AN INVESTIGATION OF SELECTED PSYCHOSOCIAL INFLUENCES ON THE RESILIENCE OF FAMILIES LIVING WITH MENTAL ILLNESS IN NYERI COUNTY, KENYA

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DECLARATION AND APPROVAL

Declaration

This thesis is my original work and has not been presented for a degree in any other University or for any other award.

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We confirm that the work in this thesis was carried out by the candidate under our supervision as university supervisors.

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DEDICATION

This study is dedicated to my late parents, Mr. Festus Gachau and Mrs. Cecilia Wangechi.

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ABSTRACT

Numerous studies have demonstrated that family members living with a person with a mental illness suffer from significant stresses, experience moderately high levels of burden and often receive inadequate assistance from mental health professionals. The major objective of this study was to find out whether selected psychosocial influences; attitudes and perceptions of family members on mental illness as well as the social support systems have significant influences on the resilience of the families living with a mentally ill member in Nyeri County, Kenya. The study was guided by two theories; Hardiness theory of Resilience by Suzanne Kobasa(1979) and the Attribution theory by Fritz Heider(1958). This study adopted the *Ex-post facto* research design. The target population was the family members who live with and take care of 600 mentally ill relatives who had have visited the Nyeri County Referral hospital in the month preceding data collection. Yamane's formula was applied to determine a sample size of 240 families who participated in the study. Ten close family members were purposively selected to take part in in-depth interviews, one family was selected for the biographical study, while the remaining 229 families were subjected to a questionnaire. The instruments were tried out in a pilot study, carried out in Laikipia County and adjustments made as was found necessary. Reliability of the instruments was determined using test-retest method and a reliability index of 0.751 was obtained, which was considered adequate. Validity was enhanced by building participant trust, spending enough time in the field as well as member checking in order to correct any errors of facts or interpretation for the qualitative data. The qualitative data was transcribed and analyzed by the researcher identifying patterns and themes, then comparing the different ideas in order to bring out underlying meanings and relationships. The quantitative data was analyzed using multi-linear regression to test the hypothesis, p=.05 significance level, with the aid of SPSS (Version 23). The results are presented in prose and also in tables. The study found that the aspects of perceptions and attitudes tested have a significant influence on the resilience of the family members who take care of their mentally ill members. It was also found that the social support these families received from both formal and informal sectors was inadequate and had a significant influence on their resilience. Interventions to alleviate the suffering of family members under this study were found to include; development of institutions where the mentally ill can be taken care of by trained staff, provision of free medical care and establishment of a scheme that supports the families financially. Based on the above findings, a model framework was developed and recommended for supporting the family members. It is recommended that continuous sensitization of the community members by the Ministry of health on mental illness be carried out to reduce stigma as well as the formation of support groups that would provide counseling and other services to those living with the mentally ill.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Wide disparities in the social, economic and cultural environments cannot conceal the common opportunities and challenges that affect the family unit world over. The family unit has been affected by the environmental, social, economic and psychosocial scenarios that transform the environment in which families exist and make their decisions. Social economic effects have continued to impact on the structure of the family in departure from the traditional patterns to the contemporary structures generated by advancement in education, migration, healthcare and employment (Mathers, 2006). Some factors such as health have however impacted on families equally regardless of their social and economic standing and have exposed constraints to the families.

Among the health factors affecting the social and economic fiber of the family unit is mental illness. Most people at a point in life are touched by addiction or a mental health condition that affect them or members of their families, a colleague or a friend. The World Health Organization (WHO) approximates that about 450 million people across the world live with a mental disorder which translates to about 12percent of the total global disease burden. The prevalence rates between high and low income countries are similar. The report further indicates that disparities exist in the amount of resources set aside to cater for mental health services between high income and low income countries. These mental disorders include 24 million with schizophrenia, 121 million people with depression and 37 million with dementia. In 2001, 12.3% of global disease burden was attributed to mental illness and it is estimated that depressive diseases will be ranked second most likely cause of disability. Neuropsychiatric conditions account for 31% of the duration lived with disability (WHO, 2011).

In African countries, a big proportion of those who suffer from mental illness have no access to relevant health care. At the same time, developing countries set aside a paltry 0.5% of their expenditure on health to mental health care as compared to developed countries which allocate more than 5percent to mental health care. As a result most families have to take care of their mentally ill at their homes. Although evidences in the developing countries are rare, a large proportion of the countries have high prevalence of mentally ill patients putting up with their immediate families. For instance, UNHS report of 2005/2006 indicates that in Uganda, 58percent of families with disabled members had at least one member with a mental illness. (UBS, 2006).

WHO proposes that the communities develop their own mental healthcare services world-wide. Nevertheless, in Africa, the success of community based mental healthcare is adversely affected by resource constraints as well as shortage of specialist practitioners in psychiatry hence, most of the services are offered in mental hospitals. The ratio of trained psychiatrists and other mental health workers to the population is still very low in most African countries.

In Kenya, the prevalence rate of mental illness is 1 in every 25 for major disorders. This compares with the prevalence rate in developed countries. According to a study carried out in Nyanza Province, mental disorders that are common are a major burden in the provision of healthcare in Kenya. The prevalence of these mental disorders were found to be generally consistent over a period of ten years, between the years 2004 and2013 (Kiima& Jenkins, 2015). In Kenya, mental health services are funded by the government with only a few being offered by the private sector. Mathari Mental Hospital based in

Nairobi, is the biggest hospital offering in-patient mental health services in Kenya (Dhadphale, Ellison& Griffin, 2003).

In Nyeri County, treatment for mental illness is offered at the Nyeri County Referral Hospital Psychiatric Unit. About 600 patients visit the unit every month, according to the records at the hospital. A few patients also receive treatment at Outspan Hospital especially those with medical insurance, since the cost of treatment is quite high for the ordinary citizen. The high number of patients seeking treatment in the two hospitals indicates that the prevalence rates of mental illness is high. No records of research studies on resilience of families living with mental illnesses in Nyeri were available.

Family members have a tremendous but often invisible role in the care of mentally ill persons. As noted in the Kirby/Keon Report in Canada, family caregivers for mentally ill persons are generally ignored despite the special predicament they find themselves in of providing most care and support to the mentally ill (Kirby/Keon, 2013). Cree (2003) affirms that in UK, family caregivers are generally excluded by the mental health care providers yet they are the ones who provide most of the care to the patients. In Africa, most of the research work has been directed on the vulnerabilities and the risks faced by the family care givers. These studies have looked at the physical and psychological effects on the family care-givers as a result of taking care of their mentally ill relatives as well as the trauma they experience (Robson, 2006). These difficulties are both psychological and physical, and the family members are always found to benefit from social support either from other family members or from friends. Support may also come from organized social groups such as churches or other groups in the community. Little attention has in the past been given to the potential benefits that accrue to the family care givers as they live with their mentally ill relatives. These benefits include development of close relationships among the family members, as well as acquiring new skills and knowledge in dealing with persons in difficult conditions and circumstances, not only those with mental illness (Donald &Clacherty, 2005).

Mental illness may cause a variety of psychosocial problems for the family members who live with the mentally ill. These problems may include a decrease in the quality of life as a result of loss of gainful employment for the mentally ill or their failure to participate in the economic activities in the community or even their own upkeep. There may also be an increase in social distance, both for the mentally ill and their family members who live with them and care for them. Family members caring for their mentally ill relative usually report feelings of stigmatization as a result of having to associate with the mentally ill. They always feel that they are treated differently by members of their extended families, friends as well as their neighbours as a result of living with the mentally ill. As a result different families come up with different coping mechanisms depending on their individual situations, such as the type of illness as well as the seriousness and the behavior of their mentally ill relative. The perceptions the family members have regarding the mental illness as well as their attitudes towards mental illness and the mentally ill, also have a bearing on the coping strategies that the family members may adopt (Ssebunnya, 2009).

In a study conducted by Masunga K. and Iseselo (2016) on the psychosocial problems of families caring for relatives with mental illnesses and their coping strategies, it was found that many of the caregivers reported that people around them had negative attitudes towards those with mental illness. As a result, the caregivers feel guilty and psychologically disturbed when they hear or see their ill relative being ostracized. Many of the participants in the same study expressed lack of support from people within and outside their families. One of the contributing factors to the lack of support was cited as ignorance of family members regarding the nature of mental illness. Most family members thought that the illness would only last a short time, so if the symptoms lasted longer than they expected, they would give up and withdraw their support.

In a report given by Chadda (2014), caregivers of mentally ill patients experience stress and a lot of anxiety due to the uncertainty associated with mental illness. This is because the illness is usually chronic, in that it may persist for a long time and even when it seems to subside, it will often recur. In most cases, people with mental illness will appear to get better, only for the illness to reappear and in most cases seem to be even more severe than before. Taking care of the mentally ill is also very demanding especially since it is very difficult to understand and satisfy their needs. Most were reported to be quite unreasonable in their demands. There is the possibility of burnout, a sense of helplessness and exhaustion occurring in these family caregivers. Since their social and leisure activities are restricted due to the mental illness, these family members may feel isolated from the society. They may find it difficult to fit in, and most will stay away altogether from all community affairs, thus increasing their feelings of being isolated and alone. Sometimes, there are high hopes that the mental illness will be cured in the initial stages of the illness, but this will go down gradually, when the sick does not show signs of improving. He also reported that most caregivers have little or no knowledge on mental illness as they start caring for their sick relative. They are therefore forced to come up with coping strategies, a lot of times employing trial and error. They may apply emotion-focused strategies such as avoidance, denial or looking to religion for help and strength when it becomes difficult dealing with the demands of taking care of their loved one. Others may take up problem-focused approaches where they come up with direct actions to solve or deal with the demands of caring for the mentally ill. These coping strategies are what will constitute their resilience.

The term resilience is taken from the physics of materials, the property of a material that enables it to resume its original shape or position after being bent, stretched or compressed. In psychiatry, resilience stands for the capacity of an individual to recover from extremes of trauma and stress. Resilience in a person reflects a dynamic combination of factors that encourages positive adaptation despite exposure to adverse life experiences, such as living with a mentally ill relative. Resilience is associated with mental health and is considered to be an essential component of successful psychosocial adjustment.

On the basis of cross-cultural resilience studies, Ungar (2008) portends that in the context of exposure to adversity, whether environmental, psychological or both, resilience has to do with the capacity of individuals to navigate their way to health-sustaining resources. Care-giving for the mentally ill exposes the families to various forms of distress, and they have to come up with ways of remaining psychologically healthy. It is this conceptualization of resilience that framed this study, in terms of how the psychological aspects (perceptions and attitudes) of family members, the support they receive (social aspect) influence their resilience as they live with family members who have mental illness.

1.2 Statement of the Problem

A combination of factors contributes to resilience, such as skills in communication and problem solving, the capacity to manage strong feelings, and a positive view of oneself among others. Many studies, however, reveal that the primary factor in resilience stems from having caring and supportive relationships both within the family and outside.

Relationships that create love and trust provide role models and offer encouragement and reassurance that help bolster a person's resilience.

Living with a member suffering from a mental illness is expected to cause significant stress to the family members, depending on several factors such as their attitudes and perceptions towards the mental illness. The social support they receive will also affect how they handle this stressful situation. In NyeriCounty, there are several families that are in distress, showing signs of stress due to poor coping skills against a situation of a family member with mental illness. There are no programs to train these families on building resilience that is based on psychosocial factors.

Studies on families living with mental illness have been conducted in the past but mainly the information is obtained from the impressions of clinicians who have worked with the families and not the family members themselves. This study therefore seeks to investigate selected psychosocial influences; perceptions of the family members towards the mentally ill, their attitudes, the social support they receive and how these affect their resilience as they take care of their mentally ill relatives.

1.3 Purpose of the Study

The purpose of the study was to investigate selected psychosocial influences on the resilience of families living with a member with mental illness and to explore strategies that may be applied to enhance the resilience of families with a mentally ill member in Nyeri County.

1.4 Research Objectives

The study was guided by the following objectives:

1. To explore the extent to which the resilience of the family members is influenced by their perceptions towards the mentally ill member.

2. To find out to what level the resilience of the family members is influenced by their attitudes towards the mentally ill member.
3. To examine the extent to which the resilience of the family members of a mentally ill member is influenced by the social support given to them.
4. To explore resilient behaviour of families living with a mentally ill member in Nyeri County, Kenya.

1.5 Hypotheses of the Study

H_o**:** There is no statistically significant relationship between perceptions and the resilience of families living with a member with mental illness in Nyeri County, Kenya.

H_o:There is no statistically significant relationship between attitudes and the resilience of families living with a member with mental illness in Nyeri County, Kenya.

H_o:There is no statistically significant relationship between social support received by family members living with mental illness and their resilience, in Nyeri County, Kenya.

1.6 Justification of the Study

The findings of the study are expected to recommend ways through which the psychosocial welfare of family members living with mental illness may be enhanced. On the basis of these findings, those in the health sector, who are the policy makers, are expected to be sensitized on the plight of families living with a member with mental illness. This should stimulate efforts to design and implement policies to address their needs, such as the training, counseling, capacity building as well as provision of alternative care for persons with mental illness.

The findings of the study are also expected to be useful to the field of counseling psychology since they will fill the knowledge gap that exists as far as psychosocial influences on the resilience of the families caring for the mentally ill is concerned and consequently inform the approaches that would be taken in counseling. The findings of this study can also form a basis for future research, since it will expose areas that may require further investigations regarding living with mental illness.

The community is also expected to benefit from the findings of the study through sensitization on the status, experiences and the unique needs of family care givers living with members with mental illness. Consequently, the stigma expressed to the family care givers living with mental illness is expected to be minimized. The family care givers are expected to benefit from the findings of the study by being equipped with effective strategies of coping with the demands and the stigma that come with having a member with mental illness in the family.

1.7 Assumptions of the Study

The study was based on the following assumptions:

1. That the perceptions of family members towards a member with mental illness influence their resilience.
2. That the attitudes of family members towards a member with mental illness influence their resilience.
3. That the social support received by families living with a member with mental illness influences their resilience.

1.8 Scope and Delimitations of the Study

This study was undertaken in Nyeri County, Kenya. Family members living with one of their members who suffer from a mental illness participated in this study. It focused on how the psychosocial aspects of perceptions, attitudes and social support influence the resilience of the family members. An in-depth exploration of their attitudes and perceptions towards mental illness was explored, as well as the social support they receive from those around them. This was done by use of questionnaires, in-depth interviews as well as a narrative interview.

1.9 Limitations of the Study

The study was carried out in only one out of the 47counties in Kenya due to limitations occasioned by the intensive nature of the study and as such; it may not have captured the scenario in the entire country due to variations in conditions and circumstances affecting families living with mental illness. Further, due to the sensitivity and emotional nature of the subject matter of the study, the subjects may not have provided entirely accurate and unbiased responses. These factors may limit generalization of the findings to the entire country.

1.10 Operational Definitions of Terms

Attitude: Refers to an expression of favor or disfavor toward a person living with mental illness by the family members.

Coping Mechanisms: These will refer to the adaptations to stress emanating from living with a member with mental illness by the family members, which enhances control on behavior or gives psychological comfort.

Mental Illness: Refers collectively to all diagnosable mental disorders; a health condition characterized by alterations in thinking. Will also refer to mood or behavior associated with distress or impaired functioning.

Mental Health: Refers to a psychological state of someone who is functioning at a satisfactory level of emotional and behavioral adjustment.

Perception: This is the belief or opinion held as well as the meaning given to a situation, in this case the mental illness of a family member.

Psychosocial influences: These are attitudes and perceptions (psychological) towards the mentally ill, as well as the social support (exchange of information with social networks such as churches, friends and extended family) received by family members.

Resilience: It is defined as an individual's ability to properly adapt to stress and adversity arising from the demands of caring for a person with mental illness. It also has to do with the capacity of individuals to navigate their way to health sustaining resources.

Social Support: This refers to the assistance available to the family members living with one of their members suffering from mental illness from other people, and the feeling that they are part of a supportive social network such as extended families, friends, and institutions such as churches that help the families cope with stressful circumstances and conditions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter discusses literature related to the study and also identifies the knowledge gaps that exist. The chapter discusses the past studies carried out on perceptions towards mental illness, attitudes towards mental illness, social support systems, and resilient behavior of families who live with a member with mental illness. The theoretical and conceptual framework for the study is also given.

2.2 Perceptions towards Mental Illness

As a result of the misunderstandings and myths associated with mental illness, mentally ill persons may be stigmatized and labeled in stereotypical names such as mad-men, morons, lunatics, maniac and psycho. According to WHO (2011), the major obstacles facing the mentally ill are stigma and discrimination and it is the shame and fear of these that prevent them from seeking treatment and care for their disorders. Stigma creates a hidden burden among the mentally ill, eventually resulting in unwillingness to seek help and thus delay in rehabilitation results.

Investigating current mental health perceptions is critical since it affects the nature of care the patients receive and also the effect on the care givers. Previous studies have time and again found different opinions regarding mental illness and psychotherapy. Whalley (2007) in a study in the USA found out that unemployment of people with mental illness is rampant resulting in them depending wholly on their relatives for upkeep and all their needs. It was also found that some communities strongly oppose the establishment of psychiatric facilities near their locality, seeing it as a bad omen. He notes that high unemployment rates among the mentally ill increases the burden on the patient’s relatives by denying them means of providing for themselves.

The perceptions held by family members will determine how they relate with the mentally ill relative. They may not be able to acknowledge the civil rights of the sick as they may try to conceal their relative’s mental illness or hospitalization. They may withdraw from social contact and as a result they may not access social support and other services that may be available in the society for the mentally ill. There is also the possibility of family members being unable to cope with the stress associated with the mentally ill, leading them to distance themselves and not be willing to assist them. When neglected, the mentally ill may end up on the streets and their chances of living normal lives may be very minimal as a result. Other family members may further aggravate the situation by making inappropriate or hurtful comments towards the mentally sick and may consider them as stupid or unreliable and blame them for family problems. These behaviours will not be effective in supporting the mentally ill or enhancing the resilience of the family members. The present study seeks to explore the perceptions of family members living with the mentally ill and the effects this may have on their resilience as they live with the mentally ill member.

Inadequate knowledge concerning the causes and manifestation of mental illness as well as devastating views is a concern in many countries, particularly the developing countries. Lack of adequate knowledge regarding mental illnesses is what has been found by different studies to be a key cause of destructive perceptions that people hold regarding mental illnesses. There are people who associate mental illnesses with being possessed with evil spirits, witchcraft or curses, and not as diseases .A study carried out in Tanzania to establish the knowledge of communities on mental illnesses revealed that the peoples’ understanding of mental illnesses was quite poor. Most people believe that the mentally ill are not able to perform regular jobs, maintain friendships or be integrated into the community. It was also found that some people held a mistaken belief based on religion that mental illnesses may be as a result of sin. They seem to believe that deliberately breaking God’s laws may result in behavior that is harmful to self as well as others (Chikomo, 2012).

A study was carried out in Kenya, and sought to determine the understanding and views towards mental illnesses among personnel in medical facilities. It was found that, despite the staff’s awareness on recognition, diagnosis and management of mental illnesses, most of them still held cultural views about mental illnesses. Many still held the view that mentally ill persons are of no value to the society or their families. Others said that mentally ill persons are dirty, senseless, and dangerous, thus cannot be trusted. Others held the view that they are erratic and it is difficult to predict their behaviour, or plan for them. Family members are likely to hold similar views, greatly affecting how they live with their mentally ill relatives. The negative attitudes that society has towards the mentally ill persons lead to behaviors that may worsen the state of the sick person (Ndetei, Khasakhala, Mutiso, Mbwayo, 2011).

2.3 Attitudes towards Mental Illness

In the Western world, it is largely believed that mental illnesses are usually caused by psychosocial factors such as experiences during childhood or the social surroundings that one grows up in. Such experiences as abuse, both physical and emotional in the early years of a child’s life, may cause developmental problems that may result in emotional or mental problems in later life. Trauma or even bullying are also factors that may cause problems in individuals. Although biological factors areaccepted as contributing factors to mental illnesses, environmental factors are considered to be more important. Some studies done in Germany however, suggest that some severe mental illnesses, such as schizophrenia are more likely to be caused by genetic factors, while other common mental disorders, such as depression, are caused by environmental factors (Khan, Tahir, Khan, 2011). In Germany, Angermeyer and Dietrich (2006) conducted a literature evaluation of studies of public viewpoints and attitudes towards people with mental illness (PWMI) that were available between 1990 and 2004. Among the findings of the study were that mental illness usually disenfranchise people, reduce their position and make them powerless. Historical and studies across cultures have found that there is active discrimination and harassment of PWMI which accelerated their psychosocial dysfunction (Dols, 2002).

Views held on mental illness, usually determine the pattern of attitudes that will be directed towards the mentally ill by individuals. Several studies have found that beliefs held about the origin of mental illnesses may affect how one of seeks help, whether they follow up on treatment as well as how they respond to the treatment. A study conducted in Malaysia found that, people believed that mental illnesses were caused by supernatural agents, or were a result of possession by spirits or a result of witchcraft. There were those who hold the view that mentally ill persons are erratic and cannot be contained or understood, while others said that they can never lead normal lives. There were still others who said that mentally ill persons, even after treatment, should be isolated since they are violent and thus a danger to other people. Myths are also common where some said that psychiatric treatment causes brain damage as evidenced by patient’s robotic-like behaviour. These beliefs are likely to determine how mentally ill persons and their relatives seek help (Khan, Hassali, Tahir& Khan, 2011).

At the same time, improved awareness about mental illnesses, have been found to result in more positive attitudes towards mentally ill people. According to a survey carried out in Japan, problems in interpersonal relationships were found to contribute to the causes of mental illnesses, which indicate that they can be treated or managed through social interactions (Jorm, 2000). Those who believe that mental illnesses can be treated are more likely to seek early treatment or help, which may result in better outcomes for the sick as well as better attitudes from the family members and consequently better care from family members.

In Africa, numerous studies have been conducted to create understanding on the attitudes towards mental illnesses. A study carried out in Nigeria showed that lack of information about mental illness lead to negative attitudes towards the mentally ill. The fact that people lack knowledge on mental illness means that they are not able to assist their relatives who are sick and in most cases may neglect them and allow them to roam around the streets. Not realizing that medical attention could assist their relatives, they just watch helplessly as their loved ones get worse. The study found that the attitudes and beliefs of the general public determined the help-seeking behavior of mentally ill persons and their relatives (Kabir, Iliyasu, Abubakar&Aliyu, 2004).

Correspondingly, a study done in South Africa amongst the Afrikaan speaking, showed the following results; 83% were of the opinion that mental illnesses were caused by factors such as difficulties at work, family relationships, or stressful events in life (psychosocial stress), 42.5% held that mental illnesses are hereditary or the result of brain disease which can be hereditary (medical disorder).World Health Organization has accepted that, knowledge on the causes of mental illness is different in different cultures and in most cases is inadequate, and thus public education and more openness about mental illness is necessary. Improved knowledge on the causes of mental illness should lead the mentally to seek help to and promote helpful attitudes towards the mentally ill. Furthermore, adequate knowledge on mental illness can help in dealing with the negative attitudes that people may have towards those with mental illnesses (Chikomo, 2012).Therefore, negative viewpoints about causes of mental illnesses and lack of sufficient knowledge are known to be key causes of the negative attitudes that people hold regarding mental illnesses. Studies on the attitudes towards mental illnesses on family care-givers are generally lacking. This study therefore, seeks to explore the attitudes of family members towards the mentally ill in the locale of the study and how these attitudes influence their resilience as they live with the mentally ill.

2.4 Social Support Systems

Social support is an exchange of information by individuals, and accessing social support is an adaptive problem- focused strategy. It may be obtained from social networks or formal networks. Social networks include churches, friends and extended family while the formal networks are health care and educational institutions. Families have the responsibility of transitioning the treatment of their mentally ill relative from inpatient psychiatric care to taking care of them at home.

DiMatteo (2004) found a relationship between the social support received and the quality of life of patients with a mental illness as well as that of the care-givers. Those who received social support were found to be more accepting of their situations, were more resourceful, hardier and displayed a great progress in the quality of life of the family. Killaspy (2006) came to the conclusion that social support cushions against life events that are stressful, increases adherence to medical treatments and results in great improvement for those suffering from mental illness as well as other health benefits.

Perception of social support, even when it is actually not there, was found to be beneficial to those with serious mental illnesses. The psychological benefits include increased self-esteem, feelings of empowerment, optimal functioning, and higher quality of life which may result in recovery. Absence of social support on the other hand, has been linkedto more severe psychiatric symptoms such as poorer sense of self-esteem, lower levels of functioning and poor overall health and reduced possibilities for full integration into the community. Males and females were found to have different preferred source of social support, females benefiting more from integration into social networks (Quigley, 2003).

These studies do not indicate how the social support affects the care-givers or family members living with the mentally ill; this study therefore sought to evaluate the support systems available to the family members in the locale of the study, and how they influence their resilience.

2.5 Resilient Behavior of Families living with Mental Illness

Resilience has various definitions that cover biological, psychological as well as environmental processes. Normally, resilience is characterized by the existence of good outcomes even in adversity, sustained fitness under stress and includes fast recovery from trauma (Masten & Coatsworth, 2008). Resilience is seen not as a static trait, but as a dynamic progression that may change with time and different circumstances (Cicchetti&Toth, 2008). The terms “invulnerable” and “invincible” were used to describe people who were stigmatized but were able to adjust well. These terms give the idea of a static trait or characteristic found in people who are able to cope with stigmatizing situations and are not overwhelmed by the negative emotions projected to them due to their position or condition (Wyman, 2009).

Later, researchers have taken individual resilience as part of general developmental processes instead of looking at it in terms of invulnerability and invincibility, viewing it as a more dynamic aspect (Luthar, 2000). When resilience is defined as a process instead of a trait, a fuller picture with more dimensions helps us understand that certain aspects might produce resilience in a given social context, but not in another. It also means that in designing effective interventions, it may be necessary to teach or sustain skills or attributes that are specific to a given context.

An understanding of a family's adaptation and functioning helps us in accepting the family's efforts to manage the situations resulting from living with severe mental illness, and may indicate the family's efforts to achieve balance, consistency, and harmony. Family adaptation is observed as positive change and a successful sense of balance among the sick individual, the family care-givers, and community levels of performance (McCubbin&McCubbin, 2003).

It is expected that families constantly adjust as the illness or family situation changes to accommodate the person with mental illness. This adjustment and adaptation due to a chronic illness may affect the family emotional and physical well-being negatively and also impair family functioning (Rowat & Knafe, 2005). Severe mental illness is known to affect all aspects of family operations and family relationships and roles may be altered, sometimes permanently (Marsh, 2002). These changes may include; financial obligations, state of employment where one may be forced to change jobs or lose the job altogether, social life, physical well-being, marital relationships, and the carrying out of household activities. Saunders (2009) found that families taking care of a family member who is schizophrenic, if they used more problem-solving skills and coping strategies, they would function more competently as a family unit. Those who received adequate social support were found to experience less psychological distress and family related behavioral problems.

In general, investigations on how families living with severe mental illness adapt and function, has changed from the previous unhealthy, dysfunctional family to the healthy, functional family which constantly need to adjust and adapt accordingly. The unhealthy models of how families function are being replaced by a more positive outlook that identifies the characteristics of successful families which emphasize family flexibility, reliability, predictability, and harmony (Stinnett & DeFrain, 2005). It has also been found that chronic illnesses in a family may result in positive aspects within the family, such as improved family growth, closeness among the family members, and stability (Mishel, 2000).

Family members adopt various strategies to help them cope with the stress emanating from the demands of living with a person suffering from a mental illness. Coping strategies may take various forms, including; emotion-focused, problem focused and avoidant coping strategies. Emotion-focused coping involves changing one’s own emotional reaction, and may include releasing unexpressed emotions, looking for distractions, managing aggressive feelings, meditating as well as using relaxation techniques. It may also involve seeking social support, and seeking acceptance. The main aim of emotion-focused coping is to alter the meaning of that which brings stress or to remove attention away from it. Emotion-focused coping has varied styles but they all focus on reducing the negative emotions brought about by the stressor, and it is therefore action-oriented (Admiral, Korthagen, &Wubbels, 2000).

