice the heralding signs and symptoms in time before the condition worsens.

It must also be remembered that some of the psychiatric conditions are chronic hence full participation by relatives is of utmost importance. The relatives' participation in the care of these patients should also help in building the patients' self confidence and self esteem so as to maintain the patient's personal dignity and respect.

Family involvement in the care is of utmost importance if the Alma Mater declaration of 1978 of health for all by the year 2000 is to become a reality.

OPERATIONAL DEFINITIONS

For the purpose of this study, terms have been defined as follows:-

Family Centred Care:

This is rendering nursing care focused on the family and its full participation.

Mentally Ill Patient

An individual who does not think, feel or act as he should, that is in accord with reality.

Family

A group of people which includes a father, mother, children and extended family members.

Nursing Process

A systematic method of applying problem-solving techniques to the practice of professional nursing. This is by:-

- (1) Analysis or assessment of patient's health needs;
- (2) Data collection;
- (3) Planning for nursing care;
- (4) Implementation of the planned care; and
- (5) Evaluation.

Comprehensive/Holistic Nursing Care:

This is nursing an individual as a whole, encompassing the spiritual, social, physical and emotional realms.

Biopsychosocial Being:

This is the biological, psychological, and social make up of a person.

Maslow's Hierachy of Needs:

Sequential arrangement of need priority, as follows:-

1. Physiological needs
2. Need for security and safety
3. Need for love and belonging
4. Need for self esteem
5. Need for self actualization

Basic Needs:

Physiologic, security and safety needs and need for love and belonging.

Rehabilitation:

Re-education of an individual to promote independence.

Institutionalisation:

The formal confinement of patients to a mental hospital.

Primary Health Care:

This is essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978).

CHAPTER II

LITERATURE REVIEW

Today nursing practice and even medical practice is aiming at the achievement of health for all by the year 2000 and mental health is one of the components of Primary Health Care.

Therefore, a patient should be looked at as a biopsychosocial being and in order to achieve this, the nursing process cannot be divorced from carrying out total patient care. Since a mentally ill patient is in an effective state, observations, planning, implementation and evaluation of the care has to be carried out with the help of the relatives.

For relatives to be actively involved in the care, they must have an understanding of the patient's condition and this can be done by simple explanation of the condition by the nurse or the doctor. But the nurse is the one who is with the patient most of the time, therefore the responsibility is largely his or hers. Mtonga (1985) says that some nursing staff may feel that it is not their role to seek out the key persons in the patient's life and offer them information. On the other hand, these persons may find the hospital environment threatening and may not know how and who to ask. It is human nature to want to help in caring for an ill relative but most often, the relatives are not helped in this endeavour. Nurses usually appear too busy and the key person amongst the relatives may assume that he is not necessary, otherwise they would have told him. No wonder in the hospitals today, whether a mental hospital or not, there are times when relatives ask about their patient's condition, the nurses are too busy to give satisfactory answers. Instead they say, "ask the doctor, he knows better". Such a statement could also mean ignorance on the part of the nurse.

Another thing to note is that, the general trend in Zambian hospitals today is that relatives are not granted permission to see their patients if they came in a little earlier or later than the scheduled visiting time (Mtonga, 1985). But does this need to be so? The relative for sure is showing concern for the patient and the nurse would not lose anything if the relative was allowed to see the patient. If anything the patient gains as he would feel loved and cherished by his relatives. However, the trend at Chainama Hills Hospital is that the hospital remains open to the patient's relatives everyday from 08.00 - 18.00 hours. In the implementation of mental health there is need to bring resources closer to all people in need while utilizing the help of all who are capable of giving it. These range from the family up to the health personnel in the hospital (Health by the People Implementation Primary Health Care in Zambia, 1978). According to Murray & Zenter (1979), the patient, family and the nurse should collaborate in performing the nursing activities. Therefore, relatives must be given the chance to participate in the management of their mentally ill patients. Patient-Society confrontation provokes anxiety in the community because people find it difficult to understand and deal with the psychiatric patients. The fear is therefore extended to the patients through protective distancing maneuvers like cruelty, hatred and isolation of patients physically and emotionally (Mukonze, 1984). WHO (1975) says it is important to recognise that such attitudes toward mental illness are common not only in the general population, but also among administrators, planners, politicians and health personnel. These attitudes contribute to patients roaming the streets and frequent re-admissions

In view of this, relatives must be given the chance to participate in the management of their mentally ill patients. Burling et al (1956) says that relatives also play a very important role in that a patient derives a lot of satisfaction and support from them, as such, they should also be involved in the care. But how can a patient derive satisfaction and support from the relatives when they are only allowed participation when the patient's condition has deteriorated and all he awaits is death? There is need for nurses to be sympathetic and feel the pain and disillusionment relatives with mentally ill patients go through. Barton (1962) says that family care has a stimulating effect upon the institutionalized patient. Surely no man is an island, man would not stand the absence of close relatives in health let alone in illness. One develops nostalgia for home and for the people who mean a lot in life. If the relatives are not permitted to fully render the care, the patient feels unwanted as well as not important to the family any longer and such a state would depress the mental patient and accentuate his affective state even further. To fail to involve the family is equivalent to a physician deciding not to carry out a full examination in the case of an organic disorder. Also family involvement enables the family to see the full plight of their relationship with the patient (Bruggen & Davi 1977). When a person's basic needs are satisfied, there is a feeling of pleasure, happiness and enthusiasm (Kron Thora, 1971). To have a sense of belonging, be loved and cared for instils a sense of security in an individual ill or well. This is the third step in Maslow's hierachy of needs. Non fulfilment of this need, therefore, adversely affects security and physiological needs of an individual.

In their study, Hymovich & Bernard (1979) say that for families to learn the psychotherapeutic skills the psychiatric nurses should include them. Information about the patient and development of the illness is almost exclusively obtained from the family that support services can be obtained. Equally important is that family members have the strongest incentive as well as opportunity to be or become accurate and reliable reports (WHO, 1986).

In rendering nursing care to mental patients it must be remembered that relatives do not relinquish care and support of the patient to the hospital staff, the same applies to non-psychiatric patients. It is imperative therefore that nurses should realise that the patient's family have not abandoned all claims to a patient because he has been admitted to hospital (Pearce, 1969).

An individual's disturbed psychological status represents a problem with which the social environment and especially the family has to deal (Mathias & Angermeyer, 1982). Mental disorders have many psychological social and economic consequences for the family, most of them negative in their effect. Much is demanded of them in the way of adaptation and coping and their success or failure in these tasks may have great influence on the further course of the illness. Therefore, the relationship between the patient and his family is clearly of special importance in this respect. Only when there is this patient-family interaction will the nurses and other hospital personnel realise how much the patient's illness affects the family members. This is important in psychiatry because if the family fails to cope, under stress, family members may also end up with mental break-down. It is the duty of the nursing personnel therefore to enhance family-patient relationships so as to alleviate the anxiety in the patient as well as the relatives and close friends.

