PARENTING EXPERIENCES OF MOTHERS LIVING WITH CHRONIC MENTAL DISORDERS AT MATHARI HOSPITAL

BY:

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE CONFERMENT OF THE DEGREE OF MASTERS OF SCIENCE IN NURSING (MENTAL HEALTH AND PSYCHIATRIC NURSING) OF THE UNIVERSITY OF NAIROBI

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DECLARATION

I, Francis Njagi Kabugua declare that this thesis is my original work and has not been submitted for award of any degree in any other institution.

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CERTIFICATE OF APPROVAL

This thesis has been submitted to School of Nursing Sciences Board for examination with our approval as the university supervisors.

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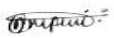
Irene G. Mageto BScN, MscN, PhD, Signature  Date 3rd December 2020
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DEDICATION

To all the people who suffer from mental disorder and associated stigma.

To mental health and psychiatric nurses whose knowledge, skills and abilities enable them to work in an exceptionally challenging environment.

To all those who create a therapeutic environment among the patients, family members and the communities.

To all mental health professionals and other health care provider for their efforts in offering specialized care to the patients.

To my family members for their patience, endurance, and understanding during my absentia.

I believe that the results of this study will contribute towards the improvement of families experiencing mental disorders.

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LIST OF ABBREVIATIONS AND ACRONYMS

CDC	-	Centers for Disease Control and Prevention
ERC	-	Ethics and Research Committee
KMHP	-	Kenya Mental Health Policy
KNH	-	Kenyatta National Hospital
MMSE	-	Mini-Mental Status Examination
MSU	-	Maximum Security Unit
NCCS	-	National Council for Children's Services
NGO	-	Non-governmental Organization
PPD	-	Postpartum Depression
PPDKenya	-	Postpartum Depression Kenya
SDGs	-	Sustainable Development Goals
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations International Children's Emergency Fund
UON	-	University of Nairobi
WHO	-	World Health Organization

OPERATIONAL DEFINITIONS

Chronic Mental Disorders: -are serious mental illness that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely, which include schizophrenia, bipolar disorders, and major depressive disorders.

Lived experience: -is the representation of choices and encounters of mothers living with mental disorders, and the knowledge they gain from choices and encounters.

Living with Chronic Mental Disorders: - Existing amid persistent for a long time or constantly recurring mental disorders, which includes schizophrenia, bipolar disorders, and major depressive disorders, where mothers strive to achieve control and survive through various actions and behavior; and use a variety of coping skills, that covey their lived experience of handling psychological and emotional disorders.

Mental Disorders: - are combinations of abnormal thoughts, behavioral, perceptions, or mental illness. The impact can vary from mild, through moderate to severe damage of personal functioning, which substantially interferes with certain parenting skills including their capability to express interest in their kids.

Parenting: - refers to the procedure of supporting and promoting child's intellectual, emotional, physical, and social growth from infancy to adulthood, which entails a great deal of routine and consistency, concentrating on developing children's independence, giving them a sense of control, discipline, strategies for building resilience.

Parenting experience: - is child rearing empirical knowledge, attitudes, expectations, perceptions and practices, gained through involvement in childcare.

Resilience: -Successful adaptation to attain good quality life when experiencing the symptoms of mental illness, reinforce interactions as well as make favorable alterations to life and priorities, and the mothers will move forward in life with a sense of mastery, confidence, competence in self-care and parenting.

ABSTRACT

Background: Globally, it is estimated that upto 50% of persons living with mental disorders in developed states and 85% in third world nations are parents with one or more dependent children. Approximately 15.6% of pregnant mothers and 19.8% of mothers in puerperium experience a mental disorder that affects their ability to effectively carry out their parental role. Economic, interpersonal, social, and intrapersonal factors related to chronic mental disorders like schizophrenia, bipolar disorders, and depression have negative effect on mothers' parenting capabilities that eventually affect child's growth and development.

Objective: To explore the parenting experiences of mothers living with chronic mental disorders.

Methodology: A transcendental (descriptive) phenomenological qualitative research design was used. Mothers identified with schizophrenia, bipolar disorders, and major depressive disorders were purposively selected from those attending mental health clinics at Mathari hospital. In-depth interviews were conducted to obtain data on their lived parenting experiences. A total of 15 participants were recruited. Interviews were conducted up to 15^{th} interview when data saturation occurred. These interviews were audio recorded using a Sony ICD PX333 digital voice recorder with participants' permission. The researcher transcribed the recorded interview verbatim. He created short phrases equivalent to different codes. The created codes were compared throughout interviews, pinpointed the patterns among them and generated themes pertinent to the study goals.

