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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, South Africa. **Methods:** 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 mental health care user (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 gave up hope, walked away from trouble and sought 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

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 (Karnieli-Miller et al., 2013). Mental health services are particularly under-budgeted for in South Africa and the bigger portion of that small and insignificant budget goes to in-patient care rather than community and family-based care structures (Lund et al., 2013), hence the continued caregiving of most MHCUs by their relatives at a family level.

Often such caregivers not only 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, 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 (Kishor et al., 2018).

Family coping is 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 (Goossens 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 (Monyaluoe et al., 2014).

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 (Mokwena & Ngoveni, 2020; Shiraishi & Reilly, 2019). 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 (Shiraishi & Reilly, 2019; Mavundla et al., 2009).

Purpose of the study

To identify and describe the coping mechanisms and strategies used by caregivers of MHCUs diagnosed with serious mental illness to cope with their burden of care.

2. Methodology

2.1. Study Design

The current qualitative aspect of the study was cross-sectional in its design and descriptive in nature. It used an explorative qualitative approach. It was conducted with a non-probabilistic sample of family caregivers of their relatives with serious mental disorders, without any employment agreement or compensation.

[It must be noted that the original overall study was a mixed methods 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 KwaZulu-Natal, South Africa, were previously reported and published in the paper with the following link (https://doi.org/10.3390/healthcare11192686). This current paper only reports on the qualitative phase (Phase 2) of the study, i.e. the coping mechanisms and strategies of family caregivers of their MHCU relatives].

2.2. Study Setting

The study was conducted at the rural uMkhanyakude Health District, which is the second largest district in the Province of KwaZulu-Natal. The district has a population of about 625,846, 53 Primary Health Care (PHC) facilities and a population of about 4400 mental health care users in their registers. 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 scores which determined the burden of care category in Phase 1 (the Quantitative aspect of the research) 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 (the Qualitative aspect of the research).

2.4. Sampling and Sample Size

Purposive sampling procedure was used to select participants for this Phase 2 of the study. These 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 report 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 were 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 thematic analysis to explore and classify the self-reported coping strategies and mechanisms of participants as emerging from in-depth interviews. Thematic analysis fits well with any qualitative study which attempts to explore complex research issues and is so flexible that it can be incorporated into any epistemological approach (Braun & Clarke, 2006).

Data analysis of the current research followed the six steps of thematic analysis as presented in Brawn & Clarke Framework which involved researcher familiarization with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes and eventually writing up the report.

During the data analysis process, 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 mechanisms. The pre-determined domains of coping mechanisms which were established using the deductive approach of thematic analysis were behavioural, cognitive and avoidance (BCA), as adopted from the Irish study conducted by Kartalova-O'Doherty & Tedstone Doherty, where coping mechanisms by family caregivers were dealt with. 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.

Following the inductive approach of the thematic analysis, 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.

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. The ages of the caregivers ranged between 32 and 65 years, with a mean of 52.3. Most of the caregivers were females (83%, n = 30).

See Table 1 below:

Table 1. Socio-demographic information of the family caregivers.

	Frequency (n)	Percentage (%)
Age (n = 36)		
≤40 years	02	05.56
41 - 60 years	19	52.78
≥61 years	15	41.66
Age (Mean 52.3; SD 10.4; Min 32; Max 65)		
Gender (n = 36)		
Female	31	86.11
Male	05	13.89
Level of education (n = 36)		
No formal education.	08	22.22
Primary	16	44.44
Secondary	09	25.00
Tertiary	03	8.33
Marital status (n = 36)		
Co-habiting	07	19.44
Married	11	30.56
Single	16	44.44
Widowed	02	5.56

Continued

Employment status (n = 36)		
Employed	05	13.89
Unemployed	31	86.11
Religion (n = 36)		
Christian	34	94.44
Nazareth	01	2.78
None	0	0.00
Other	1	2.78
Number of children		
None	04	11.11
1 - 4 children	24	66.66
More than 5 children	08	22.22
Monthly family income		
Below R2000	14	38.88
R2001 - R4000	16	44.44
R4000 - R10,000	04	11.11
Above R10,000	02	5.55

Socio-demographic information of mental health care users

The majority of the mental health care users to be cared for were males and fell within the age range of 36 to 55 years with a mean of 39.75. They were almost all unemployed and cared for mostly by their parents, followed by the siblings.