Families are desperately concerned, their interest goes deeper than professional interest of a nurse and they would not willingly do anything to hinder the recovery of their loved ones (Pearce, 1969). Often family therapy helps other family members assume responsibility for the family's and patient's welfare (Irving, 1973).

Brown et al (1972) in a series of studies carried out at the Medical Research Council's Social Psychiatry Unit in London, say that over the past twenty years a constant relationship has already been established between the outcome of mental illness and the emotional atmosphere in the family generated by the patient's key relative. These studies found out that patients with relatives who expressed emotional support while the patient was hospitalized had a less risk of a relapse than those patients whose relatives did not show support and concern. This is enough proof to cause the hospital to reconsider its nursing practice.

Besides, patients would express their deep seated problems or desires better to somebody they know and have trust in (Pearce, 1969). We should not overlook the fact that patients with mental disorders are very sensitive therefore we should not ignore the family.

Irving (1973) says families differ in their expression of anxiety, guilt or concern for the patient. Some families are demanding and critical of the service or care the patient is receiving. Some are suspicious and distrustful of the staff who are caring for the patients. Others are rejecting, neglectful or even abusive toward the patient.

Naturally the nurse would be hurt and angry if she or he took the family's behaviour personally and this would interfere with nurse-family relationship.

Trying to change the family's behaviour by arguing or criticizing would even worsen things. Ignoring the family or keeping them from seeing the patient would just increase the family's anxiety. As a nurse dealing with such a situation, try to allay the family's anxiety and help them understand the situation the patient is in. An explanation of what is being done for the patient may elicit their cooperation (Irving, 1973) and nurse-family relationship would be enriched.

Mereness and Taylor (1978) says that family centred care is a relatively new treatment modality, but used to be practised in the past by the family physician and the public health nurse. These professional workers realized that the effectiveness of treatment of an individual was either enhanced or interfered with by the attitudes of his family. In addition, these professionals often became quasi-family members and were consulted and included during family crisis. Until recently, it has seemed most expeditious of time and resources for the individual to be treated by professionals who were specialists. Consequently this approach has put the family in a position of second-class citizens and has deprived the health personnel of a valuable resource.

Lately there is a growing number of mental health professionals who believe that any attempt to treat individuals in isolation from their families is either futile or, if helpful to the individual, is at the expense of the equilibrium of his family system (Mereness & Taylor, 1978). Promotion of mental health and the prevention and treatment of mental illness will occur only when the needs of the individual are considered within the context of the family system which remains as the fundamental social unit of our society (Mereness & Taylor, 1978).

In conclusion, the designated patient is an actively participatory sub-system linked to the family upon which the intervention must therefore focus (Woodbury & Woodbury, 1969). When a family member is removed from the family, either through prolonged hospitalization or by geographical relocation, it is not uncommon for the family to enter into a state of acute disequilibrium that may manifest itself by such actions as divorce of the parents. This phenomenon is equally well documented in families in which a chronically physically ill person had died (Mereness & Taylor, 1978). In nursing mental patients, the knowledge of social sciences which help the understanding of human behaviour that stable, secure, loving family life help in the development of mental health is an advantage as the care giver would be afforded the understanding of human behaviour and human interaction. It is of no help to the patient to be left alone in the care of hospital personnel whom the patient regards as complete strangers. Although the family involvement concept is quite new, it is worth trying if every human being is to be found healthy by the year 2000. WHO (1985) states that togetherness begins with the bond between the mother and child. The family, the community, all these levels play their part in enhancing recovery of a mental patient. Family centred care therefore, promotes holistic nursing care of mental patients and patients with organic problems.

CHAPTER III

STATEMENT OF THE PROBLEM

Family members of mental patients experience a lot of anxiety. Many of them do not know the cause of the psychiatric illness (Psychiatric Annals, 1972). As a result they may have guilty feelings and many may blame themselves for the patient's illness. The anxiety leads to non acceptance of psychiatric patients by their families and this leads to lack of proper care after discharge from the hospital. Generally, lack of proper care by relatives after hospital discharge has led to patients roaming the streets to scrounge for food and very often in dustbins where there is easier access to pieces of leftovers and other throw-aways.

Mambwe (1986) says that a mental patient may have a relapse or his ailment may re-occur without proper after care. Lack of after care once the patient is discharged from hospital is therefore another major factor in the concept of rehabilitating former mental patients.

Most relatives of hospitalized mental patients are not fully involved in caring for these patients. This leads to problems as relatives end up thinking that the patients are under the care of hospital personnel alone and that they are not skilled and have no medical or nursing knowledge so as to render help to their loved ones. The relatives may feel inadequate and think that they do not matter to the patient as a result the patient feels neglected and unwanted by his own people and this may lead to strained affection between the patient and his relatives. Non involvement of patients' relatives in the care is contrary to the concept of family centred care (and Zambian society in general).

In order to institute treatment the psychiatrist must depend on the family and allow the family to depend on him (Lazure, 1966) because by nature of the disease process, these patients may pose a problem in cooperating with hospital personnel. They may run away from hospital if they constantly see unfamiliar figures with them, hence the relatives' help in the care may cause the patient to cooperate and health could be delivered efficiently. Contact with the family dynamics can bring additional assistance to the patient based on sounder understanding of the family (Lazure, 1966). When relatives are not involved in the care, they may blame the hospital for any fatal outcome of the 'illness.' No wonder relatives are at a loss as how best to interact with their mentally ill patients. This is why they do not see the importance of advising the patients to take medication while in hospital and at home after discharge.

Therefore, family involvement in caring for mental patients is imperative and should be encouraged because participation would give them confidence in caring for their mentally ill relatives as they will be afforded the opportunity to understand the patient's behaviour. After all, when these patients are discharged from hospital they go back to stay with their families. The study therefore aimed at gathering the views of relatives of hospitalized mentally ill patients. The research question for the study was:-

What are the views of family members in the management of hospitalized mentally ill patients?

The hypotheses for the study are:-

1. Relatives of hospitalized mentally-ill patients may not take part in the care of these patients because they feel it is the responsibility of the hospital.
2. Relatives do not care for their mentally ill patients when they are hospitalized because the hospital personnel do not encourage them to do so.
3. Relatives of hospitalized mentally ill patients do not participate in the care because they feel that they lack the skill and the knowledge to do so.
4. Relatives of hospitalized mentally ill patients may not take part in caring for these patients because they do not want to be identified with a relative who has a mental illness.

It is hoped therefore that the findings of this study will promote family participation and enhance nurse-family interaction. This will increase understanding of each other's role in that the nurse will appreciate the care rendered by relatives, the relatives and the patient will also benefit from a warm helping relationship that will develop between them. This will improve communication and enhance public relations as relatives and the public at large will have a positive approach to hospitalization.

CHAPTER IV

METHODOLOGY

1. RESEARCH DESIGN

A research design is a skeleton framework which gives guidelines to the investigator for conducting a study.