Problem-focused coping involves reducing or eliminating a stressor. The aim is to try and deal with what causes the problem by gathering information concerning the problem and then learning new ways of managing the problem. This strategy involves being able to manage and therefore it is the best way to cope since it reduces psychological distress (Bouteyre, Maurel, &Bernaud, 2007). Avoidant coping is on the other hand, a maladaptive mechanism characterized by the effort to avoid dealing with a stressor. When clinically depressed individuals apply this form of coping, they exhibit less improvement and greater dysfunction.

Holahan, Holahan, Moos, Brennan &Schutte (2005) carried out a ten year longitudinal study and found that those who applied avoidant coping at baseline were more prone to experience chronic and acute stressing situations when tested four years later and to display depressive symptoms in ten years. When applied, avoidant coping has been associated with greater psychological distress in general populations with no clinical issues and problem-focused approach found to be the most effective at reducing psychological distress (Wijndaele, Matton, Duvigneaud, Nefevre, Bourdeaudhui & Duquet, 2007).

In a qualitative study conducted to investigate the coping strategies of people with serious mental illness, it was found that out of 40 participants, 19 cited spiritual beliefs to have played a major role in their recovery. Spirituality was seen to provide some form of meaning to the unpredictability associated with their illness. The support from their congregations in form of prayers, and believing in a benevolent God combined to provide a positive emotion-focused coping strategy (Quigley, 2003).

Cultural factors also determine the coping strategies employed by individuals. Culture is related to the way people deal with everyday problems. The stress and concern of maintaining the image as expected by the cultural community usually have harmful effects on how an individual copes and may affect their health (Matthew, Dimsdale&Nelesen, 2005). Seeking social support has been found to be an effective way coping for people faced with high levels of stress. Such individuals reported fewer symptoms of anxiety and depression as a result of the social support received, as compared to people who did not(Crockett, Iturbide, Torres, McGinley, Raffaelli & Carlo, 2007). The demands of living with a mentally ill person are stressful; this study seeks to investigate the coping strategies that family members employ and how they influence their resilience, given that most studies record how the mentally ill cope with their illness and avoid relapse.

2.6 Theoretical Framework

A review of previous writings on invulnerability confirms that various theorists have attempted to explain the construct of resilience as well as its relationship with other constructs. The various theories advanced emphasize on resilience as a characteristic of an individual which determines how they respond to stress and adversity rather than a process. More contemporary models also talk about resilient functioning as a trait or a personality characteristic. This study adopted the Hardiness theory of resilience as well as the Attribution theory.

2.6.1 Hardiness Theory of Resilience

Hardiness theory was propounded by Kobasa in 1979 with an aim to explain psychosocial characteristics which moderate the stress-illness association and stress resilience (Wiebe & Williams, 1992). Hardiness is a factor that motivates and enables one to resolve stressful situations and be able to adapt and deal with health problems. Individuals who possess this distinct personality structure are able to remain healthy even when they experience high levels of stress (Jennings & Stagger, 1994).

Two major aspects from existential theory are relevant to hardiness and support the nature of the construct. The first is that personality is taken as a dynamic actively constructed process and that the stressful aspects of life can be turned into opportunities for growth in positive ways. Secondly, hardiness is made up of three factors that encompass cognitive and behavioral processes that cushion against stressful events and determines the way in which an individual reacts to them (Tartasky, 1993).

These three factors include commitment, control and challenge. Commitment has to do with a person’s ability to believe in their importance and their own value, to have confidence in the activities one is involved with, as well as involvement in all aspects of life in general. It is believed that this provides a sense of purpose which provides the courage to face stressful situations and to reduce the perceived threat. The control factor is explained as the ability to believe and to act as though one is able to influence events, and to provide explanations about events as they take place. It is expected that this allows people to have confidence that they can change the way events occur and manipulate stressors. The factor of challenge is grounded on the belief that the environment is not static and therefore provides opportunities for individuals to grow instead of having feelings of threat and insecurity. Hardy people are able to welcome challenge and convert it to a resource to enable them cope with any form of stress (Tartasky, 1993).

The construct implies that the presence of hardiness lessens the impact of stressful life events on the individuals who are described as being hardy unlike those who do not possess the attribute. This means that hardy individuals are able to remain healthy in the face of stressful conditions, especially in living with a serious illness, such as mental illness (Wiebe & Williams, 1992). Hardiness is also known to assist the individual’s coping response by giving them the courage to elicit appropriate social support required (Funk, 1992).

This theory informs this study appropriately since living with mental illness is expected to be stressful, but if family members develop hardiness, they can turn this into positive growing opportunities by incorporating the three factors of the theory. Incorporating the aspects of commitment and control in their care-giving would assist them in changing their perceptions on mental illness and thus influence their attitudes towards those who are mentally ill. Being hardy would also assist the family members in welcoming the challenge of living with the mental illness which will prompt them to acquire the appropriate social support that would assist them in coping.

2.6.2 Attribution Theory

The proponent of Attribution theory was Fritz Heider (1958), and it attempts to explain the mind process whereby individuals try to explain and draw conclusions regarding what causes events to occur. He differentiated between internal and external explanations that people give to explain events. Internal attributions are related to the characteristics of the individual, and may include; ability, attitudes, personality, mood, and effort, which are understood to have caused a particular behavior, while the external attributions are the external factors, such as the task involved, other people, or even luck, for being the cause of an event or a certain outcome to take place.

Earlier in his work, Heider considered the logical-empirical strength of attribution theories and made fairly global claims on the way people do things. He argued that people try to make sense of their social world in a systematic way, thus behaving like naïve psychologists. For Heider (1958), people actively interpret the events that occur in their lives, using consistent and logical ways of making sense of their interpretations. They do this in order to both understand and attempt to control the world around them.

Studies have examined the general class of attitudes and attributions which influence the perceptions towards the mentally ill as well as the opinions which represent the understanding of the general public about a variety of physical and psychiatric disease groups. These studies have identified the attitudes which are related to how the research participants rated a disease group on specific scales. Two categories of views were commonly found across samples. There are those who understand illness in terms of how severe it is, that is, how an illness relates to morbidity and the quality of life. The other category understood illness in terms of controllability, that is, if the person has anything to do with the onset of the disease and how they cope with it (Long, 1990). This second dimension of controllability was found to be related to the classification of illnesses, as physical and psychological-behavioral disorders. The main difference between these diseases is that the psychological behavioral disorders are believed to be under relatively more control of an individual (Crandall & Moriarty, 1995). This last dimension directly relates to the assumptions of attribution theory. Traditionally, mental illnesses were believed to be more stable, which rarely improve.

This theory is relevant to this present study because, the way the family members living with a member with mental illness will interpret the illness, will highly influence their attitudes towards the mental illness and how they take care of the sick individual. If for example they believe that the person brought the illness onto themselves, they are likely to think that they can control the symptoms, and this will affect how they react towards them. If on the other hand they believe that the mental illness cannot be treated, especially if they attribute it to witchcraft or evil spirits, then they may neglect them, believing that nothing can be done. These attributions will have an effect on their attitudes as well as their perceptions towards the mentally ill member of the family; consequently these will have an influence on the resilience of the care-givers.

2.7 Conceptual Framework

This section proposes a conceptual framework within which psychosocial factors influence resilience of family members living with a member who is mentally ill. It is expected that as families live with a mentally ill member, their attitudes and perceptions towards him or her, as well as the social support that they receive will have a bearing on the nature and level of the resilience of these family members caring for the mentally ill. Figure 1 displays the conceptual framework developed for the study.

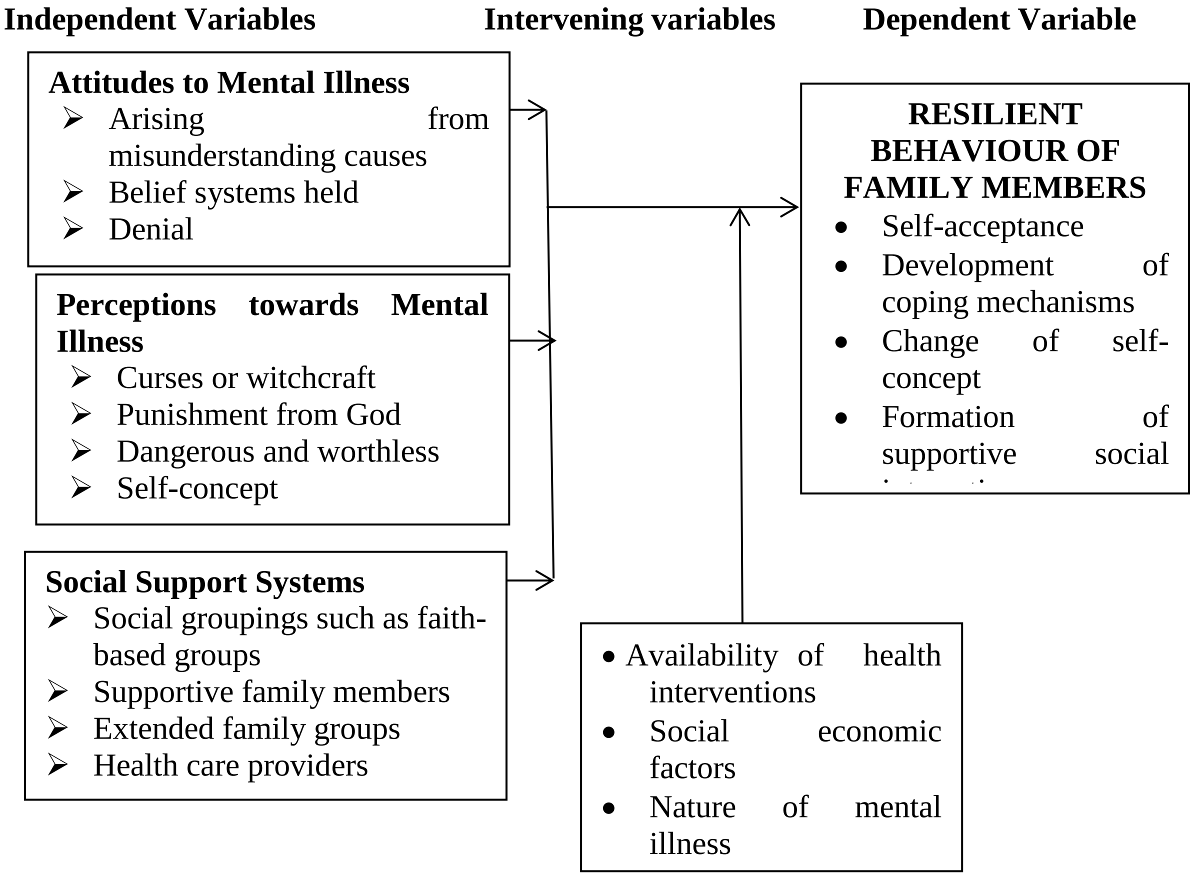

Figure 1:.Conceptual Framework for the Study
Source: Researcher (2016)

2.8 Summary and Study Gaps

Past studies and theories mainly deal with aspects to do with the mentally ill patient; such as how they cope with the illness and the social support they receive, in regard to their healing as well as chances of relapse. Most studies were also found to have collected data from the clinicians who work with the mentally ill at the medical facilities and not the family care-givers who live with their mentally ill relatives. Not much research has been carried out on the psychosocial influences on the resilience of the members of the family who take care of the mentally ill patient. In addition, the past studies are descriptive in nature and thus fail to examine the intricacies under which the family members who care for the mentally ill member operate. The present study carried out an in depth examination of the influences of selected psychosocial influences on the resilience of the family members using in-depth interviews in addition to the data collected using questionnaires.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter presents the methodological approaches adopted by the study and is organized in sections addressing the research design, location of the study, target population, sample and sampling procedures, description of research instruments, reliability and validity, data collection procedure, data analysis procedures and ethical considerations.

3.2 Research Design

The study adopted the *ex-post facto* research design. This design was appropriate for this study since the purpose was to examine how the independent variables have already affected the dependent variable. The researcher therefore examined how the perceptions and attitudes of family members towards mental illness, as well as the social support they receive as they live with the mentally ill influences their resilience. These effects have already taken place naturally without the researcher's manipulation on the process, which is what *ex-post facto* approach to research entails.

Biographical research design was also applied in which one family which has lived with a mentally ill member for over ten years was identified. Biographical research seeks to understand the changing experiences and outlooks of individuals in their daily lives, what they see as important, and how to provide interpretations of the accounts they give of their past, present and future (Denzel, 2000). For the purpose of this study, members of the identified family were interviewed to give their life story in relation to living with the member with mental illness.

3.3 Location of the Study

The research was conducted in Nyeri County. The Nyeri County Referral Hospital was purposively selected for this study since it has a well-organized psychiatric unit from which particulars of persons with mental illness was obtained.

3.4 Target Population

Population refers to all the individuals or elements that meet the sampling criteria (Burns & Grove 2005). According to records at the Nyeri County Referral Hospital, about 600 mentally ill patients visited the hospital each month. The target population was the immediate family members of the 600 mentally ill patients who had visited the hospital in the month preceding data collection.

3.5 Sampling Procedure and Sample Size

A sample is a small group obtained from the available population while sampling is a research technique used for selecting a given number of subjects from a target population as a representative of that population (Orodho, 2004). In this study, the sample size for the families to participate in the study was calculated based on Yamane's formula (Yamane, 1967).

$$n = \frac{N}{1 + Ne^2}$$

Where; n= the sample size

N = the size of population

e= the error margin

By using Yamane's formula for determining the sample size with an error margin of 5%, the calculation from a population of 600 families yields a sample size of 240 families.

Ten close family members, such as a spouse or a parent were purposively sampled to be interviewed. Criterion sampling was used to select one family that had lived with mental illness for over ten years and was therefore, rich in information and participated in the biographical study. The remaining 229 families completed the questionnaire. Table 1 shows the composition of the sample.

Table 1
Sampling Matrix

Instrument	**Sample size**	**Percentage Composition**
In depth interview Schedule	10	4.1
Narrative interview Schedule	1	0.4
Questionnaire	229	95.5
TOTAL	**240**	**100.0**

3.6 Description of Research Instruments

The study used two research instruments; questionnaires and semi-structured interview guides prepared by the researcher. Semi-Structured interview guides had a set of questions that guided the interview but not dictated it. The questions for the close family members sought to bring out their experiences as they live with the mentally ill member of the family; their perceptions about the mental illness, their attitudes towards the mentally ill, and the social support they receive from others. In order to allow the interviewer to concentrate, the sessions were tape recorded and a research assistant was engaged to capture other details regarding body language of the participating members as well as those of other family members who were present.

The questionnaires were administered to family members living with a mentally ill member and contained items on perceptions of family members about mental illness, attitudes towards mental illness, and the social support they received. Likert scale was used to quantify the extent to which the respondents agreed or disagreed with the set of statements given.

3.7 Piloting the Study Tools

It is important that the research instruments be piloted as a way of fine tuning them and testing their reliability. A pilot study was carried out from a similar sample drawn from the neighbouring Laikipia County. The results obtained from the pilot study were used to fine tune the research instruments.

3.8 Reliability and Validity

3.8.1 Reliability

Reliability is an examination of the stability or consistency of the responses given by the participants. Reliability is also concerned with the researcher’s ability to collect and record information accurately. The researcher increased the consistency of the study by documenting all procedures and setting up a detailed protocol. Transcripts were also checked for any errors, and it was ensured that there were no drifts in definitions of codes or their applications during the coding process. Test retest method was used to examine the reliability of the questionnaire. The questionnaire was administered twice within duration of two weeks to a sample consisting of 10% of the sample used for the final study and two sets of completed questionnaires obtained. The two sets of completed questionnaires were correlated to obtain the reliability index (α). A reliability index o α=0.751 was obtained, which was considered adequate (Mugenda & Mugenda, 2003).

3.8.2 Validity

Validity is concerned with the accuracy and truthfulness of research findings. Qualitative validity is based on determining if the findings are accurate from the standpoint of the researcher, the participant or the readers. This can also be referred to as the credibility, the quality, rigor or trustworthiness of the research. Researcher bias is a major threat to validity, since invalid information may result from the perspective the researcher brings to the study.

This study enhanced validity by focusing on building participant trust in order to access more detailed and honest data, as well as spending enough time in the field to give the researcher time to clarify information. Member checking also gave the participants a chance to correct any errors of facts or errors of interpretation. Validity of the research instruments was ensured by making any corrections as was found necessary after the pilot study.

3.9 Data Collection Procedure

After obtaining a letter of introduction from Mount Kenya University, the researcher applied for a research permit from the National Commission for Science, Technology and Innovation (NACOSTI).Authority to collect data in the county was also obtained from the Nyeri County Commissioner, the County Director of Education and the County Director of Health. The researcher visited the Nyeri County Referral Hospital where a sample was taken from the records of those who had visited the facility in the previous month. Arrangements were then made with the sampled families on when to visit their homes for data collection. On arrival to the homes, rapport was created with family members involved, explaining the purpose of the study before administering the questionnaires to them or conducting the interviews.

The in- depth interviews, which were audio taped, lasted about 55 to 60 minutes for each family member, and were conducted at the homes where the families lived with the mentally ill persons, since people usually feel most comfortable in a familiar setting. At the beginning of the interviews, the researcher concentrated on putting the respondents at ease to enable them feel comfortable before the substantive areas of the interview guide were introduced. The principal investigator moderated the interview while the research assistant mainly controlled the environment including note taking, operating the audio recorders and taking care of any interruptions. Critical observations of non-verbal reactions were noted during and after the interviews making sure that most important information was collected. Field notes were taken which were blended with the recorded data during analysis.

For the family taking part in the biographical research, narrative interview was used, in which a very close family member was interviewed, in this case the husband of the mentally ill. In the first part of the interview, the interviewee was asked, by means of an initial question to give a full narration of events and experiences from living with the mentally ill. This narrative was not interrupted by further questions but was encouraged by means of non-verbal and paralinguistic expressions of interest and attention. The interviewee was given space to emphasize what is important to them and to structure the narration on his or her own terms. In the second part of the interview, the interviewee was questioned in order to elaborate on topics and events already mentioned as well as other issues that may not have been addressed in the free narration. These interviews were also tape-recorded to be transcribed later for analysis.

3.9 Data Analysis Procedures

Audio-taped data from in-depth interviews were transcribed verbatim in the original vernacular language in full, capturing all the words spoken, including false starts, significant pauses, laughs or any other features. This was then translated by an expert to help reduce researcher bias. To make sure that the data is transcribed correctly, the transcripts were checked against the tape recording. After transcription the bulk of interview transcripts were printed to get the hard copy on which the analysis was based.

Interview notes and ideas were jotted down and the transcripts were read several times so that the researcher can grasp the global sense of the descriptions. In the next step, meaning units were constituted which helped to clarify implicit matters to an extent that is not possible from a holistic perspective. Comments were assigned for each meaning units at the margins of the transcripts. These comments were attempts at summarizing or paraphrasing, notes of associations that came to mind or may have been preliminary interpretations. Emerging theme titles were also noted on the other margin.

After recording the themes in the sequence in which they came up in the transcripts, the researcher looked for connections and made a more analytical order of the themes. In the process, some themes clustered together while others emerged as super-ordinate concepts. This process was repeated for each participant and a final table of super-ordinate themes was constructed.

In both margins of the hard copies of the transcripts, the patterns were jotted in a crystallized meaning (condensed meaning) which were then transferred in a different sheet of paper for further analysis. Memos were used to summarize the patterns of the condensed meaning before transferring to the master paper sheet. To identify the source of data in the memo and in the text, identification (ID) numbers of informants were used when transferring the condensed meaning to the master paper sheet, so that the source could be easily traced and accessed. In this sheet of paper, coding schemes were developed with the abstracted categories and themes. Different categories, condensed meaning units or codes were compared for underlying meaning and relationships at the interpretation level which formed the themes. In the final stage, the themes were translated into a narrative account in which the themes were explained and illustrated and presented in a strategy that linked to the literature and the objectives of the study.

Analysis of the narrative interview was done by reconstruction of the life history by carrying out a microanalysis of individual text segments. Contrastive comparison of the life history (the experienced life) and the life story (narrated life) was done in order to transform the implicit issues to the explicit especially with respect to psychological meaning. This transformation allowed the analysis to reveal meanings that were lived but not necessarily clearly articulated or in full awareness.

The researcher's data analysis also included the use of inferential statistics. The data obtained from the respondents, which provided indicators for each of the objectives were analyzed using percentages, mean and standard deviation in order to establish the relationship between variables. Pearson chi-square tests were also used to test the association between gender of the respondents as well as the duration of time they had lived with the mentally ill, and their perceptions and attitudes towards their mentally ill relatives. Linear regression analysis of the effect of each independent variable on the dependent variable was worked out as a way of assessing the relationship between the variables. Analysis of variance (ANOVA) was carried out to test the statistical significance of each of the independent variables on the dependent variable and thus test the hypotheses.

3.10 Ethical Considerations

In the process of carrying out the research, the participants were protected from any harm or loss and their psychological well-being and dignity was preserved. They were fully informed about the research procedure and were asked to give their consent before data collection took place. Honesty was observed in reporting the findings whereby there were no manipulations or undue assumptions. The responses gathered were treated with utmost confidentiality to protect the respondent's privacy. The respondents were also assured that the results obtained would be used for research purposes only, and that they would have access to any publications arising from the study.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.1 Introduction

This chapter discusses the data analysis and findings from the questionnaires completed as well as from the conducted interviews. The data from the questionnaires were statistically analyzed using inferential statistics with aid of the SPSS version 23 program. The response rate and the characteristics of the sample are given in the first section, followed by the empirical findings of the study and discussion of the findings.

4.2 Response Rate

A total of 229 questionnaires were distributed and 11 interviews conducted. 187 questionnaires were returned and all the in-depth and narrative interviews were conducted. The total response rate was therefore 82.5%.

Table 2
Response Rate

Instrument	**Sample size**	**Response rate**
In depth interview Schedule	10	10
Narrative interview Schedule	1	1
Questionnaire	229	187
TOTAL	**240**	**198**

According to Edward (2000) a response rate of 80% and above is absolutely satisfactory while 60-80% is quite satisfactory. A rate below 60% is barely acceptable. This response rate of 82.5% obtained in the present study was therefore considered sufficient to credence the findings.

4.3 Sample Demographics

4.3.1 Gender of the Respondents

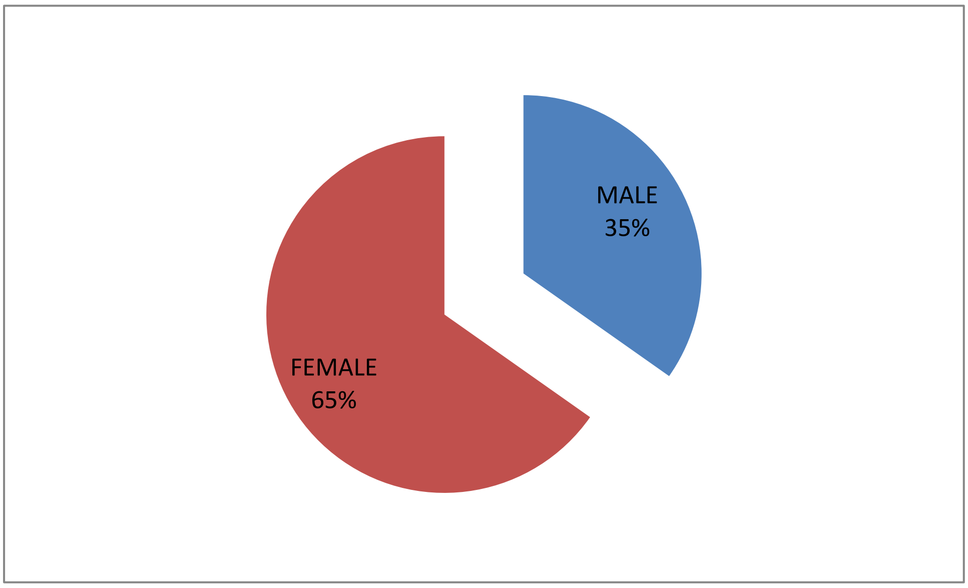

Figure 2. Distribution of Respondents by Gender

The sample comprised of 122(65.2%) female and 65(34.8%) males. This indicates that more women than men act as care givers for family members living with mental illness. In most cultures, females are socialized into care-giving. In general, more women than men act as care-givers for their children and so are more likely to be the ones taking care of other dependent relatives as well.

4.3.2 Length of experience with a family member with mental illness

The study further sought to establish the length of experience of the family members living with a member with mental illness. Figure 3 displays the results obtained.

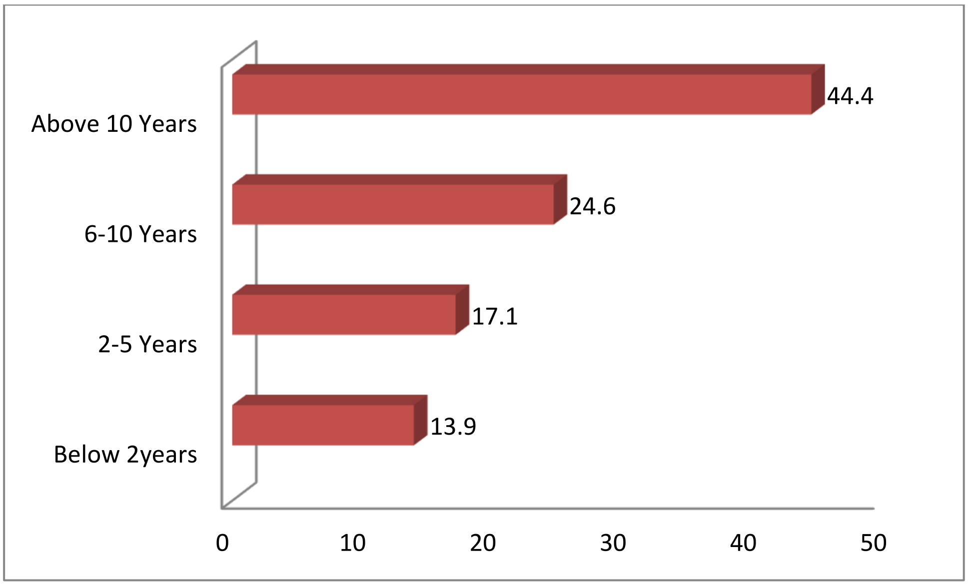

Figure 3.Distribution of Respondents by length of experience with a mentally ill member

Analysis of the distribution of respondent's sample by the number of years of experience living with a family member with mental illness indicated that all clusters of years were represented with majority of the respondents 83(44.4%) had more than 10 years. Only 26(13.9%) of the respondents had an experience of less than 2 years living with a family member living with mental illness. The distribution of the sampled respondents indicated that majority of the respondents in the sample had relatively long term experience living with a member with mental illness and were therefore experienced enough to be able to provide reliable responses.

4.4 Perceptions of Family Members towards Mentally Ill Member

The first objective of the study was to explore how the perceptions of families towards a member with mental illness influence their resilience. To achieve this objective, the researcher used a set of statements and asked the respondents to indicate the extent to which they agreed or disagreed with them. Table 3 displays a summary of the responses obtained. The researcher used five statements as indicators of the perception of family members towards the member living with mental illness and a likert scale against each statement to measure the extent to which the respondents agreed or disagreed with the statement. The magnitude of the influence was measured on the likert Scale of 1-5 where 1- strongly agree, 2- Agree, 3- neutral,4- disagree, and 5- strongly disagree. The average of the responses obtained for each statement was computed and the mean was used to ascertain the extent to which the respondents agreed or disagreed with the statement. Interpretation of the range of the means obtained for each statement was done as follows: 1-1.5 implied strongly agree; 1.6-2.5 implied agree; 2.6-3.5 implied neutral; 3.6-4.5: implied disagree and 4.6 - 5.0: implied strongly disagree.