See Table 2 below:

Table 2. Socio-demographic information of the mental health care users.

Variable	Frequency (n)	Percentage (%)
Age (n = 36)		
≤40 years	13	36.11
41 - 60 years	19	52.77
≥61 years	04	11.11
Age (Mean 39.75; SD 10.92; Min 23; Max 63)		
Gender (n = 36)		
Female	9	25.00
Male	27	75.00

Continued

Level of education (n = 36)		
No formal education	03	8.33
Primary	08	22.22
Secondary	19	52.77
Tertiary	06	16.66
Marital status (n = 36)		
Co-habiting	04	11.11
Married	01	2.78
Single	29	80.55
Widowed	02	5.55
Employment status (n = 36)		
Employed	01	2.78
Unemployed	35	97.22
Diagnosis (n = 36)		
Schizophrenia	21	58.33
Bipolar mood disorder	14	38.89
Major depressive disorder	01	2.78
Disability grant (n = 36)		
Yes	25	69.44
No	11	30.56
Relationship to caregiver		
Parent	20	55.55
Sibling	07	19.44
Spouse	05	13.88
Other	04	11.11

3. Findings

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 needed when they are having a crisis. The focus of the in-depth interviews was to identify coping mechanisms 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 nine coping strategies identified were themes (which were classified under specific three domains of coping mechanisms) and the seventeen 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. Figure 1 below shows the domains of coping mechanisms (in black colour), the themes (in green colour) and the sub-themes (in blue colour). See Figure 1 below.