Abdellah and Levine define a research design as:-

'The detailed work of determining the study format which takes place after the problem has been concretely formulated and hypothesis stated if any. It is concerned with how the data are to be collected, includes fundamental questions of how the study subjects will be brought into scope of the research and how they will be employed within the research setting to yield the required data'¹

There are two types of research designs, the experimental design and non-experimental design. The non-experimental is sometimes referred to as a survey. There are several types of surveys, for this study a descriptive survey was found appropriate. This design was chosen because the study aimed at gathering views of mentally ill patients' relatives on hospital management of these patients.

¹F.G. Abdellah and Eugene Levine, Better Patient Care Through Nursing Research (London: Collier MacMillan, 1979) P.17

In a survey the investigator investigates a group of people. A large number of people can be surveyed which in turn would permit generalization of findings to a larger target population. The other reasons for choosing a survey were that it is less expensive, less burdensome and can be completed in a shorter period of time.

2. RESEARCH SETTING

The study was conducted at Chainama Hills Hospital which is the only mental hospital in Zambia. It is in Lusaka Province, which is the capital city of Zambia. The hospital is situated in the eastern side of the city. It is about twelve (12) kilometres from the town centre on the Great East Road leading to the International Airport. Chainama serves as a referral centre for all mental illnesses in the country. It also offers curative and rehabilitative services. Chainama Hospital trains enrolled psychiatric nurses, psychiatric clinical officers and clinical officers for general surgical/medical practices. Medical and Nursing students from the University of Zambia and students from Lusaka School of Nursing also go to the Chainama Hills Hospital for their psychiatric clinical experience. The hospital is divided into two sections. There is Chainama East, the section for forensic psychiatric which has one hundred and ten beds. The other section is Chainama West with four hundred and twenty beds. This section has six wards, two admission wards, two rehabilitation wards, one chronic ward and one children's ward.

A-ward is for chronic male patients, B-ward for acute male admission, C-ward for acute female admission, D-ward for female rehabilitation and F-ward for mentally subnormal children. The children's ward is adjacent to their day care centre.

Supportive services include records department, in-service department, transport section, occupational therapy, a day care centre, pharmacy department, catering and laundry departments and administration.

The Senior Medical Superintendent does the administrative duties with the help of the Principal Hospital Administrator, a Senior Executive Officer and a Senior Nursing Officer.

Ward level management is by the nursing officers, registered psychiatric nurses and general registered nurses and the Clinical Officers.

Chainama Hills Hospital was chosen as the setting for the study because the learning institution for the researcher was in the same city, Lusaka. The other reasons were that the researcher was familiar with the hospital and had been meeting the staff on the wards previously hence facilitating interaction and good inter-personal relationship with the respondents and the staff. The hospital was easily accessible and respondents readily available for interview. The interviews were carried out on B-ward for acute male admissions, C-ward for acute female admissions, D-ward for female rehabilitation and E-ward for male rehabilitation. This was because relatives with patients in these wards had an equal chance of being interviewed and both sexes were catered for.

The male admission ward has sixty-one (61) beds with an overflow of bed occupancy at different times of the year. A general registered nurse runs this ward with two other general registered nurses. There are twelve psychiatric enrolled nurses, nineteen mental attendants. For cleaning purposes of the ward and maintainance of cleanliness of the ward environment there are fourteen (14) classified daily employees.

The female admission ward has seventy (70) beds but handles over 70 patients at different times during the year. However, some patients are forced to remain on the ward because some relatives are reluctant to take them back to their homes. A general registered nurse runs this ward.

There is another general registered nurse, twelve enrolled psychiatric nurses, sixteen mental attendants, and fourteen classified daily employees.

The female rehabilitation ward has a bed capacity of 38 beds, and has three (3) registered general nurses and seven (7) enrolled psychiatric nurses. The patients are referred from the acute ward to the rehabilitation ward as they improve.

This is the preparatory ward for discharge. Hence patients are involved in occupational therapy where they learn knitting, sewing, and basket making. While on the ward they are encouraged to sweep their rooms, make beds and adorn their rooms and dining hall with flowers. If food is available, they are encouraged to cook it.

PILOT STUDY

A pilot study is a small preliminary investigation of the same general character as the major study (Treece & Treece, 1982). It is designed to acquaint the researcher with the problems to be corrected in preparation for the larger research project. It also provides the researcher with an opportunity to try out the procedures for collecting data.

A pilot study was not done due to time limit in which the study had to be completed and submitted to the University authorities on time.

SAMPLE: SELECTION AND APPROACH

A sample of fifty (50) respondents who were relatives of hospitalized mentally ill patients in male and female admission wards, female and male rehabilitation wards were interviewed. Before data collection, a letter asking for permission to obtain information from the patients' relatives was sent to the Principal Nursing Officer of Chainama Hills Hospital. A copy was also sent to the Senior Medical Superintendent. The letter briefly described the nature of the study (Appendix I). A letter was received from the Nursing Officer authorizing the study to be conducted (Appendix II). The ward in-charges gave verbal permission upon presentation to them of the letter from the nursing officer.

Due to the time limit and lack of adequate funds to carry out the study, only fifty (50) subjects were interviewed, therefore findings should not be generalized without a lot of caution. The respondents discussed in previous paragraph were chosen by systematic random sampling during their visits. The step used was that every third respondent up to the 10th respondent in female and male rehabilitation ward was taken.

The admission wards had extra five respondents each because there were more patients hence more relatives. Simple random sampling was used because it is one of the probability methods of selecting subjects.

A simple random sample was chosen because it was more applicable to this study which involved a selection of patients' relatives. Random choice allows every member of the population equal chance to be included in the sample representing the total population (Treece & Treece, 1982).

5. INSTRUMENT USED TO COLLECT DATA

The instrument used to collect data for the study was a structured interview schedule which provided primary data. This instrument helped in collection of personal information on respondents which may not be easily divulged by respondents. (A copy is included as Appendix III).

STRUCTURED INTERVIEW SCHEDULE

The interview schedule was composed of pre-determined closed and open ended questions. Abdellah & Levine (1965) define a structured interview as an instrument used to gather data by verbal questioning of the study, subjects and recording of the answers. Personal interviews are regarded as the most useful methods of collecting data because of information they yield (Treece & Treece, 1982).

This method was used in anticipation that some respondents were not able to read and write as there is high rate of illiteracy in Zambia.

OTHER ADVANTAGES ARE:

- . Repetition of questions not understood by respondents was done.
- . The instrument catered for the illiterate and handicapped for example the blind.
- . The instrument saved time and money for postage.
- . Respondents did not give "I don't know" responses and no question was left blank.
- . Abdellah & Levine (1965) state that:

The investigator using the structured interview does not need to be highly skilled in interviewing and

- . The structured interview offers great ease of processing data. However, Treece & Treece (1982) discuss the following disadvantages:-

1. Data collected may be unreliable because of heavy dependence upon the respondents' ability to accurately recall some past events.
2. Some respondents tend to reserve some of their true reactions to questions, especially those who get suspicious or worried about seeing their responses written down.
3. Information obtained tends to be relatively superficial because it becomes difficult to probe deeply when questions are focusing on sensitive issues like human behaviour and feelings.
4. It is demanding of personal time (interviewer's time) and is expensive in terms of material resources needed.

