Resilience factors in families living with a member with a mental disorder

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Thesis presented in partial fulfilment of the requirements for the degree of Master of Arts (Psychology) at the University of Stellenbosch.

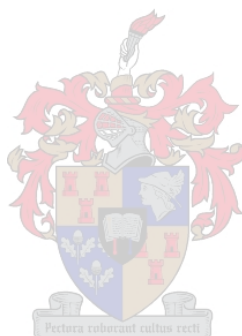Supervisor: Prof A P Greeff

December 2006

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis consists of my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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ABSTRACT

An immense burden is placed on families caring for a member with a mental disorder as a result of deinstitutionalisation in South Africa. The aim of present study was to identify resilience factors in families living with and caring for a member with a mental disorder.

The focus was on families living in an underprivileged, semi-rural area; caring for a patient using the state-sponsored psychiatric services. Using a cross-sectional survey design, interviews were conducted with 34 family representatives. During these interviews, qualitative and quantitative data was gathered by means of a biographical questionnaire, an open-ended question and set of self-report questionnaires. The results yielded from the data analysis are in keeping with findings from international and South African family resilience studies.

After content analysis of the qualitative data, three themes related to resilience factors emerged: internal factors within the home, external factors outside of the home and factors related to the member with a mental disorder. The most commonly mentioned resilience factors cited by the family representative were religion and spirituality, characteristics of individual family members (excluding the patient), family characteristics, and social support. Spearman's correlations and best subsets multiple regression analysis were performed on the data to ascertain which factors are significantly correlated or associated with family adaptation. In both statistical analyses, communication styles of the family unit were the most important. Spearman's correlations further revealed that in addition to family communication, the ability of the family to work together, and communication between the marital couple had the strongest correlation with adaptation. Passive acceptance of problematic issues in the family has a negative correlation with family adaptation. The two most significant predictor variables of family adaptation are the family's style of family communication during crises and the family's use of passive appraisal as a coping style.

OPSOMMING

Die werklikheid van deïnstitusionalisering in Suid-Afrika plaas tans 'n geweldige las op gesinne gemoeid met die sorg van 'n lid met 'n geestesversteuring. Die doel van hierdie ondersoek was om veerkragtigheidsfaktore te identifiseer in gesinne wat 'n gesinslid met 'n geestesversteuring versorg.

Die fokus was op gesinne uit 'n lae sosio-ekonomiese en semi-plattelandse gebied, wat sorg vir 'n pasiënt wat gebruik maak van staatspsigiatriese dienste. 'n Eenmalige, dwarssnit opname-navorsingsontwerp is gebruik. Onderhoude is gevoer met verteenwoordigers uit 34 gesinne. Sowel kwalitatiewe as kwantitatiewe data is ingesamel met behulp van 'n biografiese vraelys, 'n oop-einde vraag en 'n stel selfrapporterings-vraelyste. Resultate van hierdie ondersoek bevestig dié van vorige navorsing.

Uit die ontleding van die kwalitatiewe data blyk dit dat veerkragtigheidsfaktore in drie kategorieë voorkom, naamlik interne faktore in die huis; faktore ekstern aan die huishouding en faktore wat met die pasiënt verband hou. Die veerkragtigheidsfaktore wat deur die meeste gesinsverteenwoordigers aangedui is, was godsdiens, karaktereienskappe eie aan individuele gesinslede (uitgesluit die pasiënt), oorhoofse gesinskenmerke, en algemene sosiale onderskraging. Beide die Spearman-korrelasies en die meervoudige regressie-ontleding onthul die kommunikasiestyl van die gesin as die belangrikste veranderlike. Verdere ontleding van Spearman-korrelasies identifiseer die vermoë van die gesin om saam te werk en kommunikasie tussen die ouerpaar, as faktore wat die sterkste verband hou met gesinsaanpassing. Passiewe aanvaarding van probleme in die gesin het 'n negatiewe verband met gesinsaanpassing. Die mees beduidende voorspellers van gesinsaanpassing is die gesin se kommunikasiestyl tydens krisistye en die passiewe beoordeling van krisissituasies.

ACKNOWLEDGEMENTS

to step back and take stock before plunging headway into the next task. Most of all for the incredible faith you seem to have in me – when I listen to you I feel like I can take on the world!

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And finally, to the participants and their families. Thank you for taking the time to share, laugh, reflect and open your hearts. I am humbled by your grace, honesty, humility
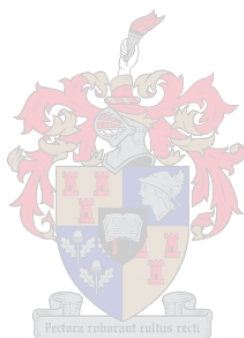
And resilience.

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CHAPTER ONE

Introduction

1.1 Introduction

Across the globe, even in developing countries, there is economic and societal progress, evident in improvements in quality of life and life expectancy (Desjarlais, Eisenberg, Good & Kleinman, 1995). Even so, illness, disability, and death will affect all people at some point in their lives – through either personal experience, or that of a family member or friend. The difference in these experiences lies in the type, severity and duration of the condition that is faced (Rolland & Walsh, 2005). The impact of chronic trauma, such as a mental disorder, on individual family members and multiple family subsystems is clearly supported by strong empirical evidence (Kiser & Black, 2005). In fact, the burden that families bear when caregiving is so strong that this burden is the only focus of the family experience of mental illness (Marsh & Lefley, 1996). The present study focuses on the resilience of families burdened with the care of a member with a mental disorder. Literature regarding the background to the research problem is presented, followed by the research question and rationale for the present study, and finally, an outline of the thesis.

1.2 Background and context of study

With increased longevity, and economic and societal progress, there has been an escalation in social problems, civil unrest, and chronic social, behavioural and health problems. Social developments are currently being offset by an increase in mental health problems, and without intervention, these developments will soon be negated by mental illness (Desjarlais et al., 1995; World Health Organisation [WHO], 2003). The WHO (2003) estimates that there are as many as 450 million people suffering from a mental or behavioural disorder worldwide and that one in four families has at least one member currently suffering from a mental or behavioural disorder. This places a significant burden on the entire population.

The burden of disease on a population is determined by measuring the gap between the current health of the population and the ideal situation where the entire population lives to old age in full health. There are two measurement components to the burden of disease - the Disability Adjusted Life Year (DALY) and the Years Lived with Disability (YLD). The DALY is a calculation of the time lived with disability and the time lost because of premature death – each DALY being equivalent to a year of healthy life lost. The YLD is

calculated on the incident cases of the disease. Globally, 13% of disability adjusted life years and 33% of years lived with disability are as a result of mental disorders (WHO, 2002). Depression, alcohol-use disorders, schizophrenia and bipolar disorders account for four of the six leading causes of YLD. At any point in time there are more than 150 million people suffering from depression and about 25 million suffering from schizophrenia – and it is expected that the burden of mental disorders will rise significantly over the next 20 years (WHO, 2003).

In addition to individuals who are affected by mental health problems, growing numbers of families are struggling to cope with multiple challenges, as they are faced with the burden of chronic disorders over longer periods of time (Rolland & Walsh, 2005). As Karp (2001, p. 13) states, "Mental illness is a contagious disease in its effect on others". Communities and countries pay a staggering price in terms of human misery, disability, lost economic productivity and increased use of medical services (Desjarlais et al., 1995; WHO, 2003).

In South Africa, mental disorders are the second leading cause of DALY, second only to HIV/AIDS. Mental disorders account for more disability than the following causes respectively: cardiovascular diseases; unintentional injuries; intentional injuries; sense organ diseases; and all forms of cancer - malignant and benign (WHO, 2003). However, because public health statistics focus largely on mortality rather than incidence or impact on functioning, national and international health statistics grossly under-represent the true burden of mental disorders, as these conditions are not the immediate cause of death (Desjarlais et al., 1995).

In the past, in accordance with the pathogenic paradigm that has dominated health and social sciences in practise and research (Kiser & Black, 2005; Strümpfer, 1999), the South African Government concentrated most of its mental health resources on the treatment of mental disorders, as opposed to prevention of illness and the development of mental health (Freeman & Pillay, 1997). Over the past few years however, mental health in South Africa has received increasing attention as it develops from a marginalised, misunderstood field of mental disorders, to a prioritised concept where mental health is a component of overall health (Health Systems Trust, 2001; Masilela, 2000).

After the political reformation in South Africa in 1994, a new Mental Health Care Act was promulgated. This Act encourages the normalising and destigmatising of mental health issues by incorporating the concept of mental health on a continuum of overall wellness (Kritzinger & Magaqa, 2000; Strachan, 2000a). This Act emphasizes community care and

one of the priorities proposed is the integration of mental health into primary health care, as outlined in the Primary Health Care approach. This approach includes goals for the empowerment of, and collaboration with, communities (Freeman & Pillay, 1997). There is an envisaged shift from the traditional "curative, institution-based approach to a more user-centered, preventative one" (Kritzinger & Magaqa, 2000, p. 296). Integral to the Primary Health Care approach is the deinstitutionalisation and community integration of mentally ill and disabled persons. In keeping with the international deinstitutionalisation trend that started in Europe and America in 1954 (Aderibigbe, 1996), the National Directorate of Mental Health and Substance Abuse identified deinstitutionalisation as a priority in 1997 (Simon-Meyer, 1999). The idea behind deinstitutionalisation is to take services closer to the mentally ill patient and provide care in an environment as close to the family as possible; as opposed to bringing the patient to the services by removing the patient from society (Kritzinger & Magaqa, 2000; Masilela, 2000; Strachan, 2000b).

In contrast to the principles behind deinstitutionalisation, this process is not always driven by considerations for the patient's quality of life, but often by political, economic and legal constraints (Health Systems Trust, 2001; Kritzinger & Magaqa, 2000; Strachan, 2000b). Kritzinger and Magaqa (2000, p. 296) state that "in order to reduce expenditures, patients are often discharged from psychiatric hospitals back to their families and communities". They further explain that "families are expected to take care of these patients without receiving the necessary training and support for this task" (p. 296). Deinstitutionalisation requires a number of resources to be in place, which will require a considerable investment in terms of finance, human resource and training. Primary and regional psychiatric services are required, including options such as rehabilitation programmes, and housing and chronic care facilities in the community (Health Systems Trust, 2001; Robertson et al., 1997). It is imperative to provide sufficient support for these patients when they leave hospital. Families of psychiatric patients require training and resources to properly care for and support these patients in their home environment (Clarke, 1994; Dartnall, Porteus, Modiba & Schneider, 2000).

Mental disorders are more prevalent in a context of poverty (Seeman & Göpfert, 2004). In the poor, rural areas of South Africa, there is a notable lack of the necessary mental health services and a relative shortage of mental health workers. Due to safety issues in urban areas, there is a tendency of mentally ill individuals to return home to the rural areas and mentally healthy individuals to seek employment in urban areas, thus

placing an added burden on families, communities and health services (Kritzinger & Magaqa, 2000; Robertson et al., 1997).

Mental disorders are devastating in their effect on the patient and family (Clarke, 1994; Desjarlais et al., 1995; Health Systems Trust, 2001; Karp, 2001; Kritzinger & Magaqa, 2000; Marsh & Lefley, 1996, Robertson et al., 1997). Family members are often reluctant to take on the role of caregiving because the burden of care is so considerable. Even so, they are often the primary caregivers of people with mental disorders (Health Systems Trust, 2001; Kritzinger & Magaqa, 2000; Simon-Meyer, 1999). The impact that mental disorders have on the entire family's quality of life is beyond that which can be defined by Disability Adjusted Life Years. The extent of the burden of mental disorders on the family is very difficult to assess and quantify, and is consequently often ignored (WHO, 2003). In contrast to the case of physical illness, like cancer, where a patient will rarely question the diagnosis, patients suffering from mental disorders will often vehemently deny the disease label and refuse to comply with treatment. Consequently, mentally ill persons often treat their caregivers with hostility instead of appreciation (Karp, 2001).

Each culture has unique norms that dictate degrees of caregiving. For instance, parents are expected to extend more sympathy to their children than they will receive in return. Each person living with a person diagnosed with a mental disorder, whether he/she is a spouse, parent or sibling, has an unique story to tell. However, in negotiating the boundaries of involvement, striking similarities are identified - including the experience of obligation and emotions such as frustration, responsibility, love, anger and resentment (Karp, 2001).

As Kritzinger and Magaqa (2000, p. 299) explain: "The impact that mental illness has on family relationships is largely disruptive and tends to cause interpersonal difficulties. The effects are particularly devastating for the person acting as caregiver." Persons suffering from mental disorders often behave in an incomprehensible manner that may be socially objectionable or threatening. Not only is this behaviour confusing to the family but often to the patient too (Karp, 2001). In addition to the distress of seeing the impact of a mental disorder on a loved-one, families often fear, and are exposed to, stigma and social discrimination by the community (Kritzinger & Magaqa, 2000; WHO, 2003).

In addition to mental health professionals and researchers, the government recognises the pressing need to include the family in the focus on the treatment and prevention of mental health problems. The National Department of Health stipulate core standards for

mental health care for people with severe psychiatric conditions in South Africa. These standards include health promotion and prevention, and patient and caregiver participation (Muller & Flisher, 2005b). Two of the outcome indicators for the evaluation of these standards are the alleviation of family burden and caregiver satisfaction (Muller & Flisher, 2005a). Families are the single most crucial community resource for the mentally ill and should be acknowledged as such. A central component to meaningful community care is adequate support of families who care for the patients, which will have long term treatment outcomes and cost benefits (Clarke, 1994; Desjarlais et al., 1995; Health Systems Trust, 2001; Muller & Flisher, 2005a; Szabo, 2006).

1.3 Research problem

In South Africa, there is a substantial burden placed on families living with a member with a mental disorder. Very little is known about the factors that buffer these families from this burden, or that help the family adapt to this burden. This aim of the present study is to identify variables that could be positively associated with adaptation in these families. The question the study will aim to answer is: Which resources could be associated with resilience in families caring for a family member with a mental disorder?

Mvududu and McFadden (2001, p. 38) define the term 'resource' as "…a generic term that describes all sorts of things, which are needed to enable people to live a life of quality, at least comfortably and at best happily." Various factors influence whether a person will perceive or value something as a resource. These factors include culture, religion, ethnicity, socio-economic status and gender (Mvududu & McFadden, 2001). In the present study a resource is understood to be any qualities, resources, factors or characteristics that could be positively associated with resilience and these will be collectively referred to as resilience factors.

