A Qualitative Enquiry on the Experiences of Family Caregivers of Mental Health Care Users in Rural UMkhanyakude Health District, KwaZulu-Natal, South Africa

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Article

A Qualitative Enquiry on the Experiences of Family Caregivers of Mental Health Care Users in Rural UMkhanyakude Health District, KwaZulu-Natal, South Africa

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Abstract: Background: Globally, family caregivers develop experiences specific to their home caring activities of their mental health care user relatives. This results in them adopting coping strategies and coping mechanisms, which may be positive or negative. The strategies and mechanisms shape the resultant adaptation context from which theoretical frameworks develop over time. Coping is often influenced by the cultural and belief systems, as well as available and received support from personal relationships, which suggests a need to enquire about burden of care among people in different settings. **Study Objectives:** To identify and describe the coping mechanisms and strategies used by family caregivers of their mental health care user relatives during the home caring process in a rural setting in KwaZulu-Natal. **Methods used:** In-depth interviews were used to collect data from a sample of 36 family caregivers for chronic and serious mental disorders. Nvivo version 14 was used to analyse the data. **Findings:** The sample was made up of 36 participants who experienced different levels of burden of care. Nine themes emerged from the data and were classified under the three domains of coping mechanisms/styles; the active behavioural coping mechanisms, the active cognitive coping mechanisms and avoidance coping mechanisms. Themes which were classified under the active behavioural coping mechanisms were, help seeking behaviour, negotiating with MHCU and being firm with the MHCU. Being patient and positive, commitment to care and give everything up to God were the themes which fell under the active cognitive coping mechanisms. Themes grouped under avoidance coping mechanisms were given up hope, walk away from trouble and seeking revenge. Themes under the active cognitive coping mechanisms as well as avoidance coping mechanisms, were the most interchangeably applied by participants in all levels of burden of care; with themes classified under the active behavioural coping mechanisms being the least used.**Conclusion:** It is recommended that caregivers need to be empowered with coping skills, which will enhance their coping mechanisms.

Keywords: family care givers; mental health care user; coping mechanisms; coping strategies; home caring process; caregiver burden

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1. Introduction

Mental illness impacts heavily on both the caregiver and the patient, and its real accumulative burden of impact world-wide may be much more than what is being reported (Vos et al, 2020). In the absence of adequate mental health infrastructure, many low- and middle-income countries, including South Africa, family caregivers experience many challenges, and have to assume multiple roles as they provide care for persons with mental illnesses (Karmiel et al, 2013; Freeman et al, 2015).

Often such caregivers struggle with the skills to respond to the person's symptoms, but also have to negotiate with other difficult family members, thus weakening family relationships because of the care giving conflicts among family members (Ntsayagae et al, 2017; Rahmani et al, 2019).This burden during home caring process requires adequate and relevant resources, including information sharing on more positive coping mechanisms as family members have little or no choice, but to cope with the situation. Caregivers need positive coping mechanisms, self-care, internal motivators and intrinsic behaviors which will result in mastery, resilience, and self-efficacy to handle care giving responsibilities (Mathur et al, 2018).

Family coping is therefore one of the fundamental dimensions of family health. The family coping ability is thus considered to be the capacity or ability of the family to effectively deal with, use the available resources wisely, in spite of their inadequacy in the face of stressful events (Goosens et al, 2008; Iseselo et al, 2016). Possession of positive coping skills to care for family members therefore enables family members to mitigate the related unpleasant reality (Rice, 2012).

The coping ability of a family also involves behavioural and/or cognitive efforts which are aimed at managing or regulating the stressful situations. Family coping strategies can potentially strengthen and reserve family resources to protect them from stressful situations and ensure proper management of their dynamics. These coping strategies are manifested through correct communication channels and the promotion of positive self-esteem among the members of the family concerned (Ae-Ngibise, 2015; Osundina et al, 2017). The cultural system of coping is therefore influenced by various elements of the social system, religious beliefs and the way that people receive support from their personal relationships. In these settings, cultural rules, social structure and religious beliefs are strongly linked to positive interaction between family members, thus creating a strong bond among them (Mavundla et al, 2009; Osundina&Fatoye, 2017).