Disadvantages were minimized in the following manner:-

1. Questions were stated in simple language.
2. The instrument was corrected and approved by the course supervisor. This was done to minimize errors in the instrument because a pilot study was not done.
3. The purpose of the study was clearly explained to the respondents and that notes were to be taken down during the interview.
4. Respondents were assured of confidentiality that their names will not be indicated on paper.

QUESTION SEQUENCE

The respondents were asked closed and open ended questions. The closed ended questions required respondents to give only one possible answer. Open ended questions aimed at obtaining demographic data such as age, marital status of both the respondents and the patient, educational background and position of the patient in the family. Questions 4 and 5 needed factual answers regarding relatives' knowledge about the patients' illness. Questions 15 - 21 helped to assess the relatives' concern for the patients. Questions 24, 28-29 helped to assess how much the relatives participated or how much the relatives desired to participate in the care of the hospitalized patients. The questions designed helped the investigator to collect relatives' views about the care of the hospitalized patients. Responses would help determine whether relatives would desire to fully participate in caring for their hospitalized patients.

DATA COLLECTION

The interviews were conducted in female and male admission wards and rehabilitation wards, at Chainama Hills Hospital during the month of April 1987. The interviews were scheduled during this month because this was the period when the instrument for collecting data was ready. Interviews were carried out during the weekends because this was the most convenient time for the researcher as there were lectures to attend during the week.

Interviews were conducted between 10:00 hours and 16:00 hours because visiting times are open from 08:00 hours to 18:00 hours every day. This time was chosen because it was convenient for the researcher and it allowed the researcher to get back to the place of residence when it was still day. The interviews were conducted in the sister's office to allow for privacy and minimize disturbance from patients and members of the nursing staff. Silence could not be maintained in the admission wards due to noise by the patients.

At the beginning of each interview, the researcher introduced herself. Rapport was established by asking general questions about the respondent's well being and about the family. A brief introduction of the study was given to the respondents, this further helped the respondent to relax and the researcher gained the respondents' cooperation. Each interview took about twenty (20) minutes because some questions were probing. Since the relatives' mental status were sound no problems were encountered during the interview. The interviewer did not encounter any language barrier.

DATA ANALYSIS

In mid-May, 1987, data were ready for analysis. Data collected for the study were analyzed manually because the sample size was small, fifty (50) subjects. The responses were listed tallied and put into categories. Data collected are not useful unless arranged in a meaningful way so that it is possible to derive patterns of relationships (Polit & Hungler, 1978). Tallying was done using the method of four (4) vertical bars with slash for the fifth observation. The tallying technique systematically arranges numerical values into a frequency distribution, making it convenient to see at a glance the number of times each value was obtained (Polit & Hungler, 1978). The data were also arranged in percentages. Percentages are descriptive statistics used to describe and synthesize obtained empirical observations and measurements (Polit & Hungler, 1978).

CHAPTER V

PRESENTATION OF DATA

This Chapter presents the data collected from the subjects in the study. Sweeney & Olivieri, (1981) state that tables summarize meaningful results enabling the reader to understand the author's intention in the study. The responses for a particular question are presented in table form. The sample consisted of fifty (50) respondents.

TABLE 1

SEX DISTRIBUTION OF RESPONDENTS

SEX	NUMBER OF RESPONDENTS	PERCENTAGE
MALE	21	42
FEMALE	29	58
TOTAL	50	100

TABLE 2

AGE DISTRIBUTION OF RESPONDENTS

AGE RANGE IN YEARS	NUMBER OF RESPONDENTS	PERCENTAGE
16 - 25	11	22
26 - 35	20	40
36 - 45	14	28
46 and over	5	10
TOTAL	50	100

TABLE 3:

MARITAL STATUS OF RESPONDENTS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
SINGLE	4	8
MARRIED	41	82
DIVORCED	3	6
WIDOWED	0	0
SEPARATED	2	4
TOTAL	50	100

TABLE 4:

TIMES THE PATIENT HAS BEEN HOSPITALIZED

NUMBER OF HOSPITALISATION	NUMBER OF RESPONDENTS	PERCENTAGE
ONE	20	40
TWO	17	34
MORE THAN TWO	13	26
TOTAL	50	100

TABLE 7:

RELATIVES' KNOWLEDGE ABOUT PATIENTS
ILLNESS

KNOWLEDGE ABOUT PATIENTS' ILLNESS	NUMBER OF RESPONDENTS	PERCENTAGE
YES	23	46
NO	27	54
TOTAL	50	100

TABLE 8:

RESPONDENTS' RELATIONSHIP WITH THE PATIENT

RELATIONSHIP WITH THE PATIENT	NUMBER OF RESPONDENTS	PERCENTAGE
UNCLE	1	2
GRANDMOTHER	1	2
AUNT	2	4
WIFE	6	12
CHILD	7	14
HUSBAND	9	18
SISTER/BROTHER	16	32
OTHER	8	16
TOTAL	50	100

TABLE 9:

THE POSITION OF THE PATIENT IN THE FAMILY

POSITION IN THE FAMILY	NUMBER OF RESPONDENTS	PERCENTAGE
FIRST BORN	9	18
IN THE MIDDLE	36	72
LAST BORN	5	10
TOTAL	50	100

TABLE 10:

PATIENTS' MARITAL STATUS

MARITAL STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
SINGLE	22	44
MARRIED	24	48
DIVORCED	4	8
TOTAL	50	100

TABLE 11:

NUMBER OF PATIENTS WITH CHILDREN

PATIENTS WITH CHILDREN	NUMBER OF RESPONDENTS	PERCENTAGE
WITH CHILDREN	36	72
WITH NO CHILDREN	14	28
TOTAL	50	100

TABLE 12:

NUMBER OF PATIENTS WITH SIBLINGS

PATIENTS WITH SIBLINGS	NUMBER OF RESPONDENTS	PERCENTAGE
WITH SIBLINGS	45	90
WITH NO SIBLINGS	5	10
TOTAL	50	100

TABLE 13:

EDUCATIONAL LEVEL ATTAINED BY THE PATIENT

EDUCATIONAL LEVEL	NUMBER OF RESPONDENTS	PERCENTAGE
NO FORMAL EDUCATION	9	18
GRADE 1 - 4	3	6
GRADE 5 - 7	18	36
GRADE 8 - 10	12	24
GRADE 11 - 12	8	16
TOTAL	50	100

TABLE 14:

PATIENTS' EMPLOYMENT STATUS

EMPLOYMENT STATUS	NUMBER OF RESPONDENTS	PERCENTAGE
TEACHER	2	4
SALES REPRESENTATIVE	1	2
POLICEMAN	1	8
SIGN WRITER	1	2
TYPIST	1	2
UBZ DRIVER	1	2
STUDENTS	6	12
SUBSISTENCE FARMERS	6	12
HOUSEWIFE	10	20
UNEMPLOYED	16	32
MARKETEER	2	4
TOTAL	50	100

TABLE 15:

NUMBER OF TIMES RELATIVES VISIT THE PATIENT IN A
WEEK

TIMES PATIENTS IS VISITED IN WEEK	NUMBER OF RESPONDENTS	PERCENTAGE
ONCE PER MONTH	1	2
ONCE	4	8
TWICE	10	20
THREE TIMES	12	24
FOUR TIMES	6	12
FIVE TIMES	1	2
DAILY	16	32
TOTAL	50	100

TABLE 16:

DURATION OF RELATIVES' STAY AT EACH VISIT

DURATION OF STAY AT EACH VISIT	NUMBER OF RESPONDENTS	PERCENTAGE
15 MINUTES	7	14
30 MINUTES	16	32
45 MINUTES	4	8
1 HOUR	9	18
1-1/2 HOURS	5	10
2 HOURS	6	12
2-1/2 HOURS	0	0
3 HOURS	2	4
3-1/2 HOURS	0	0
4 HOURS	1	2
TOTAL	50	100

TABLE 20:

IS IT THE DUTY OF THE HOSPITAL PERSONNEL ALONE TO CARE FOR THE HOSPITALIZED PATIENT?