Table 3
Perceptions of Family Members towards Mentally Ill Member

KEY: SA=Strongly Agree, A=Agree, N= Neutral,D=Disagree, SD=Strongly Disagree

Statement	**Extent of agreement or disagreement (%)**					**Mean**	**Std. Deviation**
	SA(1)	**A(2)**	**N(3)**	**D(4)**	**SD(5)**		
B1. Mental illness is as a result of a curse to the family members	17.1	21.9	21.4	39.6	0.0	2.834	1.131
B2. Mental illness originates from witchcraft/ sorcery/ black magic	0.0	17.1	21.9	21.9	39.0	3.829	1.128
B3. Mental illness is a form of punishment for a sin committed/ a bad omen	0.0	17.1	21.4	39.6	21.9	3.663	1.005
B4. Mentally ill persons are dangerous and should be avoided	0.0	17.1	21.4	21.4	39.6	3.834	1.131
B5. Mentally ill persons are worthless, dirty and senseless	17.1	21.9	0.0	61.0	0.0	4.096	1.467

4.4.1 Perception of mental illness as a result of a curse in the family

Descriptives displayed on Table 3 indicate that majority of the respondents neither agree nor disagree with the statement that mental illness is as a result of a curse to the family members($\bar{x} = 2.834$, sd=1.131) however still an appreciable proportion of the respondents; cumulatively 39% agreed with the statement. The findings thus imply that although a proportion (21.4%) of the respondents are neutral about the presence of mental illness in the family being a curse, there is a general perception that mental illness could be as a result of a curse to the family.

The study further sought to establish whether the perception of mental illness to be a result of curse in the family differed across the duration the family members had lived with the mentally ill. Tables 4 and 5 summarize the results obtained.

Table 4
Duration of living with the patient and perception of mental illness as a curse

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	16	2	0	6	24
2-5 Years	9	9	2	9	29
6-10 Years	0	2	30	6	38
More Than 10 Years	17	30	0	49	96
Total	**32**	**34**	**32**	**70**	**187**

According to the information displayed on Table 4, majority of the respondents 49(51%)who had lived for more than 10 years with the mentally ill family members do not perceive mental illness to be as a result of a curse in the family. On the other hand, the majority of the family members 18(75%) who had lived for a short time with the mentally ill member perceive mental illness to be as a result of curse in the family. The findings indicate that families, after living for a long time with the mentally ill member, seem to change their perception that mental illness is as a result of curse in the family. Those who have lived for a short duration with the mentally ill appear quite unsure about the cause of the mental illness.

Table 5
Chi Square test for duration of living with mental patient and perception of mental illness as a curse

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	187.449[a]	9	.000
Likelihood Ratio	190.017	9	.000
Linear-by-Linear Association	.016	1	.898
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 5 indicates that $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the perception that mental illness is a result of curse in the family. Further, the findings have indicated that the more the time spent with the mentally ill family members, the greater the tendency to adopt the perception that mental illness is not a result of curse in the family.

Further, the study sought to establish whether gender of the respondents was associated with the perception of the mental illness as a result of curse in the family. Table 6 presents the results obtained.

Table 6
Gender of Respondents and perception of Mental illness as a curse

		Mental illness as a curse				
		Strongly Agree	Agree	Neutral	Disagree	Total
Gender of Respondent	Male	17	16	19	32	84
	Female	15	25	21	42	103
Total		**32**	**41**	**40**	**74**	**187**

According to the information presented in Table 6, the perception that mental illness is a result of curse in the family is more prevalent among the male respondents (39%) than among female respondents (38%). The results however indicate that the disparity in the perception across the genders is marginal.

Pearson test for association was used to test whether there was any plausible association between gender and the perception of the respondents about mental illness and curse in the family. The results were as summarized in Table 7.

Table 7
Chi Square Test for Association of Gender of Respondent and Perception of Mental illness as a Curse

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.638[a]	3	.651
Likelihood Ratio	1.639	3	.651
Linear-by-Linear Association	.281	1	.596
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 7 indicates that p>0.05 which implies that there is no association between gender and the perception that mental illness is a result of curse in the family. The findings thus indicate that there is no significant difference in the wayboth males and females perceive the relationship between mental illness and curse in the family.

4.4.2 Perception of mental illness as a result of witchcraft/ sorcery or black magic

Descriptives displayed on Table 3 shows the perceptions of family members as to whether mental illness originates from witchcraft/ sorcery or black magic. Majority of the respondents disagree with this statement($\bar{x} = 3.829$, sd=1.128) and only 17.1% of the respondents agree with the statement. This implies that generally, the respondents do not perceive mental illness to be as a result of witchcraft, sorcery or black magic.

The study further sought to establish whether the perception of mental illness to be a result of curse in the family differed across the duration the family members had lived with the mentally ill. Tables8 and 9 show the results obtained.

Table 8

Duration of living with the patient and perception of mental illness as a result of witchcraft/ sorcery or black magic

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	6	2	6	10	24
2-5 Years	9	9	7	4	29
6-10 Years	0	0	12	26	38
More Than 10 Years	17	30	28	21	96
Total	**32**	**41**	**43**	**61**	**187**

According to the information displayed on Table 8, all the respondents 38(100%)who had lived for 6-10 years with the mentally ill family members do not perceive mental illness to be as a result of witchcraft/ sorcery or black magic. On the other hand, the majority of the family members 10(42%) who had lived for a short time with the mentally ill member also do not perceive mental illness to be as a result of witchcraft/ sorcery or black magic. The findings indicate that there is no significant disparity across the length of time lived with the mentally ill member on the perception that mental illness is as a result of witchcraft/ sorcery or black magic.

Table 9

Chi Square test for duration of living with the mentally ill patient and perception of mental illness as a result of witchcraft/ sorcery or black magic

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	84.931[a]	9	.070
Likelihood Ratio	99.124	9	.083
Linear-by-Linear Association	.275	1	.600
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 9 indicates that p>0.05 which implies that there is no association between the length of time lived with the mentally ill family member and the perception that mental illness is a result of witchcraft/ sorcery or black magic implying that all respondents perceived the relationship between mental illness and witchcraft/ sorcery the same way.

Further, the study sought to establish whether gender of the respondents was associated with the perception of the mental illness as a result of witchcraft/ sorcery or black magic. Table 10 presents the results obtained.

Table 10

Gender of Respondent and the perception of Mental illness as a result of witchcraft/ sorcery or black magic

		Mental illness a result of witchcraft				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	16	18	33	84
	Female	15	25	23	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 10, the perception that mental illness is a result of witchcraft in the family is more prevalent among the males (52%) than among women (15%). These results indicate that the disparity in the perception across the genders is appreciable, considering only the percentages.

Pearson test for association was used to test whether there was any significant association between gender and the perception of the respondents about mental illness and witchcraft. The results were as summarized in Table 11.

Table 11
Chi Square test for association of Gender of Respondent and Perception of Mental illness as a Result of Witchcraft/ Sorcery or Black Magic

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.466[a]	3	.690
Likelihood Ratio	1.467	3	.690
Linear-by-Linear Association	.117	1	.732
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 12 indicates that $p>0.05$ which implies that there is no statistically significant association between gender and the perception that mental illness is a result of witchcraft. It is therefore concluded that according to the findings, both genders perceive witchcraft as a cause of mental illness in the family in the same way.

4.4.3 Perception of mental illness as a form of punishment or a bad omen

Descriptives displayed on Table 3 indicate that a small number of the respondents($\bar{x} = 3.663$ sd=1.005) do not view mental illness as a form of punishment or a bad omen. However, an appreciable proportion of the respondents, cumulatively (38.5%) view mental illness in a family as a form of a punishment being meted on the family or a bad omen.

The study further sought to establish whether the perception of mental illness to be as a form of punishment or a bad omen differed across the duration the family members had lived with the mentally ill. Tables12 and 13 summarize the results obtained.

Table 12

Duration of living with the patient and perception of mental illness as a form of punishment or a bad omen

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	16	0	6	2	24
2-5 Years	9	2	9	9	29
6-10 Years	20	18	0	0	38
More Than 10 Years	17	0	49	30	96
Total	**59**	**20**	**74**	**41**	**187**

According to the information displayed on Table 12, all the respondents 38(100%)who had lived for 6-10 years with the mentally ill family members do not perceive mental illness to be as a form of punishment or a bad omen. On the other hand, the majority of the family members 16(67%) who had lived for a short time with the mentally ill member perceive mental illness to be as a form of punishment or a bad omen while only 17(18%) of those who had lived with the mentally ill member for more than ten years perceived the mental illness as a punishment. The findings indicate that there is significant disparity across the length of time lived with the mentally ill member on the perception that mental illness is as a form of punishment or a bad omen.

Table 13

Chi Square test for duration of living with the mentally ill patient and perception of mental illness as a form of punishment or a bad omen

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	187.449[a]	9	.000
Likelihood Ratio	190.017	9	.000
Linear-by-Linear Association	5.044	1	.025
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 13, $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the perception that mental illness is a form of punishment or a bad omen implying that although respondents in all categories perceived mental illness as a punishment or a bad omen, less of those who had lived with the mentally ill for a long time viewed the illness as a punishment than those who had lived with them for a shorter period. The perception that mental illness is a form of punishment or a bad omen is thus viewed differently across the different categories of length of stay with the mentally ill.

Further, the study sought to establish whether gender of the respondents was associated with the perception of the mental illness as a form of punishment or a bad omen. Table 15 presents the results obtained.

Table 14

Gender of Respondent and Mental illness as a form of punishment or a bad omen

		Mental illness a result of witchcraft				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	16	18	33	84
	Female	15	25	23	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 14, the perception that mental illness is a result of witchcraft in the family is more prevalent among the males (52%) than among women (15%). These results indicate that the disparity in the perception across the genders on the issue of witchcraft as a cause of mental illness is appreciable.

Pearson test for association was used to test whether there was any significant association between gender and the perception of the respondents about mental illness as a form of punishment or a bad omen. The results were as summarized in Table 15.

Table 15

Chi Square Test for Association between Gender of Respondent and the Perception of mental illness as a form of punishment or a bad omen

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	25.281	3	.000
Likelihood Ratio	162.494	183	
Linear-by-Linear Association	187.775	186	

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 15 indicates that p<0.05 which implies that there is an appreciable association between gender and the perception of mental illness as a form of punishment or a bad omen. Further, the findings have indicated that both genders perceive mental illness and witchcraft in the family in the differently, the male respondents viewed mental illness as a form of punishment more than the female respondents. The result from the chi square test confirms the descriptives in Table 15.

4.4.4 Perception that the mentally ill family members are dangerous

The study also sought to establish if the members viewed the mentally ill as dangerous and should thus be avoided. Majority of the respondents($\bar{x} = 3.834$, sd=1.131) did not agree with the statement that mentally ill persons are dangerous and should be avoided, however, a sizable proportion (17.1%) of the respondents were of the view that mentally ill persons are dangerous and should be avoided.

The study further sought to establish whether the perception of the mentally ill family member to be dangerous differed across the duration that the family members had lived with the mentally ill. Tables16 and 17 summarize the results obtained.

Table 16
Duration of living with the patient and perception of the mentally ill member to be dangerous

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	6	16	0	2	24
2-5 Years	9	7	2	11	29
6-10 Years	0	0	22	16	38
More Than 10 Years	17	28	0	51	96
Total	**32**	**51**	**44**	**60**	**187**

According to the information displayed on Table 16, majority of the respondents 51(53%)who had lived for more than 10 years with the mentally ill family members do not perceive mentally ill family member to be dangerous. On the other hand, the majority of the family members 22(92%) who had lived for a short time with the mentally ill member perceive mentally ill family member to be dangerous. For those who had been with the mentally ill for between 2-5 years, 55% agreed that the mentally ill are dangerous while only 37% did not view them as such. Majority of the category of those who have lived for between 6-10 years were neutral on this perception, they neither agreed nor disagreed with this statement. The findings indicate that families who live for a long time with a mentally ill member gradually change their perception that the mentally ill member is dangerous.

Table 17
Chi Square test for duration of living with the mentally ill patient and perception of mentally ill member to be dangerous

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	179.943[a]	9	.000
Likelihood Ratio	182.736	9	.000
Linear-by-Linear Association	1.176	1	.278
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 17 indicates that $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the perception that the mentally ill family member is dangerous. Further, the findings have indicated that the more the time spent with the mentally ill family members, the greater the tendency to adopt the perception that the mentally ill member is not dangerous.

Further, the study sought to establish whether gender of the respondents was associated with the perception of the family members whether the mentally ill member is dangerous. Table 18presents the results obtained.

Table 18

Gender of Respondent and perception of the mentally ill to be dangerous

		Mentally ill are dangerous people				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	27	18	19	20	84
	Female	15	23	21	44	103
	Total	**42**	**41**	**40**	**64**	**187**

According to the information presented in Table 18, the perception that the mentally ill members are dangerous is more prevalent among the males (63%) than among the females (54%). The results however indicate that the disparity in the perception across the genders is marginal.

Pearson chi square test of association was used to test whether there was any plausible association between gender and the perception of the respondents on whether the mentally ill are dangerous. The results were as summarized in Table 19.

Table 19

Chi Square Test for Association between Gender of Respondent and perception that mentally ill members are dangerous

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.569[a]	3	.666
Likelihood Ratio	1.567	3	.667
Linear-by-Linear Association	1.102	1	.294
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 19 indicates that $p>0.05$ which implies that there is no statistically significant association between gender and the perception that mentally ill family members are dangerous. Further, the findings have indicated that both genders perceive mentally ill members to be dangerous in the same way.

4.4.5 Perception that mentally ill family members are worthless, dirty and senseless

The study sought to establish the respondents' view on whether the mentally ill family members were worthless, dirty and senseless. Majority of the respondents, 61% disagreed with the statement and only 17% agreed that the mentally ill were worthless, dirty and senseless($\bar{x} = 4.096$, sd=1.467)

The study sought to establish whether the perception that mentally ill family members are worthless, dirty and senseless, differed across the duration the family members had lived with the mentally ill. Tables20 and 21 summarize the results obtained.

Table 20
Duration of living with the patient and perception that mentally ill family members are worthless, dirty and senseless

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	12	24
2-5 Years	9	7	13	29
6-10 Years	0	3	35	38
More Than 10 Years	17	28	51	96
Total	**32**	**44**	**111**	**187**

According to the information displayed on Table 20, 45(47%) of those who had lived with the mentally ill for more than ten years,and12(50%) who had lived for a short time with the mentally ill member perceive mentally ill family members to be worthless, dirty and senseless. The findings indicate that there is no significant disparity across the length of time lived with the mentally ill member on the perception that mentally ill family members are worthless, dirty and senseless.

Table 21
Chi Square test for duration of living with mental patient and perception of mentally ill family members as worthless

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	33.654[a]	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases	187		

a. 2 cells (16.7%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 21 indicates that $p<0.05$ which implies that there the association between the length of time lived with the mentally ill family member and the perception that mentally ill members are worthless, dirty and senseless is statistically significant.

Further, the study sought to establish whether gender of the respondents was associated with the perception of the mentally ill family members to be worthless, dirty and senseless. Table 22 presents the results obtained.

Table 22
Gender of Respondent and perception that mentally ill family members are worthless, dirty and senseless

		Strongly Agree	**Neutral**	**Disagree**	**Strongly Disagree**	**Total**
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 22, the perception that mentally ill family members are worthless is more prevalent among the females (63%) than among males (42%). The results however indicate that the disparity in the perception across the genders is appreciable.

Pearson chi test for association was used to test whether there was any significant association between gender and the perception of the respondents about the mentally ill members being worthless, dirty and senseless. The results were as summarized in Table 23.

Table 23
Chi Square Test for Association between Gender of respondent and Perception that Mentally ill family members are worthless, dirty and senseless

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654a	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases			

According to the information on Table 23 indicates that p<0.05 which implies that there is an appreciable association between gender and the perception that mentally ill family members are worthless, dirty and senseless.

To test the relationship between perceptions towards mental illness and the mentally ill and resilience, linear regression was used where respondent's perceptions towards mental illness, the independent variable(IV) was regressed against resilience of family members, dependent variable(DV). The results were as summarized in Tables 24.

Table 24

Model Summary of perceptions towards mental illness (IV) and resilience DV)

Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.327[a]	.107	.102	.39305
a. Predictors: (Constant), B5				

Table 24 shows the Model Summary of perceptions towards mental illness (IV) and resilience (DV). The value of R^2 was used to quantify the extent to which perceptions of the family members towards mental illness influence their resilience in caring for the mentally ill member. The findings of the study indicated that R^2=0.107 which implies that the perceptions of family members towards mental illness and the mentally ill member predict a 10.7% of the variation in their resilience in caring for the mentally ill member. This implies that perceptions towards mental illness and the mentally ill family member have a relatively high impact on their resilience in caring for the mentally ill member.

Table 25

ANOVA of perceptions towards mental illness (IV) and resilience (DV)

Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	Regression	3.430	1	3.430	22.203	.000[a]
	Residual	28.581	185	.154		
	Total	32.011	186			
a. Predictors: (Constant), B5						
b. Dependent Variable: E1						

The study further sought to establish whether the impact of perceptions towards mental illness and the mentally ill on care giver’s resilience was statistically significant. Table 25shows the Analysis of Variance (ANOVA) carried out on the variables. The value of significance (*p*-value) was used to estimate the extent to which the perceptions influence resilience of family members of the mentally ill was statistically significant. A small *p*-value (close to 0.00) implies a greater statistical significance of the influence and vice versa. The findings indicated that the *p*-value is small ($p<0.05$) implying that the relationship between perceptions towards mental illness and the mentally ill on care giver's resilience is statistically significant and that aspects of perceptions tested have a significant influence on the care giver's resilience.

The study further sought to test null hypotheses linking perceptions towards mental illness and the mentally ill and resilience of care giver. Hypothesis testing was done using *p*-value to test the level of statistical significant of the impact of the independent variable indicated by the *p*- values. The impact was taken to be statistically significant if $p<0.05$ and vice versa. The *p*-value is tabulated in Table 25.

The first hypothesis stated that H_o: There is no statistically significant relationship between perceptions and the resilience of families living with a member with mental illness. The regression output (Table 26) indicated a high statistical significance of the relationship between the variables ($p=0.00$) indicating that the impact of perceptions of family members towards mental illness and the mentally ill member on resilience of the care givers is statistically significant and thus null hypothesis is rejected.

The researcher also carried out in depth interviews to obtain deeper insights into the perceptions of family care givers on mental illness and the mentally ill. The interviewees were guided to give their perceptions by use of questions. The first question sought to know how the family members had realized that their relative had mental illness. The interviewees reported a sudden but gradual change in behavior that signaled the onset of the mental illness. This change occurred either in adolescence or adulthood, according to those interviewed. Below are direct reports of these responses:

> *“My husband started having odd behavior, like moving about aimlessly and talking to himself…it was very strange because it was sudden”*
>
> *“My daughter started behaving in an odd manner when she was in form 2. You would tell her something and she would behave as though she had not heard, and then just laugh. It got to a point when she did not want to bathe or she would just start undressing, even in public…”*
>
> *“My wife started suddenly having signs like of fear, she stopped breastfeeding our baby, she refused to eat, and she would not even talk. She appeared depressed.”*
>
> *“We were told that my brother one day, just left his office, did some shopping and then left it on the streets, saying it was too heavy. He then walked all the way to his house, which was quite far. His wife said he was saying very strange things…it was obvious something was wrong.”*
>
> *“My daughter would leave home to go to school, and then turn back for no reason. Her teachers said she was behaving funny…we thought it was cerebral malaria. Then one day she started tearing everything, papers, her books…even her clothes.”*
>
> *“Initially we did not know it was mental illness, we (her siblings) thought she was just spoilt, that our parents favoured her. When the rest of us were doing various chores, she was just in her room. We thought she was reading…something was definitely not right, her behaviour was abnormal…but she had not always been like that.”*
>
> *“His friends said we was reading too much and was not willing to spend time with them anymore. Previously, after school, they would play football…but now he was withdrawn, all he wanted was to be alone and study. At home, it was the same…he suddenly was not interested in any activities with his siblings, he just kept to himself. It was new…”*

Two main themes seem to emerge from these responses, namely; age of the person at the onset of the illness and the idea of sudden onset of the illness. All the interviewees reported that the mental illness became evident in teenage or in early adulthood. My data seems to suggest that none had been born with the mental illness regardless of what the interviewees consider to be the cause of the illness. According to Parek (2015), about fifty percent of mental illnesses start by age 14 while three quarters begin by age 24. He however indicates that most major illnesses are not abrupt but small changes in behavior, feelings or in thinking may appear much earlier before the illness becomes evident.

The interviewees also indicated that their relatives became ill suddenly. When probed further, most said they had not noticed anything unusual with the individual in their earlier years. The fact that early signs were not noted by most family members may be an indication of denial or that what may have been considered as normal behavior previously could have been warning signs but were ignored. One interviewee however, said the her brother had unusual behavior much earlier but no one thought it could have ended up being mental illness;

> *"In his school days, my brother had exaggerated beliefs of his abilities. He even dropped out form 5 to get a job because he said that what the teachers were teaching was too easy, he knew it all and so found no reason to remain in school. We also remember that even from a very early age, he had very dramatic mood shifts."*

The fact that family members view the illness as abrupt may elicit perceptions that will have an effect on how they cope with the mentally ill. Since the illness appears when the family members are not prepared, they usually have no idea how to deal with their mentally ill relative. They may perceive the illness as a disruption of their normal pattern of life, and some may even blame the sick relative for this disruption which is usually very unpleasant. A subsidiary theme related to this was denial. The interviewees said that it was difficult to accept their loved ones' condition. Some thought it was a temporary situation that would change and their relative would go back to their normal life. It was difficult for them to imagine that their relative would remain in the new situation that they found themselves in. Some even tried to look for answers in terms of causes of what could have brought about the situation and how to correct it. Some thought it could be a physical problem that could be treated or an external stressor that could be removed. It was frustrating for them to find that they could not help their loved one, or make the situation better for them. This was evident when the symptoms did not go away and for most of the interviewees, their relatives seemed to get worse with time.

> *"I thought my wife's condition was because she was anemic and was under a lot of stress. So I decided that we should not have more children yet. I also tried to be home more often to assist her with the burden of taking care of the children and ensure that she ate well…but that did not seem to help."*
>
> *"I suggested to my husband to look for another job. I thought his current job was too stressful."*
>
> *"We thought our brother was having problems with his wife…my parents tried to talk to her to find out what could be wrong. They even met with her parents to discuss ways of assisting them to live together better. We also thought they could have been having financial constraints since his wife was not working at the time."*
>
> *"I wondered if we were putting too much pressure on our son to perform well in school. I discussed this with his teacher as well, suggesting that even the school should not put him under pressure."*

Denial is also portrayed in some families where they thought the mentally ill member was deliberating behaving in an odd manner or was pretending to be sick. One participant put it this way:

> *"…but my father thought that my brother was pretending. Even after being on treatment for quite a while, my father still believed that my brother's behavior was deliberate. He would say that he was just naughty and was always seeking attention. He said that he behaves in that way and does whatever he does just to get his own way and intimidate others."*

This kind of denial in some of the family members may create tension within the family. According to Hatfield (1991), when some members of the family fail to understand the reality of the illness, there is likely to be tension and chances are that there will be interference in meaningful family relationships. The family members who accept the reality of the illness may feel like they need to protect the person who is ill from those who do not, and who may blame the ill person for their behavior which may not be acceptable. This will then have the effect of dividing the family, and bringing about misunderstandings among the family members. The family members will most likely attribute these problems to the presence of the mentally ill member in the family. The mental illness is thus perceived as one which brings division in the family, and the coping strategies employed, as well as how the mentally ill person is treated by the individual family members, are likely to be dependent on these perceptions. In some families, the mentally ill was largely ignored and left to do whatever they pleased, including roaming the streets. This was seen to be the result of division within the family on how the sick relative should be treated.

The second question posed to the interviewees was aimed at exploring the views held by the family members on the causes of mental illness. Below are direct answers from some of the interviewees:

> *"He appeared disturbed, it was like something was really disturbing him…I think he was stressed."*
>
> *"The doctor said my wife was anemic. She had already had three children very close to one another and she was very young. I think I had put her under too much stress also, even before she got her own babies, she was taking care of my late sister's four children, and I was working far from home. Maybe it was too much for her."*
>
> *"It appeared like she was stressed, like something was disturbing her…maybe adolescent issues."*
>
> *"During the Maumau uprising, my sister was a young girl and we are told that one day there was an attack in the village. As my mother was running away, with my sister strapped on her back and there were gunshots…she must have been very scared. My parents said the trauma could have caused the mental illness."*
>
> *"Sometimes I wonder if something could have happened to her, like could she have been sexually harassed or even raped…and she was afraid to talk about it. What we could see was that she was very disturbed."*
>
> *"Combined with the stress that my brother could have been having from his wife, I always thought that my brother was on some drugs. He used to*

> *take a lot of alcohol, but it also seemed that he could have been taking some other drugs."*
>
> *"My son could have been reading too much…I have heard that someone may go mad due to too much reading. Or maybe he was under too much pressure and his mind could not cope…"*
>
> *"When she went to Nairobi, may be something happened…like she stole something or associated with bad people who were jealous of her, and someone did something to her…like bewitching."*

The major theme emerging from these responses was that mental illness could be as a result of a combination of biological, psychological and environmental factors according to the respondents. This agrees with the literature review where it was found that mental illnesses could be brought about by psychosocial factors, biological as well as environmental factors. The explanation is that an individual can inherit a susceptibility to a mental illness and that the interaction of multiple genes with other factors such as stress, abuse or trauma can then trigger the mental illness (Khan, Tahir, Khan, 2011). The interviewees mentioned stress emanating from work or school life as well as from family interactions as possible causes of mental illness. A biological factor, such as the case of anaemia, combined with having to take care of a young family, was also seen as a possible cause of the illness. One respondent mentioned trauma as a possible cause of the mental illnesses. This would then explain why they sought treatment from hospitals and in some cases tried to alter some circumstances involving the mentally ill.

Another theme which emerged from the data was that mental illness could be as a result of cultural factors which included unresolved family issues as expected in their culture, curses or involvement of spirits as well as passing on characteristics in the naming system in the kikuyu culture.

> *"Later, we learnt about the naming system in the kikuyu culture and discovered that the person she was named after (my father's sister) had mental illness. A cousin and a niece named after the same person also had*

> *similar problems. So we actually now relate the mental illness to the name."*
>
> *"Mental illness can be as a result of some things not done, like if bride price is not paid"*
>
> *"I tried to find out if she had ever stolen something or if she had been cursed...you know such things can bring about mental illness"*
>
> *"We tried to find out if there were any issues in the family which could have caused the illness. You know, like something that was not done, or an elder who was disrespected and said something in anger…a curse, or something like that."*
>
> *"At one time, my brother had gone out of the country and he got sick shortly after he came back. Could he have involved himself in some things to do with witchcraft or even the occult? We have always wondered what happened there…"*

These views held by the family members were found to have an influence on how they treated their mentally ill relative and how they dealt with the issues arising from living with them. The family holding the view that the illness is pegged on the name seemed hopeless as far as cure is concerned. Although they take their relative to hospital for treatment, their belief is that for those already given the name, the situation cannot change. Their solution was to stop giving the name to family members, a solution for those born later.

It would be expected that those with the view that mental illness have cultural causes would go to traditional healers, but this was not found to be the case. All the interviewees reported seeking help from the formal health care system, the dispensaries in their areas and hospitals. None of the interviewees indicated seeking any form of traditional help. The researcher however, was informed that in the region, central Kenya, most people may not feel comfortable reporting that they sought traditional healing since what is considered the societal norm is Christian approaches in all matters or the modern medicine.

> *"Here we are Christians; we also have embraced development and do not rely on the traditional methods that our parents used, but on the modern treatment methods."*

However, there are those who acknowledged the involvement of evil spirits and reported taking their loved ones for prayers.