In the present study, 'family' is understood to mean a multigenerational group of people, bound by blood or legal ties living together in a home. Extended family is understood to be relatives outside of the home. Although family structures may be diverse, a transcendent sense of family is created through sharing adversity and commitment (Walsh, 2003a).

Using a cross sectional survey design, interviews were conducted with family representatives to gather qualitative and quantitative data that was analysed for factors that could be associated with family adaptation, as an indicator or family resilience.

1.4 Rationale for the present study

As opposed to the pathogenic paradigm which viewed individuals as helpless victims of their circumstances, a resilience-orientated focus is empowering and allows for strength and personal development (Strümpfer, 1999). Taking into account the changing structure of the family and increasing social problems, the concept of family resilience is particularly relevant to our times. This approach builds mutual support, and encourages flexibility, shared hope, and innovation. Contrary to problem-solving being the goal of intervention as it has been in the past, it is now possible to focus on problem-prevention through repairing families and empowering them to meet future challenges (Rolland & Walsh, 2005; Walsh, 1996; 1998).

The cost of mental health problems on affected individuals, families, communities and countries may be avoided if the existing knowledge about prevention and treatment is applied and an effort is made to generate the knowledge that society needs (Desjarlais et al., 1995). Although the prevention and promotion aspects of mental health are receiving an increasing amount of attention, there is still much work to be done (Strachan, 2000a). With a global move towards a strengths orientated paradigm, and a separate though equally important move towards deinstitutionalisation, it is imperative to investigate which factors enable families to adapt to the strain of caring for a member with a mental disorder. A thorough literature search has shown that there is insufficient international and South African research on the factors that buffer families from this burden of care.

If resilience factors in these families are identified, scientifically sturdy interventions may be developed to improve family adaptation by building on the inherent strengths in the family (Garmezy, 1993; Walsh, 1996). The present study could thus serve as the groundwork for further studies and strength based interventions.

Gathering South African data will enable researchers to judge whether international theories on family resilience are appropriate for this country's diverse population. If the theories are found lacking, the relevant data may be used to develop more appropriate theoretical models for use within the South African context. This will assist helping professions across the board in providing a more effective service to families in distress. Families could be empowered to adapt more effectively to crises through psycho-education workshops, intervention programmes and awareness campaigns.

Persistent challenges (for example: a mental disorder in the family) impact on the entire family. Recovery of the family as a whole may be facilitated by focussing on key family processes that support adaptation. By understanding family resilience it is possible

to identify and encourage key processes that empower families to manage crises more effectively and emerge as a more resilient unit from stressful situations. When the family unit is empowered to function more effectively through fostering family resilience, individual resilience is also encouraged (Walsh, 1996; 2003b).

1.5 Outline of thesis

Following from the above, Chapter Two deals with the development and definition of the concept of family resilience, the Resiliency Model of Family Stress, Adjustment and Adaptation; and finally, resilience factors that have been identified in family resilience studies, internationally and in South Africa.

Chapter Three - the methodology chapter - covers the cross-sectional research design; the identification of participants and the demographic characteristics of the sample; the measures used; the research procedure; and finally, the methods of data analysis.

In Chapter Four the results of the content analysis of the qualitative data are presented, followed by the results of the Spearman correlations, and finally, the results of the best subsets multiple regression analysis.

In Chapter Five the results and limitations of the present study are discussed, recommendations made and final conclusions drawn.
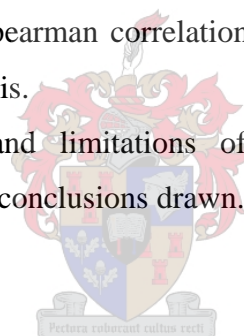
1.6 Conclusion

It is clear that mental disorders cause immense suffering to affected individuals and the families that care for them, both globally and in South Africa specifically. It has been shown that there is a need to identify resilience factors in families caring for a member with a mental disorder and the benefits of a family resilience approach have been outlined. In addition to the strains of daily life, under-resourced communities in South Africa are being challenged by the process of deinstitutionalisation. It is imperative to strengthen families to cope with multiple crises with which they are faced.

CHAPTER TWO

Theoretical Conceptualisation of Family Resilience

2.1 Introduction

During the first half of the twentieth century, health and social sciences were characterised by a pathogenic paradigm, in practise and in research. In the past half a century however, the focus has started shifting from treatment, to include a focus on prevention and enhancement (Kiser & Black, 2005; Strümpfer, 1999). One of the forerunners of this field was Antonovsky, who coined the term 'salutogenesis', literally meaning origins ('genesis') of health ('saluto') (Antonovsky, 1979). The pathogenic paradigm had a limited focus - a dichotomous view of a person being in a state of either health or illness. The concept of salutogenesis however, creates a multidimensional continuum that runs between two impossible poles – perfect health and perfect illness. Adopting this approach allows one to identify the factors pushing a person to one end of the continuum or the other (Antonovsky, 1979). The study of family resilience adopts a salutogenic approach in recognising that families posses the inherent capabilities to deal with any major crisis, including serious mental illness; and crises provide an opportunity to families to grow closer and to change in constructive ways (Marsh & Lefly, 1996).

This chapter will cover the history and development of the concept of resilience, and more specifically of family resilience. After illustrating the concept of family resilience using the Resiliency Model of Family Stress, Adjustment and Adaptation, research regarding protective factors that enhance resilience will be presented.

2.2 Resilience

Traditionally, in keeping with the pathological orientation of theory and practise of family therapy, research focussed on pathology in individuals who have grown up with mentally ill parents and in dysfunctional families (Walsh, 1996). The first resilience studies, conducted in the 1970s, aimed to identify resources in children who revealed no obvious signs of damage, regardless of having been exposed to stressors that were known to excercise a negative impact on them (Garmezy, 1993; Masten & Coatsworth, 1998; Walsh, 1996). The term used to refer to these children was 'invulnerability' (Walsh, 1996), metaphorically constituting a black and white concept judged to be either present or absent, based on the presence of psychopathology, scholastic achievement and intellectual functioning (Lam et al., 1999). The term invulnerable implies an inability to be wounded or harmed, an assumption that researchers found to be incorrect. It was not that the

children were invulnerable to stress, but rather they were able to regain a prior or improved level of functioning after being affected by a stressor. The word resilience, which literally means 'able to return to normal shape after stretching' (HarperCollins, 1995), was chosen as a more appropriate term to describe these individuals. 'Resilience' is associated with an aspect of flexibility to it and encapsulates the notion that "under adversity an individual can bend, lose some of his power and capability, yet subsequently recover and return to the prior level of adaptation" (Garmezy, 1993, p. 129; Strümpfer, 1999).

Resilience represents the ability to competently withstand and adapt to the impact of significant life challenges. As such, it can only be identified in the context of exposure to adverse circumstances and there needs to be evidence of adaptation and fortitude (Hawley & DeHaan, 1996; Lam et al., 1999; Marsh & Lefley, 1996; Masten & Coatsworth, 1998; Strümpfer, 1999; Walsh, 2003a).

Resilience is manifested through adaptation and competent functioning and is therefore not negated by emotional distress. A resilient individual does not necessarily display behavioural competence and coping in all spheres of life (Garmezy, 1993; Gilgun, 1999; Lam et al., 1999). For example: a survivor of childhood sexual abuse may be able to build enduring friendships but be unable to maintain healthy romantic relationships.

In the past two decades systems-based researchers and family therapists have also made the shift towards a focus on identifying and enhancing family competencies and strengths thereby facilitating a clearer understanding of the key processes of healthy family functioning (Walsh, 2003b). This paradigm shift has led to the development of the term 'family resilience', defined by McCubbin and McCubbin (1988, p. 247), as "characteristics, dimensions, and properties of families which help them to be resistant to disruption in the face of change and adaptive in the face of crisis situations".

As a family level construct, resilience is conceptualised as a dynamic, relational process that develops over time, as opposed to a fixed set of attributes of temperament, personality and intellect, in its individuals (Hawley, 2000; Hawley & DeHaan, 1996; Kiser & Black, 2005; Lee et al., 2003; McCubbin, Thompson & McCubbin, 1996; Robinson, 2000; Walsh, 1996; Walsh 2003b). As Rutter states (1985, p. 608), "Resilience resides primarily in how people deal with life changes and what they do about their situations as opposed to the buffering effect of some supportive factor operating at one point in time." Family resilience goes beyond merely surviving a crisis and encompasses the potential for growth that may well be borne of adversity (Boss, quoted in Walsh, 2003b). This makes

allowance for the perspectives and challenges of each individual member while seeking to identify effective family responses in a crisis situation (Walsh, 2003a).

Family resilience is a construct that is difficult to define and operationalise. Lam et al. (1999) point out that the closer the concept of resilience is examined, the more indefinable the term becomes and therefore an understanding of multiple domains of risk and competence is more valuable than a global definition of resilience. To illustrate the process, a model of family resilience is presented.

2.3 The Resiliency Model of Family Stress, Adjustment and Adaptation

McCubbin and McCubbin (1988) developed a cyclical model of family resilience which aims to explain why, in similar circumstances, some families fall apart and others thrive. This model - the Resiliency Model of Family Stress, Adjustment and Adaptation (hereon referred to as the Resiliency Model) - is based on four models, the first of these being Reuben Hill's ABCX model, proposed in 1949. The ABCX model focuses on the pre-crisis functioning of the family and emphasises the interaction of three components in producing a crisis (X), namely: the stressor (A), the family's resources for dealing with the stressor (B), and the family's interpretation of the stressor (C) (Golby & Bretherton, 1999; McCubbin & McCubbin, 1996).

The second and third models expanded on Hill's ABCX model to include a focus on both pre- and post-crisis factors and processes, which enable a family to adjust to and prevail over adversity. The first of these two models is the Double ABCX Model, proposed by McCubbin and Patterson in 1983, which particularly focuses on coping and social support, and emphasises that crisis resolution is a process, and not simply a once-off event (Golby & Bretherton, 1999; McCubbin & McCubbin, 1996). In the same year, McCubbin and Patterson extended the Double ABCX model to include the Family Adjustment and Adaptation Response (FAAR) Model. The emphasis in the FAAR model is on comprehensively describing the family processes involved in the efforts to equalise demands and resources (McCubbin & McCubbin, 1996).

The fourth model was developed in 1989 by McCubbin and McCubbin and is known as the T-Double ABCX Model of Family Adjustment and Adaptation. This model also focuses on pre- and post-crisis factors, but included an emphasis the role of levels of family appraisal and the typology of established patterns of family functioning in adjustment and adaptation (McCubbin & McCubbin, 1996).

The fifth and final model, referred to as the Resiliency Model of Family Stress, Adjustment and Adaptation, was developed in 1988 by McCubbin and McCubbin. The important difference in this model *vis a vis* previous ones is an emphasis on the family's post-crisis situations that have an impact on their long-term soundness (McCubbin & McCubbin, 1996).

Numerous assumptions underlie the Resiliency Model. The main assumption is that change and adversity will challenge all families as a normal part of the life-cycle. When a stressor occurs, the four major domains of affected family functioning are interpersonal relationships; community relationships; development, well-being and spirituality; and structure and function. In the process of adjusting and adapting to the adversity, the main goals of the family are to achieve harmony and balance, which they attempt to do by developing unique competencies and functioning patterns to protect the individuals and family unit while encouraging the growth and development thereof. During this process emphasis is placed on including and integrating current family functioning patterns, family coping and family problem solving (McCubbin & McCubbin, 1996).

As indicated in the name, the Resiliency Model consists of two phases – adjustment and adaptation. The adjustment phase deals with family stress, defined by McCubbin and McCubbin (1996, p. 22) as 'a state of tension brought about by the demand-capability imbalance in the family'. This phase is influenced by protective factors, which buffer the family from the impact of a stressor. The adaptation phase on the other hand, deals with family crisis, defined as 'a state of imbalance, disharmony, and disorganisation in the family system'. In this phase, recovery factors play a big role in enabling the family to 'bounce back' from the impact that the stressor has had. Therefore, adjustment is pre-crisis (but post-stressor) recovery, whilst adaptation is post-crisis recovery (McCubbin & McCubbin, 1996). It is beyond the scope of this chapter to provide a comprehensive description of the entire model. However, sufficient information will be supplied to clarify why the present study uses of adaptation as a dependent variable.

2.3.1 The adjustment phase

The adjustment phase, outlined in Figure 1, is a sequence of interacting elements that determines the outcome of the family's exposure to a stressor. A stressor interacts with family vulnerability which in turn impacts on the family's typology of established patterns of functioning. These components interact with both the family's resistance resources and the family's appraisal of the stressor, which finally interact with the family's problem

solving and coping strategies to produce an outcome. This process is represented in Figure 1.
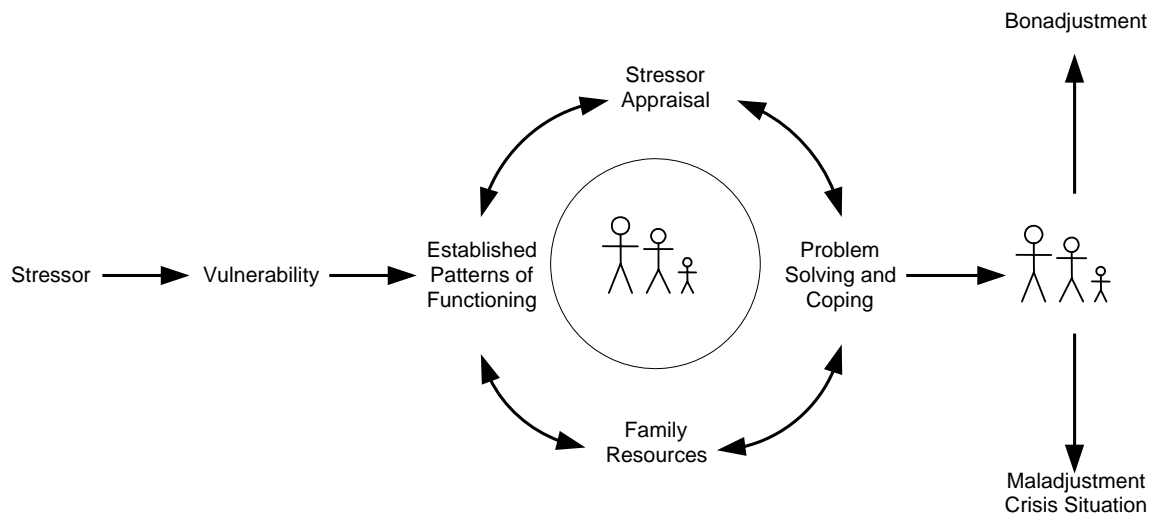
Figure 1. Adjustment phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1996).