Purpose of the Study

To determine the burden of care coping mechanisms and strategies used by family caregivers of MHCUs diagnosed with serious mental illness.

2. Methods

2.1. Study Design

The original study was a mixed method sequential study design, and the quantitative results on the burden of care of family caregivers for people diagnosed with serious mental disorders in a rural health district in Kwa-Zulu-Natal, South Africa were previously reported (https://www.mdpi.com/2227-9032/11/19/2686), and this paper only reports on the qualitative phase of the study.

2.2. Study Setting

The study was conducted at the rural UMkhanyakude Health District, which is the second largest district in the Province of Kwa- Zulu Natal. The district has a population of about 625 846, 53 Primary Health Care facilities and a population of about 4 400 mental health care users in their registers, (DHIS, 2023). Because of its rural setting, access to basic health services is not easy as many people walk long distances to the nearest facility.

2.3. Recruitment of Study Participants

Recruitment of all the participants from various categories of care giving burden depended on the previously determined Zarit Burden Interview (ZBI) scale score which determined the burden of care category, and that the participants were willing to avail themselves for the second interview. The community health workers assisted in contacting the potential participants, to invite them for the 2nd phase of the study.

2.4. Sampling and Sample Size

The participants were purposely selected from the bigger sample of 357 caregivers (sample of Phase 1, the Quantitative Phase). The Phase 2 participants were selected based on their scores obtained from the ZBI scale , and included those with highest, lowest and middle scores.Such scores were categorized as little or no burden (0–20), mild to moderate burden (21–40), moderate to severe burden (41–60) and extreme severely burdened (61–88). A maximum of 25 to 30 participants is recommended for qualitative studies using interviews (Guest et al, 2020).Initially, only the extreme severely and little or no burdened participants were to be interviewed, but in order to prevent bias, a few from the rest of the categories were later included. As a result, 36 participants were included in this qualitative arm, from across the categories of burden of care: 20 from the highly burdened, 9 from the lowly burdened, 3 from moderately burdened and 4 from mildly burdened.

2.5. Data Collection

On the day of data collection, the researcher was allocated a private room within the clinic. The purpose of the 2nd phase of the study was explained again, the participants were given an opportunity to ask questions which was followed by the administration of the informed consent (including permission to use the digital recorder) and the in-depth interview questionnaire (which lasted between 30 and 45 minutes). The participants were remunerated for transport costs.

2.6. Data Analysis

The qualitative inquiry used content analysis to explore and classify the self-reported coping strategies and mechanisms of participants as emerging from in-depth interviews.

The qualitative audio recordings were transcribed verbatim, translated into English, typed into Word and transported into Nvivo version 14. The first few transcripts were read several times to identify phrases and/or sentences (themes) that relate to the 3 pre-determined categories or domains of coping styles or coping mechanisms. The pre-determined domains of coping mechanisms or coping styles were behavioural, cognitive and avoidance (BCA), as adopted from the Irish study where coping mechanisms by family caregivers were dealt with, (Kartalova-O'Doherty &Tedstone Doherty, 2008).

Phrases and/or sentences that were aligned to the same ideas were copied verbatim and grouped together under the particular code. A codebook was created from the first few transcripts, with several codes and definitions of each code and these codes were applied to all the transcripts. The codebook was refined as more transcripts were coded. The verbatim phrases/sentences were used to support the theme under which they were coded during the writing of the narrative.

In order to capture the essence of coping as dealt with in the current study, the three pre-determined domains of coping mechanisms or styles were adopted from the Irish study (Kartalova Doherty & Teddie O'Dorherty, 2008). These Irish authors define coping strategy as a specific coping behaviour or technique applied by an individual in a stressful situation (e.g. doing household chores), whereas a coping mechanism or coping style is a broader classification of specific coping strategies. The coping mechanisms or styles are classified into three domains; the active behavioral, active cognitive and the avoidance coping mechanisms (called the BCA coping mechanisms or styles), with various strategies under each as specifically experienced by the family caregivers of their mental health care giver relatives.