Results: Three main themes were identified. These were, lived parenting experiences of "being a trustworthy mother, challenges in parenting roles and perceived support systems." The findings highlighted that the challenges of working with parents with mental health issues cannot be addressed with a one-size-fits-all approach. Initiatives to facilitate the effective support of parents and their children need to be informed by contextual factors, including clinical practice.

Ethical issues: Confidentiality was maintained throughout the study. Participation was voluntary, through the participants providing a written informed consent. The protocol

was reviewed and approved by KNH/UoN-ERC and Mathari hospital administration. Study was conducted within the dictates of the approved guidelines.

Benefits and Significance of the study: The study produced rich information regarding how mothers make sense of their mental health problems and associated motherhood; generated evidence-based data to inform the hospital management board concerning the value of organizing services to satisfy the needs of the mothers and their children when mothers are hospitalized.

CHAPTER ONE: INTRODUCTION

1.1 Background Information

Parenting refers to the process of educating and bringing up children from infancy up to adulthood. It entails aspiring to realize the child's developmental, psychological, physical, and emotional needs (Connolly et al, 2017; Parenting for Brain, 2020). Good parenting is characterized by nurturance, responsiveness, consistency, autonomy, warmth, and appropriate developmental supervision of the child at all stages of development (Tanaka et al, 2018).

Globally, it is estimated that upto 50% of persons living with mental disorders in developed states and 85% in third world nations are parents with one or more dependent children (WHO, 2019). Approximately 15.6% of pregnant mothers and 19.8% of mothers in puerperium experience a mental disorder that affects their ability to effectively carry out their parental role (Mental Health Foundation, 2019; WHO, 2019). In UK and USA altogether, 33.3% of the females with chronic mental illness are parents with dependent children (Mental Health America, 2019). In Sweden, 7.8% of young individuals have a parent hospitalized owing to psychiatric disorders, and 18.1% of mothers have mild mental disorders not requiring hospitalizations. In rural KwaZulu-Natal, 48% of new mothers suffer from postnatal depression (South African College of Applied Psychology, 2019) and an average of 33.1%, in Ghana and 33.5% in Cote d'Ivoire of mothers' experiences severe depression (Nan et al, 2014). In Kenya, over 200,000 women are predisposed to Postpartum Depression annually (PPDKenya, 2018).

Pamela et al (2019) stated that parenthood is a normative life encounter for the majority of people. It defines the meaning and roles of adulthood. When parents fail in their parenting roles, they face unending humiliation and shame (Foster et al, 2018). Motherhood may be a normalizing life experience for women suffering from mental disorders, and prefer referring to themselves as parents than as patients (American Psychiatric Association, 2019). The majority of mothers suffering from mental disorders describe parenthood as promoting their growth and development; children give them joy and motivate them to take their treatment, even though it is stressful (Tartakovsky, 2018).

As per Hussain et al (2016), bringing up a child is a daunting task, and any emotional disorder in the mother may have adverse effects on the health of a child. Maternal mental illnesses are associated with many child health disorders such as low birth weight, diarrhea diseases, malnutrition, and premature cessation of breastfeeding as well as reduced help-seeking or preventive behaviour (Theodoritsi et al, 2018). Mental illness is by nature episodic and children may experience more than one episode of parental mental illness, influencing several developmental phases, increasing the risk of behavioural disorders, and cognitive delays as they grow (Maybery and Reupert, 2018). The heritability of parental mental disorders by their children is 32-56% (Ruud et al, 2019). According to ResearchGate (2019), the genetic heritability of bipolar problem is 60-85%, depression, 34-48%, schizophrenia, 73-90%, and for anxiety disorders, is 30-40%.

The chronicity of a specific diagnosis on parenting practices increases the risk to children (American Psychological Association, 2019). The children of parents with psychosis may be directly engaged in the delusions of parents, while parents with anxiety disorders are unlikely to give their children independence and demonstrate low degrees of sensitivity (Tungpunkomet, 2017). Increased depression reduces mothers' response to the needs of children and causes intense suffering and disability (PPDKenya, 2018).

Jones et al (2016) indicated that some mothers see their children as a source of solace and comfort. This can result in children assuming huge roles at a tender age such as maintaining the household, providing for their siblings and parent. Bell et al (2018) add that these children are more prone to developmental disorders, less likely to be ready for school, get poor results in school and may not even start high school education. According to the National Institute of Mental Health (2019), 60 % of adolescents in juvenile confinement have behavioral, cognitive, or emotional problems. This may hinder the attainment of Vision 2030 whose aim is to create "a globally competitive and prosperous country with a high quality of life to all its citizens in a clean and secure environment by 2030" (Waweru, 2020) and SDGs Goal 4 on quality education, Goal 3; good health and well-being and Goal 1; eradication of poverty (United Nations, 2019).