The outcome of this process falls on a continuum ranging from bonadjustment, which is the ideal for which families strive, to maladjustment, which would necessarily imply a crisis situation. If the family achieves a state of bonadjustment, the existing family typologies are maintained and very little, or no change at all, is required. However, the crisis situation that results from maladjustment to a stressor forces the family to adjust its typologies so as to achieve harmony and balance. In the event of this crisis situation occurring, the family moves into the adaptation phase (McCubbin & McCubbin, 1996).

2.3.2 The adaptation phase

As indicated in Figure 2, numerous complex elements interact to predict the family's level of adaptation to a crisis situation. An explanation follows the diagram.
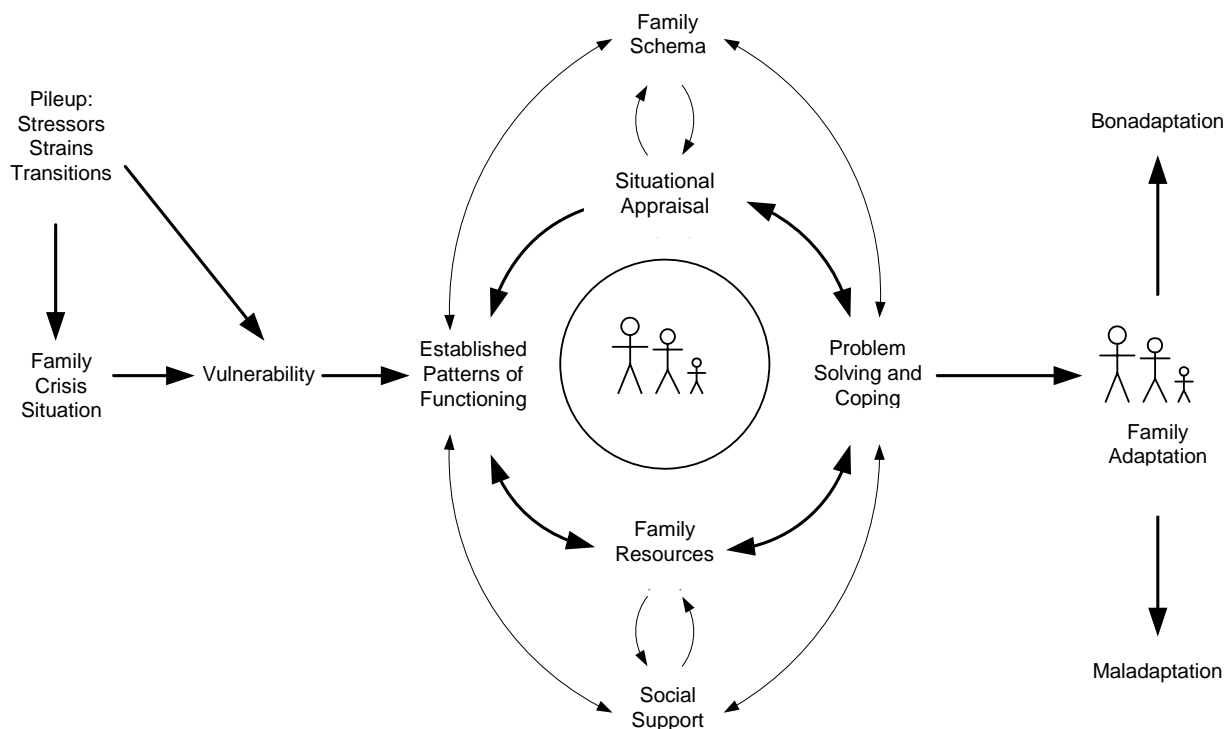
Figure 2. Adaptation phase of the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin & McCubbin, 1996).

The family crisis situation resulting from an inability to adequately adjust to a stressor in the adjustment phase, is exacerbated by the pile-up of strains on the family. Strains may be related to the family's particular life stage, for instance, having a new-born baby in the house; or be unexpected stressors, such as a death in the family. This accumulated stress impacts on the family patterns of functioning (McCubbin & McCubbin, 1996).

There are two categories of patterns of functioning in the adaptation phase: newly instituted patterns of functioning and retained or adjusted patterns of functioning. The patterns of functioning both have an effect on and are affected by the family's situational appraisal (McCubbin & McCubbin, 1996).

In the adjustment phase the family's stressor appraisal plays a role in the process. The stressor appraisal is the family's definition of the stressor and how they foresee it impacting on them. In the adaptation phase, however, it is the family's situational appraisal, which has an impact on the process. Situational appraisal is the relationship between the way the family views the stressor and the capabilities that they believe they have. McCubbin and McCubbin (1996) define five fundamental levels of appraisal during a family crisis, all of which are influenced by inter alia the ethnicity and culture of a

family. These levels are stressor appraisal; situational appraisal; paradigms; coherence and schema. Paradigms are the "expectations and rules which are shared and adopted by the family unit to guide the family's development of specific patterns of functioning in specific areas of family life" (p. 42). Coherence is understood to be "the motivational and appraisal bases for transforming the family's potential resources into actual resources, thereby facilitating changes in the family systems, coping and, promoting the health of family members and the well-being of the family unit" (p. 42). Finally, the family schema is "a structure of fundamental convictions, values, beliefs and expectations" (p. 39). The family's situational appraisal has an impact on the type of problem solving and coping mechanisms that the family will use, and how effectively the family are able to use them.

The family engages in problem solving and coping behaviours to manage tension, reduce or eliminate stressors and acquire new resources. These behaviours in turn affect and are affected by the way in which the family views, makes use of, and is able to obtain resources (McCubbin & McCubbin, 1996).

The last aspect to consider in the adaptation sequence is family resources, which emanate from three potential sources, namely individual family members; the family unit and the community. One of the most important resources is support which appears in numerous forms, namely family, kin, social and community support (McCubbin & McCubbin, 1996).

Again, the outcomes fall on a continuum bound on the positive side by bonadjustment, and on the negative side by maladjustment. In the event of bonadjustment, established functioning patterns are largely maintained. In the event of maladjustment on the other hand, a crisis results, requiring change within the family's established functioning patterns so as to achieve harmony and balance (McCubbin & McCubbin, 1996).

From the above it is clear that family resilience encompasses the maintenance of internal conditions conducive to communication; the positive growth of its members; the unification of family bonds; formation and maintenance of social support outside of the home and an attempt to minimise the impact of a stressor on the family (McCubbin, Thompson & McCubbin, 1996). The indication of the degree to which the family is successful in doing so, is evident in their level of adaptation. The most commonly identified outcomes of family resilience are family adjustment and adaptation, and family well-being (Lee et al., 2003).

Although DeHaan, Hawley and Deal (2000) agree that families progress through a series of stages in response to major stressors, they stress that not all families go through

the same stages or follow the same trajectory. Some will skip stages while others might vacillate between stages. Due to the different structural, interpersonal, social, socioeconomic, cultural and religious factors that interact with family processes over time, resilience presents itself in a unique manner in each family (DeHaan, Hawley & Deal, 2002; Hawley, 2000).

The advantages of a family resilience approach is that it recognises that healthy families do not, by definition, have to be problem free and, therefore, allows for the identification of variables that foster effective adaptation in the context of adversity. The reparative potential of all families is affirmed and families are recognised as having the potential to foster resilience and master their life challenges (Walsh, 2003b).

A number of researchers have endeavoured to identify which factors enable a family in crisis to adapt to or cope with the situation. These factors fall into two categories, protective factors and recovery factors. Protective factors are resources that buffer individuals from a stressor (Hawley, 2000; Hawley & DeHaan, 1996; Rutter, 1985). They operate over time and directly and indirectly influence processes and interpersonal reactions (Hawley & DeHaan, 1996; Rutter, 1985). Recovery factors on the other hand, are factors that help a family to restore effective family functioning after a crisis period (McCubbin et al., 1996). Together, protective and recovery factors may be referred to as resilience factors.
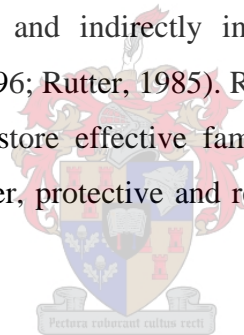
2.4 Resilience factors

There are three recurrent themes in the literature regarding resilience factors: those in the individual, those in the family and those in the community (Garmezy, 1993; Lam et al., 1999; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; Mederer, 1999; Werner & Smith, n.d.). Rutter (1985) explains that the particular coping strategy that a person employs is not as important as the fact that they act proactively instead of simply reacting or taking a passive stance towards the problem. In itself, simply having a proactive approach to dealing with the crisis, serves as a protective factor (Barnard quoted in Strümpfer, 1999; Cohen, Slonim, Finzi & Leichtentritt, 2002; Walsh, 1996; 2003a).

There are a number of individual factors affecting personal and family resilience. These factors include temperament; self-esteem; flexibility; and optimism, hope and a positive outlook (Garmezy, 1993; Karp, 2001; Lam et al., 1999; Lee et al., 2003; Masten & Coatsworth, 1998; Walsh, 1996; 2003a; Werner & Smith, n.d.).

Factors that manifest themselves in the family as a unit can be broadly categorised into belief systems, organisational patterns and communication patterns.

Belief systems incorporate the way the family think about adversity, their attitude towards the crisis, their religious beliefs and their outlook on life. The following resilience factors facilitate adaptation: affirming belief systems (Walsh, 1996); unifying values and beliefs (Cohen et al., 2002; Walsh & Pryce, 2003); a shared, positive perception of their family unit (Hawley, 2000; Lee et al., 2003); hope, optimism, humour, trust and a sense of security (Cohen et al., 2002; Lee et al., 2003).

Resilience factors in the organisational patterns in the family unit refer to features of the family unit itself, and family processes that facilitate coping and adaptation. Resilient families are more likely to be characterised as coherent, meaning that they are able to reframe a crisis as a challenge that is comprehensible, meaningful and manageable and that they generally believe that adverse circumstances will eventually result in a favourable way (Antonovsky, quoted in Hawley 2000; Lee et al., 2003). A related concept found in resilient families is a sense of cohesion, characterised by mutual support, collaboration and commitment (Cohen et al., 2002; Garmezy, 1993; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; Walsh, 2003a; Werner & Smith, n.d.). Resilient families are committed to a shared goal (Daly, 1999) and have a strong collective sense of 'we', as opposed to an individualistic sense of 'I' that normally dominates Western culture (Lee et al., 2003; Walsh, 2003a).

Other resilience factors found in the family unit include mutual understanding and attachment among family members (Cohen et al., 2002; Hall, 2004; Lee et al., 2003); a climate of mutual trust, empathy and tolerance for individual differences (Cohen et al., 2002; Walsh, 2003a); and possessing and maintaining rituals in the family (Barnard quoted in Strümpfer, 1999). Flexibility is also a key element to family resilience and involves the system's ability to appropriately shift roles as needed (Cohen et al., 2002; Hall, 2004; Lee et al., 2003; Walsh, 2003a). For instance, if the breadwinner parent is incapable of working due to a psychiatric diagnosis, he or she should be able to take on some responsibilities at home when the partner goes out to work.

Communication is the basis of many family processes. Families adapt better to crises when there is clear, congruent, open communication and emotional expression among family members; and freedom and safety to express positive and negative emotions. This enables constructive conflict resolution; collaborative problem-solving and effective joint

decision making. (Cohen et al., 2002; Lee et al., 2003; Walsh, 1996). Lam et al. (1999) specifically cite good communication between parents.

Research consistently supports the notion that social support is a resilience factor in that it encourages and reinforces coping efforts. This includes support from extended family, friends, neighbours, community groups, faith congregations and colleagues (Cohen et al., 2002; Garmezy, 1993; Hall, 2004; Lam et al., 1999; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; Walsh, 1996; Werner & Smith, n.d.). However, Rutter (1985) cautions that it is not sufficient to simply have a large social support system. It is not the extent or frequency of social contacts that matters, but rather individuals' satisfaction with their relationships.

Religion and spirituality have been identified by a number of researchers as a resilience factor on both an individual and family level (Beavers & Hampson, 2003; Cohen et al., 2002; Hawley, 2000; Kiser & Black, 2005; Marsh & Lefly, 1996; Thompson, 1999; Walsh & Pryce, 2003). Walsh and Pryce (2003) define religion as "an organised belief system that includes shared, and usually institutionalised, moral values, beliefs about God or a Higher Power, and involvement in a faith community" (p. 339). Spirituality on the other hand, is a broader term encompassing transcendent beliefs and practices which may be experienced within or outside of an organised religion. Involvement in a faith community has a number of advantages, including health and social benefits and support during difficult times (Walsh & Pryce, 2003).

Three international studies were explored that focussed on resilience in families with a member specifically with a mental disorder. Resilience factors that were unique to these families over and above the common factors found in the other family resilience studies, included assistance of professionals, memberships in a mental health advocacy organisation and acquiring essential information about mental illness (Marsh & Lefly, 1996).

Acceptance allows carers to let go of the need to control the situation and to focus on coping instead; and furthermore, to respect the relevant family member for his/her struggle with the disorder, as opposed to constantly measuring the ill member up to lost pre-illness potential (Karp, 2001).

Marsh and Lefly (1996) found that certain characteristics of the member suffering from a mental disorder were reported as resilience factors. Family representatives reported that it helped them to adapt if the mentally ill member had positive personal qualities; recovered to some degree and made contributions to the family, other consumers, the

mental health system or society. Some families experience a sense of pride in themselves or in the ill member as they learn to cope effectively with the disease, which was another feature seen as enhancing resilience (Marsh & Lefly, 1996). In families where the patient complied with medical treatment, the family typically exhibited more sympathy as they felt that compliance with medical treatment indicated an acceptance of responsibility on the part of the patient for getting well. In short, people are more willing to help those who appear to be helping themselves (Karp, 2001).