RESPONSE	NUMBER OF RESPONDENTS	%
YES	15	30
NO	32	64
OTHER	3	6
TOTAL	50	100

TABLE 21:

RELATIVES' ADVICE TO THE HOSPITAL PERSONNEL

RELATIVES' ADVICE	NUMBER OF RESPONDENTS	%
KEEP UP WITH THE GOOD WORK	12	24
HOSPITAL PERSONNEL TO BE KIND, LOVING, UNDERSTANDING & PATIENT WITH PATIENTS	18	36
BE MORE OPEN TO RELATIVES	15	30
NO ADVICE	5	10
TOTAL	50	100

TABLE 22:

GIVEN A CHANCE, WOULD THEY STAY IN WITH THE
PATIENT TO HELP IN CARING
FOR HIM/HER?

RELATIVES RESPONSE	NUMBER OF RESPONDENTS	%
YES	38	76
NO	12	24
TOTAL	50	100

TABLE 23:

ANYTHING THE RELATIVE WANTED TO KNOW

RELATIVES' RESPONSE	NUMBER OF RESPONDENTS	%
ABOUT THE PATIENTS' ILLNESS AND PROGNOSIS	25	50
HOW ABOUT TRYING TRADITIONAL HEALERS IF ALL FAILED	3	6
WHY SOME HOSPITAL STAFF ARE ABUSIVE	5	10
NOTHING	17	34
TOTAL	50	100

CHAPTER VI

DISCUSSION OF THE FINDINGS

The purpose of the study was to find out the views of mentally ill patients' relatives on hospital management of these patients. Table 1 showed that both male and female relatives visit the patients. The sex distribution could indicate that once one family member is ill the rest too are affected. The emotional difficulties of one family member, whether they require hospitalization or not, place strain and additional responsibilities on other family members (Fromer, 1979).

The age table showed that relatives of all ages visit the patients. From this table it is apparent that all family members including siblings actively visit their patients. Fromer (1979) says that hospitalization compounds the stress and adds some that is unique to itself such as the need for the family and the patient to conform to behaviours that are neither understood nor explained. These create an extremely stressful situation with which even the most adaptive people have difficulty coping.

The majority of the patients' relatives were married, eight-two (82) percent. This could indicate that they are a responsible group of people and feel duty-bound to visit the patients in hospital. Out of the married people, females may have added responsibilities as Mukonze (1984) in her study states that there are many more other activities that women perform such as taking care of a sick family member which demands more of the mother's attention. Therefore a patient in hospital is an extra responsibility.

Table 4 showed that forty (40) percent of the patients were hospitalized once while thirty-four (34) percent two times and twenty-six (26) percent more than two times. The high rate of admissions could be attributed to a lack of a stable, secure, loving family life which helps to assist individuals to develop attitudes about self and others that make it possible to adjust to the pressures of adulthood and to live a satisfying and productive life (Mereness & Taylor, 1978). Musonda (1984) in a study by Siegel (1970) stated that in the United States of America adolescent admissions and young adults accounted for a major segment of the treatable population in mental hospitals. This statement could be supported by Table 6 which indicated that 36% of hospitalized patients were between 16 - 25 years. The cause for first admissions could primarily be attributed to a lack of a stable, secure, loving family life. Re-admissions could be due to victimization and stigmatisation by relatives and friends. The stigma attached to mentally ill persons makes them have a problem of being accepted in the community. Their efforts may be undermined even when they are well and able to work again (Sheahan, 1973). Mukonze (1984) in Haber et-al (1982) adds that mental disorders deprive individuals of their major institutional functions, such as status, roles and degrees of self-determination, and diminish their sense of autonomy. The other compounding factor could be the hard economic situation prevailing in the country. Most Zambian families are doing away with the Extended Family System and are adopting the Western Nuclear Family System. In view of this, relatives who have nobody to support them become destitutes who in search of food and shelter from dustbins and bus stations eventually find themselves in a psychiatric hospital.

The economic difficulties which Zambian families are going through have brought about problems in meeting educational needs of young school going boys and girls. As a result they discontinue school in their teens because parents do not have enough money to send them to school. This leads to early unplanned marriages for girls who lack preparation for coping with marital responsibilities. This ultimately leads to a high incidence of admissions to Chainama Hills Hospital as reviewed by Mukonze (1984). Following the same trend in which some girls discontinue school, boys find themselves unable to secure employment and in their frustration turn out to be delinquents. The adolescent problems are usually related to growing up and the stresses of adolescence usually relate to family, school or society (Musonda, 1984). Table 5 showed that eighty-eight (88) percent of the patients' relatives had religious affiliations. This was a positive sign because according to Notter & Spalding, (1976) we no longer think of health merely as the absence of disease. Instead, we regard health as a state of physical, mental, emotional and spiritual wellbeing, in which the individual is able to function to the optimum extent of his potentialities. It must be remembered that family members suffer fear of the outcome of the patients' illness and experience a sense of guilt, inadequacy and helplessness due to lack of proper understanding of the patient's illness. They may lack the ability to alleviate the patient's suffering. Such a family crisis puts the family in a vulnerable state and unless they have strong coping mechanisms, some of the family members may end up with mental disorders. A strong religious affiliation may provide assistance in coping with the stress of illness.

Mental disorders have no age limit. Patients with mental problems ranged from less than sixteen (16) years to over forty-six (46) years. The majority of cases fell between 16 - 25 years (36%) and 36 - 45 years (20%). 12% were under 16 years or over 46 years. Therefore mental disorders are common from adolescence throughout adult life. There are some periods in life when the individual is more vulnerable emotionally than at others. These critical periods are adolescence, post partum period, menopause and old age (Mereness & Taylor, 1978). Also, some of the situations that may produce psychogenic conflicts include serious financial problems, loss of a dearly loved friend or relative, a broken marriage, loss of a job, failure to receive an important promotion, or disappointment in the integrity of a trusted friend or spouse (Mereness & Taylor, 1978).