> *"Friends advised me that my daughter's illness could be as a result of evil spirits, and I thought so too at the time. So I stopped her medication and took her for prayers. But the illness came back…"*
>
> *"We always believed that God can deliver our brother from whatever evil spirits, so we have prayed and requested other people to pray for him. Sometimes we would see a positive change, but somehow he would still go back to the same behaviour."*
>
> *A sense of helplessness was expressed by these family members, where they do not get the help they expect and are thus forced to rely on the medication from the doctors which in almost all the cases, according to the interviewees, did not provide cure to their loved ones.*
>
> *"It appears the medication keeps her cool, kind of contained…she does not seem to get better…she is just there."*
>
> *"The injection keeps him calm. So long as he gets it once a month, he kind of functions normally. But he has never gone back to his original self."*
>
> *"The treatment helps her I would say. But you see, she was not able to go back to school, she is not her normal self even now after so many years of treatment."*
>
> *"My wife has never gone back to the way she was after more than twenty years of treatment. She keeps fluctuating; sometimes she is fairly normal and can participate in the chores around the home. But it is like she even develops new odd behaviors…sometimes she has attempted to commit suicide, other times she cannot stand some colours, like colour red…and she is still on treatment. So I wonder…does this treatment make her better…?*
>
> *"These days she appears better after continuous treatment, but only slightly."*
>
> *"My brother has been on treatment for almost thirty years now…but you saw him…he cannot be said to be well. He keeps fluctuating, but for some years now, he has not been able to work."*

The data shows that although they seek treatment from hospitals, their relatives are not getting better. All the respondents report that their relatives never got backto their original normal selves even after treatment. Any time that treatment was stopped or not taken consistently, the ill relative would still show signs of the illness in their behaviour, sometimes even getting worse. It was noted that for some, treatment was not followed consistently for various reasons. Some cited financial constraints while others hoped that their relative was well and did not require treatment any more, only for the symptoms to reappear. There were also cases where the patients themselves refused treatment either directly or secretly threw away the drugs.

> *"Since it was very difficult to supervise my brother, especially since his wife left him, it was difficult for us to know if he had taken his medication. Sometimes he would say he had gone to the dispensary for the injection, while he had actually used the money provided for other purposes. We would only know that he was not taking medication when he got very sick, sometimes even violent"*
>
> *"My sister refused to take all other medication; she would throw away the medication secretly, or flush it in the toilet. Now she only gets the injection once a month, but the nurse has to come home and inject her, she refused to go to the clinic"*
>
> *"Financial constraints have at times made me not get her medication on time. If I go to the government facility and they do not have the medicine, I have to wait until it comes or when I get money to buy some. Sometimes even getting the bus fare to go to the hospital is a challenge"*

The researcher asked the interviewees how their sick relative participated in their own care and upkeep. The aim was to establish how they perceive them, and how this influences their coping with the needs, expectations and demands of their sick relative. The responses from the interviewees were quite varied; some indicated that it was quite a burden to take care of their sick relatives, while others said that they are usually not sure what to expect from them, since they are erratic and not predictable in behaviour, making it quite stressful.

> *"No, she does not participate in any way in her upkeep. We do everything for her. We have employed someone to take care of her; cook for her, clean and keep watch so that she does not leave the compound. She does not bathe or wash her clothes unless she is told…but even then, it is very difficult to convince her. And then she usually throws away her dirty clothes. Sometimes when they are washed, she will take them from the lines and throw them to the latrine,"*
>
> *"He is able to take care of himself some of the times…even may go to work if he gets it. But there are those times when he does not. At such times, he may even refuse help, he will stay in his dirty clothes and not bathe…it is very difficult to convince him to do anything when he is a bad state."*
>
> *"She takes care of herself somehow, even participates in household chores, but not all the time."*
>
> *"I have to tell her what to do. She cannot even take care of her child…I need to tell her to change her clothes and wash them, if she is not told,she will not bathe or wash her clothes."*
>
> *"It all depends on her state at any given time; there are those times that she can behave fairly normally but other times she does nothing at all, even when she is persuaded. Sometimes she is just like a zombie…I do not know if it is the medication."*
>
> *"Most of the times he takes care of himself, he can even cook. Other times he demands that someone washes his clothes or may demand money to eat in a hotel. But he has nothing of his own, he does not work and we have to provide for him."*

All these responses show that it is burdensome to take care of the sick relative. For all those interviewed, the sicknesses had caused their relatives either to drop out of school or from employment and were therefore not able to contribute for their upkeep in any way. This has affected the quality of life in the family in general as so much energy and time as well as financial resources go to taking care of the sick family member. The sick relative is viewed as a liability, contributing very little if at all, but requiring so much in form of care and material support. This agrees with the findings of Ssebunnya (2009) where he said that living with mental illness cause a variety of psychosocial problems for the family. One of these problems he mentioned was the decrease in the quality of life for all the family members. This was evident from those family members interviewed. The family members have to invest their time, and in some cases put aside other activities that would improve their own lives, in order to take care of their sick relatives. A lot of money also goes to the upkeep of the sick, either in treatment or in employing extra help for them.

This perception of the mentally ill as a burden for the family, will affect the coping strategies employed by the family as well as their resilience.

4.5 Attitudes towards a Family Member Living with Mental Illness

The second objective of the study was to find out how the attitudes of families towards a member with mental illness influence their resilience. To achieve this objective, the researcher used a set of five statements and asked the respondents to indicate the extent to which they agreed or disagreed with these statements. Table 26 displays a summary of the responses obtained. The researcher used five statements as indicators of the attitudes of family members towards the member living with mental illness and a likert scale against each statement to measure the extent to which the respondents agreed or disagreed with the statement. The magnitude of the influence was measured on the likert Scale of 1-5 where 1- strongly agree, 2- Agree, 3- neutral,4- disagree, and 5- strongly disagree. The average of the responses obtained for each statement was computed and the mean was used to ascertain the extent to which the respondents agreed or disagreed with the statement. Interpretation of the range of the means obtained for each statement was done as follows: 1-1.5 implied strongly agree; 1.6-2.5 implied agree; 2.6-3.5 implied neutral; 3.6-4.5: implied disagree and 4.6 - 5.0: implied strongly disagree.

Table 26

Attitudes of Family Members towards Mentally Ill Member

KEY: SA=Strongly Agree, A=Agree, N= Neutral, D=Disagree, SD=Strongly Disagree

Statement	**Extent of agreement or disagreement (%)**					**Mean**	**Std. Deviation**
	SA(1)	**A(2)**	**N(3)**	**D(4)**	**SD(5)**		
C1. Mentally ill persons can never be normal again	18.1	20.9	25.4	31.6	4.0	3.658	1.429
C2. Mentally ill persons are always violent and unpredictable	10.8	17.1	33.3	21.2	17.6	3.615	0.968
C3. Mentally ill persons expose a lot of stigma to their families	16.4	40.3	21.4	11.5	10.4	2.481	1.018
C4. Mentally ill persons are a burden to other family members since they have to be given attention and be provided for	37.9	27.1	14.2	11.5	9.3	1.390	0.489
C5. Mentally ill persons cannot be engaged in any productive ways	16.2	37.8	18.9	16.8	10.3	3.042	1.394

4.5.1 Attitude that mentally ill members can never be normal again

Descriptives displayed on Table 26 indicate that majority of the respondents disagree with the statement that mentally ill persons can never be normal again($\bar{x} = 3.658$, sd=1.429) however still an appreciable proportion of the respondents; cumulatively 39% agree with the statement. The findings thus imply that, majority of the respondents believe that mentally ill persons can be normal again.

The study further sought to establish whether the attitude that the mentally ill family member can never be normal again differed across the length of time the family members had lived with the mentally ill. Tables27 and 28 summarize the results obtained.

Table 27
Duration of living with the patient and the attitude that a mentally ill member can never be normal again

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	6	16	0	2	24
2-5 Years	9	7	2	11	29
6-10 Years	0	4	29	3	38
More Than 10 Years	17	28	0	51	96
Total	**32**	**51**	**40**	**64**	**187**

According to the information displayed on Table 28, majority of the respondents 51(53%)who had lived for more than 10 years with the mentally ill family members, disagreed with the statement that mentally ill person can never be normal again, while 45(47%) agreed with the statement. On the other hand, the majority of the family members 22(92%) who had lived for a period of less than two years with the mentally ill member, agreed with the statement, holding the attitude that the mentally ill can never be normal again. Only 8%held the attitude that the mentally ill member can be normal again.

Table 28

Chi Square test for duration of living with mental patient and attitude that the mentally ill family member can never be normal again

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	179.943[a]	9	.000
Likelihood Ratio	182.736	9	.000
Linear-by-Linear Association	1.176	1	.278
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 28 indicates that p<0.05 which implies that there is an association between the length of time lived with the mentally ill family member and the attitude that the mentally ill member can never be normal again. Further, the findings have indicated that the more the time spent with the mentally ill family members, the greater the tendency to adopt the attitude that the mentally ill family member can never be normal again.

Further, the study sought to establish whether gender of the respondents was associated with the attitude that the mentally ill member can never be normal again. Table 29 presents the results obtained.

Table 29

Gender of Respondent and attitude that the mentally ill member can never be normal again

		Mentally ill member can never be normal again				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 29, the attitude that the mentally ill member can never be normal again is more prevalent among the male (20%) than among females (15%). The results however indicate that the disparity in the perception across the genders is marginal.

Pearson chi square test of association was used to test whether there was any plausible association between gender and the attitude that the mentally ill member can never be normal again. The results were as summarized in Table 30.

Table 30
Gender of Respondent and the attitude that the mentally ill member can never be normal again

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.466[a]	3	.690
Likelihood Ratio	1.467	3	.690
Linear-by-Linear Association	.556	1	.456
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 30 indicates that p>0.05 which implies that there is no association between gender and the attitude that the mentally ill member can never be normal again. Further, the findings have indicated that both genders have the attitude that the mentally ill member can never be normal again in the same way.

4.5.2 Attitude that mentally ill persons are always violent and unpredictable

Majority of the respondents disagree with the statement that mentally ill persons are always violent and unpredictable($\bar{x} = 3.615$, sd=0.968) and only 27.9% of the respondents agree with the statement. The standard deviation of 0.968 indicates that the respondents were unanimous in the opinion that mentally ill persons are not always violent and unpredictable. This implies that generally, the mentally ill persons are not always violent and unpredictable.

The study further sought to establish whether the attitude that the mentally ill family members are always violent differed across the duration the family members had lived with the mentally ill. Tables31 and 32 summarize the results obtained.

Table 31
Duration of living with the patient and attitude that the mentally ill family members are always violent and unpredictable

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	6	2	6	10	24
2-5 Years	9	9	7	4	29
6-10 Years	0	2	8	28	38
More Than 10 Years	17	30	28	21	96
Total	**32**	**41**	**41**	**73**	**187**

According to the information displayed on Table 31, a sizeable proportion of the respondents 28(29%) who had lived for over ten years with the mentally ill family members were neutral on the statement that the mentally ill are always violent and unpredictable, 47(48%) agreed with the statement while the rest 21(23%) of the respondents disagreed with the statement. This may indicate that the mentally ill are violent and unpredictable some of the times but not always. On the other hand, 10(42%) of the family members who had lived for a short time with the mentally ill member disagreed with the statement, while 8(33%) agreed with the remaining 25% being neutral. The findings indicate that there is no significant disparity across the length of time lived with the mentally ill member on the attitude that the mentally ill family members are always violent and unpredictable.

Table 32

Chi Square test for duration of living with mental patient and the attitude that the mentally ill family members are always violent and unpredictable

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	84.931[a]	9	.070
Likelihood Ratio	99.124	9	.083
Linear-by-Linear Association	.275	1	.600
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 32 indicates that p>0.05 which implies that there is no association between the length of time lived with the mentally ill family member and the attitude that the mentally ill family members are always violent and unpredictable implying that all respondents had the same attitude regardless of the length of the time they had lived with the mentally ill family member.

Further, the study sought to establish whether gender of the respondents was associated with the attitude that the mentally ill family members are always violent and unpredictable. Table 33 presents the results obtained.

Table 33

Gender of Respondent and the attitude that the mentally ill family members are always violent and unpredictable

		Mentally ill family members are always violent				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	35	14	84
	Female	15	23	46	19	103
	Total	**32**	**41**	**81**	**33**	**187**

According to the information presented in Table 34, the attitude that the mentally ill family members are always violent and unpredictable is more prevalent among the males (20.2%) than among women (14.5%). The results however indicate that the disparity in this attitude, that the mentally ill are always violent and unpredictable, across the genders is marginal.

Pearson test for association was used to test whether there was any significant association between gender and the attitude that the mentally ill family members are always violent and unpredictable. The results were as summarized in Table 34.

Table 34
Gender of Respondent and attitude that the mentally ill family members are always violent and unpredictable

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.067[a]	3	.785
Likelihood Ratio	1.061	3	.786
Linear-by-Linear Association	.738	1	.390
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 34 indicates that p>0.05 which implies that there is no association between gender and the attitude that the mentally ill family members are always violent and unpredictable. Further, the findings have indicated that both males and females have the same the attitude that the mentally ill family members are not always violent and unpredictable.

4.5.3 Attitude that mentally ill persons expose a lot of stigma to their families

Majority of the respondents($\bar{x} = 2.481$ sd=1.018) agree with the statement that mentally ill persons expose a lot of stigma to their families. However, an appreciable proportion of the respondents, cumulatively (21.9%) have a contrary opinion.

The study further sought to establish whether the attitude that mentally ill persons expose their families to a lot of stigma differed across the duration the family members had lived with the mentally ill. Tables35 and 36 summarize the results obtained.

Table 35
Duration of living with the patient and attitude that mentally ill persons expose their families to a lot of stigma

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	2	16	0	2	24
2-5 Years	9	9	2	9	29
6-10 Years	0	5	26	7	38
More Than 10 Years	17	49	0	30	96
Total	**38**	**74**	**40**	**41**	**187**

According to the information displayed on Table 35, majority of the respondents 66(68.8%)who had lived for more than 10 years with the mentally ill family members have the attitude that mentally ill family members expose the family to a lot of stigma. On the other hand, the majority of the family members 18(75%) who had lived for a short time with the mentally ill member have the same attitude that mentally ill family members expose the family to a lot of stigma. This attitude is also held by those who had lived with the mentally ill for 2-5 years, where 18(62%) agreed that the mentally ill expose the family to a lot stigma. The findings indicate that the attitude that the mentally ill family member exposes a lot of stigma to their families is held by all the respondents regardless of the length of time they had lived with the mentally ill family member.

Table 36
Chi Square test for duration of living with the mentally ill and the attitude that mentally ill family members expose the family to a lot of stigma

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	187.449[a]	9	.000
Likelihood Ratio	190.017	9	.000
Linear-by-Linear Association	3.178	1	.075
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

The information on Table 36 indicates that p<0.05 which implies that there is an association between the length of time lived with the mentally ill family member and the attitude that mentally ill family members expose a lot of stigma to the family. Further, the findings have indicated that as family members live longer with the mentally ill family member, their attitude that his/ her presence in the family exposes a lot of stigma to the family reduces.

Further, the study sought to establish whether gender of the respondents was associated with the attitude that mentally ill family members expose a lot of stigma to the family. Table 37 presents the results obtained.

Table 37

Gender of Respondent and attitude that mentally ill family members expose a lot of stigma to the family

		Mentally ill family members expose a lot of stigma to the family				
		Strongly Agree	Agree	Neutral	Disagree	Total
Gender of Respondent	Male	17	32	19	16	84
	Female	15	42	21	25	103
Total		**32**	**74**	**40**	**41**	**187**

According to the information presented in Table 37, the attitude that mentally ill family members expose a lot of stigma to the family is more prevalent among the males (58.3%) than among women (55.3%). The results however indicate that the disparity in the perception across the genders is marginal.

Pearson test for association was used to test whether there was any plausible association between gender and the attitude that mentally ill family members expose a lot of stigma to the family. The results were as summarized in Table 38.

Table 38

Chi Square test for association between gender and theattitude that the mentally ill member exposes the family to a lot of stigma

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.638[a]	3	.651
Likelihood Ratio	1.639	3	.651
Linear-by-Linear Association	.862	1	.353
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 38, p>0.05, which implies that there is no association between gender and the attitude that the mentally ill family members expose the family to a lot of stigma. Further, the findings have indicated that both gender have the same attitude towards the stigma exposed to the family be the presence of the mentally ill family member.

4.5.4 Attitude that mentally ill persons are a burden to other family members

The study also sought to establish whether the mentally ill persons are seen as a burden to other family members since they have to be given attention and be provided for. The findings indicated that majority of the respondents($\bar{x} = 1.390$, sd=0.489) strongly agreed with the statement that mentally ill persons are a burden to other family members since they have to be given attention and be provided for, however, a sizable proportion (20.8%) of the respondents were of the view that mentally ill persons are not a burden to other family members although they have to be given attention and be provided for.

The study further sought to establish whether the attitude that mentally ill persons are a burden to other family members differed across the duration the family members had lived with the mentally ill. Tables39 and 40 summarize the results obtained.

Table 39
Duration of living with the mentally ill and attitude that mentally ill persons are a burden to other family members

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	16	0	6	2	24
2-5 Years	9	2	9	9	29
6-10 Years	0	31	5	2	38
More Than 10 Years	17	0	49	30	96
Total	**32**	**40**	**74**	**41**	**187**

According to the information displayed on Table 39, majority of the respondents 31(81.5%)who had lived for 6-10 years with the mentally ill family members have the attitude that mentally ill persons are a burden to other family members. On the other hand, quite a good proportion of the family members 16(67%) who had lived for a period of less than two years with the mentally ill member also had the attitude that mentally ill persons are a burden to other family members. However, only 17(17.7%) of those who had lived for more than ten years with the mentally ill viewed them as a burden, 49(51%) were neutral, indicating that they did not want to commit themselves as far as this statement was concerned. The findings indicate that the longer the family lives with the mentally ill; they tend to change the attitude that the relative is a burden to the family.

Table 40
Chi Square test for duration of living with mental patient and the attitude that mentally ill persons are a burden to other family members

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	187.449[a]	9	.076
Likelihood Ratio	190.017	9	.000
Linear-by-Linear Association	5.044	1	.025
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 40 indicates that $p>0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the attitude that mentally ill persons are a burden to other family members. This shows that the longer the family lives with the mentally ill, the less likely it is for them to view the sick member of the family as a burden to the rest of the family.

Further, the study sought to establish whether gender of the respondents was associated with the attitude that mentally ill persons are a burden to other family members. Table 42 presents the results obtained.

Table 41

Gender of respondent and the attitude that mentally ill persons are a burden to other family members

		Mentally ill persons are a burden to other family members				
		Strongly Agree	Agree	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	51	33	0	0	84
	Female	63	40	0	0	103
	Total	**114**	**73**	**0**	**0**	**187**

According to the information presented in Table 41, the attitude that mentally ill persons are a burden to other family members is held by the male and the female respondents. A higher percentage of the male respondents however, strongly agreed as compared to the female respondents. The results indicate that there is little disparity in the attitude of the respondents that the mentally ill family member is a burden to the family.

Pearson test for association was used to test whether there was any significant association between gender and the attitude that mentally ill persons are a burden to other family members. The results were as summarized in Table 42.

Table 42

Chi Square Test for Gender of Respondent and the attitude that mentally ill persons are a burden to other family members

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	25.281	3	.000
Likelihood Ratio	162.494	183	
Linear-by-Linear Association	187.775	186	

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 42 indicates that $p<0.05$ which implies that there is an appreciable association between gender and the attitude that mentally ill persons are a burden to other family members. Whereas the findings have indicated that both males and females have the same attitude that mentally ill persons are a burden to other family members, more of the male respondents chose the option of strongly agree than the female respondents.

4.5.5 Attitude that mentally ill persons cannot be engaged in any productive ways

A large majority of the respondents($\bar{x} = 4.096$, sd=1.467) neither agreed or disagreed with the statement that mentally ill persons cannot be engaged in any productive ways. A proportion of the respondents (44%) were however of the view that the mentally ill cannot be engaged in some productive ways.

The study further sought to establish whether the attitude that that mentally ill person cannot be engaged in any productive ways differed across the duration the family members had lived with the mentally ill. Tables43 and 44 summarize the results obtained.

Table 43

Duration of living with the patient and the attitude that mentally ill persons cannot be engaged in any productive ways

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	2	16	0	2	24
2-5 Years	9	9	2	9	29
6-10 Years	0	10	23	5	38
More Than 10 Years	17	49	0	30	96
Total	**38**	**74**	**40**	**41**	**187**

According to the information displayed on Table 43, majority of the respondents 66(68.8%)who had lived for more than 10 years with the mentally ill family members have the attitude that mentally ill persons cannot be engaged in any productive ways, while a substantial proportion (31.2%) disagreed with the statement, indicating that they can be engaged in productive ways. On the other hand, the majority of the family members 18(75%) who had lived for less than two years with the mentally ill member have the same attitude that mentally ill persons cannot be engaged in any productive ways, with only 8% having the attitude that the mentally ill can be engaged in productive ways. The findings indicate that the attitude that mentally ill persons cannot be engaged in any productive ways is held by all the respondents regardless of the length of time they had lived with the mentally ill family member. However, a sizeable proportion of those who have lived with the mentally ill relatives have the attitude that they can be engaged in productive ways.

Table 44
Chi Square test for duration of living with the mentally ill patient and the attitude that mentally ill family members cannot be engaged in any productive activity

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	187.449[a]	9	.000
Likelihood Ratio	190.017	9	.000
Linear-by-Linear Association	3.178	1	.075
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

The information on Table 44 indicates that $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the attitude that mentally ill persons cannot be engaged in any productive ways. Further, the findings have indicated that as the family members spend more time with the mentally ill family member, their attitude that mentally ill persons cannot be engaged in any productive ways changes, and they begin to believe that they can be engaged in productive ways.

Further, the study sought to establish whether gender of the respondents was associated with the attitude that mentally ill persons cannot be engaged in any productive ways. Table 45 presents the results obtained.

Table 45

Gender of respondent and the attitude that mentally ill persons cannot be engaged in any productive ways

		Mentally ill persons cannot be engaged in any productive ways					
		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	14	19	84
	Female	15	23	25	19	21	103
Total		**32**	**41**	**41**	**33**	**40**	**187**

According to the information presented in Table 45, the attitude that mentally ill persons cannot be engaged in any productive ways is less prevalent among the male (29.7%) than among female respondents (36.9%). The results however indicate that the disparity in the perception across the genders is not very substantial.

Pearson test for association was used to test whether there was any plausible association between gender and the attitude that mentally ill persons cannot be engaged in any productive ways. The results were as summarized in Table 46.

Table 45
Chi Square test for gender of respondent and the attitude that mentally ill persons cannot be engaged in any productive ways

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.655[a]	4	.799
Likelihood Ratio	1.655	4	.799
Linear-by-Linear Association	.144	1	.705
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 46 indicates that $p>0.05$ which implies that there is no association between gender and the attitude that mentally ill persons cannot be engaged in any productive ways. Further, the findings have indicated that both genders have the same attitude towards the engagement of the mentally ill persons in any productive activity.

To test the relationship between attitudes towards mental illness and the mentally ill and resilience, linear regression was used where respondent's attitudes towards mental illness (IV) was regressed against resilience of family members (DV). The results were as summarized in Tables 47 and 48.

Table 46
Model Summary of attitudes towards mental illness (IV) and resilience (DV)

Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.412[a]	.1697	.117	.3205

a. Predictors: (Constant), C5

Table 47shows the Model Summary of attitudes towards mental illness (IV) and resilience (DV). The value of R^2 was used to quantify the extent to which attitudes of the family members towards mental illness influence their resilience in caring for the mentally ill member. The findings of the study indicated that $R^2=0.1697$ which implies that the attitude of family members towards mental illness and the mentally ill member predict a 16.97% of the variation in their resilience in caring for the mentally ill member. This implies that attitudes towards mental illness and the mentally ill family member have a relatively high impact on the family members' resilience in caring for the mentally ill member.

Table 47
ANOVA of attitudes towards mental illness (IV) and resilience (DV)

Model		**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
1	Regression	3.573	1	3.627	21.362	.002[a]
	Residual	27.264	185	.147		
	Total	33.122	186			

a. Predictors: (Constant), C5

b. Dependent Variable: E1

The study further sought to establish whether the impact of attitudes towards mental illness and the mentally ill on care givers' resilience was statistically significant. Table 48shows the Analysis of Variance (ANOVA) carried out on the variables. The value of significance (*p*-value) was used to estimate the extent to which the attitudes towards mental illness and the mentally ill influence the resilience of the family members. A small *p*-value (close to 0.00) implies a greater statistical significance of the influence and vice versa. The findings indicated that the *p*-value is small ($p<0.05$) implying that the relationship between attitudes towards mental illness and the mentally ill on care givers' resilience is statistically significant and that aspects of attitudes tested have a significant influence on the care givers' resilience.

The study further sought to test null hypotheses linking attitudes towards mental illness and the mentally ill and resilience of care givers. Hypothesis testing was done using *p*-value to test the level of statistical significant of the impact of the independent variable indicated by the *p*- values. The impact was taken to be statistically significant if $p<0.05$ and vice versa. The *p*-value is tabulated in Table 48.

The second hypothesis stated that H_o: There is no statistically significant relationship between attitudes towards the mentally ill and the resilience of families living with a member with mental illness. The regression output (Table 49) indicated a high statistical significance of the relationship between the variables ($p=0.002$) indicating that the impact of attitudes of family members towards mental illness and the mentally ill member on resilience of the care givers is statistically significant. Thus the null hypothesis; There is no statistically significant relationship between attitudes towards the mentally ill and the resilience of families living with a member with mental illness, is rejected.

The researcher also carried out in depth interviews to obtain deeper insights into the attitudes of family care givers on mental illness and the mentally ill. The attitudes formed by the family members are usually dependent on how they perceive the mental illness, and their experiences as they live with the mentally ill. The researcher asked the interviewees to describe their life with their sick relative. Below are their responses:

> *"It is not easy to see her in her current situation, especially when I remember the person she was. My sister was very intelligent, the best teacher I knew…she did so much for me and other family members. It is very difficult for us to accept her situation, very disturbing to see her the way she is. I always try my best to help her, but sometimes she refuses. She can be very rude and abusive. One time, when I would take time to*

> *clean her up and make her hair, she asked me what I hoped to gain from helping her. She said to me;'go get your own daughter, name her after me and take care of her in your own house'. And from that time she would not let me groom her or make her hair. It really hurts."*
>
> *"It is very disturbing for us as a family. We can never be sure what he will say or do at any given time. Sometimes it is so hard to discuss any family matter with him; it is like I have to deal with situations concerning the family on my own."*
>
> *"I would say it is very disturbing. It worries me a lot especially when I think about her future…what will happen to her? Who will take care of her if and when I am not there anymore?"*
>
> *"I would describe living with her as very disturbing. I do not feel ashamed because I love her as my wife, but there are places I cannot go with her. I cannot take her to functions like parties or any outing. In such circumstances I feel like I do not have a partner. I have accepted her illness…but it is hard living with her."*
>
> *"It is disturbing, I could say it is also kind of shameful; people treat us differently…it is like we chose to have this problem. People do not like to associate with us."*
>
> *"I would describe living with my brother as difficult, stressful and very disturbing. It used to bother me a lot especially when my parents were alive, he would really disturb them. My brother can be very difficult to deal with, he is very demanding and can be quite unreasonable. A lot has changed in our family especially since his wife left him and we have to take care of him. We do not always seem to agree on issues concerning him, as a family."*
>
> *"It is very difficult. My daughter can be very unpredictable, sometimes she insults me and even threatens to beat me up. I usually do not know what to do at such times…it is a difficult situation for me as a mother."*

The major theme arising from the interviewees is that living with the mentally ill is quite disturbing. They have had to deal with discrimination and stigma from the members of the society where they live and are regarded as different. They also have to deal with changes within the family resulting from the illness, ranging from changing roles especially when the bread winner in the family is the one who gets sick, to changes in the family relationships occasioned by the presence of the sick relative. The stability of the family is greatly affected by the mental illness as is brought out by the spouses who said that they had to make a decision to stay on in the marriage, meaning that at some point they had considered leaving. One of the interviewees reported that her brother's wife left him after he got the mental illness. These situations are found to shape the attitudes that the family members hold towards their sick relatives, and the data seems to suggest that with time the family members have developed positive attitudes towards the mental illnesses, thus developing coping mechanisms that have helped them to live with their mentally ill relatives.