2.7. Socio-Demographic Profile of the Participants for Phase 2

The total sample of the qualitative phase was 36 participants, from across the categories of all levels of burden of care. From these participants, 56% (n=20) was from the extremely severely burdened category, 25% (n=9) from little to no burden category, 8% (n=3) from moderate to severe burden category and 11% (n=4) was from mild to moderate burden category. Their ZBI scores ranged between 8 and 85, with more scores within the extremely severely burdened category, as per the high number of participants belonging to this burden category.

3. Findings:

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The qualitative findings outline the themes which emerged during the analysis of data. The interview guide closely looked at the difficulties experienced by the family caregivers, the support they get most of the time, and particularly need when they are having a crisis. The focus of the in-depth interviews was to identify coping mechanisms or coping styles used by family care givers to navigate the difficult ways of caring for their relatives with serious or severe mental disorders across the categories of their perceived caregiver burden. The coping strategies identified were themes (which were classified under specific domains of coping mechanisms or styles) and the feelings displayed or actions shown during the execution of those coping strategies were sub-themes. The sub-themes were depicted by the quotations that the participants uttered.

See Table 1 below:

Table 1. shows the domains of coping mechanisms, themes and sub-themes.

Domain	Theme	Sub-theme
Active Behavioural Coping Mechanism	Help Seeking behaviour	-Talking about the problem -Reaching out for help
	Being firm with the MHCU	-Standing their ground and not yielding to demands of the MHCU -Threatening to take legal actions against bad behaviour
	Negotiating with the MHCU	Bribing the MHCU towards desired behavior
Active Cognitive Coping Mechanism	Commitment to care	-Actions of acceptance (taking resolution to care) -Showing unconditional love
	Reaching out to higher powers	-Praying for supernatural power intervention -Undergo fasting -Holding on to faith
	Being patient and Positive	-Feelings of trust -Holding no grudges
Avoidance Coping Mechanism	Given up hope	-Feelings of hopelessness -Feelings of helplessness -Feeling of powerlessness
	Walk away from trouble	-Avoiding stressful situations
	Desiring justice	Seeking revenge

Theme 1: Help Seeking Behaviour

This theme refers to the point of realization reached by the family caregivers as they experience the challenging situation of care giving that outside help or support is needed to effectively deal with that situation. The help sought involved different coping strategies which they developed, and covered a range of sources from which help is sought. In many cases help is sought when crisis situation is faced with. The social networks, including neighbours, provided the support needed, especially when the MHCU relative being cared for, was violent. Help was also sought from community service delivery outlets (the hospital, the clinic and sometimes police station) and other family relatives.

Sub-Theme 1: Talking About the Problem

“My neighbour is staying with a mentally ill relative in her house and she usually encourages me to stay strong and persevere because she understands what I am going through; and I feel comforted after our talk", (53 year old female, extremely severely burdened, taking care of her 29 year old son with Bipolar Mood Disorder).

Sub-Theme 2: Reaching out for Help

"If he starts chasing us with dangerous weapons, I scream for help. Neighbours come to our rescue, hold him down and tie him with ropes while awaiting transport to take him to the hospital",(34 year old female, extremely severely burdened, taking care of her 36 year old husband with Bipolar Mood Disorder).

Theme 2: Being Firm with the MHCU

For the caregivers, this meant standing their ground and not yielding to demands of the MHCU. The family caregivers often used firmness to deal with such unreasonable demands.

"If he is demanding for something I cannot give him, I tell him straight in the face, he may sulk initially but will later understand that I won't change my decision in order to please him", (47 years of age female, mild to moderately burdened, caring for her 36 year-old age brother with Bipolar Mood Disorder).

"Ï am strict about budgetary issues, he must give R700 from his disability grant money as a contribution towards the monthly family groceries, (62 year old female, no to little burdened, caring for a 34 year old son with Schizophrenia).