South African family resilience studies conducted on families in a variety of socio-economic, cultural and crisis contexts found similar results to studies conducted internationally. The following resilience factors were commonly identified: communication (Greeff & der Kinderen, 2003; Greeff & Human, 2004; Greeff & Le Roux, 1999; Holtzkamp, 2004); social support (Greeff & der Kinderen, 2003; Greeff & Human, 2004; Holtzkamp, 2004); intrafamilial emotional and practical support (Greeff & Human, 2004; Holtzkamp, 2004); family time spent together (Greeff & Le Roux, 1999); religion and spiritual support (Greeff & der Kinderen, 2003; Greeff & Le Roux, 1999; Holtzkamp, 2004; coherence and the family's internal strengths, ability to work together and to depend on each other (Greeff & Human, 2004); and individual characteristics of family members (Greeff & der Kinderen, 2003; Holtzkamp, 2004).

In a qualitative study, Greeff and Ritman (2005) found that the specific personality characteristics reported as contributing to family resilience were optimism, perseverance, religion and spirituality, expression of emotion and self-confidence.

2.5 Conclusion

A salutogenic family resilience approach forms part of the relatively young, strengths-based paradigm in psychology. Although it is challenging to operationalise resilience as a family level construct, family resilience can be measured by evaluating family adaptation. A number of researchers identified resilience factors in a variety of ways. The methodology used in the present study to identify resilience factors in families living with a member with a mental disorder, is described in Chapter Three.

CHAPTER THREE

Methodology

3.1 Introduction

An immense burden is placed on families caring for a member with a mental disorder as a result of deinstitutionalisation in South Africa (Clarke, 1994; Pillay, Foster & Freeman, 1997; Marsh & Lefley, 1996). The aim of the present study is to identify resilience factors in families living with and caring for a member with a mental disorder. The focus is on families who are living in an underprivileged, semi-rural area; who are caring for a patient using state-sponsored psychiatric services. These factors, collectively referred to as resilience factors, include protective and recovery factors.

This chapter will deal with the manner in which these factors were identified by covering an explanation of the research design; the identification of participants, including a demographic description of the sample; the measures used; the research procedure; and finally the data analysis methods.

3.2 Research design

The present study used of a cross-sectional survey design. The research involved the gathering of both quantitative and qualitative data. Neuman (2003) explains that where multiple measures are used to explore the same phenomena in social research, the design is referred to as triangulation. Struwig and Stead (2001) further explain that when using triangulation researchers are able to complement data from quantitative sources with qualitative data and vice versa, thereby being able to determine whether both analyses provide similar patterns. In the present study interviews were conducted in which the researcher employed a biographical questionnaire, an open-ended question designed to gather qualitative information and a set of self-report, quantitative measures.

3.3 Participants

The population for this study was families, living with and caring for a member with a mental disorder, who are residing in a semi-rural area in the Western Cape. Participants were included in the study based on three criteria. First, the participant had to be living with a patient receiving treatment for an Axis I mental disorder as classified by the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000). Secondly, the participant had to be at least 21 years of age and thirdly, be a family member of the aforementioned patient.

Participating families were identified by means of the family member receiving treatment at the local community psychiatric clinic. After obtaining the necessary permission, telephonic contact details for the families of all patients were obtained from the clinic files. Where no contact details were available in the file, contact was made with the family via the patient. Of the approximately 1000 files searched, only 174 contact numbers could be found. Of these, only 59 numbers enabled contact with the family of the patient in the file. Problems experienced with the other 115 numbers included lines that had been disconnected, and inaccurate or outdated information in the files.

In addition to the 59 families that could be contacted telephonically, the psychiatric nurse referred 14 other family representatives for interviews. Of the 73 families with whom contact could be made, 38 family representatives accepted the invitation and came for interviews; 15 could not attend the appointments; 5 accepted but repeatedly missed appointments and 4 declined the invitation. Eleven patients did not live with a family member and their families were thereby excluded because of the inclusion criteria.

Of the 38 data sets, 2 were excluded because of problems with inclusion criteria and another 2 reflected unreliable response sets. Unreliable response sets are identified by reversed items, where respondents consistently answer in the positive or negative to a number of questions with an apparent disregard for the content. For example: on a Likert scale measure the participant will answer 'strongly agree' to every question, even questions that directly contradict each other. If the answers are found to be inconsistent in their application, it is assumed that the respondent is not cognisant of the question and the data obtained is therefore unreliable (Bryman & Cramer, 2004).

A total of 34 (N) data sets were obtained for the present study. Of the participants who completed the data sets, 94% (n=32) were Afrikaans speaking and 5.8% (n=2) were English speaking. In terms of race, 88.2% (n=30) were coloured and 11.7% (n=4) were white. Two-parent, extended families comprised 44.1% (n=15) of the sample, two-parent nuclear families comprised a further 35.2% (n=12) and single-mother extended families 21% (n=7) constituted the rest of the sample. Of the family representatives interviewed, 50% (n=17) were the parent of the patient; 29.4% (n=10) were the spouse; 14.7% (n=5) the sibling; 2.9% (n=1) an aunt and a 2.9% (n=1) a child of the patient. The mean number of family members per household was six, with 70% (n=24) households earning an estimated gross annual income of R30 000 or less. The mean age of the patient being cared for was 33 years (SD 12.1), 58.8% (n=20) were male and 41.2% were (n=14) female. All patients had been diagnosed with, and were receiving treatment for a disorder classified on Axis 1

of the Diagnostic and Statistical Manual of mental disorders (American Psychiatric Association, 2000). The diagnoses of the patients, on the basis of which families for this study were identified, were: psychotic disorders, 50% (n=17); mood disorders 38.2% (n=13); adjustment disorders 5.8% (n=2) and substance-related disorder and developmental disorder each 2.9% (n=1).

3.4 Measures

A questionnaire was compiled to gather biographical information about the family (see Appendix A). This questionnaire included an open-ended question regarding the factors that the participant attributes to his/her family being able to cope while caring for a family member with a mental disorder (see Appendix B). In addition to this, seven self-report, quantitative questionnaires were posed. The measures were originally compiled in English but have been translated into Afrikaans through translation and back translation. Given the option of being interviewed in either English or Afrikaans, 32 participants chose to be interviewed in Afrikaans and 2 participants preferred to be interviewed in English. The following quantitative measures were used:

3.4.1 The Family Attachment Changeability Index 8 (FACI8)

The FACI8 was developed by McCubbin, Thompson and Elver (1995). It was used in the present study as a measure of family adaptation. In accordance with the theoretical model underlying this research, adaptation served as the dependent variable.

This index is designed to evaluate family functioning by measuring attachment and changeability. The Attachment subscale measures how attached family members are to each other by analysing the time they spend together and the nature of their communication. Families who engage in activities as a unit and confide in each other as opposed to confiding in people outside of the home, are more attached. An example of an Attachment subscale item is 'It is easier to discuss problems with people outside the family than with other family members'. The participant responds to these items on a Likert-type scale ranging from never to always.

The Changeability subscale measures the level of flexibility in the relationships between family members by scrutinising factors, such as whether the family is prepared to compromise when problems arise, or whether rules can be changed, for example: 'Our family tries new ways of dealing with problems'.

This measure consists of 16 statements about the family for which the respondent has to indicate on a 5-point Likert scale (ranging from never to always), how applicable the

statement is to the family at that time. The Attachment subscale has an internal reliability (Cronbach alpha) of .73 and the Changeability subscale has an internal reliability of .80 (McCubbin, Thompson & McCubbin, 1996). In the present study the internal reliability (Cronbach alpha) of the Attachment subscale was .71 and the Changeability subscale, .67. Item analyses of the subscales showed that deleting a single item (item 6) on the Changeability subscale would improve the internal reliability coefficient to .78.

The following questionnaires were used to measure potential resilience variables associated with family adaptation:

3.4.2 The Social Support Index (SSI)

The SSI, developed by McCubbin, Patterson and Glynn (1982), measures the extent to which families have integrated into their community; the degree to which families find support in their community; and the level of network and emotional support that families feel that the community provides.

The SSI consists of 17 items that the participant responds to (with specific reference to their family) on a 5-point Likert scale, ranging from strongly disagree to strongly agree, for example: 'People can depend on each other in this community'. This measure has an internal reliability (Cronbach alpha) of .82 and a test-retest reliability of .83 (McCubbin et al., 1996). In the present study, the SSI was found to have an internal reliability (Cronbach alpha) of .77 and a split-half reliability of .67.

3.4.3 The Relative and Friend Support Index (RFS)

The RFS, developed by McCubbin, Larsen and Olson (1982), measures the extent to which the family uses the support of friends and relatives as a coping mechanism. The RFS consists of 8 items rated on a 5-point Likert scale ranging from strongly disagree to strongly agree, for example: 'We cope with problems by seeking advice from relatives'. This measure has an internal reliability (Cronbach alpha) of .82 (McCubbin et al., 1996). In the present study, the RFS was found to have an internal reliability (Cronbach alpha) of .79.

3.4.4 The Family Problem Solving and Communication Scale (FPSC)

The FPSC, developed by McCubbin, McCubbin and Thompson (1988), evaluates the positive and negative patterns of family communication related to family coping during a crisis. This measure consists of 10 items on a 4-point Likert scale, which ranges from false to true. These items are divided into two subscales, one for evaluating positive communication and one for evaluating negative communication in the family during conflict situations.

The positive communication subscale, referred to as 'Affirming Communication', refers to the type of communication that diffuses a situation by conveying caring. For example: 'When our family struggles with a conflict which upsets us, we try to stay calm and talk things through'.

The negative communication subscale, referred to as 'Incendiary Communication', focuses on communication that exacerbates a conflict situation. For example: 'When our family struggles with a conflict which upsets us we scream at each other'.

The FPSC has a total internal reliability (Cronbach alpha) of .89, the Affirming Communication subscale has an internal reliability of .86 and the Incendiary Communication subscale has an internal reliability of .78 (McCubbin et al., 1996). In the present study, the Cronbach alphas were found to be as follows: FPSC total scale .73; Affirming Communication .72 and Incendiary Communication .70.

3.4.5 The Family Hardiness Index (FHI)

The FHI, developed by M.A. McCubbin, McCubbin and Thompson (1986), measures the fortitude and durability of the family unit by evaluating its characteristics of hardiness. This index relates to whether the family views change as being a positive process necessary for growth; whether the members have an active approach to dealing with challenges; and whether the family as a unit has an internal locus of control (McCubbin et al., 1996). The instrument has 20 items rated on a 5-point Likert scale ranging from false to not applicable. Focussing on the collective 'we', rather than an individualistic 'I' perspective, items were constructed to slot in with one of three subscales:

The Commitment subscale measures the family's ability to work together, their internal strengths and their dependability with statements such as 'We believe that things will work out for the better if we work together as a family'.

The Challenge subscale measures their ability to learn, to positively reframe crises as challenges and to seek out new experiences as challenges using statements such as 'We seem to encourage each other to try new things and experiences'.

The Control subscale measures the extent to which the family have an internal locus of control and feel that they are in control of their circumstances as opposed to being the victims of fate with items such as 'We realise our lives are controlled by accidents and luck'.

The FHI has a test-retest reliability of .86; an internal reliability (Cronbach alpha) of .82 for the total scale; .81 for the Commitment subscale; .80 for the Challenge subscale and an internal reliability of .65 for the Control subscale (McCubbin et al., 1996). In the

present study, the reliability coefficients were found to be as follows: Commitment .68, Challenge .64, Control .75 and FHI total .36.

3.4.6 The Family Crisis Oriented Personal Evaluation Scales (FCOPES)

The FCOPES, developed by McCubbin, Larsen and Olson (1981), is designed to identify the problem-solving and behaviour strategies used by the family during crises. This is achieved by evaluating the internal and external coping strategies of the family. Internal coping strategies exist between the family members or within the family system. External coping strategies exist between the family and the social environment or involve the handling of problems that emerge outside the family boundaries but affect the family. This measure consists of 30 items rated on a 5-point Likert scale ranging from strongly disagree to strongly agree. These items are divided into 5 subscales, as follows:

Acquiring Social Support – this subscale measures whether the family is able to actively seek support from their social network consisting of relatives, neighbours and friends. For example: 'When faced with difficulties in our family we respond by asking neighbours for favours and assistance'. This subscale has an internal reliability (Cronbach alpha) of .83 on the original version (McCubbin et al., 1996), and in the present study, an internal reliability of .88.

Reframing – this measures whether the family is capable of positively redefining stressful situations to make these more manageable. For example: 'When faced with difficulties in our family we respond by accepting that difficulties occur unexpectedly'. This subscale has an internal reliability (Cronbach alpha) of .82 on the original version (McCubbin et al., 1996), and in the present study, an internal reliability of .61.

Seeking Spiritual Support – this subscale measures the family's ability to seek out spiritual support. For example: 'When faced with difficulties in our family we respond by having faith in God'. This subscale has an internal reliability (Cronbach alpha) of .80 on the original version (McCubbin et al., 1996), and in the present study, an internal reliability of .68.

Mobilizing Family to acquire and accept Help – this measures the extent to which the family is able to seek out resources in the community and accept help from others. For example: 'When faced with difficulties in our family we respond by seeking professional counselling and help'. This subscale has an internal reliability (Cronbach alpha) of .71 on the original version (McCubbin et al., 1996), and in the present study, an internal reliability of .70.

Passive Appraisal – this subscale measures the ability of the family to simply accept problematic issues, without actively trying to solve them, thereby minimizing reactivity. For example: 'When faced with difficulties in our family we respond by believing that the problem will go away if we wait long enough'. In the original version, this subscale has an internal reliability (Cronbach alpha) of .63 (McCubbin et al., 1996) and in the present study, an internal reliability of .37.

Although a total score may be obtained by adding the subscale scores together, the present study only uses the subscale scores since it is of more value to be able to identify which specific coping behaviours are correlated with family adaptation, as opposed to evaluating overall coping. This measure has an internal reliability (Cronbach alpha) of .86 for the total scale and a test-retest reliability of .81 (McCubbin et al., 1996).