Another aspect explored in order to determine the attitudes of the family members is how comfortable they were talking with other relatives or friends about their mentally ill relative. Below are their responses to this question:

> *"I do not feel comfortable talking about this situation because most people are not helpful in any way. So I do not see the need to talk about it, even members of the extended family members do not seem to care."*
>
> *"Although I talk to people about her, I find that most people look at us differently. Some people seem to think that I am not also quite okay…like am also mentally sick. They do not understand how I can live with such a person all these years and not marry another wife. There is stigma towards us; we are not taken as if we are a normal family."*
>
> *"I do not talk about it, after all nobody seems to care about us…so what the point of talking about it is?"*
>
> *"It is not always easy to talk about it, most people do not understand. Even some family members do not want to be involved in his upkeep."*
>
> *"We keep our issues to ourselves. Nobody seems to care what we go through, even when he gets very sick, it is difficult to get someone to help me take him to the hospital."*

The theme emerging from these responses is that of stigmatization. The family members feel that people around them look at them negatively due to the mental illness and that would be the reason they are not able to comfortably discuss issues relating to the mentally ill with other relatives or friends. They feel that most people do not understand them and what they have to go through while others show no concern, thus no need to share anything with them. Ssebunnya (2009), reported that most family members who take care of the mentally ill have to deal with feelings of stigmatization as a result of having to associate with the mentally ill. They however come up with different coping mechanisms which are based on their individual situations and their different views on the mental illness. Those who reported being able to comfortably talk about their mentally ill relative, have got to this point with time and have reached a point of acceptance and are thus able to withstand the stigma; they have learnt to cope. One family member even hoped that by talking to people about their sick relative, they could get suggestions on how to deal with her or even find a solution for her.

> *"I have no problem talking about it now because I have accepted the situation and I know we have done everything we could for her. I even like talking about this illness; maybe someday I may find a person who can give us a solution to her problem."*
>
> *"Since I accepted her situation, I now have no problem talking about her illness. But previously, I would wonder what people would think about my family if I said that my wife has mental illness."*

The researcher, in a bid to find out the general belief system of the families towards the mental illness, and consequently the overall attitudes held by them, asked the interviewees to describe these beliefs as individuals as well as for the family in general. The responses given by all the interviewees indicate that mental illness is not taken to be like any other illness. Almost all families associated the illness with cultural (family) issues including those who said that they later accepted it as a medical condition requiring modern scientific approaches of treatment. Some family members said that mental illness is hereditary; they believed it runs in families.

> *"I tried to investigate if there was history of mental illness in her family…"*
>
> *"We tried to ask the older people in the family, our uncles and other relatives if there had been mental illness in the family."*

> *"We found out that the person she was named after was mentally sick. Even a cousin and a niece named after the same person had mental illness. We see mental illness as a condition passed on in the family and naming system in the kikuyu culture has something to do with it. It must be transmitted in the name."*

Other families considered unresolved family issues to have brought about the mental illness. The issue of cultural practices came up, such as payment of dowry.

> *"Some family members said that it could be that something was not done in the right way. Usually I hear that if you receive bride price for your daughter while you have not done the same for your wife, or may be your mother's was not paid, then mental illness could result. Those things are very complicated and I do not understand them."*

> *"There are some things that people believed in the traditional society, like in the payment of dowry, I have heard that some mistakes can cause mental illness in the family, especially receiving bride price for your daughter when you did not pay for you wife."*

The issue of curses also came up from the interviewees as a possible cause of mental illness. A curse may be pronounced by an elder who is displeased by someone who disrespects them, and the problem may be seen in later generations, and may manifest as mental illness. Stealing was cited as a crime which could result in mental illness, since some people can cast spells.

> *"Maybe something happens that makes an elder so angry that they pronounce a curse."*

> *"I tried to find out if she had ever stolen anything. There are people who put a spell on those who steal their property. You have heard of people being made to 'eat grass'… that is a form of madness…it is mental illness cast on someone. Such things happen,"*

The belief systems held by the family members shape their attitudes towards the mental illness and consequently their sick relative. These attitudes will then inform the way the sick person is handled, the treatment they seek and how they live with him or her in general. As Chikomo (2012) observed; adequate knowledge on mental illness can help in dealing with the negative attitudes that people may have towards those with mental illness. If family members believe that there could have been a curse, although they may take their relative to hospital, they will most likely have an expectation (though they may not voice it) that their loved one would only get better if the issue of the curse is dealt with, or if a customary issue has been ignored, that it is done in the right way. That would explain the reason why most tried to find out these issues before they even sought treatment from the hospitals. If a family holds the belief that the illness is due to the naming, the family may change the name for future generations, but it seems that this does not help the one who is already unwell. This must then remain a helpless situation for the sick relative and the family may have no hope of healing since changing of the name of a person already grown up did not seem to be an option.

> *"The name could not be changed, now that she was grown up and already sick anyway. But nobody is given that name any more in the family when it was noted that all those given that name 'Wangari' were all at some point in their lives getting mentally sick."*

4.6 Social support received by family members living with mental illness

The third objective of the study was to assess how the social support received by families living with mental illness influences their resilience. To achieve this objective, the researcher used a set of four statements and asked the respondents to indicate the extent to which they agreed or disagreed with them. Table 49displays a summary of the responses obtained. The researcher used four statements as indicators of the social support systems accessible to family members living with mental illness and a likert scale against each statement to measure the extent to which the respondents agreed or disagreed with the statement. The magnitude of the influence was measured on the likert scale of 1-5; where 1- strongly agree, 2- Agree, 3- neutral,4- disagree, and 5- strongly disagree. The average of the responses obtained for each statement was computed and the mean was used to ascertain the extent to which the respondents agreed or disagreed with the statement. Interpretation of the range of the means obtained for each statement was done as follows: 1-1.5 implied strongly agree; 1.6-2.5 implied agree; 2.6-3.5 implied neutral; 3.6-4.5: implied disagree and 4.6 - 5.0: implied strongly disagree.

Table 48
Social Support systems accessible to families living with a mentally ill member
KEY: SA=Strongly Agree, A=Agree, N= Neutral,D=Disagree, SD=Strongly Disagree

Statement	**Extent of Agreement or Disagreement (%)**					**Mean**	**Std. Deviation**
	SA(1)	**A(2)**	**N(3)**	**D(4)**	**SD(5)**		
D1. Social networks such as religious centers and friends do not offer adequate support to the family members with a mentally ill member.	57.9	37.1	2.1	1.9	1.1	1.3904	0.4891
D2. Formal social networks such as healthcare and educational institutions do not offer adequate support to families with a mentally ill member	16.2	58.4	20.3	3.1	2.0	1.425	0.5376
D3. Many healthcare providers do not admit mentally ill as inpatients leaving the burden of catering for the mentally ill persons entirely to their families	23.4	40.3	14.4	12.5	9.4	2.013	0.6207
D4. The families living with the mentally ill face isolation from friends and other social networks such as relatives and immediate communities in which they live.	37.1	41.1	16.2	4.6	1.1	2.786	0.7238

4.6.1 Social support from social networks such as religious centers and friends

Descriptives displayed on Table 49 indicate that majority of the respondents (57.9%) strongly agree with the statement, while another 37.1% of the respondents agreed with the statement that social networks such as religious centers and friends do not offer adequate support to the family members with a mentally ill member, ($\bar{x} = 1.3904$, sd=0.4891). The findings thus imply that social networks such as religious centers and friends do not offer adequate support to the family members with a mentally ill member as only a very small percentage of the respondents (5%) disagreed with the statement.

The study further sought to establish whether the feeling that social networks such as religious centers and friends do not offer adequate support to the family members with a mentally ill member differed across the duration of time that the family members had lived with the mentally ill. Tables50 and 51 summarize the results obtained.

Table 49
Duration of living with the patient and the view that social networks do not offer adequate support to the family members with a mentally ill member

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	14	10	0	0	24
2-5 Years	25	4	0	0	29
6-10 Years	12	21	5	0	38
More Than 10 Years	75	21	0	0	96
Total	**114**	**73**	**40**	**64**	**187**

According to the information displayed on Table 50, all of the respondents 96 (100%)who had lived for more than 10 years with the mentally ill family members have a view that social networks do not offer adequate support to the family members with a mentally ill member. On the other hand, all family members 24(100%) who had lived for a short time with the mentally ill member also have the view that social networks do not offer adequate support to the family members with a mentally ill member. The findings indicate that all the respondents regardless of the duration they had lived with the mentally ill member have a view that social networks, such as religious centers and friends, do not offer adequate support to the family members with a mentally ill member.

Further, the researcher used Pearson Chi square test to establish whether there was a statistically significant association between the length of time respondents had lived with their mentally ill relative and their view about whether the social networks, such as religious centers and friends, accessible to them offer adequate support. Table 51 displays the results of the test.

Table 50
Chi Square test for duration of living with mentally ill patient and social support offered to the families

	Value	**Df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	79.060[a]	3	.000
Likelihood Ratio	93.442	3	.000
Linear-by-Linear Association	2.070	1	.150
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 5 indicates that $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and whether they view the support offered by social networks, such as religious groups and friends, as adequate to the family members with a mentally ill member. Those who had lived for a long time with the mentally ill seem to get less social support than those whose relatives had been sick for a shorter time. It is possible that social support groups give up and neglect the families living with a member with mental illness when they do not get better with time.

Further, the study sought to establish whether gender of the respondents was associated with the view that social networks, such as religious groups and friends, do not offer adequate support to the family members with a mentally ill member. Table 52 presents the results obtained.

Table 52

Gender of respondent and social support offered to the family members with a mentally ill member

		Social networks do not offer adequate support to the family members with a mentally ill member				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	51	33	0	0	84
	Female	63	40	0	0	103
	Total	**42**	**41**	**0**	**0**	**187**

According to the information presented in Table 52, the view that social support networks, such as religious groups and friends, do not offer adequate support to the family members with a mentally ill member is common to both gender and it is viewed the same way across the gender.

Pearson chi square test of association was used to test whether there was any plausible association between gender and the view that social networks, such as religious groups and friends, do not offer adequate support to the family members with a mentally ill member. The results were as summarized in Table 53.

Table 51

Chi Square test for gender of respondent and social support offered to family members living with a mentally ill member

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	.004[a]	1	.950
Likelihood Ratio	.000	1	1.000
Linear-by-Linear Association	.004	1	.950
N of Valid Cases			

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 53, $p>0.05$ which implies that there is no association between gender and the view on social support offered to family members living with a mentally ill member. Both male and female respondents view the social support offered by religious groups and friends as inadequate.

4.6.2 Social Support from formal social networks such as healthcare and educational institutions

The data shows that 16.2% of the respondents strongly agreed with the statement that formal social networks such as healthcare and educational institutions do not offer adequate support to the families living with member with mental illness. However, 58.4% of the respondents agreed with the statement, and only 5.1% disagreed with the statement. It is therefore concluded that majority of the respondents agree with the statement that formal social networks such as healthcare and educational institutions do not offer adequate support to families with a mentally ill member($\bar{x} = 1.425$, sd=0.5375).The standard deviation of 0.5375 indicates that the respondents were unanimous in the opinion that formal social networks such as healthcare and educational institutions do not offer adequate support to families with a mentally ill member. This implies that generally, the formal social networks such as healthcare and educational institutions do not offer adequate support to families with a mentally ill member.

Further, the study sought to establish whether there was disparity in the view of the respondents on the social support offered by the formal social networks such as healthcare and educational institutions to family members living with a mentally ill member and the duration of time lived with the mentally ill relative. Table 54 displays the results obtained.

Table 52
Duration of living with the patient and view that formal social networks such as healthcare and educational institutions do not offer adequate support

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	12	24
2-5 Years	9	7	13	29
6-10 Years	1	2	35	38
More Than 10 Years	17	28	51	96
Total	**32**	**41**	**114**	**187**

According to the information displayed on Table 54, 45(46%) respondents who had lived for more than 10 years with the mentally ill family members do not think formal social networks such as healthcare and educational institutions offer adequate social support to family members living with a mentally ill member. On the other hand, half of the family members 12(50%) who had lived for a short time with the mentally ill member also did not think formal social networks such as healthcare and educational institutions as capable of offering adequate social support to family members living with a mentally ill member. The findings indicate that there is no significant disparity across the length of time lived with the mentally ill member and the view held on the support given by formal social networks.

Further, the researcher used Pearson Chi square test to establish whether there was a statistically significant association between the duration of time respondents had lived with their mentally ill relative and whether the formal social networks, such as healthcare and educational institutions offer them adequate support. Table 55 displays the results of the test.

Table 53
Chi Square test for association between duration of time lived with mentally ill patient and the view that formal social networks do not offer adequate support

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	79.060[a]	3	.000
Likelihood Ratio	93.442	3	.000
Linear-by-Linear Association	2.070	1	.150
N of Valid Cases	187		

a. 2 cells (16.7%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 55 indicates that p<0.05 which implies that there is an association between the length of time lived with the mentally ill family member and views held about the social support offered by formal social networks such as healthcare and educational institutions. Those who have lived for a short time with the mentally ill have a higher percentage of those who strongly agreed with the statement that the formal social networks, such as healthcare and educational institutions do not offer adequate support to those families living with a member with mental illness.

Further, the study sought to establish whether gender of the respondents was associated with the way they viewed the social support offered by formal social networks such as healthcare and educational institutions, either as adequate or inadequate. Table 56 presents the results obtained.

Table 56

Gender of Respondent and the view that formal social networks such as healthcare and educational institutions do not offer adequate support

		Social support offered by formal social networks such as healthcare and educational institutions				
		Strongly Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 56, the view that social support offered by formal social networks such as healthcare and educational institutions is inadequate is more prevalent among the females (63%) than among males (42%).

Pearson chi test for association was used to test whether there was any significant association between gender and the view that social support offered by formal social networks such as healthcare and educational institutions is inadequate. The results were as summarized in Table 57.

Table 54

Chi Square Test for Gender of respondent and view that social support offered by formal social networks such as healthcare and educational institutions is inadequate

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654a	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases			

According to the information on Table 57 indicates that $p<0.05$ which implies that there is an appreciable association between gender and the view that social support offered by formal social networks such as healthcare and educational institutions is inadequate. More female respondents than male respondents view the support given by formal social networks, such as healthcare and educational institutions as inadequate.

4.6.3 Admission of mentally ill to health care facilities

The researcher sought to know from the respondents whether their mentally ill relatives are usually admitted to the hospitals. Majority of the respondents($\bar{x} = 2.013$, sd=0.6207) agree with the statement that many healthcare providers do not admit mentally ill as inpatients leaving the burden of caring for the mentally ill persons entirely to their families. The small proportion of respondents who disagreed with this statement indicates that it is only in very rare cases that the mentally ill are admitted in the hospitals.

Further, the study sought to establish whether there was disparity in the view that the healthcare providers do not admit the mentally ill as inpatients, leaving the burden of caring for them to the family members, with the duration of time lived with the mentally ill relative. Table 58 displays the results obtained.

Table 58
Duration of living with the patient and view that many health workers do not admit the mentally ill as inpatients

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	10	24
2-5 Years	5	5	19	29
6-10 Years	18	16	4	38
More Than 10 Years	40	34	22	96
Total	**41**	**31**	**115**	**187**

According to the data, a larger proportion of those who had lived for a shorter time with the mentally ill held the view that the mentally ill are admitted to the hospitals than those who had lived for more than ten years with their mentally ill relatives.

Further, the study sought to establish whether gender of the respondents was associated with the view that healthcare providers do not admit the mentally ill as inpatients, leaving the burden of caring for them entirely to their families. Table 59 presents the results obtained.

Table 59
Gender of Respondent and the view thatmany healthcare providers do not admit the mentally ill as inpatients

		The mentally ill are not admitted as inpatients by the healthcare providers				
		Strongly Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	19	10	20	35	84
	Female	42	12	23	26	103
	Total	**51**	**22**	**43**	**61**	**187**

According to the information presented in Table 59, only 22% of the male respondents agreed with the statement that healthcare providers do not admit the mentally ill to the hospitals, while 40.7% of the female respondents agreed with the statement. This could be attributed to the fact that the females are the ones who are more often directly involved in the care of the mentally ill and could be more specific in keeping records of when their loved ones were admitted in the hospitals.

4.6.4 Isolation from friends and relatives and the immediate communities

The study also sought to establish whether the families living with the mentally ill face isolation from friends and other social networks such as relatives and immediate communities in which they live. The findings indicated that majority of the respondents($\bar{x} = 2.786$, sd=0.7238) neither agreed nor disagreed with the statement that families living with the mentally ill face isolation from friends and other social networks such as relatives and immediate communities in which they live. Though some respondents indicated that they face isolation from friends and other social networks such as relatives and their immediate communities, the findings indicated that families with a member living with mental illness do not encounter appreciable isolation from friends, relatives and the communities they live in.

The study further sought to establish whether the view that families living with the mentally ill face isolation from friends and other social networks such as relatives and the immediate community where they live varied with the duration of time that the family members had lived with the mentally ill. Tables 60 summarize the results obtained.

Table 60

Duration of living with the patient and the view that families living with the mentally ill face isolation from friends, relatives and the immediate community

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	3	4	16	1	24
2-5 Years	5	4	18	2	29
6-10 Years	0	0	38	0	38
More Than 10 Years	25	18	48	5	96
Total	**31**	**26**	**120**	**8**	**187**

Majority of the respondents across the different durations of living with the mentally ill were neutral with only a small proportion agreeing with the statement that they face isolation from friends, relatives and the communities that they live in. For those who had lived for over ten years with the mentally ill, 50% were neutral concerning this statement; while 44.7% agreed that they faced isolation. On the other hand, for those who had lived with the mentally ill for less than two years, 66.7% were neutral, 29% agreed with the statement leaving only 4.3% who disagreeing with the statement.

Generally, majority of the respondents expressed the opinion that formal and informal social networks such as churches, schools, members of the extended family, healthcare providers among others do not offer adequate support to the families of members living with mental illness. However, families with mentally ill members were neutral when asked if they faced isolation from friends and other social networks such as relatives and immediate communities in which they live.

To test the relationship between social networks accessible to families with a mentally ill member and their resilience, linear regression was used where access to social networks

(IV) was regressed against resilience of family members (DV). The results were as summarized in Tables 61 and 62.

Table 61
Model Summary of access to social networks (IV) and resilience (DV)

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.424[a]	.180	.175	.37672
a. Predictors: (Constant), C5				

Table 61shows the Model Summary of access to social networks (IV) and resilience (DV). The value of R^2 was used to quantify the extent to which access to social networks influence their resilience in caring for the mentally ill member. The findings of the study indicated that $R^2=0.180$ which implies that the access to social networks predict 18% of the variation in their resilience in caring for the mentally ill member. This implies that access to social networks have a relatively high impact on their resilience in caring for the mentally ill member.

Table 62
ANOVA of attitudes towards mental illness (IV) and resilience (DV)

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	5.756	1	5.756	40.561	.000[a]
	Residual	26.254	185	.142		
	Total	32.011	186			
a. Predictors: (Constant), D2						
b. Dependent Variable: E1						

The study further sought to establish whether the impact of access to social networks on care giver's resilience was statistically significant. Table 62 shows the Analysis of Variance (ANOVA) carried out on the variables.The value of significance (*p*-value) was used to estimate the extent to which access to social networks influence the resilience of the family members caring for a mentally ill member. A small *p*-value ($p<0.000$) implies a greater statistical significance of the influence and vice versa. The findings indicated that the *p*-value is small ($p<0.000$) implying that the relationship between social networks and caregivers' resilience is statistically significant and that aspects of access to social networks tested have a significant influence on the caregivers' resilience.

The study further sought to test null hypotheses linking access to social networks and resilience of care giver. Hypothesis testing was done using *p*-value to test the level of statistical significant of the impact of the independent variable indicated by the *p*- values. The impact was taken to be statistically significant if $p<0.05$ and vice versa. The *p*-value is tabulated in Table 61.

The third hypothesis stated that H_o: There is no statistically significant relationship between social support received by family members living with mental illness and their resilience, in Nyeri County, Kenya. The regression output (Table 62) indicated a high statistical significance of the relationship between the variables ($p=0.000$) indicating that the impact of access to social networks by families of members living with mental illness on resilience of the care givers is statistically significant and thus the null hypothesis is rejected.

The researcher also carried out in depth interviews to obtain deeper insights into the influence of access to social networks on the resilience of family members living with a member who is mentally ill. According to the literature review, it is expected that there is a relationship between the social support received and the quality of life of patients with mental illness as well as that of their care givers (Killaspy, 2006). When asked the social support they receive from their extended families, friends, community or church; these were the responses given:

> *"We do not receive any social support. Unfortunately, even considering the fact that my sister was at one time earning a good salary, but was retired on medical grounds, can you imagine her pension was never remitted?! We tried to follow it up to no avail. So we have not received any payments since late 1980s,leaving the whole burden on us…we wish the government could intervene in such cases."*
>
> *"I do not get any support from anyone, not even the relatives. I remember one time he had taken a drug overdose and when I called for help to take him to hospital, no one came, not even his brothers…they are usually not concerned about what happens to him. Only my father-in-law (his father- but he passed away last year) would assist me. Now I am usually left on my own as far as his care is concerned."*
>
> *"I find what people consider as help is not helpful to me. Friends tell me to find out the family issues which brought about the illness…that does not help. The church on the other hand tells me to pray and believe…"*
>
> *"There is no form of support here in the community. I once tried to start a support group, but it became difficult because most people do not want to accept that their relatives have mental illness and that they need help."*
>
> *"There is no help at all. The church once in a while comes and prays with us…but that is all."*
>
> *"Most members of the family just stay away; they do not want to be involved. One of my brothers says that he (the sick one) cannot be helped because he is too stubborn. There is no support from the community either. As for the church, they come to pray with us sometimes…it helps a little to give us peace and hope."*

The data agrees with a study conducted by Masunga & Iseselo (2016), where care givers reported that they did not receive support from people within and outside the families. This lack of support could be as a result of failure to understand the nature of mental illness, expecting it to be cured within a short time, such that when this does not happen, they give up and withdraw their support. This could explain why those who have lived with mental illness for a shorter time reported more social support than those who had lived with the mentally ill for longer periods. As a result of this lack of social support, the family members have had to struggle alone and come up with strategies of coping with their mentally ill relatives.

The interviewees were asked to describe the kind of help they received from the hospitals where they took their loved ones for treatment. And this is how they responded:

> *"Just the medication, and it is not free… we have to pay for it."*
>
> *"The only help we get from the hospital is medication. Although it is not free, we appreciate the fact that they prescribe the medication even when we have to go and buy it and that they give him the monthly injection."*
>
> *"When I first took her to the hospital, the doctors explained to me about the illness and that I had to make sure she took her medication. This is sometimes difficult, but I have to come up with ways of making her take the medication. I wish this medication was free…we have to pay."*
>
> *"The hospital has helped us to calm him down when he becomes too wild. A few times he has been admitted in the ward for some time and this at least has ensured that he took medication."*
>
> *"The hospital staff was quite helpful when we took him to the hospital when he first got sick. We wouldn't have known what to do to control him. Afterwards, all they do is give the prescription and we go buy the medication."*

The responses indicate that the assistance that the family members would expect from the healthcare professionals and the hospitals is insufficient. The cost of medication was also cited as a problem, coupled with lack of advice on how to cope with the mentally ill. Social support is known to have psychological benefits such as increased self-esteem, feelings of empowerment and results in higher quality of life. Absence of social support on the other hand is linked to poorer sense of self-esteem and lower levels of functioning (Quigley, 2003). The sense of helplessness observed in the care-givers could be linked to this lack of social support. The interviewees expressed feelings of helplessness as they took care of their loved ones.

> *"I feel left completely alone…nobody cares about her. Sometimes I am completely helpless and unsure of what to do."*
>
> *"The others are not bothered what happens to him. I am usually left on my own."*
>
> *"A few of us do all what we can for our sister, the others do not get involved. We do what we can for her."*

This lack of social support may also have negative effects on the mentally ill. They recognize they are not accepted by some family members or members of the community. This may cause them to withdraw and not want to participate in the activities at home or in the community.

> *"It is like she resigned her life; she gave up, despaired on everything. Especially since she got laid off from her teaching job, she has no interest in anything. She has very low self-esteem, sometimes she appears like she does not even want to get better."*
>
> *"Sometimes she is very withdrawn, she refuses to talk with visitors or even some family members."*

The responses from the interviews conducted and reported verbatim above indicate that social support is not available to the families living with a member with mental illness. The little support that may appear to come from friends and local health providers and churches does not seem to provide the help the families would require. The findings indicate that social support system which may help in boosting the resilience of the families living with a mentally ill member is inadequate, inaccessible and at times what is given is not helpful at all.

4.7 Resilient Behaviour of Family Members Living with Mentally Ill Member

The fourth objective of the study was to explore the resilient behaviour of family members living with a mentally ill member and the strategies that they have developed of enhancing resilience. To achieve this objective, the researcher used a set of five statements and asked the respondents to indicate the extent to which they agreed or disagreed with them. Table 63displays a summary of the responses obtained. The researcher used five statements as indicators of the resilient behaviour of family members living with mental illness and a likert scale against each statement to measure the extent to which the respondents agreed or disagreed with the statement. The magnitude of the influence was measured on the likert Scale of 1-5 where 1- strongly agree, 2- Agree, 3- neutral,4- disagree, and 5- strongly disagree. The average of the responses obtained for each statement was computed and the mean was used to ascertain the extent to which the respondents agreed or disagreed with the statement. Interpretation of the range of the means obtained for each statement was done as follows: 1-1.5 implied strongly agree; 1.6-2.5 implied agree; 2.6-3.5 implied neutral; 3.6-4.5: implied disagree and 4.6 - 5.0: implied strongly disagree.

Table 63

Resilient behaviour of families living with a mental ill member

KEY: SA=Strongly Agree, A=Agree, N= Neutral,D=Disagree, SD=Strongly Disagree

Statement	**Extent of agreement or disagreement (%)**					**Mean**	**Std. Deviation**
	SA(1)	**A(2)**	**N(3)**	**D(4)**	**SD(5)**		
E1. We find it difficult to fully accept that the state of our mentally ill member may never change	21.9	48.1	13.2	10.5	6.3	1.781	0.415
E2. We are at times overwhelmed with stress emanating from the demands of caring for the member of our family with mental illness	19.0	33.6	21.4	16.6	9.4	1.824	0.759
E3. We more often than not feel condemned by the fact that we have one of our members of our family with mental illness	10.0	38.1	31.1	16.2	4.6	2.219	0.415
E4. We feel helpless by the fact that there is nothing we can do to overcome the negative feelings and experiences we encounter as a result of having one of our family members with mental illness	10.2	30.2	34.1	18.2	2.3	2.398	0.491
E5. We are unable to secure supportive social networks such as friends, relatives and society members who empathize with our situation.	17.1	33.9	39.0	9.6	6.1	2.219	0.719

4.7.1 Acceptance that mentally ill member may never recover

Descriptives displayed on Table 63 indicate that majority of the respondents find it difficult to fully accept that the state of their mentally ill member may never change($\bar{x} =$ 1.781, sd=0.415). The findings thus imply that the members of the families never give up on their mentally ill relatives. They continue to hold on to the possibility that their relative will still recover and go back to their normal lives.

The study further sought to establish whether the difficult to fully accept that the state of their mentally ill member may never change differed across the duration the family members had lived with the mentally ill. Tables 64 and 65 summarize the results obtained.