Sub-Theme: Threatening to Take Legal Actions Against Bad Behaviour

"If sometimes he wants to share the bedroom with his grown up sisters, I tell him it's a no-go-zone and I tell him I will call the Police to take him away to jail if he persists", (52 year old female, extremely severely burdened, taking care of her 33 year old son with Bipolar Mood Disorder).

Theme 3: Negotiating with the MHCU

This theme refers to reaching an agreement with the MHCU relative concerning the rewards he/she will get if he/she is cooperative enough. This agreement is a result of negotiations in the form of bribery, most of the time. Bribery was in the form of incentive to facilitate self-care, promote behaviour modification and improve medication compliance.

Sub-Theme: Bribing the MHCU Towards Desired Behaviour

"I tell him that if he cleans his room and makes up his bed, I will give him R10", (54 years of age female, mild to moderately burdened, caring for her 36 year-old son with Schizophrenia)

"I tell her that if she takes her medication uninterrupted for the whole week, I will buy her fried potato chips which are sold in our nearby tuck-shop", (42 old female, mild to moderately burdened, looking after her 32 year old sister with Bipolar Mood Disorder).

Theme 4: Commitment to Care

Participants have resolved that after exhausting all other alternatives to deal with the challenging situation at hand, and in the absence of a cure for their relative with mental disorder, it helps them to come to terms with the situation and accept it for what it is as it assists them to remain committed to the course of caring for their mental health care user relatives, at home. Family commitment was for them a non-negotiable aspect for caring.

Sub-Theme: Resolution of Acceptance

"I am committed to him, he is my husband", (42 year-old female, extremely severely burdened, caring for her 46 year-old spouse with Bipolar Mood Disorder)

"I have accepted my fate, he is my brother," (44 year old female, extremely severely burdened, caring for a 37 year old brother with Schizophrenia)

Sub-Theme: Show Unconditional Love

"I am his only remaining parent; draw him near you, show that you love him", (53 year-old widower , none to little burden, caring for a 32 year old son with Schizophrenia).

Theme 5: Reaching out to Higher Powers

The participants expressed feelings of being so helpless with their care giving experiences that they needed a supernatural intervention from God. This included prayer, fasting and a cry for help to ask protection from God both for themselves and their mentally ill relatives.

Sub-Theme: Praying for Supernatural Power Intervention

"I only have to leave everything to God and pray that He gives me strength to continue caring for him," (37 years old female, moderately severely burdened, caring for her 35 year-old brother with Bipolar Mood Disorder).

"I pray and sometimes undergo fasting, asking God to take care of me and my child", (64 years of age female, extremely severely burdened, caring for her 42 years of age Schizophrenic son).

"I give everything to God, sometimes I become so hopeless and my neighbour encourages me to press on and not lose faith in God," says a 42 years of age female spouse, extremely severely burdened, looking after her 51 years of age husband with Bipolar Mood Disorder).

Theme 6: Being Patient and Positive:

Participants have learnt that controlling their emotions and state of mind in a positive manner assisted in influencing the behaviour of the mental health care user. Participants were willing to forgive and forget the bad behaviour their mental health care user relatives displayed while they were in relapse. This was about showing non-discriminating approach to the MHCU, so much that he/she was included when specific decisions were taken. This is about being not to be constantly reminded of one's past flaws now and then, especially when the MHCU relative is in relapse.

Sub-Theme: Practising Tolerance

"Be patient and forgive the things he did while he was still confused", (53 year old male, moderate to severely burdened, who cares for his 47 year old brother who has Schizophrenia).

Sub-Theme: Feelings of Trust

"Accept mentally, be positive in your approach, draw him near you and include him in decision making regarding family matters, (65 years of age female, mild to moderately burdened, caring for her 33 years old daughter with Bipolar Mood Disorder)

Sub-Theme: Holding No Grudges

"Do not hold grudges against him, for the things said not in her right state of mind". (41 year-old female, none to little burdened, caring for her 35 year-old brother with Schizophrenia).