3.4.7 The Family Time and Routine Index (FTRI)

The FTRI, developed by H.I. McCubbin, McCubbin and Thompson (1986), evaluates the types of activities and routines in which the family engages and the importance that the family places on these. The FTRI is comprised of 30 Likert-type items divided into 8 subscales. The participant responds to each item on two scales, the first being the degree to which each statement applies to their family behaviour (false, mostly false, mostly true, true). The second is the level of importance that the family places on each routine (not important, somewhat important, very important or not applicable). The eight subscales are as follows:
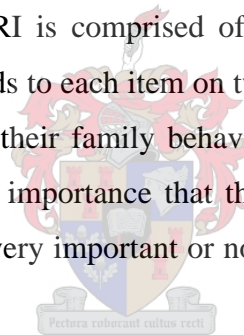
The Child Routines subscale measures the emphasis the family places on establishing predictable routines for the promotion of a sense of autonomy and order in the children.

The Couple Togetherness subscale measures the emphasis the family places on establishing predictable routines for the promotion of couple communication.

The Meals Together subscale measures the effort the family makes to incorporate family mealtimes into a predictable routine to promoting togetherness.

The Parent-Child Togetherness subscale measures the emphasis the family places on establishing predictable communication patterns between parents and offspring.

The Family Time Together subscale measures the emphasis the family places on togetherness by examining activities such as family time, quiet time and special events.

The Relative's Connection Routines subscale measures the emphasis the family places on connecting with relatives in a routine manner so as to promote meaningful relationships with them.

The Family Chores Routines subscale measures the emphasis the family places on promoting child and adolescent responsibility in the home by establishing predictable routines.

The Family Management Routines subscale measures the degree to which the family attempts to maintain order in the home through predictable routines.

In addition to subscale scores, the FTRI yields a Family Time and Routines score for routines engaged in and a Valuing of Family Time and Routines score for the value the family places on their routines.

This measure has an internal reliability (Cronbach alpha) of .88 (McCubbin et al., 1996). In the present study, the FTRI was found to have an internal reliability of .82 for Family Total and .70 for Total Important.

3.5 Procedure

To conduct this research, permission was required from the following individuals: the Regional Director of the West Coast Winelands District, the Medical Superintendent of the Stellenbosch Hospital, the community psychiatrist of West Coast Winelands District, the facility manager of the local clinic, and the chief professional nurse in psychiatry at the community psychiatric clinic. Once permission had been granted, the researcher and a psychiatric nurse contacted families to request their participation and in the event that they agreed to take part, informed consent was obtained (see Appendices C and D). The participants were given two venue options for the interview: 27 chose to be interviewed at a venue at the University of Stellenbosch and 7 chose to be interviewed at the local clinic. A taxi service was hired to transport the participants to and from the interview venues.

Time and budget constraints led to Honours students taking the Family Psychology module at the University of Stellenbosch being used as interviewers. The students were trained in the administration of the questionnaires as well as interviewing skills, ethics and confidentiality and they were required to complete an assignment on the process. The researcher conducted 19 interviews and the students conducted 15 interviews.

The biographical questionnaire was completed first, followed by the open-ended question and then the self-report measures. Appointments were scheduled for 90 minutes each but on average a data set took 70 minutes to complete. First, the interviewer was required to complete the biographical questionnaire and record the response to the qualitative question. This provided an opportunity to the interviewer a chance to build rapport with the participant, and to allow the participant a chance to ask questions. As the

literacy level of the participants was relatively low, they were given the option of filling in the quantitative data set themselves or having the interviewers fill it in on their behalf. All but three of the participants felt more comfortable with the interviewer/s filling in the questionnaires. After the biographical questionnaire and qualitative question were completed, the interviewer proceeded with the quantitative questionnaires. At the end of the interview, participants received a R25 food voucher as a token of gratitude for their time and willingness to participate.

3.6 Ethical Considerations

For the purposes of privacy and confidentiality, the researcher or the psychiatric nurse made all appointments. It was not necessary to give any information about the patient or the participant to the interviewers, because the information gathered in the interview had no reference to the patient as an individual or to the diagnosis. Interviewers were, however, sensitised that interviewees may choose to share sensitive information and were encouraged to respond empathically but to maintain professional boundaries. To minimise any discomfort that may be experienced through participation, the participants were given the option of having the interview in a language and venue with which they were comfortable. As part of the informed consent procedure, it was emphasised that the participant (family representative) was free to withdraw at any point without any negative personal consequence.

In this manner, a strenuous effort was made to ensure that participation in the research would be in no way detrimental to the participants.

3.7 Data Analysis

3.7.1 Qualitative Analysis

Qualitative analysis was performed on the data using content analysis. Content analysis produces a quantitative description of symbolic content in a text. In this context, text is understood to mean any material that serves as a medium for communication whether it be written, visual or spoken (Neuman, 2003).

The present study used of manifest coding to draw up a coding system to identify terms or actions that were located in the transcripts of the qualitative section of the interviews. As opposed to latent coding which looks for the implicit meaning in text content, manifest coding focuses on the visible, surface content (Babbie, 2002; Neuman, 2003). The latter is more appropriate to the present study as the researcher aimed to

identify factors that enabled coping and adaptation within a family. In the text being analysed these factors were expressed on the surface level.

Coding is an integral part of qualitative research. Instead of simply being a clerical task, it enables the researcher to organise raw data into themes and concepts that may then be used to analyse the data (Babbie, 2002; Neuman, 2003). The manifest coding of data in the present study took place in three stages as recommended by Neuman (2003). In the first stage, namely open coding, the researcher made a first pass through the data to assign initial codes and search for themes. During the second pass through the data, namely axial coding, the researcher focussed on the initial coded themes and examined whether categories should be added or collapsed to provide a complete coding system for the final analysis. The last pass through the data, referred to as selective coding, involved working through the previous codes and data to identify themes and contrasts in specific cases. The result after these three stages was a coding system that could be used to identify frequency. Neuman (2003) explains that frequency means counting whether or not something occurs and if something is found to occur, how often it does so. With the coding system, it was possible to work through the data, record the number of times each factor was identified and tabulate the results. In accordance with Bryman and Cramer's (2004) recommendation, the list of categories in the coding system were mutually exclusive (each item could only apply to one category) and the list was comprehensive in covering all possible categories. Where various factors fitted into one category, the category was only selected once. For instance, if a participant mentioned that the family received support from the psychologist, the psychiatrist and their Minister, the category of professional support was counted once (as opposed to three times).

The qualitative information was transcribed by the interviewer/s during the qualitative part of the interview and as far as possible the transcriptions were done word for word. Although this does raise a question as to the comprehensiveness and validity of the qualitative data - because the data required was surface level information - this method was appropriate for the researcher's type of information, purpose and resources (Lee & Fielding, 2004).

Wolcott (1994) explains that when a qualitative researcher constructs data out of experience, some things are singled out as worthy of note and others are relegated to the background - "Because it takes a human observer to accomplish that, there goes any possibility of providing 'pure' description, sometimes referred to light heartedly as 'immaculate perception'" (p. 13).

Nonetheless, Lee and Fielding (2004) are of the opinion that the validity of an analysis may be "derived from adherence to a systematic analytic procedure" (p. 543). The validity of a qualitative data analysis can be determined provided the researcher adequately reports her conduct during data collection, coding and analysis. If these steps can be evaluated and are found to be sufficiently scientific and thorough, the data may be seen as valid (Lee & Fielding, 2004).

3.7.2 Statistical Analysis

A statistical software program, Statistica 7 (StatSoft Inc., 2005) was used to calculate Spearman's correlations in order to determine which independent variables are related to family adaptation. The Spearman correlation was used as it determines "the extent to which variation in one continuous variable explains the variation in another continuous variable" (Struwig & Stead, 2001, p. 160). The Spearman correlation also measures the strength of the relationship between two variables as well as whether the relationship is positive or negative (Struwig & Stead, 2001).

Multiple regression analysis was also performed on the data using Statistica. Multiple regression analysis is used to examine the relationships that exist between multiple independent variables and a single dependent variable; and to determine the extent to which the independent variables can predict the dependent variable (Gujarati, 2003). In the present study multiple regression analysis was used to describe the relationship between the single dependent variable, namely family adaptation, and the other variables in the data set. This enables the identification of a systematic relationship but not necessarily a causal relationship.

In the present study, specifically best subsets multiple regression analysis was used. This is done by entering all possible combinations of variables into different regression models. The "best" subset of independent variables for predicting family adaptation are then determined by the set that gives the best fit based on the R^2 value.

3.8 Conclusion

The present study aimed to identify resilience factors that facilitate adaptation in families living with and caring for a patient receiving treatment for a mental disorder. Through a number of measures that were analysed using content analysis, Spearman's correlations and multiple regression analysis, factors associated with adaptation were identified. The limitations of the methodology are discussed in Chapter Five. The results of the data analyses are presented in Chapter Four.

CHAPTER FOUR

Results

4.1 Introduction

Analysis of the open-ended question and the self-report questionnaires revealed a number of factors that could be associated with family adaptation. The results of the content analysis of the open-ended question will be presented, followed by a presentation of the Spearman correlations, and finally, the results of the best subsets multiple regression analysis.

4.2 Qualitative results

Participant were asked to describe, in their own words, what helps their family to cope with the crisis of caring for an ill family member. Analysis of their answers revealed themes that could be organised into three categories: internal resources, external resources and factors related to the patient. Internal resources are the emotional, physical and practical resources found within the home; external resources are the resources available outside of the home and factors related to patient are those factors which are related specifically to the family member with a mental disorder. These results are presented in Table 1.
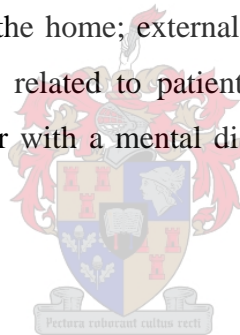
Table 1

Resilience Factors as Identified by the Family Representative (N = 34)

	Frequency	Percentage
Internal Resources – resources within the home		
Religion & spirituality - church attendance, Bible study, church activities, prayer, belief in purpose faith, a relationship with God	27	79.4
Individual characteristics – perception, attitude, hope, acceptance, perseverance, patience, tolerance	23	67.6
Family characteristics - emotional and practical intrafamilial support, love for one another, family as priority, mutual respect	21	61.8
Communication	7	20.5
Routine, structure, family activities	7	20.5
External Resources – resources outside the home		
Social support – extended family members, friends, neighbours, church community	17	50
Community resources (clinic, police, library)	9	26.4
Professional support (psychiatrists, psychologists, clergy)	7	20.5
Government grant	6	17.6
Career (job, colleagues)	5	14.7
Factors related to patient		
Acceptance / understanding of patient and / or disorder	11	32.4
Patient's positive behaviour	9	26.5
Treatment adherence	5	14.7
Giving the patient space and freedom – 'let him do his thing'	4	11.8
Keeping the patient busy	3	8.8

It follows from Table 1 that in the internal resources category, 79.4% (n=27) of participants identified religion and spirituality as a coping mechanism. This category included both mental processes and practical activities. Mental processes - such as prayer, faith, a relationship with God and a belief that the situation is part of their purpose in life - were expressed in statements, such as 'I can take care of him, God gives me the strength'. Practical religious activities outside of the home that helped the family to cope, were

expressed in statements such as 'We go to church and Bible study'. Individual characteristics of family members in the home (not including the patient) were identified by 67.6% (n=23) as a coping mechanism. Individual characteristics reflect the way individuals in the home think or feel about their situation, for example: 'It is important to accept the person, situation and your lot in life'. Family characteristics, 61.8% (n=21), include emotional and practical support shared between family members in the home expressed by sentiments such as 'Our family has become far closer and more loving of each other. This helps tremendously.' Communication, 20.5% (n=7), was expressed as a coping factor used within the home by family members, for example: 'When there's a problem we get together and hear what each one has to say'. Routine, structure and family activities were mentioned by 20.5% (n=7) of the participants, for example: 'Routine and planning helps us to get through each day'.

External resources in the present study were taken to be practical and emotional resources acquired outside of the home. Social support, expressed by 50% (n=17) of participants as a coping factor, included support from friends, community members, the religious community and members of the extended family not living in the home, for example: 'We talk to neighbours and friends in the community about our problems'. Community resources, mentioned by 26.4% (n=9) of participants, included the police, the public library and the clinic, for example: 'If he gets aggressive I phone the police and they come and pick him up to take him to the clinic'. Professional support, mentioned by 20.5% (n=7) of participants, include clergy, psychologists and psychiatrists, for example: 'The minister comes to visit us and talks to him (the patient)'. A government grant (monthly disability grant administered by the state) was mentioned by 17.6% (n=6) of participants as a factor that helps them cope. Career factors, mentioned by 14.7% (n=5) of participants, include job satisfaction (of participant), support from colleagues or stable income expressed by statement such as 'I enjoy my work. If I didn't have my work I'd go crazy'.

The category of factors related to the patient comprised of coping factors identified specifically with reference to the patient in the home. Accepting the patient or understanding him and his disorder was cited by 32.4% (n=11) of participants with statements such as 'Over time we've identified cues that start about a week in advance. These cues allow us to prepare for his aggression'. The behaviour of the patient, mentioned by 26.5% (n=9) of participants, was indicated in statements such as 'He doesn't have a job but he helps around the house a lot'. Treatment adherence, mentioned by 14.7% (n=5) of participants, helps families cope, for example: 'Now that the patient is on medication we

are doing a lot better'. Giving the patient space and freedom, mentioned by 11.8% (n=4) of participants, was expressed in the following manner 'We just let him do his thing. If that means untidying the house, then I just clear up when he goes to bed.' Keeping the patient busy, 8.8% (n=3), was reported to be effective, for example: 'I give him tasks to do that keep him busy'.