It was discovered that fifty-four (54) percent of the relatives had no knowledge about patients' illness. This supports the hypothesis that relatives of hospitalized mentally ill patients do not participate in the care because they feel that they lack the skill and the knowledge to do so. Some of the relatives' answers as to why they didn't know about the disease were:-

1. "Doctors are supposed to know".
2. "The patient was bewitched".
3. "Nobody has told us".

Such answers as quoted above could mean lack of good interpersonal relationships between the hospital personnel and the patients' families. A two-way communication is a must in the care of any patient. The hospital personnel should take time to alleviate the relatives' anxieties. Sometimes all it takes from the nurse is a simple statement of fact regarding the patient's condition, such as, "he slept better last night" (Irving, 1973).

ty-six (46) percent of the relatives know what the patient suffered from however, after analyzing the answers given, it was concluded that even those relatives who claimed to know what the patients suffered from did not fully understand the patient's illness. For example, one respondent said that the relative was suffering from;

" a snake bite" and another said

"cerebral malaria".

While it is a fact that mental patients could suffer from a snake bite or cerebral malaria, such cases would not warrant initial admission to a mental hospital!

Although mental disorders come in different forms, it is imperative that the personnel caring for such patients understand the illness and explain it to the relative in a simple and clear language. Such a simple action could go a long way in relieving tension and anxiety from the patient's relatives. As a result the relative would know how to best cooperate with the hospital staff for the betterment and recovery of the patient. It is justifiable then to say that relatives of mentally ill patients do not participate in the management of these patients because they lack the skill and knowledge.

Table 8 showed that eighteen (18) percent of the respondents were husbands to some of the patients and twelve (12) percent of the respondents were wives while fourteen (14) percent were parents to the patients. The majority thirty-two (32) percent fell into the brother/sister category. This could indicate that generally, the extended family ties are still in existence and that there is a high number of spouses and siblings being admitted to Chainama Hills Hospital.

This could be attributed to a host of factors such as lack of harmonious interpersonal relations in the home, leading to feelings of loneliness and failure to cope with demanding situations as confidants may not exist in such a home. The hard economic times in the country makes it impossible for most Zambian families to make ends meet consequently the father who in most cases is the breadwinner suffers from feelings of guilt and inadequacy because he has failed to support the family. Such a state may lead to depression or other psychosomatic illnesses such as headaches, palpitations and peptic ulcers. The wife too suffers equally, emotionally. As a home maker and care-giver she finds herself with no money to stretch until the end of the month and she has to scrounge here and there for food to feed the family. This situation over a period of time could lead to depression or other mental disorders too. The siblings could be in their adolescent stage of development where any disequilibrium in the home could lead to mental instability.

Table 9 shows that people, irrespective of the position in the family can be affected by a mental problem. In Zambia, one would expect to find a high incidence of mental disorders in the first borns because they are expected to help parents in the upbringing of the younger brothers and sisters; however, these findings indicate otherwise because there were only eighteen (18) percent first borns admitted compared to seventy-two (72) percent of patients who fall in the middle. Only ten (10) percent of the patients were last borns.

The findings for the patients' marital status in table 10 could be likened to the findings for table 8 in that forty-eight (48) percent of the patients were married and their admission could have been due to loneliness and failure to cope with demanding situations which

/resulted....

resulted from lack of harmonious interpersonal relations in the home. Also the hard economic times prevailing in the country could add on the stresses. The same reasons could have led to the admission of the patients who were single.

Table 11 revealed that seventy-two (72) percent of the hospitalized patients had children back home. Such a state of affairs increases the patient's anxiety unless the patient is well informed about the well being of the children at home. Children too are deprived of maternal or partenal love and care once either parent is hospitalized. Therefore the need for family involvement cannot be ignored. Mukonze (1984) says that children take up parental roles while still very young and this could lead to a maladjustment process which disturbs the children's growth and development. If the family were involved, such problems existing at home could be brought to light and a mother substitute could be sought for from amongst the relatives because they would be active participants in the management of the patient.

The twenty-eight (28) percent with no children were not exempted from psychological traumas. They too have loved ones who may be anxious about the patient's mental disorder because they do not understand the illness.

Table 12 showed that ninety (90) percent of the patients hospitalized had siblings while only ten (10) percent had none. Siblings are a valuable manpower resource who could be actively involved in the management of these patients in the hospital and after discharge from hospital.

The ten (10) percent who had no siblings were probably being visited by other family relations such as spouses and close friends.

The educational level attained by the patients as given in Table 13 showed that eighteen (18) percent had no formal education, six (6) percent attained Grades 1 - 4, thirty-six (36) percent attained Grades 5 - 7, while twenty-four (24) percent attained Grades 11 - 12. Therefore the highest educational level attained by the majority were between Grades 5 and 7 followed by Grades 8 and 10. There could be various reasons for dropping out of school such as failing to pass the examinations, lack of financial support, physical illness and mental illness, early indulgence in alcohol and drugs and teenage pregnancies. This was reviewed by Musonda (1984) in the study of factors contributing to the increase in the number of adolescents admitted to Chainama Hills Hospital.

The patients' employment status in Table 4 revealed that thirty-two (32) percent, were unemployed. Twenty (20) percent were housewives, twelve (12) percent were subsistence farmers, twelve (12) percent were students and four (4) percent were marketeers while twenty (20) percent were employed in other occupations. There is a high rate of unemployment in Zambia and the situation has worsened due to the hard economic days Zambia is going through which has inevitably caused a lot of factories to lay-off workers regardless of age. Unemployment contributes to the feelings of inadequacy and shame especially among men who are supposed to be bread-winners for the families. For the twenty (20) percent of hospitalized housewives, the mental disorders could have been due to social problems especially disharmony in the marriages as reviewed by Munkonze (1984).

Table 15 showed the number of times relatives visit the patients in a week. Eight (8) percent visit the patients once a week, twenty (20) percent twice a week, twenty-four (24) percent three times a week, twelve (12) percent four times a week, two (2) percent five times a week, while thirty-two (32) percent visit their relatives on a daily basis and only two (2) percent visit once per month.

This shows their concern, care and love for the patients.

Hospitalization of a family member creates a sense of loss in the family members and this is worsened by the fact that the family may be ignorant of the patient's mental disorders as earlier reviewed.

Relatives who did not visit the patients frequently had communication constraints ranging from distance, and cannot use public transport due to inadequate financial resources. One relative came from outside Lusaka. Chainama Hills Hospital is the referral hospital for the country. Males are usually bread-winners in a home and therefore, may find it difficult to make frequent hospital visits during the week because work usually goes up to 17.00 hours.

Chainama Hills Hospital is situated very far from the town centre and other industrial areas. However, Table 15 shows that relatives make an effort to be available to the patient and hospital personnel. It is therefore time that the hospital staff actively involved the relatives in the management of the mental patients. Table 16 shows the duration of relatives' stay at each visit. Fourteen (14) percent spend 15 minutes, thirty-two (32) percent spend 30 minutes, eight (8) percent spend 45 minutes, eighteen (18) percent spend one hour, ten (10) percent spend one hour and thirty minutes while twelve (12) percent spend two hours. Table 16 could be linked with Table 17 about the relatives' preferred length of stay when they visit. Twenty-two (22) percent preferred staying with the patient for one hour, eighteen (18) percent 1-1/2 hours, twenty-four (24) percent 2 hours, ten (10) percent 3 hours. While twenty (20) percent preferred to be with the patient 24 hours! The relatives who stayed with the patients for 15 minutes gave the excuse of being busy and were trying to get back to work. Those who stayed for 30 minutes said it was the scheduled length of the visit.