Table 64

Duration of living with the patient and the difficult to fully accept that the state of their mentally ill member may never change

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	14	10	0	0	24
2-5 Years	25	4	0	0	29
6-10 Years	5	25	8	0	38
More Than 10 Years	75	21	0	0	96
Total	**114**	**73**	**40**	**64**	**187**

According to the information displayed on Table 64, all of the respondents 96(100%) who had lived for more than 10 years with the mentally ill family members had difficulties in fully accepting that the state of their mentally ill member may never change . On the other hand, all family members 24(100%) who had lived for a short time with the mentally ill member also had a difficult to fully accepting that the state of their mentally ill member may never change. The findings indicated that all the respondents regardless of the duration they had lived with the mentally ill member found it difficult to fully accept that the state of their mentally ill member may never change.

Further, the researcher used Pearson Chi square test to establish whether there was an association between the gender of the respondent and the difficult to fully accept that the state of their mentally ill member may never change. Table 65 displays the results of the test.

Table 65

Chi Square test for duration of living with mental patient and the difficulty to fully accept that the state of their mentally ill member may never change

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	79.060[a]	3	.000
Likelihood Ratio	93.442	3	.000
Linear-by-Linear Association	2.070	1	.150
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 65 indicates that $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the difficult to fully accept that the state of their mentally ill member may never change. Those who had lived for over ten years with their mentally ill seem to lose hope, and some begin to think that their relatives may not go back to their original state as compared to those who have been with the mentally ill for a short period.

Further, the study sought to establish whether gender of the respondents was associated with the difficulty to fully accept that the state of their mentally ill member may never change. Table 66 presents the results obtained.

Table 66

Gender of Respondent and the difficulty to fully accept that the state of their mentally ill member may never change

		Difficult to fully accept that the state of their mentally ill member may never change				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	51	33	0	0	84
	Female	63	40	0	0	103
	Total	**42**	**41**	**0**	**0**	**187**

According to the information presented in Table 66, thedifficulty to fully accept that the state of their mentally ill member may never change is common to both the male and the female respondents. It was found that 60.7% of the male respondents agreed with the statement that they find it difficult to fully accept that the state of their mentally ill member may never change, while 61.2% of the female respondents agreed with the statement.

Pearson chi square test of association was used to test whether there was any association between gender and the difficulty to fully accept that the state of their mentally ill member may never change. The results were as summarized in Table 67.

Table 67

Gender of Respondent and difficult to fully accept that the state of their mentally ill member may never change

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	.004[a]	1	.950
Likelihood Ratio	.000	1	1.000
Linear-by-Linear Association	.004	1	.950
N of Valid Cases			

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 67 indicates that $p>0.05$ which implies that there is no association between gender and the difficult to fully accept that the state of their mentally ill member may never change. Both male and female respondents had the same view.

4.7.2 Coping with Stress emanating from Caring for the Member of our Family with Mental Illness

Majority of the respondents agreed with the statement that they were at times overwhelmed with stress emanating from the demands of caring for their member with mental illness($\bar{x} = 1.824$, sd =0.759).

Further, the study sought to establish whether there was any relationship between the length of time lived with the mentally ill and the view that the family members are at times overwhelmed with stress emanating from caring for the member in the family with mental illness. Table 68 displays the results obtained.

Table 68

Duration of living with the mentally ill and ability to cope with stress emanating from caring for the member of the family with mental illness.

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	12	24
2-5 Years	9	7	13	29
6-10 Years	0	6	32	38
More Than 10 Years	17	28	51	96
Total	**32**	**41**	**114**	**187**

According to the information displayed on Table 68, 45(46.9%) of the respondents who had lived for more than ten years with the mentally ill family members agreed with the statement that they are sometimes overwhelmed by the stress emanating from the demands of caring for the member of their family with mental illness. On the other hand, the majority of the family members 12(50%) who had lived for less than two years with the mentally ill member also agreed that the stress of taking care of their mentally ill relative was sometimes overwhelming. These results demonstrate that about half of the care givers had developed the ability to cope with stress emanating from caring for the member of their family with mental illness.

Table 69

Chi Square test for duration of living with mentally ill and the view that they are overwhelmed by stress emanating from taking care of the sick relative

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	79.060[a]	3	.0690
Likelihood Ratio	93.442	3	.000
Linear-by-Linear Association	2.070	1	.150
N of Valid Cases	187		

a. 2 cells (16.7%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 69 indicates that p>0.05 which implies that there is no statistically significant association between the length of time lived with the mentally ill family member and the ability to cope with stress emanating from caring for the mentally ill family member.

Further, the study sought to establish whether gender of the respondents was associated with the ability to cope with stress emanating from caring for the member of the family with mental illness. Table 70 presents the results obtained.

Table 70
Gender of Respondent and ability to cope with stress emanating from caring for the member of their family with mental illness

		Ability to cope with stress emanating from caring for the member of their family with mental illness				
		Strongly Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 70, ability to cope with stress emanating from caring for the member of their family with mental illness is higher among the females (63%) than among males (42%).

Pearson chi test for association was used to test whether there was any significant association between gender and the ability to cope with stress emanating from caring for the member of their family with mental illness. The results were as summarized in Table 71.

Table 71

Gender of respondent and the ability to cope with stress emanating from caring for the member of their family with mental illness

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654a	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases			

According to the information on Table 71 indicates that $p<0.05$ which implies that there is an appreciable association between gender and the ability to cope with stress emanating from caring for the member of their family with mental illness. A higher proportion of the female respondents agreed with the statement that they are at times overwhelmed by the stress emanating from the demands of caring for the mentally ill member of their families, than the male respondents.

4.7.3 Feelings of Condemnation for having a Member of the Family with Mental Illness

Majority of the respondents($\bar{x} = 2.219$ sd=0.415) agreed with the statement that they more often than not felt condemned by the fact that they have one of their family members with mental illness.

Further, the study sought to establish whether the duration of time lived with the mentally ill had any relationship with the feeling that the family members feel condemned by the fact that they have one of their family members with mental illness. Table 72 displays the results obtained.

Table 72
Duration of living with the mentally ill patient and the feeling of being condemned by the fact that they have one of their family members with mental illness

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	12	24
2-5 Years	9	7	13	29
6-10 Years	0	0	38	38
More Than 10 Years	17	28	51	96
Total	**32**	**41**	**114**	**187**

According to the information displayed on Table 72, majority of the respondents 38(100%)who had lived for 6-10 years with the mentally ill family members do not feel condemned by the fact that they have one of their family members with mental illness. On the other hand, the majority of the family members 12(50%) who had lived for a short time with the mentally ill member feel condemned by the fact that they have one of their family members with mental illness. For those who had been living with the mentally ill for more than ten years, 46.8% agreed with the statement, while the remaining 53.1% disagreed with the statement, meaning they had developed ways of coping, so they do not feel condemned.

Table 73

Chi Square test for duration of living with mental patient and feeling of condemnation by having one of the family members with mental illness

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	79.060[a]	3	.000
Likelihood Ratio	93.442	3	.000
Linear-by-Linear Association	2.070	1	.150
N of Valid Cases	187		

a. 2 cells (16.7%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 73, $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and feeling condemned by the fact that they have one of their family members with mental illness. Those who have lived with their mentally ill relatives for more than ten years seem to have developed coping mechanisms which help them to deal with the mentally ill such that they do not feel condemned.

Further, the study sought to establish whether gender of the respondents was associated with feeling condemned by the fact that they have one of their family members with mental illness. Table 74 presents the results obtained.

Table 74

Gender of Respondent and the feeling of condemnation by having one of the family members with mental illness

		Feeling of condemnation by having one of the family members with mental illness				
		Strongly Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 74, the feeling of condemnation by the fact that they have one of their family members with mental illness is more prevalent among the female (63%) than among male respondents (42%).

Pearson chi test for association was used to test whether there was any significant association between gender and the feeling of condemnation by the fact that they have one of their family members with mental illness. The results were as summarized in Table 75.

Table 75
Gender of respondent and feeling of condemnation by the fact that they have one of their family members with mental illness

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654a	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases			

According to the information on Table 75 indicates that $p<0.05$ which implies that there is an appreciable association between gender and the feeling of condemnation by the fact that they have one of their family members with mental illness. More of the female respondents agreed with the statement that they feel condemned by the fact that they have one of the members of their families with mental illness than the male respondents.

4.7.4 Feeling of Helplessness in Overcoming the Negative Feelings and Experiences

The study also sought to establish whether the families are optimistic that they can change their attitude towards their member who suffers from mental illness. The findings indicated that majority of the respondents($\bar{x} = 2.398$, sd=0.491) feel helpless due to the fact that there is nothing they can do to overcome the negative feelings and experiences they encounter as a result of having one of their family members with mental illness.

The study further sought to establish whether the feeling of helplessness in overcoming the negative feelings and experiences encountered as a result of having a member of the family suffering from mental illness, differed across the duration the family members had lived with the mentally ill. Tables76 and 77 summarize the results obtained.

Table 76

Duration of living with the mentally ill and feelings of helplessness in overcoming the negative feelings and experiences

	Strongly Agree	**Agree**	**Neutral**	**Disagree**	**Total**
Less Than 2 Years	6	16	0	2	24
2-5 Years	9	7	2	11	29
6-10 Years	0	2	36	0	38
More Than 10 Years	17	28	0	51	96
Total	**32**	**49**	**38**	**64**	**187**

According to the information displayed on Table 76, majority of the respondents 51(53%)who had lived for more than 10 years with the mentally ill family members do not express the feeling of helplessness in overcoming the negative feelings and experiences. On the other hand, the majority of the family members 22(92%) who had lived for a short time with the mentally ill member experienced a feeling of helplessness in overcoming the negative feelings and experiences. The findings indicate that families who have lived for a long time with a mentally ill member do not feel helpless in overcoming the negative feelings and experiences, this could be an indication that they have learnt to cope with time.

Table 77

Chi Square test for duration of living with mentally ill and feelings of helplessness in overcoming the negative feelings and experiences

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	179.943[a]	9	.000
Likelihood Ratio	182.736	9	.000
Linear-by-Linear Association	1.176	1	.278
N of Valid Cases	187		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 77, p<0.05 which implies that there is an association between the length of time lived with the mentally ill family member and the feeling of helplessness in overcoming the negative feelings and experiences they encounter as a result of having one of their family member with mental illness. Further, the findings have indicated that the more the time spent with the mentally ill family members, the weaker the feeling of helplessness in overcoming the negative feelings and experiences as a result of having a family member with mental illness.

Further, the study sought to establish whether gender of the respondents was associated with the feelings of helplessness in overcoming the negative feelings and experiences. Table 78 presents the results obtained.

Table 78

Gender of Respondent and feelings of helplessness in overcoming the negative feelings and experiences

		feeling of helplessness in overcoming the negative feelings and experiences				
		Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	27	18	19	20	84
	Female	15	23	21	44	103
	Total	**42**	**41**	**40**	**64**	**187**

According to the information presented in Table 78, the feeling of helplessness in overcoming the negative feelings and experiences is more prevalent among the females (63%) than among males (54%). The results however indicate that the disparity in the perception across the genders is marginal.

Pearson chi square test of association was used to test whether there was any plausible association between gender and the feelings of helplessness in overcoming the negative feelings and experiences resulting from living with the mentally ill. The results were as summarized in Table 79.

Table 79
Gender of Respondent and feeling of helplessness in overcoming the negative feelings and experiences resulting from living with a mentally ill member of the family

	Value	**df**	**Asymp. Sig. (2-sided)**
Pearson Chi-Square	1.569[a]	3	.666
Likelihood Ratio	1.567	3	.667
Linear-by-Linear Association	1.102	1	.294
N of Valid Cases	187		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 14.37.

According to the information on Table 79, $p>0.05$ which implies that there is no statistically significant association between gender and the feeling of helplessness in overcoming the negative feelings and experiences encountered as a result of having one of the family members with mental illness. Further, the findings have indicated that both genders largely experience the feeling of helpless in overcoming the negative feelings and experiences they encounter the same way.

4.7.5 Inability to Secure Supportive Social Networks

Majority of the respondents($\bar{x} = 2.219$ sd=0.719) said that they are unable to secure supportive social networks such as friends, relatives and members of the society who empathize with their situation.

The study further sought to establish whether the inability to secure supportive social networks such as friends, relatives and members of the society who empathize with their situation differed across the duration the family members had lived with their mentally ill relative.Tables80 and 81 summarize the results obtained.

Table 80

Duration of living with the patient and inability to secure supportive social networks

	Strongly Agree	**Agree**	**Disagree**	**Total**
Less Than 2 Years	6	6	12	24
2-5 Years	9	7	13	29
6-10 Years	3	0	35	38
More Than 10 Years	17	28	51	96
Total	**35**	**41**	**111**	**187**

According to the information displayed on Table 80, 45(47%) of those who had lived with the mentally ill for more than ten years, and 12(50%) who had lived for a short time with the mentally ill member agreed with the statement that they are unable to secure supportive social networks from friends, relatives or members of the society who are able to empathize with their situation. The findings indicate that there is no significant disparity across the length of time lived with the mentally ill member and the experience of inability to secure supportive social networks.

Table 81

Chi Square test for duration of living with mentally ill and the inability to secure supportive social networks

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654[a]	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases	187		

a. 2 cells (16.7%) have expected count less than 5. The minimum expected count is 4.11.

According to the information on Table 81, $p<0.05$ which implies that there is an association between the length of time lived with the mentally ill family member and the inability to secure supportive social networks. Social support seems to get less with time, the longer the family lives with their mentally ill relative, the less the support they receive from other relatives, friends or the members of the societies in which they live.

Further, the study sought to establish whether gender of the respondents was associated with the inability to secure supportive social networks. Table 82 presents the results obtained.

Table 82

Gender of Respondent and the inability to secure supportive social networks from friends, relatives and members of the society

		Strongly Agree	Neutral	Disagree	Strongly Disagree	Total
Gender of Respondent	Male	17	18	16	33	84
	Female	15	23	25	40	103
	Total	**32**	**41**	**41**	**73**	**187**

According to the information presented in Table 82, the inability to secure supportive social networks is more prevalent among the females (63%) than among males (42%). The results indicate that the disparity in the perception across the genders is appreciable.

Pearson chi test for association was used to test whether there was any significant association between gender and the inability to secure supportive social networks. The results were as summarized in Table 83.

Table 83
Gender of respondent and inability to secure supportive social networks from friends, relatives and members of the society

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.654a	6	.000
Likelihood Ratio	46.157	6	.000
Linear-by-Linear Association	1.239	1	.266
N of Valid Cases			

According to the information on Table 83, $p<0.05$ which implies that; there is an appreciable association between gender and the inability to secure supportive social networks from friends, relatives and members of the society who empathize with the family's situation. The female respondents report more failure to secure supportive social networks than the male respondents.

Generally, majority of the respondents expressed their feeling that they find it difficult to accept that there may be no way out of their current situation with their mentally ill member, with most of them feeling overwhelmed with stress emanating from the demands of caring for their member with mental illness. In addition, there is a general feeling of helplessness due to lack of adequate social support accessible to them such as supportive friends, relatives and society members who empathize with their situation.

The researcher also carried out in depth interviews to obtain deeper insights into the resilient behaviour of family members as they live with their mentally ill relatives. The first question that was asked required them to describe how it was accepting the state of their sick relative. The responses given bring out the difficulties that they have gone through in their journey with their mentally ill relative.

> *"Our parents shielded us, they kept it away from us. I guess they also had difficulties accepting her condition. When they finally allowed us to know, it was very difficult to accept…it did not come easily… we were shocked… she would shout and make a lot of noise. It is hard to imagine that she may not get better."*
>
> *"It was not easy to accept. I kept hoping that she would get better but it reached a point, after a lot of worrying and anxiety that I had to accept. But it is hard to imagine that my daughter may not be able to live a normal life."*
>
> *"It is not easy to deal with him; when it becomes very difficult, I just trust in God and he helps me to bear it. I rely on God for strength because it is not easy but since I decided to stay and not leave him (my husband), I just have to put up with him."*
>
> *"I struggled with it until I had no choice but to accept. I decided to stay on with her and support her as my wife…I really have no choice. Many of my friends have advised me to marry another wife, but I will not do that, even if she dies today; I cannot remarry. I usually think if I married another wife, she would also get mentally sick."*
>
> *"It is very difficult for me…I always wonder how her life will be and that of her daughter. I am sick (terminal illness)and I always wonder what will happen to them when am no longer able to take care of them. It is hard to imagine that she will never get better."*
>
> *"Our brother's illness is a struggle for us, but we have had no choice but to accept his situation. Since he lost his job and his wife and children deserted him, and my aged parents had to take over the burden of caring for him, we just had to take it up and accept the situation. It has been a process, a long one for us to get to where we are today."*

One major theme emerging from this data is that of a process of accepting and learning to cope with the mental illness and the issues associated with it. The interviewees describe the difficulties they have gone through before reaching to the point of accepting the situation that they have to live with. There is an aspect of denial at the beginning, hoping that their loved one would get better and would go back to their earlier normal life. This is then followed by reluctant acceptance, where they say, ‘they had no choice but to accept and learn to live with it.’ This shows that the families have had to constantly adjust as the illness progressed, and as the family situation changes.

Marsh (2002) observed that mental illness affects all aspects of a family’s operations as well as family relationships. This was observed in the families in this study; a husband who was the breadwinner is no longer able to perform his job and the wife has to take over, a wife who was taking care of her household now needs someone to take care of her. These roles are shifted to the other spouse, affecting the family’s emotional and physical well-being. The choices these spouses of the mentally ill make will determine the survival of the family. There are those who will choose avoidant coping, where one tries to avoid dealing with the stressor, and since the sickness is not going away, they may abandon the mentally ill spouse altogether. However, those who opt for emotion-focused coping, where one changes their emotional reactions towards the stressor, are the ones who have chosen to stay on and support their spouses. There are also cases of siblings who have had to take up the responsibility of their sick brothers or sisters, or parents who have to take care of their grown up children who would otherwise be self-reliant. Family set ups are completely changed as a result of the mental illness.

Another theme that emerges from the data is the role of spirituality in the coping strategies employed by the family members taking care of their mentally ill relative. Spiritual beliefs have played a role in the families' bid to cope with the mental illness. Their faith in God gives them something to hold onto when it becomes very difficult to deal with their sick relatives. Quigley (2013) reported that in a study conducted to investigate the coping strategies of people dealing with mental illness, spirituality was found to provide some form of meaning to them. The support from their congregations in form of prayers and believing in a benevolent God combined to provide a positive emotion-focused coping strategy. The interviewees reported the same as given below:

> *"There is no other way but to trust in God."*
>
> *"I pray and God helps me through."*
>
> *"The church members visit and pray with us every once in a while, this gives us hope and peace, even when things are very difficult."*
>
> *"I am sure that God will never abandon us. Even when we do not get help or support from any other source, we are sure that God is always with us and will always help us out."*

The researcher asked the interviewees to specifically explain how they normally deal with their sick relatives' demands, which are known to be sometimes unrealistic. The researcher also sought to know how they deal with the mentally ill when they are not willing to do what is expected of them, such as taking medication. The responses show that the care givers have with time, developed ways of dealing and coping with their mentally sick relatives.

> *"I avoid arguing with him, if he disagrees with something I just let it be because I realized he can be very unrealistic and I can never win. As for the medication, it is usually difficult to persuade him if he refuses, sometimes we have had to take him to hospital by force so that they give him the injection. After that he calms down and will take the other tablets."*
>
> *"So long as she is taking her medication, she is reasonable, so I talk to her and she will listen and take advice. When she becomes unrealistic, I don't argue with her, I give her time and she will eventually listen and heed to what I tell her."*

> *"My sister is only given an injection once a month; she refused to take all other form of medication, such as tablets. Since the injection keeps her calm, we stopped trying to give her any other…she used to just throw them away. She is not very vocal but usually behave in a certain way, like pour out food if she does not like it…then we understand she does not want that particular food and a different dish is prepared for her."*

> *"I usually do everything possible to make sure she takes her medication. Sometimes I have used friends to persuade her, other times I lovingly persuade her myself…she can be very difficult, she can even insult me… but I just bear it, I understand it is the illness. A few times, I have literally forced the medicine into her mouth. It is not easy, but if it is the only way, I have to make sure she takes it. On other issues, I just let her be, if she refuses to do anything, I don't argue with her. Like you saw she refused to come out and greet you…these days all she wants is watch TV."*

> *"She is not very difficult…if she makes some demands I just talk to her, and she calms down. As for the medication, she does not refuse, but I have to give her myself, she will not accept it from anybody else or take it on her own volition."*

> *"My brother can be quite unrealistic in his demands, especially when he asks for money. Most of us do not know what to do when he is like that, but my mother would always somehow calm him down. One of our sisters' now is the one who manages him. She is able to reason with him without getting annoyed, and he listens to her. Sometimes he has refused to take his medicine and then he becomes unmanageable. At such times we have taken him to the hospital by force."*

It emerges from this data that the family members have come up with practical ways of coping. When their loved ones become unreasonable, they have learnt not to argue with them, but bear with them and give them space. This can be seen as problem-focused coping where individuals gather information concerning the problem and then learn new ways of managing (Bouteyre et al., 2007). They have learnt that arguing does not bear fruit; instead they use persuasion and even allowing them to have their way when it is not harmful to them. Others have learnt to understand what the sick ones mean by some actions and responding appropriately. We find that others also use the approach of seeking social support by inviting friends to assist them or letting the family members who are able to deal with the sick one do so.

The researcher also asked the interviewees to talk about how they deal with negative feelings arising from living with their mentally ill relative. This was aimed at understanding how they have managed to cope with stress emanating from the burden of taking care of the mentally sick or from stigma that they may experience from the society. Their responses were as given below:

> *"As a family we closed ourselves out from what people say…we do not pay attention to any talk out there or even coming from the extended family. We realized peoples' talks and some opinions did not help but only added to our stress. Instead, we concentrate on taking care of our sister the best we can. Our faith in God and the fact that we can talk to each other about her within the immediate family helps us a lot."*
>
> *"It was difficult at the beginning, especially because I expected his family to assist me in taking care of him and other financial obligations like paying fees for the children. But when I realized they were not willing, I do my best to help him and take care of the family the best I can, I now do not listen to what people say and the suggestions they give because they are not helpful."*
>
> *"I have somehow learnt to live with it. I trust in God and he helps me through all the difficulties. I also have a few friends who support me, we talk and it makes it easier to bear the difficulties. When people talk and what they say is not helpful…I just ignore. I have also had to train the children to turn a deaf ear to people who say negative things about their mother. I tell them to accept her illness just like any other illness."*
>
> *"The situation is worrying, but I really have no choice but to accept it as it is and just trust God for strength. Peoples' negative talk is very hurting because we did not do anything to bring about this illness, but we just ignore the way they treat us and move on."*
>
> *"We have had to sit together as a family, the immediate family, to agree on how to deal with our brother. It was particularly difficult when our parents were alive and taking care of him, we could see how he was stressing them. We have learnt to draw strength from one another and to only listen to positive things, anything negative from any quarter, we ignore."*

These families seem to have been able to embrace the concept of hardiness, as explained in one of the theories guiding this study. Though they may be at different levels, the factors of commitment, control and challenge are evident in the way they are handling their mentally ill relatives. According to Tartasky (1993), commitment is what assists individuals to have a sense of purpose which gives them courage and strength to deal with difficult situations and face stressful situations. The interviewees in this study have chosen to be committed to the task of taking care of their loved ones and are thus able to ignore the negative aspects related to their task. Control is explained in the theory as the ability to believe and act as though one is able to influence events and have explanations for what takes place. The factor of challenge on the other hand is based on the fact that the environment keeps changing and providing new opportunities. This aspect of hardiness seems to have enabled them cope with the stress associated with the task of care-giving. It is also observed that most have been able to seek social support where they needed assistance, a characteristic associated with hardiness (Funk, 1992).

4.8 Biographical Report

The family chosen for biographical research had lived with the mentally ill member for over twenty years. Below is the narrative as provided by the husband, translated from vernacular language:

My wife was very healthy when we met. But she changed suddenly, when our third child was about a year old. She just stopped breastfeeding the baby, she could neither eat nor talk. She appeared terrified; her face showed she was disturbed, she was not communicating in any way, she was just blank. I tried everything I could, including trying to force her to eat, but she would close her mouth so tight…It was very distressing for everybody and when she did not improve, I took her to Nyeri PGH (current Nyeri County Referral Hospital).She was admitted to the hospital and the doctor said she was mentally disturbed. After treatment, she improved and started eating as well as talking. She was discharged and allowed to go home. The doctor said she would be okay…but…more than twenty years now she has never gone back to the person that she was. It is not easy.

I started wondering what could have caused this illness. The doctor had said she did not have enough blood, so I wondered; could this lack of blood have caused the illness? We have gone through a lot; sometimes she would walk away from home and we had to go all over looking for her, other times she has attempted to commit suicide. All this time she was still on treatment, so I would wonder if this treatment was helping her or not. It is like she just kept getting worse. She also started having strange behaviours such as being selective about colours. She started throwing away anything red; be it utensils, or her own clothes. Up to date, she cannot stand anything that is red in colour, it seems to make her very uncomfortable.

I still kept hoping that she would get better. I love my wife and I gave her all the support I could and we even got another baby after a few years. The doctors however advised that she was not healthy enough to continue having children, and after a lot of persuasion she agreed to undergo a permanent family planning procedure. My hope of her getting better was renewed, because I thought, if she does not get more children, then even her mental state would improve. But, it didn’t happen. She would go through periods when she appeared okay, she would cook and carry on her duties at home; but after a while she would relapse. The rainy seasons are especially bad, lightning and thunder seem to have a very bad effect on her.

Sometimes, due to financial constraints, I would not be able to get her medication on time. Other times she would also refuse to take the medication. It is very difficult for us when that happens, sometimes I have sought help from friends who have persuaded her, other times I have had to literally force the medicine down her throat. It is quite distressing. At such times it will be that she cannot sleep and is shouting and screaming, and so I am forced to take such measures because it is very disturbing for everyone and even the neighbours cannot sleep.

It is not shameful for me to have her as a wife in that condition, but it is very disturbing. I keep wishing she could be better, even for her own sake; she never seems to have joy. I cannot go with her to some places, sometimes we cannot even have visitors in our home, and she is very hostile sometimes. Our life changed a lot. I usually just hope people will understand. There is nothing I can do about it. But I have accepted this situation and try my best to live with it. It is difficult for the children too, especially when they were younger and could not understand what was wrong with their mother. But I always explain to them that their mother is sick and we have to understand her. This situation has affected their social lives as well; they are not able to bring their friends home or enjoy what other children enjoy discussing and general talk with their mother. But we have all kind of adjusted our lives to accommodate her since we actually have no choice, we accept her as she is.

Relating with other people for me is a bit difficult. Though I try to interact, even talk about my situation, I find that most people regard me negatively. Sometimes, I find that people treat me as if I was sick also, like am also mentally sick. You know like the way people are treated if in a family someone has HIV/AIDS, there is stigma and the whole family is regarded as though they are sick. It is the same for us; people do not take us positively. Some of my friends have advised me to divorce her and remarry, that I will also go mad; but I cannot do that. I have to support her because I believe that it is a God-given responsibility for me, and I always try to do for her what I would expect someone to do unto me if I was the one who was sick.

Mental illness is very complicated and one keeps trying to figure it out. I tried to find out her family history, if any of her relatives had mental illness, but I was told there was no history of abnormal behaviour. I was also wondering if she possibly had ever stolen something and was cursed or maybe something else that could result in a curse of some sort, but there was no such report given. She however told me that she had a very difficult childhood, where her sister who brought her up, after the death of her parents was very cruel to her. She would beat her up severely and she was always very terrified of her. She felt that her sister hated her, because according to her, she treated her other siblings better. I was even told of a time when she had become mute for a number of days when she was in primary class four. So, sometimes I wonder; could this problem have started way back? I also think that I put her under a lot of pressure. She was very young when we got married, she was only seventeen years old, and I was living with my late sister's three children. So, here she was, pregnant and taking care of three small children. I usually think I put her under a lot of pressure; I was working away from home at the time and she must have had it very tough. May be this also contributed in a way; maybe the burden was too heavy for her, too stressful and she was not able to tell me about it.