Theme 7: Given up Hope

Participants felt hopeless, helpless and powerless when they saw no way out of this situation due to lack of improvement within the situation of care giving. The future prospect of the situation remained bleak and the perceived outcome was bad**.** Here, some of the extremely burdened were so much in despair that they did not care if they die in the process of caring for their relatives.

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Sub-Theme: Feelings of Hopelessness

“I don’t care if I die caring for the child I gave birth to, a banana tree only produces one bunch of bananas and dies, so I won’t be the first parent to die in the process of caring for my own child”, (64 year old female, extremely severely burdened, caring for her 38 years daughter with Bipolar Mood Disorder).

Sub-Theme: Feelings of Helplessness

“Although, due to the burden of caring for my son, I sometimes wish that my heart can stop beating and I die, but hey, I gave birth to him, who else could look after him? he is my child”, (65 years of age female, extremely severely burdened, caring for her 43 year old Schizophrenic son); tears running down her cheeks.

Sub-Theme: Feeling of Powerlessness

“Every time he gets beaten up so badly by the community because of his verbal and physical abuse to them, I always apologize on his behalf; sometimes wishing that he could die first, because who will apologize for him after I am gone,” (63 years of age female, extremely severely burdened, taking care of her 38 year old son with Bipolar Mood Disorder).

Theme 8: Walk Away from Trouble:

This is about the caregiver resolving to leave his or her mental health care user relative because he / she needed time off to cool down from the abusive behaviour. Sometimes the family care giver walks away from the troublesome situation caused by the MHCU relative in order to avoid exacerbation of the problem.

Sub-Theme: Avoiding Stressful Situations

“I drink water but do not swallow it to prevent myself from responding harshly to him and thus making things worse. I therefore, leave him and go out to a quiet spot, so that I can be by myself and cool off”, (54 years of age female, extremely severely burdened, caring for a 56 year old Schizophrenic brother of her husband.)

“I distance myself from the chaos he causes by playing with the baby and singing her a lullaby until she falls asleep, and then I will cry myself to sleep too,”(63 years of age female, extremely severely burdened, caring for her 38 year old son with Bipolar Mood Disorder).

Theme 9: Desiring Justice

This theme refers to the family member wishing that something awful may happen to the person who is suspected to have played a cause role in the mental disorder of the MHCU. This often occurs if witchcraft or some extra-ordinary processes are suspected.

Sub-Theme: Seeking Revenge

“Sometimes I wished I knew who bewitched my child so that he/she can explain why this painful thing was done to my child, I am sure I can beat him/her up to death”, (65 years of age female, extremely severely burdened, caring for her 41 year-old son with Schizophrenia).

The themes and sub-themes mentioned above were shared by participants from the various burden categories as experienced and perceived by them during the in-depth interviews. See Table 2 below:

Table 2. Themes under domains of coping mechanisms as experienced by various burden categories .

ZBI –Burden Category	Themes	Domain

Mild to moderately burden category	-Being patient and positive) -Negotiating with the MHCU	Active cognitive coping mechanism Avoidance coping mechanism
Moderate to Severe burden category	-Reaching out to higher powers -Being patient and positive	Active cognitive coping mechanisms
Extremely severely burdened category	-Commitment to care -Reaching out to higher powers -Being patient and positive	Active cognitive
	-Help-seeking behavior -Being Firm	Active behavioral coping mechanism
	-Given up hope -Walk away from trouble -Desiring justice	Avoidance coping mechanism
No to Little burden category	-Negotiating with MHCU -Walk away from trouble	Active behavioural Avoidance
	-Be patient and positive -Reaching out to higher powers	Active cognitive

4. Discussion

Previous studies have reported that coping strategies are influenced by both the home environment and the personality of the caregiver, and these evolve over time, due to the dynamic nature of some of the contextual factors. This results in family coping being different within families, depending on the socio-cultural context in which the members of the families are exposed to (Ndetei et al, 2009; Ntsayagae, Poggenpoel& Myburgh, 2019). The theoretical approach regarding coping therefore is that it is a changing process which is shaped by its adaptation context. Coping in each cultural system, is thus based on the social system, religion and the way that people receive support from their personal relationships. In these settings, cultural rules, social structure and religious beliefs are strongly linked to positive interaction between family members, thus creating a strong bond between themselves as a family, (Moahi, 2012; Ae-Ngibise, 2015). The current study acknowledged the fact that family coping strategies and coping mechanisms were different within families by including participants from all caregiver burden categories in the sample which was interviewed and whose contextual factors have been dealt with in the first part of this study.