4.3 Quantitative results

4.3.1 Correlations

Spearman correlations were calculated between all the potential resilience variables measured by the questionnaires, and adaptation as the dependent variable (FACI8). The results are shown in Table 2.
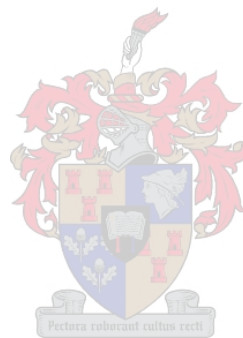
Table 2

Spearman Correlations between the Potential Resilience Variables and Family Adaptation
(Family Attachment and Changeability Index 8) (N = 34)

Variable	FACI8 – total score	
	r	p
Age of patient	0.00	0.98
Gross annual income of household	0.06	0.73
Number of people living in the home	0.56	0.01**
Social Support Index (SSI) – degree to which family finds support in their community	0.16	0.37
Relative and Friend Support Index (RFS) – family's use of friends & relatives as a coping mechanism during crises	-0.08	0.65
Family Problem Solving Communication Index (FPSC) Total – style of family communication during crises	0.79	0.01**
FPSC Affirming – positive, supportive communication patterns	0.60	0.01**
FPSC Incendiary – negative, inflammatory communication patterns	-0.77	0.01**
Family Hardiness Index (FHI) Total – fortitude and durability of family unit	0.60	0.01**
FHI Commitment – ability to work together and internal strengths	0.71	0.01**
FHI Challenge – positive reframing, ability to learn	0.36	0.04*
FHI Control – internal locus of control	0.27	0.13
Family Crises Oriented Personal Evaluation Scale (FCOPES) – problem solving behaviour used during crises		
FCOPES Social Support – ability to actively seek social support	-0.02	0.93
FCOPES Reframing – redefining negative situations in a positive way	0.21	0.25
FCOPES Spiritual Support - ability to actively seek spiritual support	-0.06	0.73

Table 2 (continued).

Variable	FACI8 – total score	
	r	p
FCOPES Family Mobilization – ability to seek out community resources & accept help from the community	0.03	0.85
FCOPES Passive Appraisal – passive acceptance of problematic issues to minimise reactivity	-0.43	0.01*
Family Time & Routine Index (FTRI) Family Time & Routines – extent to which family engages in routines	0.38	0.03*
FTRI Valuing of Family Time & Routines – degree to which the family values their routines	0.34	0.06
FTRI Child Routines – routines to promote autonomy and order in children and teens	0.23	0.20
FTRI Couple Togetherness – routines to promote communication between couples	0.52	0.01**
FTRI Meals Together – routines to promote togetherness through family mealtimes	0.28	0.11
FTRI Parent-child Togetherness – routines to promote communication patterns between parents and children	0.20	0.27
FTRI Family Togetherness – special events, family time	0.14	0.44
FTRI Relative's Connection – routines to promote meaningful connection with relatives	0.11	0.54
FTRI Family Chores – routines to promote teen & child responsibility in the home	0.31	0.08
FTRI Family Management – routines to maintain order in the home	0.11	0.54

*$p < 0.05$,   **$p < 0.01$

As shown in Table 2, a number of variables indicate a significant positive correlation with family adaptation: the number of people living in the home; style of family communication during crises (FPSC Total); positive, supportive communication patterns (FPSC Affirming); fortitude and durability of family unit (FHI Total); ability to work together and internal strengths of the family unit (FHI Commitment); family's ability to

reframe crises positively and to learn from them (FHI Challenge); family routines (FTRI Family time and routines); value family place on their routines (FTRI Valuing of family time and routines); family routines that promote communication between couples (FTRI Couple togetherness); family routines that promote teen and child responsibility in the home (FTRI Family chores routines).

Two variables showed a significant negative correlation with family adaptation, namely negative, inflammatory communication patterns (FPSC Incendiary) and the family's use of passive acceptance of problematic issues as a coping style, to minimise the emotional impact of the stressor (FCOPES Passive Appraisal).

In the next four figures, graphical representations of four correlations are presented. In Figure 3, the correlation between the number of people living in the home and family adaptation is shown.
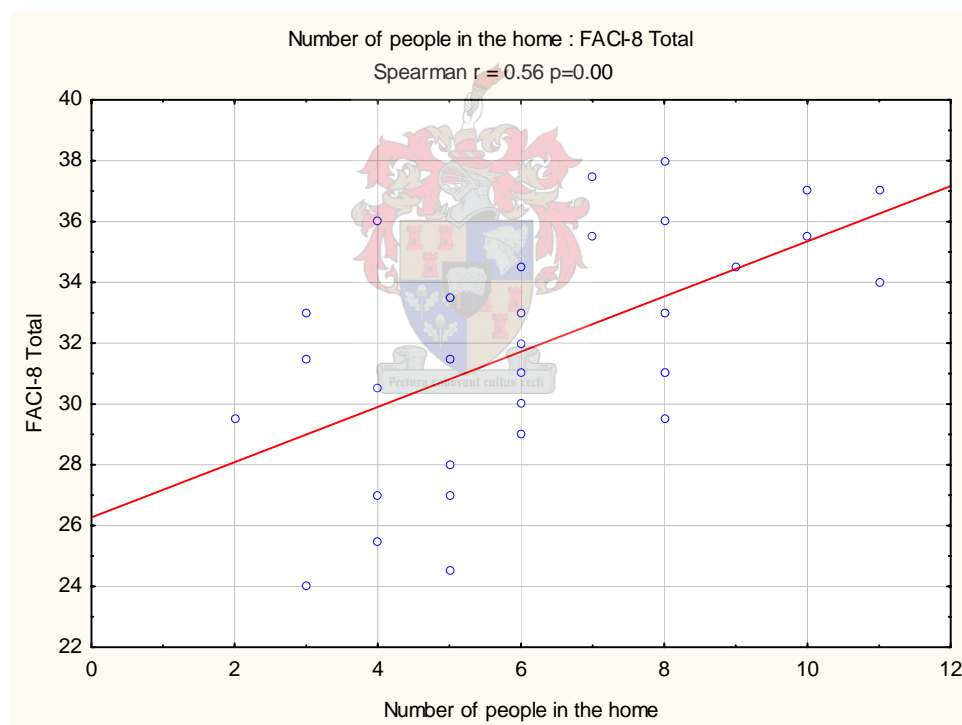
Figure 3. Scatter plot showing the relationship between number of people in the home and the FACI8 Total score.

In Figure 4, the correlation between the family's style of communication during a crisis, and family adaptation, is shown.
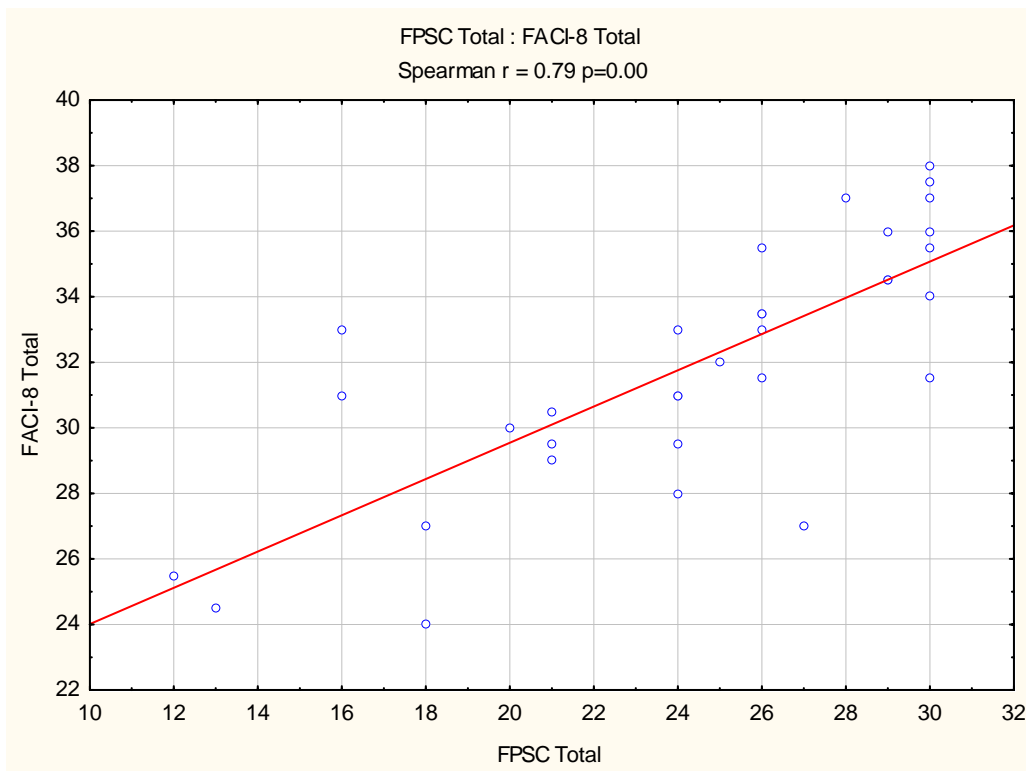
Figure 4. Scatter plot showing the relationship between the FPSC Total score and FACI8 Total score.

In Figure 5, the correlation between the family's ability to work together and internal strengths, and family adaptation, is shown.
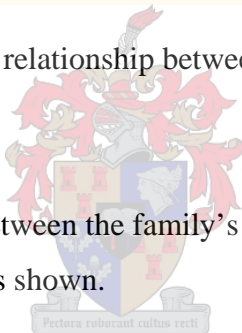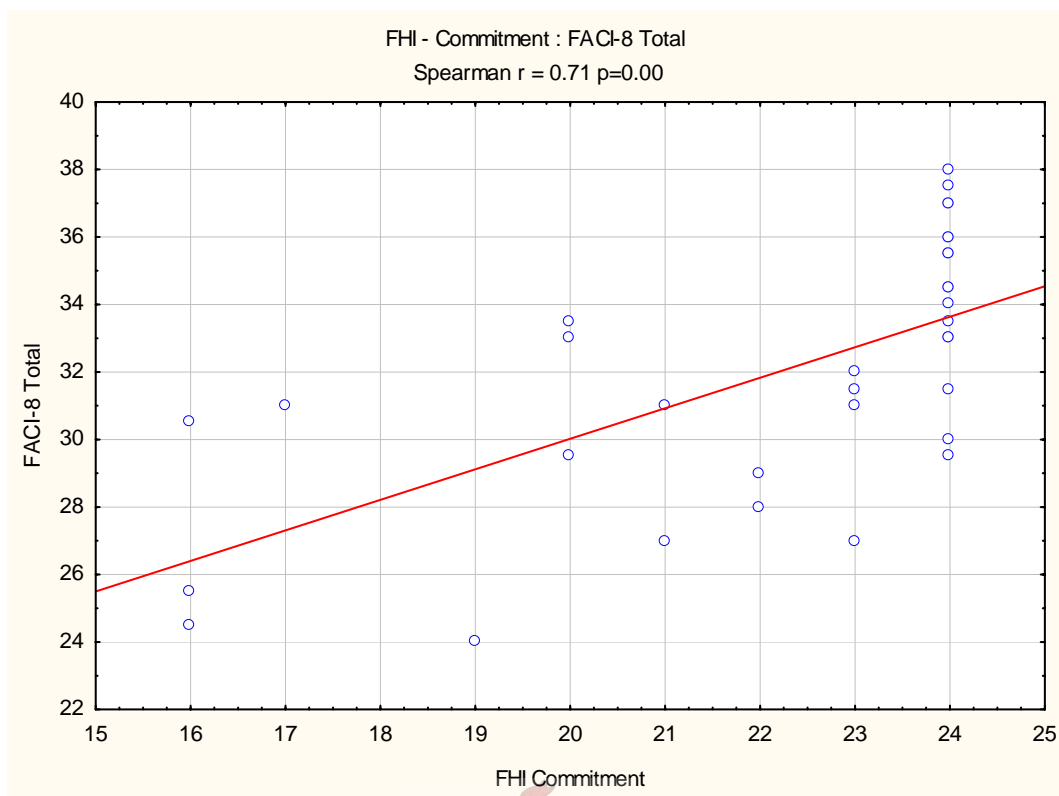
Figure 5. Scatter plot showing the relationship between the FHI Commitment and the FACI8 Total score.

In Figure 6, the correlation between the family's use of routines to promote communication between couples, and family adaptation, is shown.
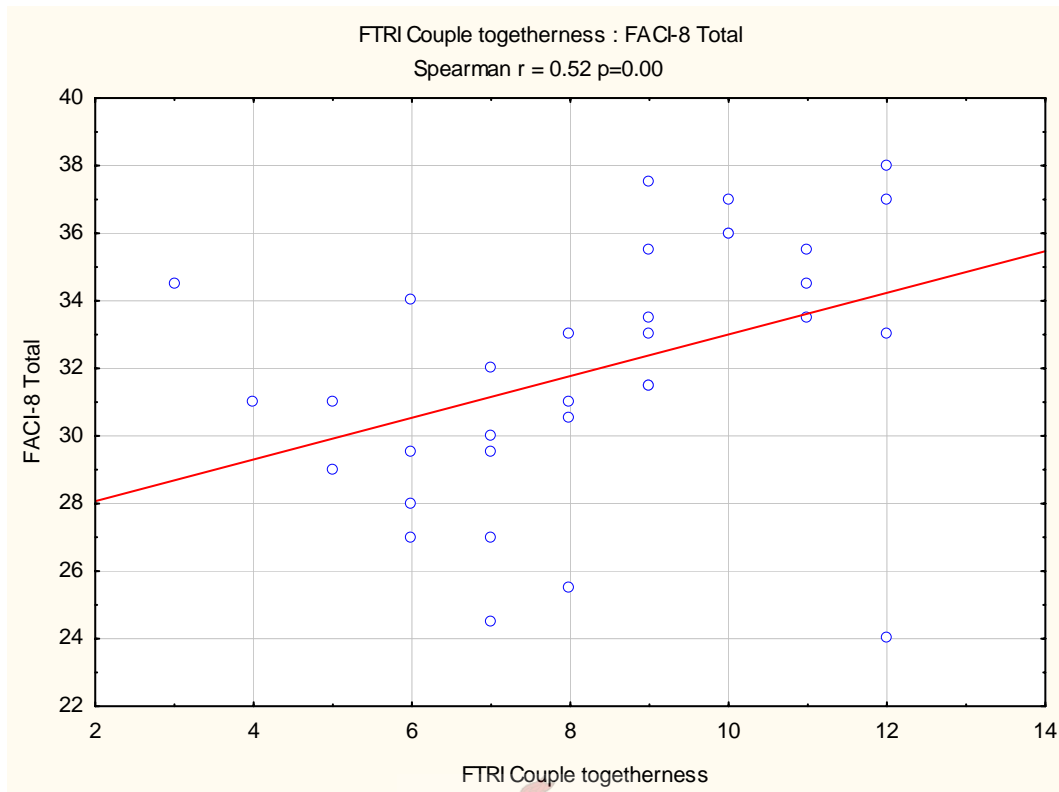
Figure 6. Scatter plot showing the relationship between the FTRI Couple Togetherness and the FACI8 Total score.