In my situation, I find I am all alone. Nobody seems to understand what I have to go through. I do not get any form of support. No organization has ever come to my aid. There is no form of guidance available or counseling for us who live with this problem. I just try to come up with ways of coping and dealing with this situation in my own way. A few years ago, I tried to bring a few people together who live with this kind of illness, to start a support group where we could meet regularly and support each other. But it became very difficult, some people do not want to accept their situation and then we had no support. I realized we needed professionals to assist us, so I gave up. You know even hospitals give us very little help, they just give the patient medication, which you have to pay for anyway, and then just tell you to take your relative home and ensure they take the medicine; that is all. We hear the government giving assistance like free treatment for HIV/AIDS, or free maternity services, but no assistance is given for those with mental illness.

Those of us living with mental illness require a lot of help. The medication has to be taken throughout life. Sometimes it is not available in the government facilities and it is very expensive in the private chemists. I wish it could also be made available in the local dispensaries; it could save us the long journeys that we have to take and the financial implication involved. If the government could also give us even a little stipend, like they are giving to the aged, it would really assist. You know these people would also benefit from food supplements because they do not always feed well. If support groups are also formed; and counselors provided, here close to us, it would really assist us.

For me, I have learnt to live with this situation. I have accepted it and always try to deal with whatever comes. I make sure she takes her medication, if she is restless or violent, I try to calm her down, if she refuses to take food I do whatever I can to persuade her; sometimes I even buy for her appetite boosters. My greatest handicap is finances. But this is not easy; it is a very difficult situation.

4.8.1 Analysis of the Narrative

Perceptions towards mental illness

The interviewee describes how the illness came about suddenly. He explains that his wife had been well since they had met and they already had three children. He seems to associate the illness with poor health as well as stress that his wife was undergoing in taking care of their children, and the added responsibility of taking care of his sister's children. He also thinks that the trauma she underwent in her early years may have contributed to this illness.

The main aspects emerging from this narrative include having to face the unexpected as well as self-blame. The illness is seen as something that disrupts the normal functioning of the family, interfering with the stability that was there previously. A mother who was taking care of her children and her household is suddenly not able to do that, and the husband is forced to take up roles that he did not have to before.

Self-blame surfaces when he starts to explain what could have brought about the mental illness. He blames himself for expecting too much from her while he was working away from home. In his words;

> *"I think I put her under a lot of pressure. She was very young, only seventeen when we got married and I was living with my late sister's three children. So here she was, having her own babies and taking care of these other three children, and I was working away from home at that time. It must have been too tough for her."*

These perceptions agree with the explanation of the Attribution theory where Heider (1958) said that human beings always attempt to interpret events that occur in their lives, in order to understand and attempt to have some control of their lives. The interviewee in this narrative seems to have expected that if he corrected the situation, and the circumstances that his wife was in, then she would get better. It was very frustrating for him when she did not improve, even after he took her to hospital and tried to adjust her living conditions.

The interviewee explains how he tried to find out what else could have caused the mental illness when his earlier explanation did not seem to hold when she did not get better. He now talks about cultural issues and says they could also cause mental illness.

> *"I tried to find out her family history, if any of her relatives had mental illness and I found no links. She however had a very difficult childhood where she was mistreated by her elder sister when her parents died."*

> *"I was also wondering…could she have stolen something and was cursed, or something else that could result in a curse of some sort."*

The fact that he sought answers from the past, on the possible causes of the illness, and that he also thought about cultural issues such as curses, indicate that his approach in dealing with the illness would then have depended on his findings. When later questioned on the traditional healing for mental illness, he chose not to discuss the subject saying that modern scientific medicine had replaced the traditional, and that Christianity was also embraced in the society.

On the issue of participation in the daily house chores and her own upkeep, the interviewee said that most of the times she requires assistance. There are those times she will carry out her duties at home, cook for the family, clean up and even work in the shamba, but more often she will just sit and do nothing at all. At such times, she has to be persuaded to take care of her own body like taking a bath, eating and the husband sometimes have to do everything for her. This shows that he perceives her as a burden; a person who requires supervision and help on a daily basis.

Attitudes towards mental illness

In his narrative, the interviewee explains how it is disturbing for him to see his wife in her present condition. He describes the experience as; 'distressing', 'very disturbing', 'very difficult', terms which express a state of helplessness in dealing with the situation.

> *"It is very distressing, very disturbing and sometimes very difficult to see and deal with my wife in the condition that she is in. There is nothing I can do about it. But I have accepted the situation and try my best to live with it."*

There is also stigma in the society and he explains that most people regard the family negatively. Friends have even advised him to divorce her and remarry. This stigma makes relating with others difficult and has alienated the family. The illness has affected the family’s social life; the children are not comfortable bringing their friends home and cannot have a normal parent-child relationship with their mother. He also says that he cannot go with her to some places, such as family gatherings and sometimes they cannot have visitors in their home.

The interviewee in his narration of his lived experience with his mentally ill wife explains that mental illness is complicated. He indicates that there could be several other causes of the illness other than what he had explained as stressful lifestyle as well as a medical condition resulting from poor health. He mentions family history and curses as well as trauma which could result from ill treatment at an early age. This shows that the interviewee has mixed feelings about the illness, which means that although he follows up on treatment at the hospital, he may hold some hidden beliefs that help for his loved one may be found elsewhere, like in traditional healing.

Attitudes held by individuals towards mental illness will determine how they seek help as well as how well they follow up on treatment. Attitudes are shaped by the belief systems held and this may explain why for this particular family, the treatment may not have been followed consistently as they have kept looking for explanations for the illness.

Social support systems

The interviewee reports that no social support is available in the community, from friends or the extended family. His efforts to bring together a few people living with a relative with mental illness did not bear fruit and he suggests that they would require professional help to have such support groups. It is expected that social support would have psychological benefits to the care givers as well as for the mentally ill. The absence of this kind of help results in helplessness as the family members feel they have to deal with the issues concerning their loved ones alone and also figure out how to deal with these issues.

He mentions that the hospitals only provide medication, indicating that he would expect more. He feels just being told to ensure the patient takes medication is not enough. Some form of education concerning mental illness would assist so that the care givers would have a better understanding of the mental illness and what to expect of their sick relatives. Some form of guidance would be required since it would equip the family care givers with skills on how to handle the sick person, and the things the care giver would need to do in different circumstances. This shows that the health care systems do not adequately meet the needs of the mentally ill as well as of those who take care of them in their homes.

Resilient behavior

From his narrative, it emerges that this care giver has struggled with his mentally ill loved one and has reached a point of acceptance. The family operations and relationships have changed but the family has learnt ways of coping and adjusting as has been necessary.

> *"I have learnt to live with the situation. I have accepted it and always try to deal with whatever comes. I make sure she takes her medication, if she refuses or she is violent, I try to calm her down. If she refuses to take food, I do everything I can to persuade her; sometimes I even buy for her appetite boosters."*

This family seems to have adopted the two positive forms of coping with the mental illness; emotion-focused and problem-focused. By using emotion-focused coping, this family has attempted to change the meaning of the mental illness as a stressor and taken it as a God-given responsibility of taking care of their sick relative. They have managed to reduce the negative emotions that would emanate from the things the sick individual would say or do. Admiral (2000) found that emotion-focused coping has different styles which all focus on reducing the negative emotions brought about by the stressor.

In applying problem-focused coping, this family has tried to gather information concerning the illness and learned new ways of managing. By so doing the care giver reports being able to manage the demands of the mentally ill including her adhering to medication as well as feeding. Though the family has been affected emotionally and physically by the illness; family relationships and roles altered, they have managed to continue to operate as a family unit by use of the problem- solving skills and coping strategies.

4.9 Implications for Practice

As the researcher interacted with the caregivers of the mentally ill, it was noted that they require psychological support. The experience of the researcher in the course of data collection was that counselors are needed in the communities. The caregivers reported having had no interaction with a counselor, and most were treating the interview sessions almost like counseling sessions and were requesting the researcher to be visiting them.

The caregivers usually find themselves in a situation where they need to take care of their relatives with no prior knowledge or any form of preparation. Most were found to be almost helpless in dealing with their mentally ill relatives. This results in psychological distress and they would benefit from support from counselors who would be willing to listen to their struggles and assist them in handling the issues, and training them in stress management. This help could be given to individual family members or in group set ups where those living with the mentally ill could be organized in support groups where they would meet regularly with a counselor, share their experiences and provide each other with the support and benefit from the therapeutic healing that occurs in groups.

Most of the mentally ill were reported to have difficulties fitting in the community due to stigmatization. Programs need to be set up that would assist them to get integrated back to the community through rehabilitation and psycho-education that would assist them carry on with regular activities that would help them earn their living and participate in the family affairs as well as what goes on in the community. Some are unable to complete their education or training since they are not able to fit into the formal settings after the onset of the mental illness which will normally have interrupted their normal routine. After treatment, many would still be able to participate in their previous occupations, but this was found not to be happening. Such programs should be conducted by trained psychotherapists who would also provide follow-up in the communities where these people live and provide them with the assistance they would require.

Sensitization on mental illness should also be carried out in the communities. The best placed to provide this education would again be psychotherapists who have the prerequisite knowledge and information to help the community understand mental illness so that they can assist the mentally ill instead of discriminating against them or treating them with contempt or suspicion which leads to stigmatization.

The researcher found that there is a great need for counselors and psychotherapists in the communities, to assist the mentally ill, the caregivers as well as those members of the community who live and interact with these people.

CHAPTER FIVE

SUMMARY OF THE FINDINGS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives the summary, conclusions and recommendations of the study. This was based on the research findings that are presented and discussed in the previous chapter.

5.2 Summary of Major Findings

The following sections provide a summary of findings of the study based on the objectives of the study.

5.2.1 Perceptions of Families towards a Member with Mental Illness

The study used questionnaires to find out the perceptions held by family care givers towards mental illness and those members of their families suffering from a mental illness. The aspects explored to bring out these perceptions included their view on the causes of mental illness; could it be as a result of a curse to the family members, from witchcraft, sorcery or black magic or is it a form of punishment for a sin committed or a bad omen. The other aspect had to do with how the family members view their mentally ill relative; as dangerous and one who should be avoided as well as whether they view the sick as worthless, dirty and senseless.

From the data collected, some viewed mental illness as a curse while others did not perceive it as a curse. The statistical analysis established that the more time lived with the mentally ill members, the less the tendency to see mental illness as a curse in the family. This perception did not vary with gender;both the male and female respondents had similar views concerning the issue of curses bringing about mental illness.

The issue of black magic or witchcraft was not considered as a cause of mental illness by most of the respondents, regardless of length of stay with the mentally ill or the gender of the respondent. It was however found that 38.5% of the respondents viewed mental illness as a form of punishment or a bad omen. More of those having this view were those who had lived with mental illness for a period of less than two years, while fewer of those who had lived with the mental illness longer held this view of mental illness being a form of punishment or a bad omen. More male respondents than the female respondents were also found to be of the opinion that mental illness is a result of a punishment or a bad omen.

According to the data, as families live with a member with mental illness, they tend to change their perception of them being dangerous. Those who had been with the mentally ill for a shorter period viewed the sick as dangerous and that they should be avoided.A slightly higher percentage of females perceive the mentally ill as dangerous as compared to the male respondents.

A sizeable proportion of the respondents, across the data viewed the mentally ill as worthless, dirty and senseless. This view was however more prevalent among those who had lived with the mentally ill for a short time than those who had been with them longer. This view was also more prevalent among the female respondents than the male respondents. There were others however, who were of the view that the mentally ill are not worthless, dirty or senseless.

The statistical analysis (linear regression) showed that 10.7% of the variation in the caregivers' resilience is explained by their perceptions towards mental illness and the mentally ill member. This means that perceptions towards mental illness and the mentally ill have a relatively high impact on the resilience of families living with a member who has mental illness. Analysis of variance (ANOVA) was used to test the statistical significance, and a small *p-value* ($p<0.005$) was obtained, implying that the relationship between perceptions towards mental illness and the mentally ill and the caregivers' resilience is statistically significant. It also means that the aspects of perceptions tested have a significant influence on the caregivers' resilience. The null hypothesis: There is no statistically significant relationship between perceptions and the resilience of families living with a member with mental illness was thus rejected.

In-depth interviews conducted also brought out the perceptions of family caregivers towards the mental illness and the mentally ill members of their families and how these affect their resilience as they live with their mentally ill relatives. It emerged from the data collected that mental illness always took the family members by surprise; the symptoms appearing suddenly either in adolescence or in adulthood. The interviewees reported that no early signs had been noted, and that their loved ones had been leading normal lives. This perception meant that they always expected that their loved one would get better and go back to their original self. The frustration was evident when this did not happen, as most reported that their relative did not get better after treatment.

Another aspect that emerged from the data is denial. Family members found it difficult to accept their relative's illness while some even believed that the sick person was deliberately behaving in an odd manner, or was pretending to be sick. This view made it difficult for those family members to accept the mental illness as it is and thus be able to cope with the demands of the sick relative. This agrees with the Attribution theory which explains that if mental illness is understood in terms of controllability, in such a way that the sick person has something to do with the illness, then it will greatly affect the coping methods of the caregivers.

The views expressed on the origin of mental illness ranges from stress and anemia to cultural factors such as curses, evil spirits, unresolved family issues and hereditary factors. All the interviewees reported seeking medical treatment from the hospitals regardless of what they considered to have brought about the mental illness.

The interviewees expressed that they have to bear the burden of taking care of their mentally ill relatives. The mentally ill are not able to participate in any economic activities most of the times, or even their own upkeep and someone has to be always available to assist them. All expressed a decrease in the quality of life in their families as a result of the illness, changes in family relationships as well as changes in roles in the family set ups.

The perceptions held by the family members have a direct bearing on the different strategies and ways that the families have developed for coping with the demands of taking care of their mentally sick relatives, which is what, can be termed as their resilience.

5.2.2 Attitudes of Families towards a Member with Mental Illness

The attitudes of the family members were explored by how they agreed or disagreed with statements regarding; whether the mentally ill can be normal again, if they are always violent and unpredictable as well as whether the presence of the mentally ill expose the families to a lot of stigma. The study also sought to know if they are viewed as a burden to the other family members as they have to be provided for and also if the mentally ill can be engaged in any productive activities.

From the data collected, 39% of the respondents were of the opinion that mentally ill persons can never be normal again, while the rest have hope that they can lead normal lives once again. Those who had lived for a shorter time with their mentally ill relatives, less than two years, were more who held the belief that their relatives were likely to lead normal lives again, but the longer the time lived with the mentally ill, the greater the tendency to adopt the attitude that the mentally ill family member can never be normal again. There was marginal disparity in the perception that the mentally ill can never be normal in the male and the female respondents.

Respondents were asked whether their mentally ill relatives were always violent and unpredictable, majority (72.1%) disagreed with the statement that mentally ill persons are always violent and unpredictable. There was no disparity found in this perception across the duration lived with the mentally ill, and no association was found between gender of the respondents and the view that the mentally ill were always violent and unpredictable. This indicates that the mentally ill fluctuate in their behavior, so they were not always violent and unpredictable.

The other aspect explored was that of stigma where 78.1% of the respondents said that mental illness exposed the family to stigma. This attitude was found in all categories, regardless of the duration of time lived with the person with mental illness. It was however found that those who had lived with the mentally ill longer reported experiencing less stigma directed towards the family than those who had lived with mental illness for a shorter time. This could be that with time, they have learnt to cope better, and have changed their attitude and how they view stigma directed to them by those around them. There was also no association between gender of the respondents and the attitude that the presence of the mentally ill exposes the family to a lot of stigma.

A high percentage of the respondents who had lived for less than two years with the mentally ill had the attitude that the mentally ill were a burden to the other family members, since they have to be given attention and be provided for, while a very small percentage of those who had lived with their sick relatives for more than ten years agreed with this statement. More of the female respondents were found to hold this attitude than the male respondents.

On the question regarding whether the mentally ill can be engaged in productive activities, majority of the respondents were neutral, they neither agreed nor disagreed with the statement that mentally ill persons cannot be engaged in any productive ways. However, a higher percentage of those who had lived for a period of less than two years with the mentally ill, had the attitude that the mentally ill cannot be engaged in any productive ways than those who had lived with them for more than ten years. This attitude was however found not to vary with the gender of the respondents.

Linear regression was used to test the relationship between attitudes towards mental illness and the mentally ill and the resilience of family caregivers. The findings were that 16.97% of the variation in their resilience in caring for the mentally ill member is explained by their attitudes. Attitudes therefore have a relatively high impact on the resilience of the family caregivers. Analysis of variance (ANOVA) was used to test whether the impact of the attitudes towards mental illness and the mentally ill on the caregivers' resilience was statistically significant. The *p*-value was less than 0.05 implying that the relationship between attitudes towards mental illness and the mentally ill and the caregivers' resilience is statistically significant and that the aspects of attitudes tested have a significant influence on the caregivers' resilience. The null hypothesis: There is no statistically significant relationship between attitudes and the resilience of families living with mental illness is thus rejected.

The data obtained from the interviews gave deeper insights into the attitudes of family caregivers on mental illness and the mentally ill.

One aspect emerging from the data is that living with the mentally ill is quite disturbing and the family members see their mentally ill relatives as the source of the stigma and discrimination from the society that they have to deal with. The family members found it difficult to discuss issues relating to the mentally ill with relatives or friends due to the stigma and feelings of being misunderstood. With time, some families have been able to overcome these negative feelings and are able to share freely and also seek for assistance as well as suggestions on dealing with their sick relative. Some families were found to have learnt to ignore outside interference and generally keep to themselves and do what they believe is best for their sick relatives.

Family members also reported the loss of stability in their families as a result of the mental illness. Stability in the families is affected when the mentally ill, usually bread winners, lose their jobs, and roles are changed within the families. Relationships among family members are also affected especially in cases when members are not able to agree on issues relating to the mentally ill family member. It was also found that some families break as a result of the mental illness where a spouse is unable to cope with the illness and chooses to leave the marriage.

The other aspect that was expressed by the interviewees was the connection of the causes of mental illness with cultural issues and unresolved family matters. The view that the mental illness could be passed on in families through the generations, such as by naming systems in the kikuyu culture, was an attitude brought out by some of the interviewees. The possibility of curses was also brought out by some interviewees, or failure to observe some cultural practices especially concerning marriage rites. Such attitudes may be hindrances to the caregivers since the only form of treatment they have are the hospitals, and most were not willing to seek traditional solutions, or these were not available. If family members believe there could be a curse, they will most likely believe that their relative would only get better if the curse is dealt with, or if a customary issue has been ignored, when it is taken care of. This will have an effect on their coping strategies since they feel helpless and are not confident that the treatment their loved ones are receiving is sufficient.

5.2.3 Social Support Received by Families Living with Mental Illness

The study assessed the whether the social support received by the respondents was adequate by requiring them to agree or disagree with statements concerning; social networks such as religious centers and friends, formal social networks such as healthcare and educational institutions. The study also inquired if the mentally ill were often admitted to the hospitals in order to ease the burden for the family care-givers and also if the families faced isolation from friends and other social networks in the communities where they live.

Majority of the respondents agreed with the statement that social networks such as religious centers and friends do not offer adequate support to the family members living with a mentally ill member. It was however noted that, the longer the families live with the mentally ill, the less the social support they receive from their families and the religious organizations. There was found to be no association between gender and the view on social support offered to family members living with a mentally ill relative.

Majority of the respondents agreed that formal networks such as health-care and educational institutions did not offer adequate support to the families living with a member with mental illness. It was found that 50% of those who had lived with the mentally ill for less than two years did not think that the support given by formal institutions was adequate, compared to 46% of those who had lived for more than ten years with the mentally ill. This view was also held by a greater percentage of the female respondents than the male respondents.

Majority of the respondents also agreed that many healthcare providers do not admit their mentally ill relatives in the hospitals, leaving the burden of taking care of them to the family caregivers. They explained that it was only on very rare occasions, only when their sick relatives were completely uncontrollable, that the health providers admitted them to the hospitals.

When asked whether the family faces isolation from friends and social networks, most family caregivers were neutral. This would indicate that there was isolation from some quarters and not from others. This was qualified from the interviews, since some reported getting assistance from some family members, some of the times, and not from others.

Linear regression was used to test the relationship between accessibility to social support and the resilience of the families living with a member with mental illness. Results obtained gave R^2=O.180, meaning that access to social support predicts 18% of the variation in the resilience of the family caregivers. This implies that social support networks have a relatively high impact on the resilience of the family caregivers living with a member with mental illness.

Analysis of variance (ANOVA) gave a small *p*-value, which means that the relationship between social support networks and caregivers’ resilience is statistically significant and that the aspects of access to social support networks tested have a significant influence on the caregivers’ resilience. Test of the hypothesis thus indicate that the relationship is statistically significant. The null hypothesis: There is no statistically significant relationship between social support received by family members living with mental illness and their resilience, was rejected.

Data collected from the interviews gave further information on accessibility to social support networks. Interviewees reported lack of social support from their extended families as well as their communities. This was seen to be as a result of most people failing to understand the nature of mental illness. Their expectation would be that the illness, just like other illnesses, should be cured within a short time after treatment. When the mentally ill do not get better, they give up and withdraw any form of support to the families. This explains why those who had lived for a shorter time with their mentally ill relatives reported receiving more social support than those who had lived for longer periods with the mentally ill.

The interviewees said that the responsibility of taking their loved ones to hospital, which was reported to be quite stressful sometimes because they resist, was entirely on them. Supervising the taking of medication is also left wholly upon them since it was only in very extreme situations that their loved ones were admitted to the hospitals. The healthcare providers only prescribed the medication or gave injections where applicable. The support given by the hospitals was described as minimal. Educational institutions did not offer much help either, since those who had been unable to fit into the conventional educational set up due to mental illness, were forced to drop out of school altogether.

The result of lack of social support is expected to have negative effects on the mentally ill as well as their relatives. This was expressed as a poor sense of self-esteem as reported by some interviewees who said their relatives appeared resigned to their conditions and did not seem to make effort to perform better in their daily lives. The care givers on their part expressed feelings of helplessness and isolation as they took care of their mentally ill relatives.

5.2.4 Resilient Behaviour of Families Living with a Mentally Ill

It was found that most families find it difficult to fully accept that the state of their mentally ill relative may never change; they still hold on to a hope that their loved one may still get better. This view was held by all the respondents regardless of the duration of time they had lived with the mentally ill. Majority of the respondents also reported feeling overwhelmed by the stress emanating from the demands of caring for their member of the family with mental illness. In addition, more of the female respondents expressed this feeling than the male respondents.

The respondents also agreed that they experience feelings of condemnation due to the fact that one of the members of their family has mental illness, with a higher percentage of those who had lived longer with the mentally ill reporting this feeling. This feeling of condemnation was also reported by 63% of the female respondents as compared to 42% of the male respondents. Majority of the respondents also agreed that there is a general feeling of helplessness due to the fact that they are not able to overcome the negative feelings and experiences they encounter as a result of living with the mentally ill. This feeling of helplessness was indicated by a larger proportion of those who had lived with a shorter time with the mentally ill than those who had been with them for less than two years.

Majority of the respondents also reported that they were unable to secure supportive social networks such as friends, relatives or the immediate community where they live, which are able to empathize with their situation. Those who had lived for less than two years with the mentally ill reported more social support than those who had been living with them longer.

Data obtained from the interviews however, bring out a process of accepting and learning to cope with the mental illness and the issues associated with living with a member of the family who has mental illness. The interviewees describe the difficulties they have gone through and the adjustments they have had to make as they continued to live with the mentally ill.

Spiritual beliefs were found to have played a role in assisting family members to cope with the challenges of living with the mentally ill. Their believe in God as well as support in form of prayers from their congregations was reported to have provided some form of meaning for them even when circumstances were very difficult. This can be seen as a form of emotion-focused coping strategy.

Some caregivers have chosen emotion-focused styles of coping and have managed to change their emotional reactions towards the mentally ill and have been able to cope. Others have employed problem-focused coping and have come up with practical ways of dealing with the demands of their mentally ill relatives. These include; not arguing with the sick relative, being patient with them, seeking support from friends and relatives to assist them when difficulties arise. Others have learnt to talk about their difficulties with trusted people who have given them assistance and a listening ear.

A number of family members who were interviewed seem to have embraced the concept of hardiness as explained in the Hardiness theory of Resilience. They have managed to have commitment, which gives them a sense of purpose and strength to face any difficulties associated with the care-giving. A sense of control was also evident, where the family members felt that they have the ability to control and influence the events that arise as they lived with their mentally ill relatives. Though at different levels, a number of family care-givers have taken the task of taking care of their loved ones as a challenge and are able to seize new opportunities from their environment.

5.3 Recommendations

The findings of this study reveal that several things need to be done in order to support the caregivers in the task they have of taking care of their mentally ill relatives. It emerged from the data that the family caregivers bear a huge burden in caring for their relatives. They require support as they take care of their mentally ill relatives. They need to be provided with information regarding mental illness; how it comes about and how it is likely to progress, as well as how to manage problem behaviors in the sick. They also require training on ways of coping with stress as well as how to take care of their own self-care. It is evident that they embark on care-giving with no knowledge on the mental illness and thus have to develop ways of coping largely by trial and error. Psycho-education is therefore necessary and should include; information on mental illness, presenting symptoms, early signs of relapse, available treatments, common side effects, and coping methods. Family care-givers also need to be guided on their own self-care including anxiety and stress management so as to remain healthy and be able to carry on the care-giving to their sick relatives.

It was also noted from the data collected that most family members attributed mental illness to cultural issues, but most of them were not willing to discuss traditional healing practices. It is therefore recommended that the medical health practitioners including the psychologists and counselors encourage the family care givers to incorporate traditional medicine where applicable. This is because most cultural beliefs surrounding mental illness may cause psychological distress which may be alleviated by traditional healing or resolving the family issues that may be associated with the mental illness.

The framework below has been recommended which can be used by all mental health practitioners who are involved in the treatment and management of mental illness.

Figure 4: Model Framework for Family Care-givers

Step	**Activities**	**Expected information and outcomes**
I	Families start to take care of their loved ones while in hospital	Reduce hostility in the minds of the patients about their family members. Family members to learn ways of caring for the sick
II	Group sessions for the family members while patient is still in hospital	General information about the illness, presenting symptoms, early signs of relapse, available treatment options, common side effects and coping methods.
III		Both the patient and family members should be prepared to leave hospital. The psycho-education will prepare them to go to the community with a message that mental illness can be treated, which will reduce stigma.
IV		Discuss day-to-day problems in the management of patients. Include the possibility of including traditional healing methods.

V	Group sessions to continue after discharge from hospital	Teach simple practical skills of management of the illness Discuss anxiety and stress management skills. Family members to discuss the issues they have faced in their care giving. Family care-givers to share ideas with others living with mental illness. Qualified counselors to be in charge of moderating these group meetings
	Formation of Support groups	These sessions should be held periodically, once a month or as the group members would find it necessary
	Follow up sessions	

Other recommendations include:

1) Establishment of systems, by the relevant government authorities, to make it easier for the mentally ill to be incorporated into the community after treatment. These would include:

Community-based mental health care facilities close to the people to reduce the distance that the mentally ill and their loved ones travel to seek treatment in the County hospitals.

2) Establishment of a financial support system where the mentally ill would be given a monthly stipend, like what is currently given to the aged in Kenya.
3) The government, through the ministry of health should train community mental health workers who would visit the mentally ill in their homes to provide support and the much needed advice to the caregivers.
4) Non- governmental organizations (NGOs) should start programs that provide support to the caregivers and be involved in the organization of support groups in the communities.
5) Facilities should be put up where mentally ill persons who need rehabilitation can be taken as in-patients. Such facilities would also take care of those who have no caregivers at their homes, either because those who would provide the care are too old or that family members are not willing to take up the care-giving role. Such facilities should be funded by the government and have professionally trained staff members. This would reduce the burden for the family members and provide help for the mentally ill.
6) Periodical campaigns should be carried out to spread community awareness on mental illness. These should be aimed at educating members of the public on issues related to mental illness in order to reduce stigma and assist to integrate the mentally ill into the society. This would also reduce the stresses that the caregivers face.