Graham (2018) in describing the routine activities of mothers suffering from mental disabilities indicated that, more than 80 % reported having difficulty offering a safe and loving environment to their young ones. In certain circumstances, a child may be forced

to separate from her mother due to the inability to continue as the sole caregiver (Sadia et al, 2019). According to Ruud et al (2019) when evaluating mothers on mental health problems, clinicians usually fail to illustrate information regarding the parents and their children's needs. The researcher argues that parenting needs are often not addressed in mental health services and consumers always report numerous unmet parenting needs.

The growth and survival of a child is a primary public health concern. A key aspect of addressing this is improving maternal mental health- SGDs Goal 3; good health and well-being (WHO, 2019). Research that assesses the childcare experiences by mothers with mental disorders is crucial in the development of measures to boost the child and maternal mental health. Therefore, exploring and describing the parenting experiences of mothers living with chronic mental disorders, how a mental disorder has influenced their parental role, and the support systems available for mothers and their children is imperative.

1.2 Statement of the Problem

According to Rampou et al (2015), severe mental disorders affect mothers' parenting skills and abilities, almost 80 % experiences difficult in childcare and require support. More than 90% of children whose parents have mental disorders may experience conflict and emotional disturbances. When the mothers are hospitalized, at least 50% of the children are separated from the families going to homes of different relatives (Graham, 2018). Most of the children stay in the home of the same relatives during the mother's hospitalization, but a few are moved more than two times, as the relatives get tired. More than 70% of children aged 12years cares for themselves and other siblings (Charlotte, 2019). The researcher in his clinical practice notes that, most of the mothers admitted in the hospital, after gaining partial insight; asks for discharge to go and attend to their children or ask the health care providers to call them to know their safety. This is usually ignored by health care workers and regarded as part of their psychotic symptoms.

In her research Silvia et al (2018), found that mental health professionals view the "health talks" with patients concerning childcare as less significant in day-to-day activity; and the needs for children are regarded as not important. The researcher observes that, when the relatives visit the patient accompanied by her children, the children are kept out of the ward as the relatives enters. This provokes aggression in the

patient as access to her children is denied. The health care providers perceive this as violent and aggressive behavior and impetuously administer tranquilizers to calm down the mother, and at times keep her in the seclusion room. However, according to Queensland Health (2017), this is a time when the health care professionals should take a chance to directly observe the parent-child relationship and offer support.

The researcher has observed mother-child interactions in the clinical set-up during visiting hours and notes that mothers play; give instructions and guide their children. They feel bonded with their children; raise their self-esteem as their rights to motherhood are respected. In an interview with Sophie et al (2017), parents expressed their apparent benefits of being with their children during the convalescent period such as accessibility to information concerning the mental disorder, their families' pleasure and motivating them to get better.

Extended separations between the mother and children have adverse effects for them both (Silvia et al, 2018). When the relatives don't bring the children to visit their mother, the researcher observes that the obsession with the custody of their children keeps on intruding in their thoughts; they may relapse while in the ward increasing the hospital stay and financial burden. Clinicians and do not address parenthood issues. They may make assumptions about the patient's ability and associates mental illness with difficulty in parenting. This affects their decisions to provide appropriate counseling and discuss information on parenting skills and supports for the mothers (Tchernegovski et al, 2018).

Community and family members offer necessary psychosocial and physical help to mothers suffering from mental disorders (Perinatal Mental Health Project, 2018). However, most mothers claim that due to cultural beliefs and associated with stigma, their children are taken away from them by close relatives denying them parenting opportunities. They express the feeling of humiliation, self-blame and doubt their parenting abilities.

1.3 Justification of the Study

According to the National Institute of Mental Health (2019), 25% of people develop mental health problems at any given moment, 3.03 % children may be depressed, 12.5 % of teenagers may have depression and 66.7 % of all families with mental health problems are not getting the help they require. Increased awareness can lead to better

information on mental illness, prevention of mental health disorders and promotion of psychosocial well-being of mothers and their children (World Health Organization, 2019).

Wagoro (2016), states that for accurate diagnosis of mental disorders, mental health professionals must be competent and have knowledge in mental health. Some clinicians believe that they have a deficient of knowledge and skills, and may develop anxiety when interviewing the mother about the safety of their children (Reupert et al, 2015). By offering additional training, the clinicians can develop competency in managing mentally ill mothers, help them harness positive experiences and build resilience within the family. According to Sadia et al (2019) mental health clinicians with adequate knowledge and skills, can effectively support the mothers and their children and respond to issues of parenting by developing a family support plan.