It may also be that the relatives felt obliged to come but felt uncomfortable and used 30 minutes as a chance to go away. However, visiting time at Chainama is open from 08.00 hours to 18.00 hours every day. This could also indicate a lack of communication over visiting times between the public and the staff at Chainama Hills Hospital. Some relatives who stayed from 1 hour to 4 hours said that they did so because they missed the patient, others wanted to entertain the patient and others wanted to observe if the patient ate the food brought from home. Other relatives said that they stayed for a long time so that they could talk to the patient, cheer the patient up and assess the patient's progress. Other relatives stayed a long time to comfort and encourage the patient. One relative said:-

"the patient is dear to us, we know him very well, we just want to express our love for him so that he does not feel neglected".

This proves that relatives do not relinquish their concern for the patient to the hospital staff. They still love and care, therefore they need to be directed by the hospital personnel so that they could be actively involved in the management of these patients. The reasons given for Table 16 explains the preferred length of stay of the relatives. Relatives love the patients. They want to suffer with them throughout the hospital stay and see that they get better and once again be a useful part of society.

'Relatives' feelings towards the patients' illness in Table 18 showed that fifty-six (56) percent felt sorry while forty-four (44) percent were sad that their loved ones had a mental problem. Therefore after looking at Tables 16, 17 and 18, it would be justifiable to reject the hypothesis that relatives of hospitalised mentally ill patients may not take part in caring for these patients because they do not want to be identified with a relative who has a mental illness.

Table 19 showed ways in which relatives would assist caring for the patient. Thirty (30) percent would assist by visiting and taking the patient food, twenty (20) percent would assist by urging the patient to take hospital treatment, fourteen (14) percent said that doctors and nurses should tell them how best to assist. Twelve (12) percent would assist by praying, eight (8) percent by telling the patient that they cared, six (6) percent would take the patient to a traditional healer, two (2) percent would assist by taking care of patient's children and eight (8) percent said there was nothing they could do to help in the caring for the patient. The relatives said they would help in the various ways as stated above because the patients were their own blood relations whom they loved and they wanted to see them get better. One of the relatives even said:-

"if you notified me, I can buy the necessary drugs for my nephew that are not available in hospital".

The twelve (12) percent who said they would pray said that there was nothing impossible with God and that God was the owner of all things. Fourteen (14) percent said that doctors and nurses should tell them how best to assist. This could mean that they do not understand the patient's illness and are therefore at a loss as how best to help in the care of the patients. This does not mean that they do not want to help in caring for these patients, they just lack direction and encouragement from the hospital personnel. This then proves the hypothesis that 'relatives do not care for their mentally ill patients when they are hospitalized because the hospital personnel do not encourage them to do so.'

The majority of Zambians hold the traditional healers in high esteem hence the need to incorporate traditional healing into orthodox medicine in Primary Health Care. This trend would help in early recognition of patients with mental or physical problems. In view of this it would be up to the individual doctor's discretion to discharge a patient so that a relative could consult a traditional healer because six (6) percent of relatives said they would help in caring for the patient in this way.

In Table 20, relatives were asked if it was the duty of the hospital personnel alone to care for the hospitalized patients. Thirty (30) percent said yes it was the hospital's responsibility while sixty-four (64) percent said no it was not the hospital's responsibility alone. Six (6) percent failed to answer. Relatives who said it was the hospital's sole responsibility to care for the patients gave reasons such as:-

1. "the hospital personnel have power over the patient"
2. "the hospital personnel know what kind of illness the patient suffers from"
3. "only the hospital can help".

This then proves the hypothesis that relatives of hospitalized mentally ill patients may not take part in the care of these patients because they feel it is the responsibility of the hospital.

The sixty-four (64) percent who said it was not the duty of the hospital alone to care for the patients gave the following

reasons:-

1. "when one member of the family suffers we all suffer"
2. "the patient needs comfort from the members of the family"

Relatives would have a full picture of the patients' illness and the nurses would also be aware about the family's mental status with regard to patient's illness.

Relatives were asked if they would stay in with the patient to help in caring for him/her if they were given a chance. In Table 22 it can be seen that seventy-six (76) percent said yes they would stay in and twenty-four (24) percent said no they would not. Those who said would stay gave the reason that they loved the patient and would love to help in any way possible for a quick recovery of the patient. Those who said they could not gave the reasons that they were employed, others said they had to take care of other children back home.

Finally, in Table 23, relatives were asked if they had any pressing question or anything they wanted to know about. Fifty (50) percent wanted to know about the patients' illness and prognosis, six (6) percent wanted to know if they could try the traditional healers if all failed. Ten (10) percent wanted to find out why some hospital staff were abusive while thirty-four (34) percent had nothing to ask. This proved that the majority of relatives were not well informed about the kind of mental disorder the patient suffered from hence it was impossible to know the prognosis. This added to the anxiety and guilty feelings. This could attribute to the relatives' loss of confidence in the hospital treatment. As a result they seek the help of traditional healers, hoping to be told the patient's problem.

As earlier discussed, the need for the hospital staff to be patient and refrain from using abusive language or punishing the mental patients cannot be over emphasized. To nurse and manage patients with mental disorders, kindness, a lot of patience and understanding are a must.

The findings established that the relatives of mentally ill patients would love to fully participate in the nursing management of these patients. But their desire is hampered by lack of proper knowledge of their patients' illness and lack of encouragement and direction from the hospital personnel.

CHAPTER VII

NURSING IMPLICATIONS, CONCLUSIONS, RECOMMENDATION
AND LIMITATIONS OF THE STUDY

1. NURSING IMPLICATIONS:

Many relatives in the study showed willingness to fully participate in the care of their loved ones. They know that it is not the duty of the hospital personnel alone to care for the patients. The problem is that they lack the direction and encouragement to do so. They therefore do not know where to start from or how best they could help. Therefore, nurses need to cultivate a warm and long lasting interpersonal relationship with patients' relatives. This could be achieved by nurses being more open and accommodating to relatives' fears and anxieties due to patients' illness. Nurses should not leave questions asked by the relatives unanswered or referring relatives to doctors unless the nurse genuinely is unable to deal with the question. As the nurse is an indispensable care giver who is with the patient 24 hours, she should know the patient better and should follow up the the patient's progress on a day to day basis. Hence she is in a better position to direct and encourage the relatives as how best they could help.

Relatives' participation in the caring system could enable them learn more about the patient's illness its etiology, course and prognosis. This would help in preventive measures for relatives themselves and the patient because some mental illnesses such as those due to alcoholism and drug abuse are preventable, if these substances are taken in moderation. This could even cut down on the number of re-admissions which are due to relapses.