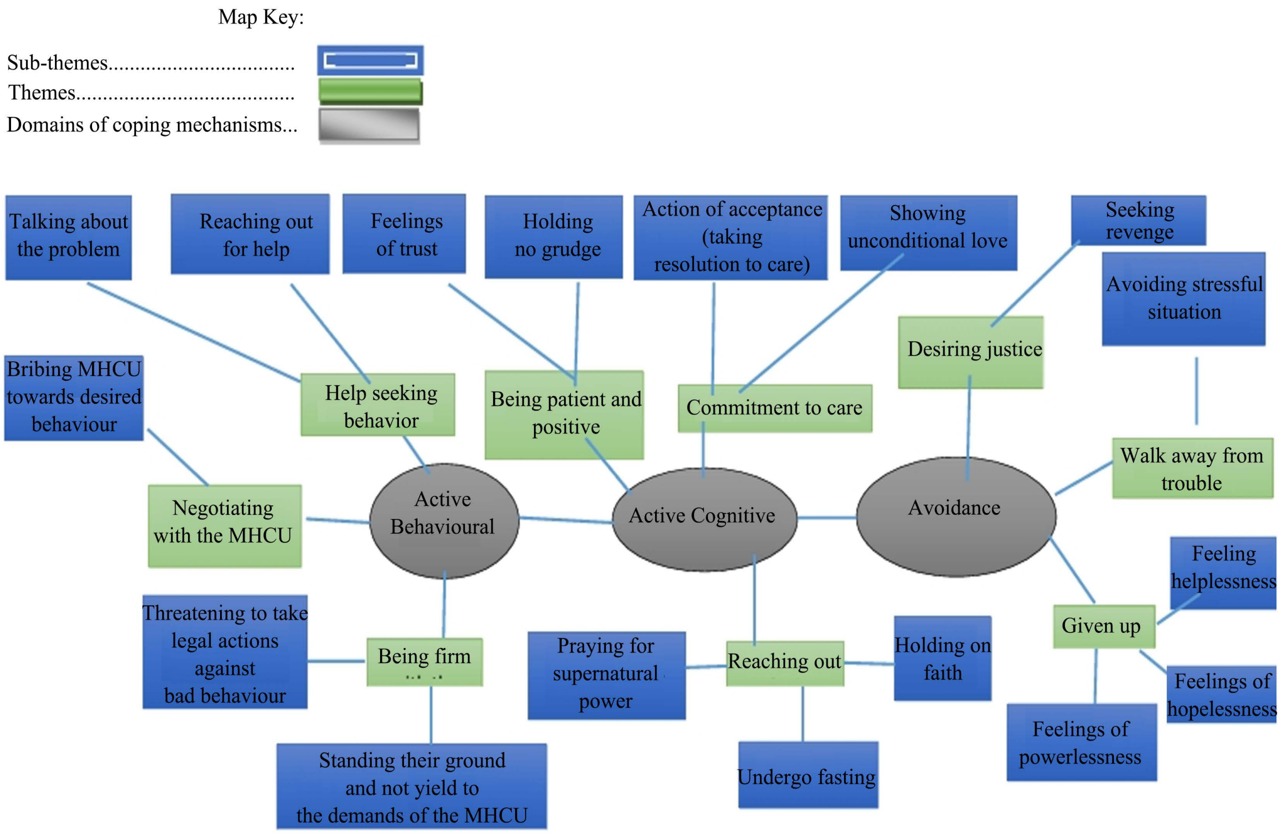

Figure 1. Domains of coping mechanisms, themes and sub-themes.

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 was sought. In many cases help was sought when crisis situation was 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. Participants used the following sub-themes as actions shown during the execution of this coping strategy.

Sub-theme: 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: 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 their MHCU relatives. The family caregivers often used firmness to deal with such unreasonable demands and sometimes threatening to report them to the local Police. The specific actions taken by participants were presented by sub-themes and their various quotes mentioned below.

Sub-theme: Not yielding to 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).

"*I 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 incentives to facilitate self-care, promote behaviour modification and improve medication compliance. Participants expressed the bribing action (as a sub-theme) through the quotations below:

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-year-old female, mild to moderately burdened, looking after her 32-year-old sister with Bipolar Mood Disorder).

Theme 4: Commitment to care

This theme refers to the state of coming to terms with the challenging situation at hand and accepting it for what it is but yet, not giving up on the course.

Here, participants had realized that after exhausting all other alternatives and in the absence of a cure for their relatives with mental disorders, home caring duties remained their responsibility. This realization helped 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. The sub-themes and their respective quotes were the actions taken by the participants during the execution of this coping strategy/theme.

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

This was about feeling so limited as a human being and needing supernatural power intervention to accomplish the task at hand.

The participants here 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. The sub-theme with its quotes below, displayed the feelings felt by the participants when they were reaching out to higher powers.

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-year-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

This theme is about controlling one's emotions and state of mind in a positive manner in order to withstand a challenging situation.

Here, participants had 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 was about being not to be constantly reminded of one's past flaws now and then, especially when the MHCU relative is in relapse. The following sub-themes and their quotes were what participants did and felt during the execution of this theme/ coping strategy:

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 cared for his 47-year-old brother who had 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

An overwhelming decision reached when the future prospect of the situation remains bleak and the perceived outcome is bad.

Here, 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. Some of the extremely burdened were so much in despair that they did not care if they died in the process of caring for their relatives. The sub-themes and their respective quotes mentioned below, were feelings displayed by participants in order to cope better with the burden of caring for their MHCU relatives.

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 refers to the action of physically or psychologically removing oneself from troublesome or stressful situations.

Here, some of the caregivers resolved to leave their mental health care user relatives because they needed some time off to cool down from the abusive behaviour.

Sometimes the family care giver had to walk away from the troublesome situation caused by the MHCU relative in order to avoid exacerbation of the problem. The following sub-theme and its quotes were the action done by participants during the execution of this particular theme or coping strategy:

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 occurred if witchcraft or some extra-ordinary processes were suspected, as depicted by the quote below:

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. Figure 2 below shows the mapping of the four categories of burden (in blue colour), the themes (in green colour) and the complimenting coping mechanisms or styles attached to each theme (in black colour). See Figure 2 below.