4.3.2 Results of the regression analysis

Best subsets multiple regression analysis was performed to determine which subset of variables are best able to predict family adaptation (as measured with the FACI8). The results of the regression analysis are presented in Table 3.

Table 3

Results of the Best Subsets Multiple Regression Analysis (N = 34)

Variable	β	t(26)	p
Degree to which family finds support in their community (SSI)	0.05624	1.05946	0.299136
Family's use of friends and relatives as a coping mechanism during crises (RFS)	-0.11479	-1.72078	0.097171
Style of family communication during crises (FPSC Total)	0.40852	4.59191	0.000099
Family's passive acceptance of problematic issues to minimise reactivity (FCOPES Passive Appraisal)	-0.32206	-2.30715	0.029267
Extent to which family engages in routines (FTRI Family Time & Routines)	0.03168	0.81335	0.423402
Degree to which the family values their routines (FTRI Valuing of Family Time & Routines)	0.09157	1.48181	0.150410
Family Hardiness Index (FHI) Total	Excluded		
FCOPES Social Support	Excluded		
FCOPES Reframing	Excluded		
FCOPES Spiritual Support	Excluded		
FCOPES Family Mobilization	Excluded		

The independent variables entered together were: the degree to which family finds support in their community (SSI); the use of friends and relatives as a coping mechanism during crises (RFS); the style of family communication during crises (FPSC Total); the acceptance of problematic issues to minimise reactivity (FCOPES Passive Appraisal); family routines (FTRI Family Time & Routines); and the value family place on their routines (FTRI Valuing of Family Time & Routines). Together, these variables account for 72% ($R^2 = 0.72$) of the variance in the FACI8 total score. From the above results it may be seen that the two significant predictor variables are the family's style of family communication during crises (FPSC Total) and the family's use of passive appraisal as a coping style (FCOPES Passive Appraisal). A negative sign in front of the beta value, as is the case for the RFS and the FCOPES Passive Appraisal indicates that an increased use of these coping styles will result in a decrease in family adaptation.

4.4 Conclusion

After analysing the data, a number of potential resilience factors were revealed. Qualitatively, religion and spirituality, characteristics of individual family members (excluding the patient), family characteristics, and social support were the most frequently mentioned resources. Quantitatively on the other hand, communication styles of the family unit had the highest value in both the Spearman's correlation and regression analysis. Spearman's correlations further revealed that in addition to family communication, the ability of the family to work together and communication between the marital couple had the strongest correlation with adaptation. Statistical analysis indicated that passive acceptance of problematic issues in the family had a negative influence on adaptation. The only other factor that indicated a negative association with family adaptation was the family's use of friends and relatives as a coping mechanism. This is an apparent contradiction, as social support (as measured on the SSI) quantitatively shows no significant relationship and qualitatively, and is the fourth most commonly reported resilience factor. These results are discussed in Chapter Five.
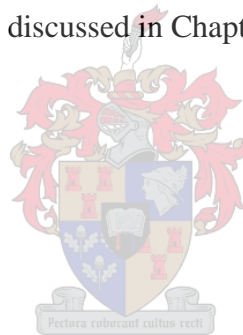
CHAPTER FIVE

Discussion and Conclusion

5.1 Introduction

The aim of this study was to identify resilience factors in families living with and caring for a member with a mental disorder. In accordance with resilience literature, family adaptation was chosen as an indicator of resilience and used as the dependent variable in the quantitative analysis. The resilience factors identified in the present study will be discussed in order of most to least frequent, as presented in the qualitative analysis. Thereafter, the limitations of the study will be discussed and recommendations will be made for future research. Finally, the implications of the results of the present study will be presented.

5.2 Discussion

In accordance with previous research (Garmezy, 1993; Lam et al., 1999; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; McCubbin & McCubbin, 1996; Mederer, 1999; Werner & Smith, n.d.), three themes emerged in the content analysis of the qualitative data, namely: individual characteristics, family characteristics and community resources. In the present study, as well as in research conducted by Marsh and Lefly (1996) on resilience in families of psychiatric patients, an additional theme emerged, namely factors related to the ill family member. Although similar factors were highlighted in all these studies, for the purposes of the present study it was useful to use the following three categories: internal resources (within the home); external resources (outside of the home) and factors related to the psychiatrically ill member.

The way in which the qualitative data was analysed enabled the identification of the most commonly cited resource factors, and not the relative importance of each of these factors to the family. The most commonly mentioned factors are not necessarily the primary resilience factors for each family. However, since these factors were emphasized by the participants as enabling their family to adapt in the first place, this implies that they are important.

In the category of internal resources, 79.3% of participants felt that religion and spirituality played a role in helping their family adapt to caring for an ill member. This finding confirms numerous studies in a variety of familial contexts (Beavers & Hampson, 2003; Cohen et al., 2002; Greeff & der Kinderen, 2003; Greeff & Le Roux, 1999; Greeff & Ritman, 2005; Hawley, 2000; Holtzkamp, 2004; Kiser & Black, 2005; Marsh & Lefly,

1996; Thompson, 1999; Walsh & Pryce, 2003). In contrast to the qualitative data however, quantitatively, religion and spirituality (measured by FCOPES Spiritual Support) had no significant correlation with adaptation –exactly what was found in a similar study conducted by Greeff and Human (2004) in resilience in families in which a parent has died. One possible explanation for this phenomenon is the way the spiritual support items are phrased in the FCOPES Spiritual Support subscale. For example, an item reads 'When we face problems or difficulties in our family, we respond by having faith in God'. A number of participants answered 'disagree' explaining that they have faith in God all the time, not just when they have a problem. All items on this subscale were phrased in the same way, and hence received the same response.

In the Resiliency Model, McCubbin and McCubbin show that individual family members can be a resilience resource for the entire family. In the present study, characteristics of individual family members in the home, excluding the patient, were reported to affect the resilience of the entire family unit by 67.6% of participants. A number of aspects cited in various studies were included in this category, such as perception, attitude, hope, perseverance, patience, tolerance and acceptance (Garmezy, 1993; Greeff & der Kinderen, 2003; Holtzkamp, 2004; Karp, 2001; Lam et al., 1999; Lee et al., 2003; Masten & Coatsworth, 1998; Walsh, 1996; 2003a; Werner & Smith, n.d.). In the present study acceptance was classified in two ways, one with specific reference to the patient or mental illness and the other, classified as an individual characteristic, was a more pervasive attitude of acceptance in general. The latter kind reflected an acceptance of 'bad things happen to good people' and that it is important 'to accept your lot in life'. This aspect was not quantitatively assessed.

Numerous researchers (Cohen et al., 2002; Hall, 2004; Garmezy, 1993; Greeff & Human, 2004; Holtzkamp, 2004; Lee et al., 2003; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; Walsh, 2003a; Werner & Smith, n.d.), underscore the value of certain characteristics of the family unit, such as emotional and practical support, love for one another and mutual respect; mentioned by 61.8% of participants in the present study. This too is shown in the Resiliency Model (McCubbin & McCubbin, 1996). Quantitatively, the Family Hardiness Index (FHI) measures specific family characteristics on three separate subscales. The family's ability to work together and internal strengths of the family unit (FHI Commitment) had a relatively strong, positive, significant correlation with adaptation. Although the FHI (Total score) measure had a surprisingly low internal reliability (.36), the commitment subscale was found to be more reliable, with an internal

reliability of .68. Contrary to findings in other studies, neither an internal locus of control of the family unit (FHI Control) nor the family's ability to learn or reframe crises positively (FHI Challenge) had a significant correlation with family adaptation. The latter of these two findings is confirmed by the non-significant correlation between family adaptation and the FCOPES Reframing subscale, which evaluates the family's ability to redefine negative situations in a positive way. A possible explanation for this is that families are unaware of how to use positive reframing as a coping skill. During the interviews participants were confused by the questions related to positive reframing and did not seem to understand what was meant by the concept, even after it was explained to them.

Social support, identified by 50% of participants, ranks as the fourth most frequently mentioned category. This finding is supported by the Resiliency Model, as well as a substantial amount of research (Cohen et al., 2002; Garmezy, 1993; Hall, 2004; Lam et al., 1999; Marsh & Lefly, 1996; Masten & Coatsworth, 1998; McCubbin & McCubbin, 1996; Walsh, 1996; Werner & Smith, n.d.). Interestingly however, not one of the three social support measure scores (SSI, RFS, FCOPES Social Support) were significantly correlated with adaptation. This contradictory finding is similar to that of Holtzkamp (2004), in a study of resilience in relocated families. In the present study, this discrepancy could perhaps be ascribed to the sampling method (convenience sampling) and micronumerosity (small sample). In addition to this possibility, other explanations arise from problems with the statistical analysis. Both the degree to which the family finds support in their community (SSI); and the family's use of friends and relatives as a coping mechanism during crises (RFS) were included as predictor variables resulting from the multiple regression analysis. However a confusing finding was that the family's use of friends and relatives as a coping mechanism during crises (RFS) had the third strongest predictor power of family adaptation – in a negative direction. Multiple regression analysis was used to determine a systematic relationship between predictor variables and family adaptation. Generally speaking, results could be interpreted as follows: for every unit that an independent variable increases, the dependent variable will on average change by the estimated coefficient value of that variable. A positive sign in front of the beta coefficient indicates that the dependent variable will change in the same direction as the independent variable, whereas a negative sign indicates that the two will change in opposite directions. In the present study, all estimated coefficients indicate signs in accordance with the literature, except for the family's use of friends and relatives as a coping mechanism

during crises (RFS), which has a negative sign. The regression results indicate that for every unit of increase in this variable, family adaptation will decrease by .11 units of measurement. This finding is not supported by the qualitative data, the Spearman correlations, or the literature, and highlights a real limitation with respect to this data. Regression analysis assumes independent variables with no linear relationship between them. In this case, although these two measures evaluate different aspects of social support, there may be some overlap between the two measures. There is a possible systematic linear relationship between the two measures, and hence the problem of multicolinearity arises. This leads to the incorrect sign of the family's use of friends and relatives as a coping mechanism during crises (RFS), since the individual impact or influence of the related variables cannot be effectively isolated (Gujarati, 2003).

Marsh and Lefly (1996) and Karp (2001) have identified accepting or understanding the patient and the illness as a resilience factor. In the present study, 32.4% of participants reported that this form of acceptance helped their family adjust to living with and caring for a member being treated for a psychiatric illness.

The family's ability to seek out and use of community resources - such as the clinic, police and the library - was relatively insignificant in both the qualitative and quantitative analyses. Only 26.5% of participants identified community resources as a resilience factor and no correlation was found between adaptation and the family's ability to seek out and accept help from the community (FCOPES Family Mobilization).

Marsh and Lefly (1996) identified another resilience factor that was not quantitatively assessed in this study, namely characteristics of the family member with a mental disorder. However, qualitatively 26.5% of the participants cited positive behaviour by the patient as a resilience factor.

Interestingly, only 20.5% of participants identified communication as a resilience factor. This is in stark contrast to previous research and the quantitative results of the present study, that communication is a key process in both family functioning and family resilience (Cohen et al., 2002; Lam et al., 1999; Lee et al., 2003; Walsh, 1996). Again, this finding is similar to that of Greeff and Human (2004). In the present study, positive, supportive communication patterns (FPSC Affirming) indicated a relatively strong positive linear relationship with family adaptation. It is noteworthy though that negative inflammatory communication patterns (FPSC Incendiary) had an even stronger negative relationship with family adaptation. This implies that although affirming communication patterns contribute significantly to family adaptation, it is more useful to guard against

hostile communication patterns, which significantly hinder the family's ability to adapt. Of the six variables that best predict family adaptation, as shown in the best subsets multiple regression analysis, the style of family communication during a crisis (FPSC Total) is singularly the strongest predictor of family adaptation. Incidentally, the only sub-category of family routines that was significantly correlated with family adaptation was the routines that promote communication between the couple (FTRI Couple togetherness). This again reiterates the importance of communication in the family. A possible explanation for communication not being reflected as a common resilience factor in the qualitative analysis, may be that participants are unaware of the impact of communication styles on their household. In addition, if communication is a coping style that the respective families do not consciously employ, it cannot qualitatively be identified as a resilience factor.

A resilience factor identified by Barnard (quoted in Strümpfer, 1999), namely possessing and maintaining rituals in the family, was echoed by 20.5% of participants who identified routine, structure and family activities as a resilience factor. Although the extent to which the family engages in routines (FTRI Family time & routines) shows a significant correlation with family adaptation, this relationship is not particularly strong. As mentioned previously, the only category of routines that had a significant correlation with family adaptation was routines that promote communication between the couple (FTRI Couple togetherness). Curiously, although the extent to which families engage in routines shows a significant correlation with adaptation, the degree to which the family values their routines shows no correlation at all. Nonetheless, both the extent to which the family engages in routines (FTRI Family time & routines) and routines that promote communication between the couple (FTRI Couple togetherness) are predictor variables for family adaptation, as shown in the multiple regression analysis.

In agreement with findings by Marsh and Lefly (1996), participants (20.5%) identified professional support as a resilience factor. This category included mental health professionals such as psychiatrists and psychologists, as well as other professionals such as clergy.

In terms of financial resources, the government disability grant awarded to people who are unable to work because of psychiatric impairment, was mentioned by 17.6% of participants. No inference could be made from this finding however, as the biographical data collated from participants does not indicate how many of the patients receive this disability grant. Quantitatively, the gross annual income of the household showed no correlation with family adaptation. Again, no inference could be made from this finding as

there is no comparison group. Although there was a range of income categories, all participants fell into a low-income bracket.

Karp (2001) explains that treatment adherence by the patient helps families to cope because families are more sympathetic towards those who make an effort to help themselves. In the present study, 14.7% of participants identified treatment adherence as a resilience factor. Contrary to Karp's reasoning however, participants explained that it is easier to adapt when the patient is on medication as the patient is then 'easier to handle'.