Relatives' participation would make them realize that a mental illness is just like any other illness of physiologic type (Irving, 1973) and that victimization and stigmatization are unfair to the patient. Such realization by the relatives could go a long way in helping patients rehabilitate and probably the number of mental patients roaming the streets could be minimized. Relatives love their patients and would love to show it even more by caring and doing all they can for the patient. In fact some nursing procedures such as a bed bath are intimate therefore would require a spouse to render such a service in order to maintain the patient's privacy, self-esteem and dignity. Involving relatives in the care could greatly help promote mental health because relatives would learn a lot as they daily interact with the patient and by so doing learn ways of preventing a mental disorder. It is time the relatives were given a chance so as to promote mental health by the year 2000.

CONCLUSION

The study looked at patients' relatives views on hospital management of mentally ill patients. It was discovered that a lot of relatives did not know the nature of the mental problem the patient suffered from. This added on to their fears and anxieties. A good number of relatives showed love and concern for their patients. This was reviewed by the fact that they visited their patients frequently and stayed with the patients for a long time from 15 minutes at the least up to 4 hours during each visit. A lot of relatives felt it was their duty as well to take care of the patient. They did not relinquish the care to the hospital personnel. Others even offered to stay in with the patient so that they could monitor the patient's progress hand in hand with the hospital staff.

With such a positive attitude by the relatives, it could be justifiable if they were allowed to take full participation in the nursing of their patients. Besides holistic nursing care incorporates the family's participation in rendering the care. The patient is part and parcel of the family system and family involvement would help maintain the family equilibrium.

RECOMMENDATIONS

In order for the hospital personnel and the society to see the importance of family involvement in the care of psychiatry patients the following could be helpful:-

- a) The hospital personnel must have a better understanding of the family as an institution.
- b) Nurses to have some training on family therapy.
- c) All relatives with mental patients to come together and form a relative support group with hospital personnel as part of this group.
- d) A committee consisting of a family member, nurses, doctors, psychologists, social worker, the clergy, paramedical staff, the Minister of Health, prominent figures of society such as businessmen, educationists, could be formed so that the problem of family involvement could be viewed from a broader perspective.
- e) The study should be done on a larger scale.

LIMITATIONS OF THE STUDY

The small sample of the population interviewed limits generalization of findings to the total population of relatives of mentally ill patients.

The time available for completion and submission of the study to the Department of Post-Basic Nursing in the School of Medicine, was short. The money for conducting the study, meeting the cost of stencils, paper and binding was not available.

APPENDIX I

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P O Box 50110
LUSAKA

13 January 1987

The Senior Nursing Officer
Chainama Hills Hospital
P O Box 30043
LUSAKA

Dear Sir,

RE: PERMISSION TO CONDUCT A RESEARCH STUDY

I am a second year student at the University of Zambia studying for a Diploma in Nursing Education.

As part of the course requirement, I am required to carry out a piece of research in an area of my choice. I am interested in finding out the views of mentally ill patients' relatives on hospital management of these patients, at Chainama Hills Hospital. In order to gather data for my research, I would be grateful if you could allow me to interview some patients' relatives.

Should you like to have a discussion before granting me permission, I will be prepared to come on Wednesday afternoon as this is the day and time I am free from lectures.

Your help will be greatly appreciated.

Yours faithfully

HELEN BANDA (MRS)

APPENDIX II

Office of the Senior Medical Superintendent
Chainama Hills Hospital

P O Box 30043

LUSAKA

February 1987

Mrs Helen Banda
School of Medicine
Department of Post-Basic Nursing
P O Box 50110
LUSAKA

RE: REQUEST FOR RESEARCH IN THE HOSPITAL

I refer to your letter in which you requested for authority to conduct a research study in this hospital.

I am glad to inform you that you have been granted permission to carry out your research. Please see me when you come.

Yours faithfully

For SENIOR MEDICAL SUPERINTENDENT

APPENDIX III

STRUCTURED INTERVIEW

For official use only

Code

-
- | | | | |
|----|---|-----------------------|---|
| 1. | SEX | MALE | 1 |
| | | FEMALE | |
| 2. | AGE RANGE | A. 16 - 25 | |
| | | B. 26 - 35 | 2 |
| | | C. 36 - 45 | |
| | | D. 46 and | |
| | | E. ABOVE | |
| 3. | MARITAL | A. SINGLE | |
| | | B. MARRIED | 3 |
| | | C. DIVORCED | |
| | | D. WIDOWED | |
| | | E. SEPARATED | |
| 4. | How many times has the patient been admitted in hospital? | | |
| | | A. FIRST TIME | |
| | | B. SECOND TIME | 4 |
| | | C. MORE THAN TWICE | |
| 5. | Do you know what the patient suffers from? | | |
| | | A. IF YES WHAT IS IT? | 5 |
| | | B. IF NO WHY? | |
| 6. | What is your relationship with the patient? | | |
| | | A. HUSBAND | 6 |
| | | B. WIFE | |
| | | C. CHILD | |
| | | D. UNCLE | |
| | | E. AUNT | |
| | | F. GRANDFATHER | |
| | | G. GRANDMOTHER | |
| | | H. OTHER | |
| | | I. BROTHER/SISTER | |

7. Have you any religious affiliation?

A. If yes what is your demonination

B. If no Why?

7

8. How old is the patient?

A. Less than 16 years

B. 16-25 years

C. 26-35 years

D. 36-45 years

E. 46 and above

8

9. What is the position of the patient in the family?

A. First born

B. In the middle

C. Last born

9

10. What is the patient's marital status?

A. Single

B. Married

C. Divorced

D. Widowed

E. Separated

10

11. How many children has the patient?
Specify

11

12. How many siblings has the patient?
Specify

12

13. What is the patient's educational level?
Specify

13

14. What does the patient do for a living?
Specify

14

15. How many times do you visit the patient in a week?
Specify

15

16. For how long do you stay with the patient when you visit? 16

17. Why that duration? Specify 17

18. For how long would you like to stay with the patient when you visit? Specify 18

19. Why that long? Specify 19

20. How do you feel about the patient being in Hospital?
A. Sad
B. Sorry
C. Nothing 20
D. Relieved from caring for him/her
E. Any other reason

21. In what way would you like to assist your patient? 21

22. Why would you like to do that 22

23. Why don't you do it? 23

24. Do you think it is the duty of the hospital personnel alone to care for the hospitalized patients?
A. If yes, Why? 24
B. If no, Why?
C. Any other reason?

25. What is your advice to the hospital personnel in caring for hospitalized mentally ill patients? 25

26. How do other family members feel about the patient's illness?
A. Sad 26
B. Sorry
C. Relieved from caring for him/her
D. Nothing
E. Any other reason?

27. Would they also like to assist the patient in any way?

27

A. If yes, how?

B. If No Why?

28. Who was looking after the patient before admission?

28

29. Given a chance, would you stay in with the patient and help in caring for him/her

29

A. If yes Why?

B. If No Why?

30. Is there anything that you would like to know?

30

END

Thank you for the time spent with you.

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