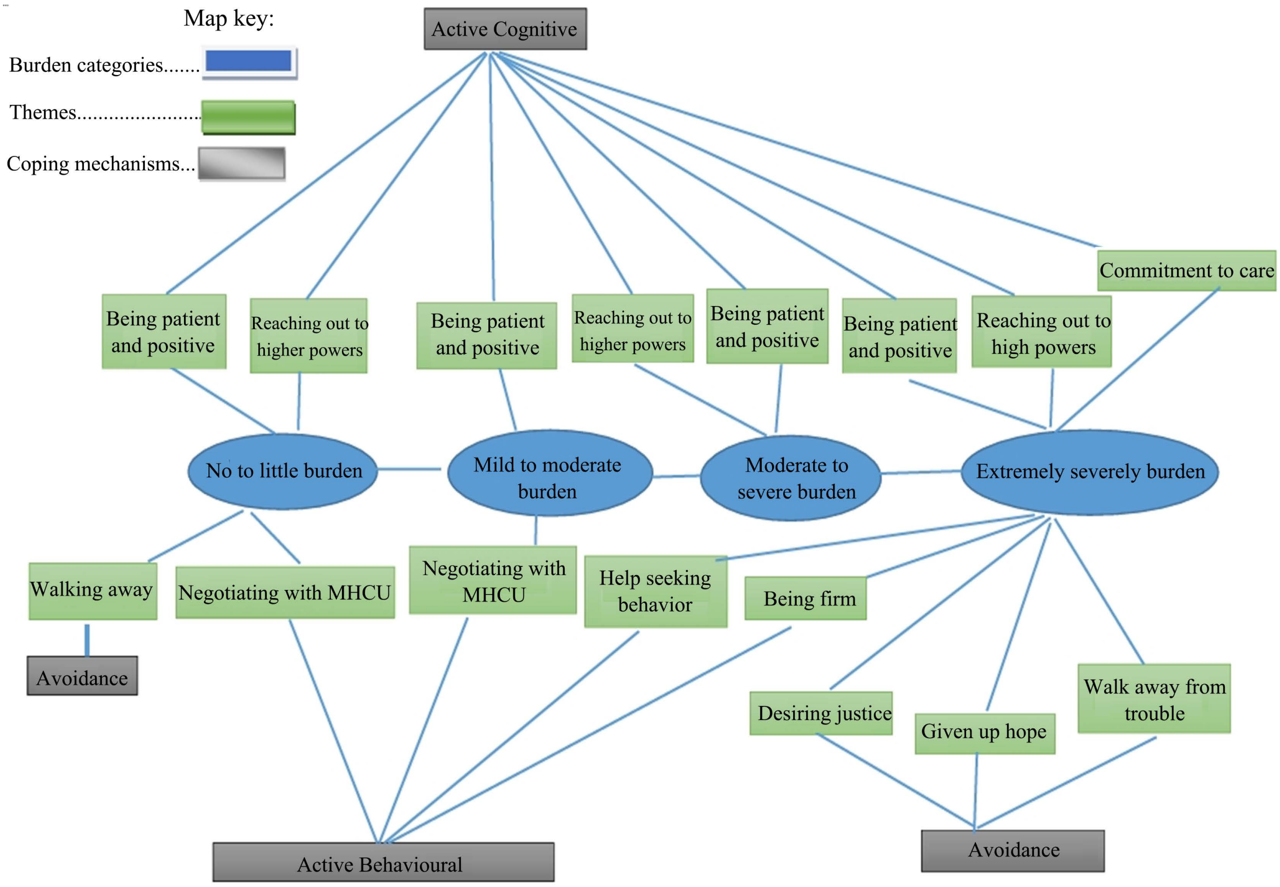

Figure 2. Themes under domains of coping mechanisms as experienced by various burden categories.

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 et al., 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; Mokwena & Ngoveni, 2020). 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 behavioural 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, whereas the moderate to severe burden category only used the active cognitive 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 mechanism was the least used and was mostly found among the two extremes of burden categories; the extremely severely burdened category and the no to little burdened category. The least usage of active behavioural coping mechanism; maybe due to the fact that a sense of resignation was more evident from the narratives in the qualitative data, in that most participants had not only resigned themselves into staying with their mentally ill relatives because it is culturally expected of them to take care of their relatives at home but also forced by lack of resources to relieve their care burden, even if it is for a short time; (more so in settings where there are limited access to formal services and no access to places like half-way houses which can offer caregiving breaks to family members).