5.4 Recommendation for Further Study

The study concentrated on the perceptions, attitudes and social support for the families with mentally ill members and how these influence their resilience. Further research may be conducted on the cultural, economic and emotional impacts of mental illness in a family.

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APPENDICES

Appendix I: Consent Form

You are requested to participate in this research which is investigating selected psychosocial influences on the resilience of families living with mental illness. Your responses will be treated in confidence and used for academic purposes only.

I am signing this form to give consent to participate in the study on the psychosocial influences on the resilience of families living with a member with mental illness. As a volunteering participant, I allow the researchers to use tape recording equipment during the interview. I am also aware that I have the right to withdraw from the interview at any time.

I am assured that confidentiality will be maintained throughout the study, and there is no way I will be identified from the data analysis in the research. Finally, I understand that all the tape recorded information and personal information is merely for the purpose of the research and it will not affect my safety in any way.

Participant’s Signature	Date
______________________	______________________
Researcher’s Signature	Date
______________________	______________________

Appendix II: Interview Guide for Family Members

Section I: Perceptions

a) How did you realize that your relative had mental illness?

b) What views do you hold on the causes of mental illness?

c) What is your view on the treatment he/she gets? (sufficient; Does he get better)

d) In what ways does he/she participate in his own care and upkeep?

Section II: Attitudes

a) How is it living with your sick relative? (Is it disturbing, upsetting, shamefuletc)

b) How comfortable are you talking to a friend or family member about the mental illness?

c) What beliefs do you as an individual or as a family have on mental illness?

Section IV: Social Support

a) Do you receive any support from friends, or the community or your church, as you take care of your relative? (What forms of support, is it sufficient?)

b) In what ways has the hospital been helping you?

c) Are there any social services available in your community for you and your relative?

Section V: Resilient Behaviour of Family Members

a) How is it accepting the state of your mentally ill member? (Difficult, manageable etc)

b) How do you deal with your sick relative’s demands? (Unrealistic demands, taking medication)

c) How do you deal with the negative feelings and experiences you encounter as a result of living with the mentally ill member in your family?

Section VI: Intervention

a) What do you think can be done to make it easier for you in taking care of your sick relative?

b) What would you recommend to others who may be going through a situation like yours?

Appendix III Questionnaire for Family Members

The purpose of this questionnaire is to obtain data on Psychosocial Influences on the Resilience of Families Living with a Member with Mental Illness in Nyeri County, Kenya and the responses obtained will be used for academic purpose only.

Please to respond to all the parts of this questionnaire. Information from this document will be confidential and in no way will it be communicated to any person. Thank you in advance (**Your name should not appear anywhere in this document**).

Section A: Personal Information

A1 Gender

a) Male ( )

b) Female ( )

A2 For how long have you lived with the mentally ill member of your family?

a) Less than 2 years ( )

b) 2 to 5 years ( )

c) 5 to 10 years ( )

d) More than 10 years ( )

Section B: Perceptions of Family Members towards Mentally Ill Member

To what extent do you agree with the following statements about the perceptions of family members towards the mentally ill member? (SA-strongly agree, A- agree, N-neutral, D-disagree, SD-strongly disagree).

Statement	**SA**	**A**	**N**	**D**	**SD**
B1. Mental illness is as a result of a curse to the family members					
B2. Mental illness originates from witchcraft/ sorcery/ black magic					
B3. Mental illness is a form of punishment for a sin committed/ a bad omen					
B4. Mentally ill persons are dangerous and should be avoided					
B5. Mentally ill persons are worthless, dirty and senseless					

Section C: Attitudes of Family Members towards Mentally Ill Member

To what extent do you agree with the following statements about the attitudes of family members towards the mentally ill member? (SA-strongly agree, A- agree, N-neutral, D-disagree, SD-strongly disagree).

Statement	**SA**	**A**	**N**	**D**	**SD**
C1. Mentally ill persons can never be normal again					
C2. Mentally ill persons are always violent and unpredictable					
C3. Mentally ill persons expose a lot of stigma to their families					
C4. Mentally ill persons are a burden to other family members since they have to be given attention and be provided for					

C5. Mentally ill persons cannot be engaged in any productive ways					

Section D: Social Support Systems for Family Members Living with Mentally Ill Member

To what extent do you agree with the following statements about the social support systems for family members living with mentally ill member? (SA-strongly agree, A-agree, N-neutral, D-disagree, SD-strongly disagree).

Statement	**SA**	**A**	**N**	**D**	**SD**
D1. Social networks such as religious centers and friends do not offer adequate support to the family members with a mentally ill member.					
D2. Formal social networks such as healthcare and educational institutions do not offer adequate support to families with a mentally ill member					
D3. Many healthcare providers do not admit mentally ill as inpatients leaving the burden of catering for the mentally ill persons entirely to their families					
D4. The families living with the mentally ill face isolation from friends and other social networks such as relatives and immediate communities in which they live.					

Section E: Resilient Behaviour of Family Members Living with Mentally Ill Member

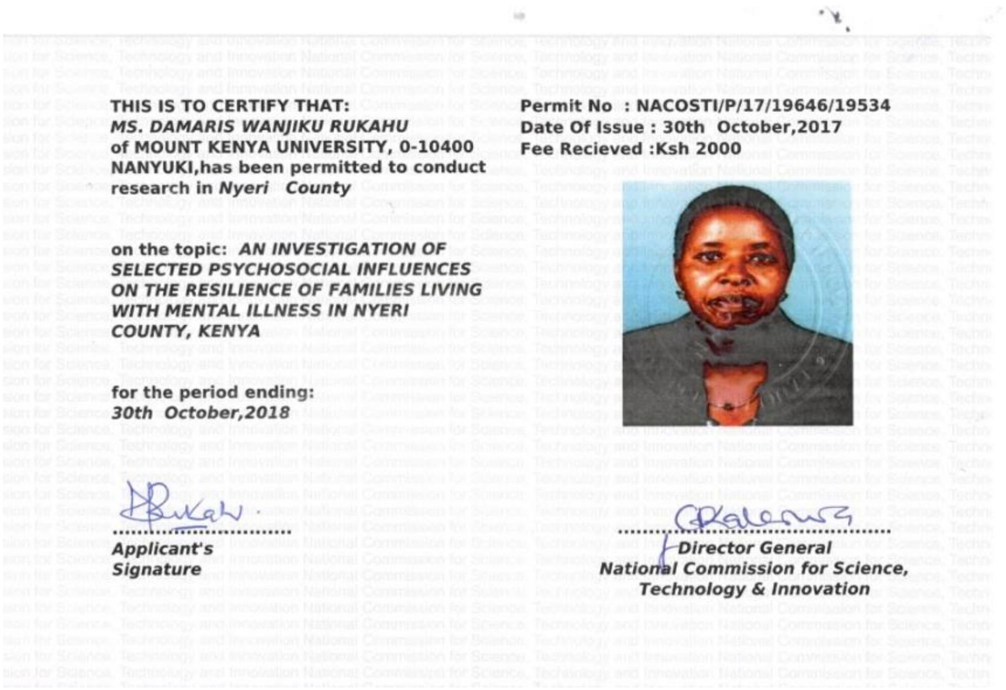
1. To what extent do you agree or disagree with the following statements about the resilient behaviour of family members living with mentally ill member? (SA-strongly agree, A- agree, N-neutral, D-disagree, SD-strongly disagree).

Statement	**SA**	**A**	**N**	**D**	**SD**
E1. We find it difficult to fully accept that the state of our mentally ill member may never change					
E2. We are at times overwhelmed with stress emanating from the demands of caring for the member of our family with mental illness					
E3. We more often than not feel condemned by the fact that we have one of our members of our family with mental illness					
E4. We feel helpless by the fact that there is nothing we can do to overcome the negative feelings and experiences we encounter as a result of having one of our family members with mental illness					
E5. We are unable to secure supportive social networks such as friends, relatives and society members who empathize with our situation.					

END

Thank you for your cooperation in providing responses

Appendix IV: Research Clearance Permit



THIS IS TO CERTIFY THAT:
MS. DAMARIS WANJIKU RUKAHU
of MOUNT KENYA UNIVERSITY, 0-10400
NANYUKI,has been permitted to conduct
research in *Nyeri County*

on the topic: ***AN INVESTIGATION OF SELECTED PSYCHOSOCIAL INFLUENCES ON THE RESILIENCE OF FAMILIES LIVING WITH MENTAL ILLNESS IN NYERI COUNTY, KENYA***

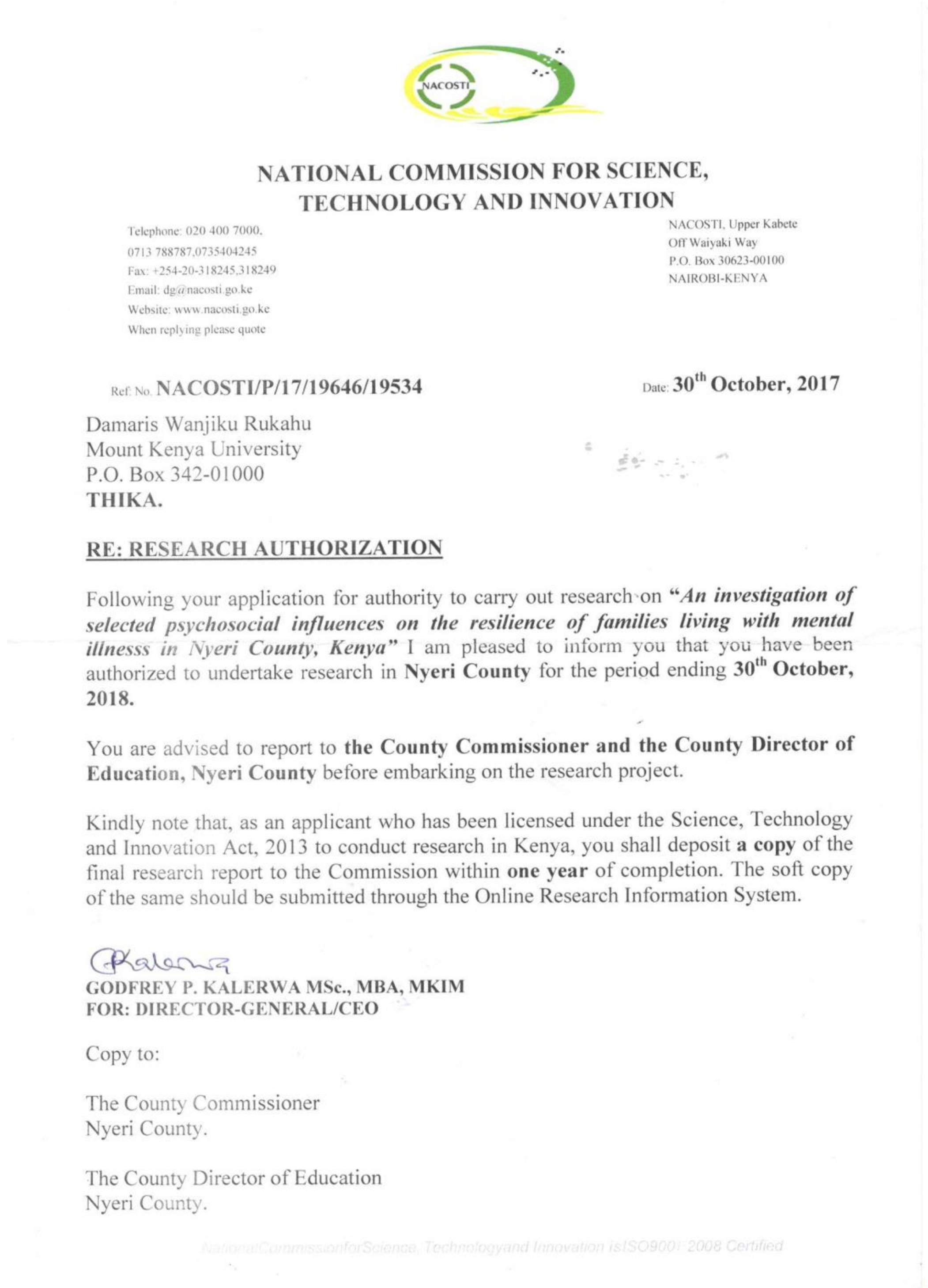
for the period ending:
30th October,2018

Permit No : NACOSTI/P/17/19646/19534
Date Of Issue : 30th October,2017
Fee Recieved :Ksh 2000

………………………
Applicant's Signature

………………………
Director General
National Commission for Science, Technology & Innovation

Appendix V: Research Authorization – National Commission for Science, Technology and Innovation



NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION

Telephone: 020 400 7000,
0713 788787,0735404245
Fax: +254-20-318245,318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No. **NACOSTI/P/17/19646/19534**

Date: **30th October, 2017**

Damaris Wanjiku Rukahu
Mount Kenya University
P.O. Box 342-01000
THIKA.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"An investigation of selected psychosocial influences on the resilience of families living with mental illnesss in Nyeri County, Kenya"*** I am pleased to inform you that you have been authorized to undertake research in **Nyeri County** for the period ending **30th October, 2018.**

You are advised to report to **the County Commissioner and the County Director of Education, Nyeri County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

GODFREY P. KALERWA MSc., MBA, MKIM
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Nyeri County.

The County Director of Education
Nyeri County.

National Commission for Science, Technology and Innovation is ISO 9001: 2008 Certified

Appendix VI: Research Authorization – Office of the County Director of Education

MINISTRY OF EDUCATION
STATE DEPARTMENT OF BASIC EDUCATION

E-Mail –centralpde@gmail.com
Telephone: Nyeri (061) 2030619
When replying please quote

OFFICE OF THE COUNTY
DIRECTOR OF EDUCATION
P.O. Box 80 - 10100,
NYERI

CDE/NYI/GEN/23/VOL.II/159

14th November, 2017

Damaris Wanjiku Rukahu
Mount Kenya University
P.O. Box 342-01000
THIKA

RE: RESEARCH AUTHORIZATION

Reference is made to Secretary National Commission for Science, Technology and Innovation letter Ref. NACOSTI/P/17/19646/19534 of 30th October, 2017 on the above subject.

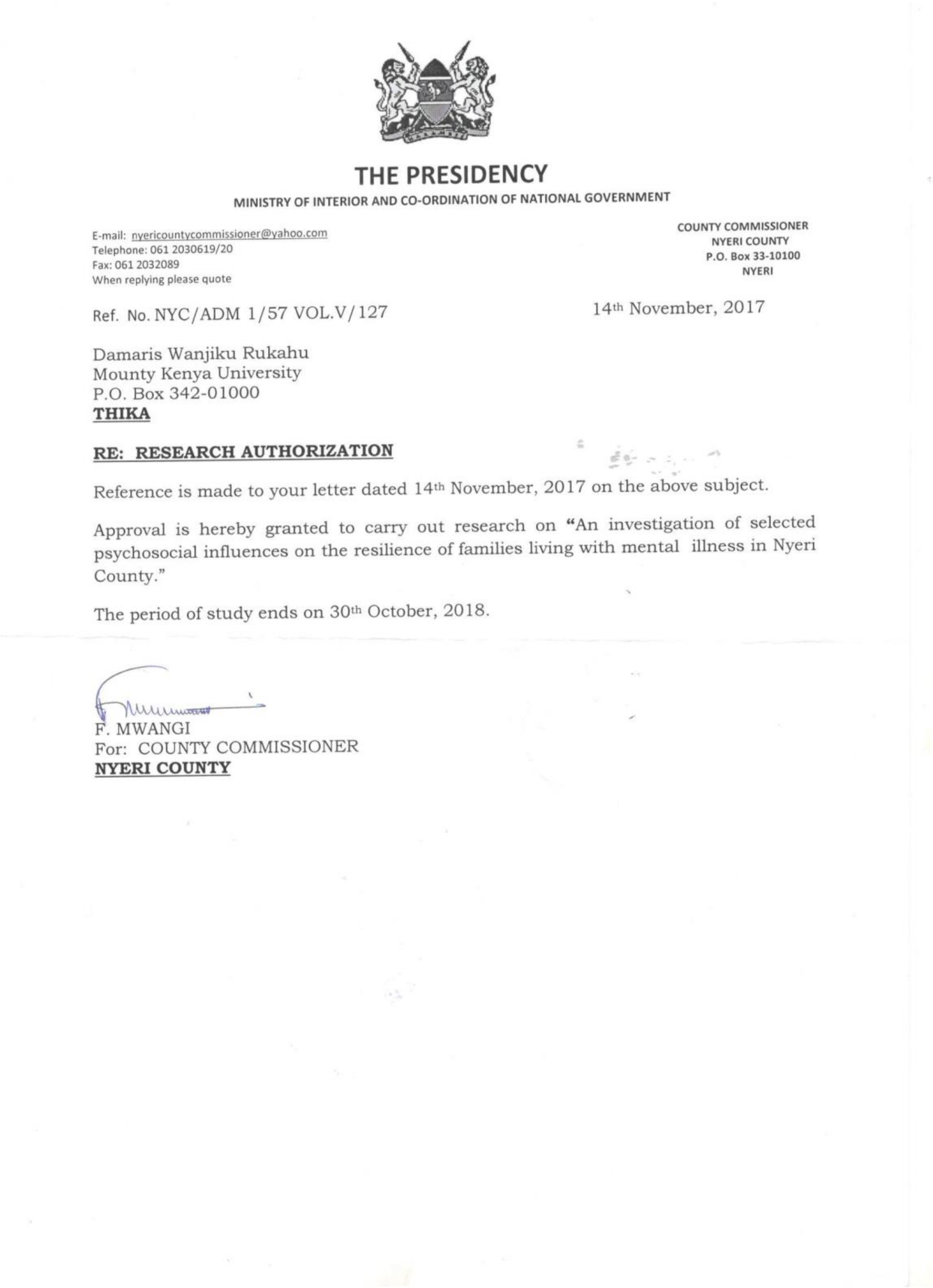
Kindly note that you have been authorized to carry out research on "***An investigation of selected psychosocial influences on the resilience of families living with mental illness in Nyeri County, Kenya***" for a period ending **30th October, 2018.**

MOSES MAKORI
COUNTY DIRECTOR OF EDUCATION
NYERI COUNTY

cc.

National Commission for Science,
Technology and Innovation,
P.O. Box 30623-00100
NAIROBI

Appendix VII: Research Authorization – County Commissioner Nyeri County



THE PRESIDENCY

MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT

E-mail: nyericountycommissioner@yahoo.com
Telephone: 061 2030619/20
Fax: 061 2032089
When replying please quote

COUNTY COMMISSIONER
NYERI COUNTY
P.O. Box 33-10100
NYERI

Ref. No. NYC/ADM 1/57 VOL.V/127

14th November, 2017

Damaris Wanjiku Rukahu
Mounty Kenya University
P.O. Box 342-01000
THIKA

RE: RESEARCH AUTHORIZATION

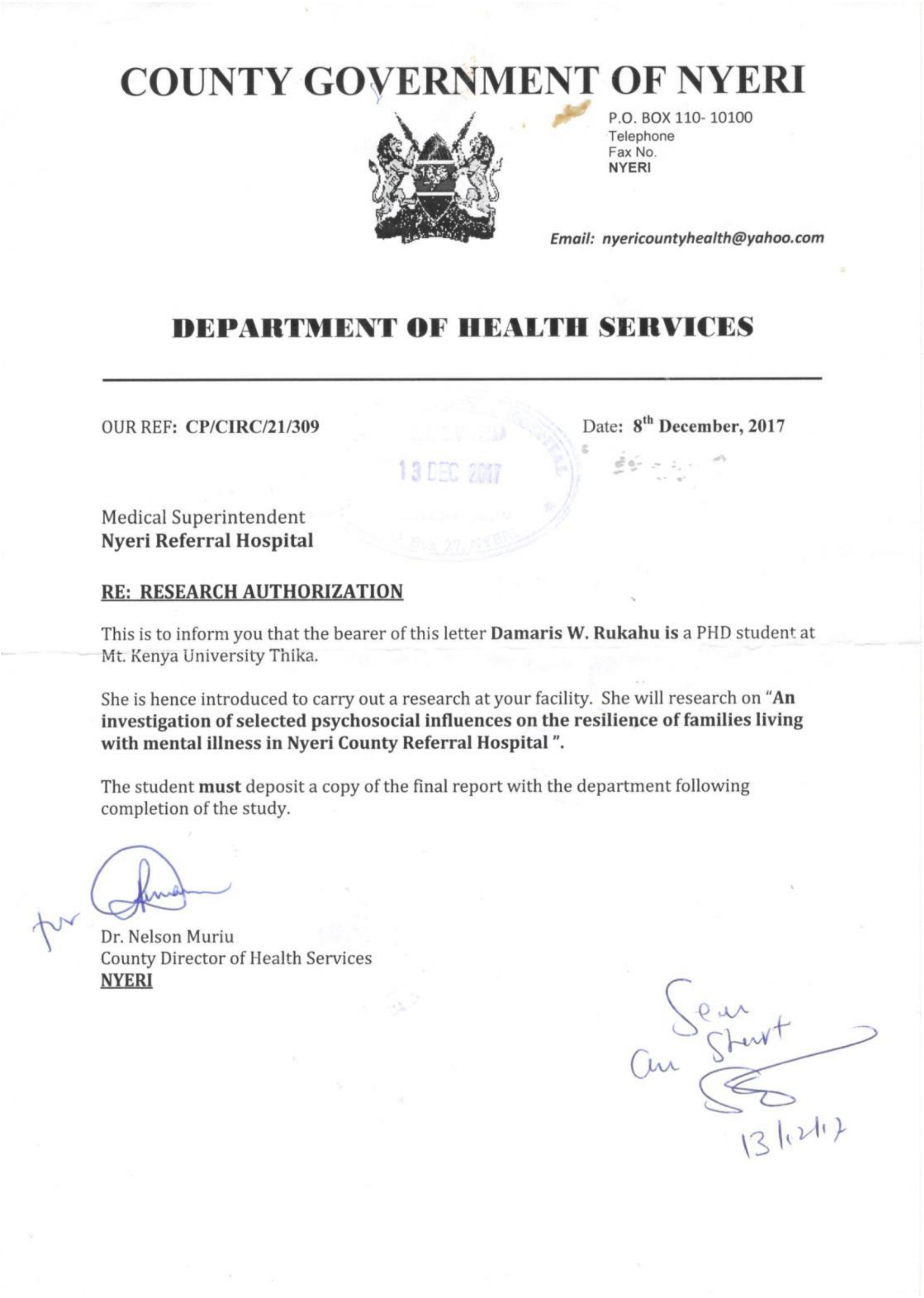
Reference is made to your letter dated 14th November, 2017 on the above subject.

Approval is hereby granted to carry out research on **"**An investigation of selected psychosocial influences on the resilience of families living with mental illness in Nyeri County."

The period of study ends on 30th October, 2018.

F. MWANGI
For: COUNTY COMMISSIONER
NYERI COUNTY

Appendix VIII: Research Authorization – Department of Health Services



COUNTY GOVERNMENT OF NYERI

P.O. BOX 110- 10100
Telephone
Fax No.
NYERI

Email: nyericountyhealth@yahoo.com

DEPARTMENT OF HEALTH SERVICES

OUR REF: **CP/CIRC/21/309**

Date: **8th December, 2017**

13 DEC 2017

Medical Superintendent
Nyeri Referral Hospital

RE: RESEARCH AUTHORIZATION

This is to inform you that the bearer of this letter **Damaris W. Rukahu is** a PHD student at Mt. Kenya University Thika.

She is hence introduced to carry out a research at your facility. She will research on "**An investigation of selected psychosocial influences on the resilience of families living with mental illness in Nyeri County Referral Hospital**".

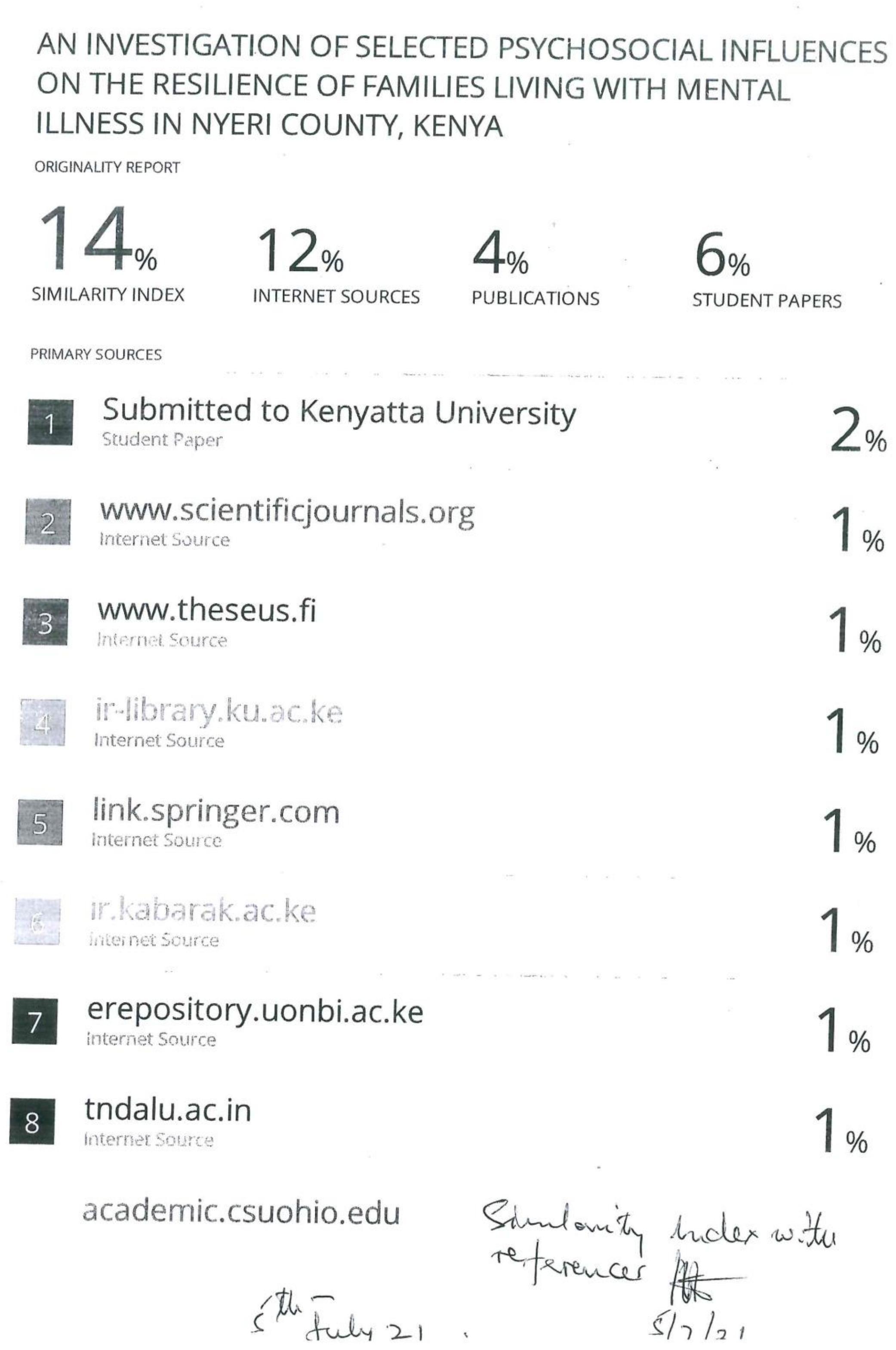
The student **must** deposit a copy of the final report with the department following completion of the study.

for

Dr. Nelson Muriu
County Director of Health Services
NYERI

Seen
Can Start
13/12/17

Appendix IX: Similarity Index Report



AN INVESTIGATION OF SELECTED PSYCHOSOCIAL INFLUENCES ON THE RESILIENCE OF FAMILIES LIVING WITH MENTAL ILLNESS IN NYERI COUNTY, KENYA

ORIGINALITY REPORT

14%	12%	4%	6%
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