The number of people living in the home had a fair, statistically significant correlation with family adaptation. Perhaps this could be ascribed to the practical support family members are able to provide.

Only two factors reflected a statistically significant negative correlation with family adaptation. The first of these is inflammatory communication patterns, as mentioned previously, and the second, the family's use of passive appraisal as a coping style (FCOPES Passive Appraisal). This contradicts similar South African studies of family resilience which have identified passive appraisal as a positive coping mechanism (Aspeling, 2004; Greeff & Human, 2004; Holtzkamp, 2004). However, other research has shown that it is more beneficial to be proactive in dealing with family crises than it is to merely passively accept the situation (Barnard quoted in Strümpfer, 1999; Cohen, Slonim, Finzi, & Leichtentritt, 2002; Walsh, 1996; 2003a). In the present study, this result is confirmed by the results of the multiple regression analysis where passive appraisal showed a systematic, negative relationship with family adaptation. This result should, however, be interpreted cautiously, since coefficients may be biased because of micronumerosity and related sample problems. The internal reliability of the FCOPES Passive Appraisal subscale in the present study was only .36.

The other factors that were identified in the qualitative data were neither quantitatively evaluated nor supported by previous research findings. These factors were: career factors of family members, like having a job to keep one busy, 14.7%; allowing the patient freedom to 'do his thing' (11.8%); and finally, keeping the patient busy (8.8%).

In terms of demographic characteristics of the patient in the home, the age of the patient showed no correlation with family adaptation. Unfortunately it was not possible to evaluate the relationships between family adaptation and the diagnosis of the patient; and family adaptation and the position of the patient in the family (for example: parent/child), as the sample was too small.

5.3 Limitations and recommendations

The aim of the present study was specifically to identify resilience factors and not to examine the way in which they operate. However, family resilience is a process that operates over time and should not be measured at a single point in time, as was the case with the cross-sectional design of the present study. Future family resilience studies may employ a longitudinal design.

Karp (2001) refers to a Japanese film, Rashomon, which depicts different versions of a violent rape and murder through the eyes of four witnesses, thereby illustrating the "relativity of truth and the inevitable subjectivity that shapes both perception and experience" (p. 146). Similarly, different family members have distinctive emotional and practical roles in the family and consequently different perceptions and experiences of matters that affect the family (Karp, 2001). Based on the aforementioned, a major limitation of this study is the fact that only one family representative was interviewed from each family. In addition to the problem of subjectivity in only using one representative, this methodology merely allowed the assessment of the perceptions of an individual member as opposed to an assessment of the entire family unit. As explained by DeHaan et al. (2002), data is gathered at an individual level and extrapolated to a family level. An improvement to this design would be to interview multiple family representatives.

Due to the design of this study and the sample used, the results cannot be generalised. The sample was very heterogeneous in terms of family structure, position of the patient in the family and the psychiatric diagnosis of the patient. It could be hypothesised that living with a child with Attention Deficit Hyperactivity Disorder would impact a family differently to living with a parent diagnosed with schizophrenia. Future studies could well focus on more homogenous groups of families, for example families living with a parent with a psychotic disorder. In addition, the focus of the present study was on resilience in families that are living with a member with a mental disorder, but no comparison group was used to compare the way that they may differ from families without a member with a mental disorder. Comparative studies would be useful in potentially isolating resilience factors that are unique to these families.

An important factor that was not taken into account, was the family's understanding or perception of the mental disorder. Their religion, culture and understanding of mental illness would presumably have an impact on the way they perceive the member with a disorder and the way that they adapt to the situation. A qualitative component evaluating this factor would improve our understanding of how family resilience operates.

Ideally, random probability sampling should be used, but the present study involved convenience sampling. It was only possible to identify participating families through their family member receiving treatment at the clinic. There may be a possibility that the type of person that agreed to take part would influence the type of data obtained. There is also a probability that the fact that the family member with the mental disorder was receiving treatment, could impact on family functioning and hence influence the data obtained. Future studies could use better sampling techniques and perhaps focus on families of people suffering from mental disorders who are not receiving treatment.

In terms of the interviews, the number of questions in the quantitative questionnaires and the response categories changing from measure to measure, caused some participants to become fatigued, frustrated and confused. In the Afrikaans interviews, some participants reported that the level of Afrikaans in the questionnaires was difficult to understand and that it was sometimes difficult to distinguish whether the items referred to the family or the extended family. The fact that most of the data sets were completed by the researcher, as dictated by the participants, raises the concern of latent social desirability on the part of the participant.

With regard to the content analysis, its reliability may be improved with multiple coders as opposed to a single coder, as was the case in the present study. Unfortunately statistical analyses were confounded by the small sample size, as well as correlations between some of the variables.
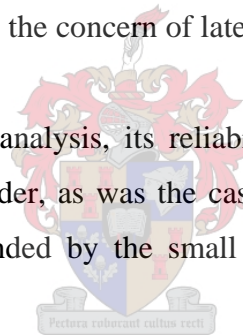
Further research is called for to address these limitations. Although this study reflected a number of limitations, many of the findings are supported by theory and research. The limitations of this study could thus be used to improve the design of future research.

A point raised during a presentation on the results of this study, is the potential negative impact that a more resilient family may have on the well-being of the patient in the family. It was proposed that less resilient families will ensure that a patient receives medical/psychiatric attention as soon as he becomes symptomatic whereas a more resilient family will be able to cope with the problematic patient for longer before calling in professional help. This is another topic for potential future research.

5.4 Conclusion

The findings of the present study suggest that interventions aimed at improving family adaptation in families living with a member with a mental disorder should target religion

and spirituality, characteristics of the family unit, and communication. Improved family adaptation is likely to have a positive impact on the health and well-being of all the family members. Simultaneously, a great deal of research still needs to be done in the challenge to operationalise and measure family resilience.
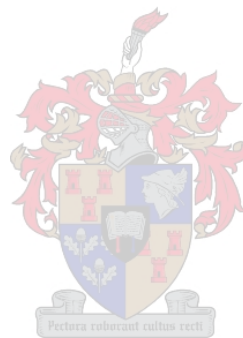
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APPENDIX A

Name of interviewer:

BIOGRAPHICAL INFORMATION

All information in this questionnaire is strictly confidential and your information will be anonymously processed.

Please cross the box most appropriate to you, or complete the statement in the space provided:

1. In which area or town do you live?………………………………………………….

2. What is your relationship to the patient attending the clinic?....................................

3. What is your home language? ☐**Xhosa** ☐ **Afrikaans** ☐ **English** ☐ **Other** (Specify)

4. Race:　　　☐ **African**　　☐ **Coloured**　　☐ **Other** (Specify)……………

5. Family composition:
a) How many adults live in your home?..

For each of the adults in your home, including you, please try and answer the following:

Adult	Male or female?	Relationship to patient (Father, mother, sibling, cousin, aunt / uncle, grandparent etc)	Age	Level of education (Primary school, high school, diploma, degree or other)	Employed?
1	M / F				Yes / No
2	M / F				Yes / No
3	M / F				Yes / No
4	M / F				Yes / No
5	M / F				Yes / No
6	M / F				Yes / No

b) How many children live in your home?
For each of the children in your home, please try and answer the following:

Child	Male or female?	Relationship to patient (Father, mother, sibling, cousin, aunt / uncle, grandparent etc)	Age	Level of education (Primary school, high school, diploma, degree or other)	Employed?
1	M / F				Yes / No
2	M / F				Yes / No
3	M / F				Yes / No
4	M / F				Yes / No
5	M / F				Yes / No
6	M / F				Yes / No

c) How would you describe the family that lives in your home?

☐ Single mother, nuclear family   ☐ Single father, nuclear family   ☐ Two-parent
                                                                         nuclear family

☐ Single mother, extended family   ☐ Single father, extended family   ☐ Two-parent
                                                                          extended family

☐ Other (Please describe)………………………………………………..……………….

5. What is your family's estimated gross income per year?

☐ Less than R10 000   ☐ R11 000 – R20 000   ☐ R21 000 – R30 000

☐ R31 000 – R40 000   ☐ R41 000 – R50 000   ☐ R51 000 or more
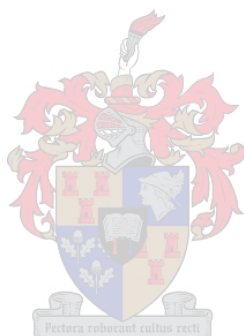
APPENDIX B

Qualitative information

In your own words, what has helped your family cope while caring for your ill family member? (For example: qualities, variables, resources, factors or characteristics)

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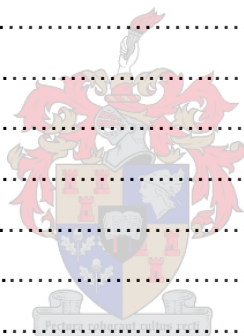…………………………………………………………………………………..……………

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Thank you for your co-operation.

APPENDIX C

Dear

I am writing to ask for your participation in a research project. The aim of this project is to determine what factors enable families to be strong in the face of a crisis. You have been chosen to take part because you live with a family member who is being treated for a psychiatric illness at the Cloetesville Community Health Clinic. We are asking 80 families to take part.

If you choose to take part, you will need to attend one, hour and a half long interview. This interview will happen at the University or at the clinic in Tennant street and will be conducted by a psychology student from Stellenbosch University. In this interview you will be asked to fill in 8 questionnaires in your choice of English, Afrikaans or Xhosa. The questions you will be asked are about: how your family experiences your community, how you cope with family problems or other difficulties, how you speak to each other, and your family routines. The student will be with you if you need any help with reading, completing or understanding the questions.

It is your choice if you want to take part or not. If you would like to stop the interview or withdraw, for any reason, you are welcome to. If you do change your mind, you do not have to explain or give a reason. If you do choose to withdraw, there will not be any negative effects or consequences for you because of this decision.

Your name and contact details will be recorded by the researcher and this information will not be available to anybody. The information you give in the interview will only be shared with the researcher. All information you share is private and confidential which means that nobody will know about what you share.

Your questionnaire results will be added to the results of the other families taking part. I will then analyse the information to see what families say helps them cope. When I have all this information I will write about it and share it with the clinic and the university so that people know how to help families in your situation. The information shared will be the results of all the questionnaires for all the families, your individual results will not be made public. The results will be shared with you and your family in the form of a workshop at the end of the year. It will also be shared with people that help families in need so that they can help families more effectively.

We can't pay you for your time, but we would like to give you a small token of thanks for taking part. If you have questions or concerns about the research, your rights or the results of the study you may phone me on 082 465 9271.

Yours sincerely,

Name……………………………………………………………………….

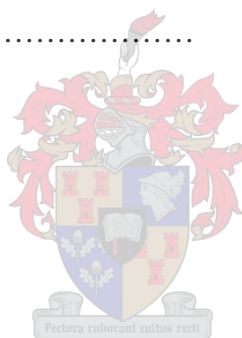Contact details…………………………………………………………………...

Section A:

1. I confirm that I have read and understood the cover letter regarding the research project.

2. I understand that it is my free choice to take part and I may choose to withdraw at any time, without giving any reason.

3. I freely choose to participate in this project.

Signature………………………………………   Date…………………………….

APPENDIX D

Geagte

Ek benodig u hulp met 'n navorsingsprojek. Die doel van hierdie projek is om uit te vind wat families sterk maak wanneer hulle 'n krisis beleef. U is gekies om deel te neem omdat u woon met 'n familielid wat psigiatriese behandling kry by die daghospitaal.

Indien u besluit u wil deelneem, sal u een, uur en 'n half lange onderhoud moet bywoon. Hierdie onderhoud sal plaasvind by die Stellenbosch Univesiteit of by die daghospitaal in Tennant Straat. In hierdie onderhoud sal u ag vraelyste moet beantwoord, in Engels, Afrikaans of Xhosa. Die vrae handel oor: hoe jou familie julle gemeenskap ervaar, hoe jou familie probleme of ander moeilikhede baasraak, hoe julle met mekaar praat en julle roetines. Die student sal die hele tyd by u wees indien u hulp nodig het om die vraelyste te lees, in te vul of te verstaan.

U het 'n vrye keuse om deel te neem of nie. Al stem u saam om deel te neem, mag u enige tyd gedurende die onderhoud van plan verander. Indien u besluit om nie verder deel te neem nie, hoef u nie 'n rede of 'n verduideliking te gee nie en daar sal geen negatiewe gevolge wees nie.

Net ek sal u naam en kontakbesonderhede hê. Hierdie inligting sal vir niemand beskikbaar wees nie. Alles wat u sê in die onderhoud sal net met my gedeel wees. Die inligting wat u gee, is baie vertroulik en privaat en sal met niemand gedeel word nie.

Nadat ek inligting by al die families gekry het, gaan ek al die inligting saamvoeg. Ek gaan die inligting analiseer om uit te vind wat dit is wat families in u situasie help om die krisis baas te raak. Ek gaan dan oor hierdie inligting skryf. Geen individuele inligting gaan gebruik word nie, net die geheelbeeld, so niemend sal ooit kan sê of een familie 'n spesifieke antwoord gegee het of nie. Hierdie skriftelike werk gaan ek vir die Universiteit, die hospital en die kliniek gee sodat hulle kan verstaan hoe om families soos u s'n beter te kan help. Teen die einde van die jaar wil ek 'n werkswinkel hou waar ek vir u en u familie kan se wat ek gevind het en met julle kan deel wat help ander families in julle situasie.

Ons kan u nie betaal vir u tyd nie, maar ons wil graag vir u 'n klein ietsie gee om dankie te sê dat u deelgeneem het.
As u vrae het oor die studie, u regte of die studie se uitslae, bel my gerus op 082 465 9271.

Vriendelike groete,

Naam……………………………………………………………………….

Kontakbesonderhede…………………………………………………………………...

4. Ek bevestig dat ek die toestemmingsbrief gelees het, en ek verstaan wat ek daarin gelees het.

5. Ek verstaan dat ek 'n vrye keuse het om deel te neem en ek mag op enige tyd onttrek sonder om 'n rede te gee.

6. Ek kies om aan hierdie projek deel te neem.

Handtekening………………………………   Datum………………………