From the current study, the extremely severely burdened category seemed to incline towards using active cognitive coping mechanism the most, followed by the avoidance coping mechanism and lastly by the active behavioral coping mechanisms. There were few combinations of coping mechanisms being used by one person in this category. The mild to moderately severe burden category also used cognitive coping mechanism more, being followed by avoidance coping mechanism. The no to little burdened category used all types of coping mechanisms; interchangeably and with ease. It was noted that active behavioural coping style was the least used and was found among the two extremes of burden categories; the extremely severely burdened category and the no to little burdened category.

The above-mentioned findings regarding coping mechanisms were different from the Irish study, Kartalova-O'Doherty &Tedstone Doherty, (2008) which established that the coping strategies or themes expressed by the participants were showing active behavioural coping mechanism (seeking professional help, talking about the problem) being mostly used; followed by the active cognitive coping mechanism (acceptance, finding inner strength in religious beliefs) and avoidance coping mechanism (trying to ignore the problem, denial, walking away from trouble). Frequently reported strategies were: seeking support from others, talking and trying to be in control.

The differences between the two sets of findings can be explained by the variations in context and the social environment. In the current study, active cognitive coping mechanism seemed to be espoused and used by the extremely burdened participants and their coping strategies were about commitment to care, being patient and positive and reaching out to higher powers; who, they believed, possessed supernatural power to help them carry the heavy burden experienced during their home caring process. This was applicable to this sample as most of the participants were Christians, and it may be that the concept may apply to other religious groups, who may refer to their deity. There was a ring of helplessness (a cry for Divine help) as the situation of caring did not give them any option, but to accept the status quo of their MHCU relatives.There were some family caregivers who were still hopeful for either a cure or a miracle, which would permanently drive away the mental illness from their relatives.

The mild to moderately-burdened used more embracing strategies, such as including the MHCU relative in the family decision-making process. These findings were similar to those reported in Ghana, which has a similar context like in South Africa, where it was reported that family caregivers mostly used active cognitive style, where caregivers relied on prayers offered by pastors and other divine instructors. The themes/coping strategies used there were, hoping for a miracle as well as new treatment regimens (Ae-Ngibise, 2015).

From the sub-Saharan countries (including South Africa), looking into coping mechanisms and strategies used by the family caregivers during the process of caring for their mental health care user relatives; participants from the Nigerian study used the avoidance coping mechanism, using denial as a theme /coping strategy and somehow blaming God for their relatives mental illness (Osundina et al, 2017).This previously mentioned study from the MICs (middle income country) reported that family caregivers' use of denial as a coping strategy and a theme has been proven to be a significant predictor of caregiver burden, thus resulting in complete avoidance of their family members with mental illness, subsequently abandoning them to psychiatric institutions (Osundina et al ,2017).

In the current research, denial as a coping strategy fell under the avoidance coping mechanism. Themes or strategies used by participants across various categories of burden to depict denial were walking away from trouble, desiring justice and giving up hope. Those coping strategies under avoidance coping mechanism were more prominent within the extremely severely burdened category.

In South Africa, people often resort to prayers after a long search for appropriate solutions in various places, which may include traditional healers, which meant they used more active behavioural coping styles first, before turning to active cognitive style as a last resort, (Van der Sanden et al, 2014; Freeman et al, 2015). In the current study, the themes/coping strategies established under the active behavioural coping mechanism were seeking for help, negotiating with MHCU relative and being firm. Here, most of the family caregivers did not want to give in to their mentally ill relatives' demands, but instead they cut deals with them and bribed them to do their activities of daily living and home chores. By so doing, the family caregivers were being firm in handling their mental health care user relatives who may be abusing their status of being ill (thus playing a sick role, unnecessarily). These coping mechanisms were mostly used by the no to little burden category as well as the mild to the moderately severely burdened category.