If a woman has a severe mental illness and needs to be admitted to the hospital, she must have access to her baby (PPDKenya, 2018; Royal College of Psychiatrists, 2019). According to Queensland Health (2017), although there is a good documented protocol on the care of families with mental disorders, it is usually not followed by mental health professionals who view the needs of children as not important. Ruepert and Maybery (2016) argue that parental-child programs may be necessary for early mother-child bonding. However, such programmes are not emphasized in mental health institutions (Charlotte et al, 2019). A lack of urgency, misinformation, and competing demands prevents policy-makers from taking stock of maternal mental disorders (Mental Health Foundation, 2019).

New knowledge generated from this research can have a tremendous impact on how individuals, societies and the mental health institutions deal with maternal mental disorders and child care. Over 80% of people with schizophrenia, and up to 60% of people with depression can be competent mothers, free of relapses with a proper combination of psychotherapy, pharmaco-therapy and family involvement (WHO, 2019). Foster et al (2018) views that, emphasis on the lived experiences of mothers with mental disorders and offering parenting information is necessary to help them develop resilience within the families.

Institutions such as Mathari hospital can be a source of accurate health information to parents and provide an environment that supports mother-child interaction while they

are still in the hospital. Therefore, it was necessary to carry out research to unearth the parenting encounters of mothers with long-lasting mental disorders attending the mental health clinics at Mathari hospital to gather evidence-based data that may persuade the institution to make policies that promote maternal mental and child health, health care providers to support mother-child interactions in the clinical set-up during the convalescent period.

1.4 Significance of the Study

The research generated evidence-based data on intra-personal experiences on parenting by the mothers living with mental disorders, which can advise the institution on the establishment of practice and policies which could allow mothers to access their children while admitted in the hospitals, support mothers in parenting roles and develop future training for mental health personnel to improve interventions for maternal mental disorders.

Promoting mental health and well-being for mothers is essential for health and social functioning at an individual level and the social and economic well-being of societies. This will go along in realization of social and economic pillar of Vision 2030 and SDGs Goal 4 on quality education, Goal 3; good health and well-being and Goal 1; eradication of poverty.

A clear understanding of the child-care encounters by mothers suffering from mental disorders is important for KMHP 2015-2030, towards achieving the best mental health standards. This research can offer details that might be utilized for the establishment of practice guidelines that may promote favorable conditions for the parent facing mental disorders, reduction of child mortality, increase universal health care, and re-orient health policies and resources to fulfill the women's mental health needs throughout their reproductive lives.

1.5 Purpose of Study

This study aimed at exploring the lived parenting experiences of mothers living with chronic mental disorders at Mathari hospital.

1.6 Research Questions

i. What are the lived parenting experiences of mothers, living with chronic mental disorders?

ii. What do mothers suffering from chronic mental disorders attending mental health clinics at Mathari hospital see as challenges in their parenting role?
iii. What do mothers suffering from chronic mental disorders attending mental health clinics at Mathari hospital perceive as supporting them in their parenting roles?

1. 6.1 Broad Objective

The main objective was to explore the experiences of mothers attending the mental health clinics at Mathari with regards to parenting while living with persistent mental disorders.

1. 6.2 Specific Objectives

The specific objectives were to:

i. Explore the lived experiences of mothers attending the mental health clinics at Mathari hospital with regards to parenting while living with persistent mental disorders.
ii. Find out the challenges faced by mothers attending the mental health clinics at Mathari hospital with regards to their parenting role while living with persistent mental disorders.
iii. Establish available support systems that facilitates parenting for mothers with recurring mental disorders visiting mental health clinics at Mathari hospital.

CHAPTER TWO: LITERATURE REVIEW

2.1 The Concept of Parenting

Globally parenting practices share three main goals: ensuring children's health and protection, preparing children for life as fruitful adults and transmitting cultural values (Connolly et al, 2017; Tanaka et al, 2018). Parenting behavior and practices are directly observable, parent-child interactions that parents assume to support certain socialization goals, depends on parenting awareness, attitudes, and practices (Kuppens and Ceulemans, 2019). Both parenting behavior and parenting styles affect child behavior and well-being (Pinquart, 2017).

Stelios et al (2018) suggested that there are four styles of parenting and the majority of the parents exhibit one of the styles which includes authoritative, authoritarian, permissive, and neglectful. According to Shek and Zhu (2019), child-rearing styles vary due to certain factors which include culture, personality, parental background, educational level, socio-economic status, family size, religion, parental mental health status, children's character, parents' experiences, expectations from family, the supports available within the community, and policies that affect the nature and accessibility of supportive services.