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. Socio-cultural and socio-economic factors like high prevalence of Christianity among the family caregivers (94.44%), the high percentage of caregivers being females (86.11%) versus the high percentage of males being looked after (75%) and high unemployment rate for both the family caregiver (86.11%) and MHCU relative (97.22%) might have also contributed to the difference in the coping mechanisms identified from the Irish study. 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 used there were, hoping for a miracle as well as new treatment regimens (Ae-Ngibise et al., 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 means they use more active behavioural coping mechanism first, before turning to active cognitive mechanism as a last resort (Ae-Ngibise et al., 2015; Osundina et al., 2017). In the current study, the 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 coping 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 (as a coping strategy) 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 from him and talking to the neighbours as well as doing house chores were the 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, allows for processing of thoughts and feelings, gaining insight into developing positive coping strategies (Navidian et al., 2012; Cotton, 2015). 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 improves the home caring process and impacts positively on the rehabilitation process of their MHCU relatives (Adeosun, 2013).

5. Conclusion

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 (Encinas-Monge et al., 2024). 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 resilience and personal strength, (Martínez-Montilla et al., 2017).

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; (hence the adoption, adaptation and the application of the MSPSS tool by the health professionals). The targeted support programmes must be aimed at strengthening the family care giver support system because these carers are patient, positive and committed to care (cognitive coping); thus minimizing chances of them applying avoidance coping mechanism, which is more detrimental to the home caring process of a MHCU relative.

7. Limitations of the Study

The study was cross-sectional in nature, and therefore does not establish causality. Follow up over time of the phenomenon investigated is lacking and there was no control group. 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 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.

8. Ethical Considerations

Clearance certificate with protocol code—SMUREC/H/111/2021: PG and was approved by the Ethics Committee of Sefako Makgatho Health Sciences University on 01 July 2021. The confidentiality of the data was guaranteed. Permission to record the interviews was requested and all the participants signed an informed consent from once they received all the information necessary about the details of the study.

9. Future Research

For future research, it is recommended that an intervention study to implement the Multi-Dimensional Scale of Perceived Social Support (MSPSS) tool be conducted to assess its appropriateness and effectiveness in identifying and strengthening the support system of the caregivers, so that they could develop positive mental health towards healthy coping mechanisms. This could lessen the burden of care among family caregivers, especially within the South African context.

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Author Contributions

J. T. N. conceptualized the study with K. E. M. supervising all the aspects of the study. J. T. N. collected data, administered the project and drafted the initial analysis. J. T. N. drafted the manuscript and K. E. M. provided the review and editing functions. K. E. M. acquired the funding for the study and publishing costs. Both authors attended to the corrections of the manuscript, provided the final review and approved the manuscript. Both authors have read and agreed to the published version of the manuscript.

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Institutional Review Board Statement

The study was conducted in accordance with the Declaration of Helsinki, and approved by Ethics Committee of Sefako Makgatho Health Sciences University; protocol code—SMUREC/H/111/2021: PG, on 01 July 2021.

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study.

Data Availability Statement

The data presented in this study are available on request from Sefako Makgatho Health Sciences University. The data are not publicly available because the university does not yet have a platform to avail its data to the public.

Conflicts of Interest

The authors declare no conflicts of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

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Supplementary Materials

The supporting information is attached: In-depth interview guide (English and IsiZulu language versions), MSPSS tool and the informed consent for participants (English and IsiZulu language versions). **Table 1**, **Table 2** and **Figure 1**, **Figure 2** appear in the text.

Abbreviations

The following abbreviations are used in this manuscript:

MHCU:	Mental Health Care User
MICs:	Middle Income Countries
ZBI:	Zarit Burden Interview
BCA:	Behavioural, Cognitive, Avoidance