A few studies in the South African context had concerns about the adoption of positive family coping strategies as part of the active behavioural coping mechanism. Such a coping strategy like seeking spiritual support may result in negative consequences, such as delaying the search for support from other services (Van der Sanden et al, 2014; Freeman et al, 2015). Oyebode et al, (2013) reported about positive coping strategy; "good humour and positive interaction which included singing". From the current study, singing to him and dancing for him while smiling at him (as a positive active behavioural mechanism) was the least used. These positive active behavioural mechanisms consisted of seeking professional help, problem solving and talking to relatives and neighbours. Although singing is mentioned in literature as one of the coping strategies, dancing was not found in literature.

From the active behavioural coping mechanism domain, the action of "drinking water" by the participant when his or her mental health care user relative's behavior was at its worst, catered for two purposes. Firstly, that of calming oneself down and secondly, that of avoiding to respond harshly, thus making the situation worse and uncontrollable. If the act of leaving the place and "drinking water" is used in this context, it becomes a coping strategy and a theme under avoidance coping mechanism.

Seeking for help by him and talking to the neighbours as well as doing house chores were most prominent strategies in active behavioural coping mechanism. Crying openly or on the sly were negative active behavioural coping strategies which were used by the extremely burdened participants in the current research; the positive active behavioural strategies were mostly used by the no to little burdened participants.

Literature also has reported that social support, in the form of support groups, allow for processing of thoughts and feelings, gaining insight into developing positive coping strategies (Lefley, 2010). From the in-depth interviews, some caregivers were supported by their neighbours and church members to enable them to carry the burden. This suggests that family caregivers need additional resources to support their mental health, such as social support as well as psycho-educational support.

On that note, the current study being not an intervention study, could only suggest the adoption, adaptation and implementation of the Multi-Dimensional Scale of Perceived Social Support (MSPSS) tool by mental health care professionals for family caregivers which can help the family care givers to develop positive mental health so as to strengthen their support system in order to cope with their burden of care. MSPSS is a brief research tool designed to measure perceptions of support of family caregivers of MHCU relatives from three sources, i.e. family, friend and a significant other. The scale consists of 12 items with 4 items for each subscale. It is about identification of the caregivers' support and strengthening thereof, towards their positive mental health and has been implemented with positive outcomes in Brazil (Souza et al, 2017). Positive mental health of family care givers of MHCU relatives improves the home caring process (Adeosun, 2013; Martinez-Montilla et al, 2017).

5. Conclusions

It is evident that all over the world, regardless of culture, socio-economic status or age, caregivers experience similar frustrations, but more importantly, are finding similar coping skills and support strategies to be helpful. By learning to accept the situation and by implementing alternative coping methods, family caregivers' mental health can be improved (Iseselo et al, 2016). It must therefore be emphasized that the well-being of a family is determined by family integrity, functioning and positive coping. Many families therefore emerge from coping with challenges of care giving with a renewed sense of resiliency and personal strength (Cotton, 2015).

6. Recommendations

It is recommended that mental health professionals at primary health care level must align their service delivery plans with identification of the needs of the family caregivers, the stresses they are faced with and assist them in developing healthy coping mechanisms as well as refer to social services, which can benefit the MHCUs.

7. Limitations of the Study

As previously mentioned, the study was not an intervention study, so it could not implement but only can suggest the adoption, adaptation and implementation of the Multi-Dimensional Scale of Perceived Social Support (MSPSS) tool by mental health professionals for family caregivers which can help the family care givers to develop positive mental health so as to strengthen their support system in order to cope with their burden of care.

Supplementary Materials: The following supporting information can be downloaded at the website of this paper posted on Preprints.org.

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