According to Marcin (2019), authoritarian parenting styles expect the child to follow the strict rules set by the parents and failure to result in punishment. The parents are insensitive to their children's desires and are generally not encouraging (Bell et al, 2018). Children of authoritarian parents tend to have an unhappy character, are less autonomous, appear anxious, have lower self-esteem, display behavioural problems, achieve poorer academically, have inferior social skills, and are more prone to mental problems (Kuppens and Ceulemans, 2018). Conversely, the authoritative parenting style is much more autonomous (Inge et al, 2019). Parents create rules and procedures that their children are expected to follow. They are receptive, assertive and collaborative (Gouveia et al, 2016). Children of authoritative parents are contented, autonomous, achieve higher in academics, build up good self-esteem, interrelate with peers using proficient social skills, and have better mental health (Hess and Pollman, 2019).

Ryan et al (2017) stated that permissive parents have little demands to make of their children. They allow them a lot of independence; barely discipline them. Children

cannot follow rules, have poor self-control, have self-centered tendencies, experiences difficulties in interaction and social relations (Husain et al, 2016).

Uninvolved parenting is accredited with little demands and few communications. Though the parents accomplish the desires of the children, they hardly get emotionally involved (Ingulia et al, 2019). Correspondingly, they are often unresponsive, unconcerned or neglectful to their children (Marcin, 2019). According to Foster et al (2018), these parents tend to have had mental issues such as maternal depression, physical abuse or child neglect when they were kids. Children of neglectful parents are more impulsive, cannot self-regulate emotion, encounter more delinquency and antisocial behavior (Murphy et al, 2018).

2.2 Effective Parenting and Child Growth and Development

Parents are vital assets for children in supervision and support of positive emotional health and well-being (CDC, 2019; Parenting for Brain, 2020). To respond to the varied needs of their children, parents require adequate knowledge on developmental milestones, child safety, the role of professionals and parenting supportive social systems (Sadia et al, 2019).

Parenting competency has been found to have control of child performance (Silvia et al, 2018). Research by Henshaw and colleagues (2015), found that maternal self-efficacy was related to children's regulatory skills through its association with competence-promoting parenting practices, which included family routines, quality of mother-child interactions. Parents' ability to foster a sense of belonging and self-worth in their children is vital to the children's early development (Queensland, 2020). On the contrary, an erratic environment may weaken children's self-confidence in their capacity to manipulate their environment and foresee consequences, which may affect children's ability to regulate their behaviour depending on the situation (Seulki-Ku et al, 2019). Parents' abilities to understand, interpret, and act in response to their children's desires are compromised (Conway et al, 2017), by factors like parental depression, parent's physical and psychological inability to give quality parenting (Halse et al, 2019).

The process women take with their health care providers before becoming pregnant can support healthy pregnancy and birth outcomes for mothers and babies (PPDKenya, 2018). These include initiating supplements such as folic acid, treating pre-existing

physical and psychological problems and promoting healthy behaviours (Perinatal Mental Health Project, 2018).

Breastfeeding has many short and long-term benefits for both kids and mothers. Breast milk boosts babies' immunity to infectious illness, and the best supply of nutrients to help babies grow (Chung, 2019). Breastfeeding encourages bonding between mothers and their babies (WHO, 2019). According to the United Nations (2019), breastfeeding may promote mothers' health by reducing risk for postpartum depression.

Parents' modeling of healthy eating practices for their children and offering healthy foods, during toddlerhood, may result in children being more likely to eat such foods (Mukhtar, 2019). Children of these parents have good eating habits and nutritional practices (Mazarello et al., 2015). Parenting information regarding proper nutrition, how to sooth a crying baby, expressing love and warmth is significant for children's growth (Ackerman, 2019; Cherry, 2019). Parents who are unable quiet their crying babies experience sleep deficiency, have self-doubt, may discontinue breastfeeding earlier, and may encounter more conflict and dispute with their partners and children (Hirsh, 2019; Tartakovsky, 2018).

Parents contribute to children's emerging social competency, which is entangled with other developmental areas such as cognitive, physical, and emotional (Silvia et al, 2018). Parents socialize their children to take part in routine activities and family rituals (Umberson and Thomeer, 2020), adopt culturally suitable morals and behaviors that allow them to be socially knowledgeable and act as members of a societal group (Beckwith, 2018; Hammond, 2017).

Parents take part in an important role in children's acquisition of language, literacy, and numerical skills competencies that are related to future accomplishment in school and society (Kale and Aslan, 2020). Shared literacy behavior such as book reading exposes children to new terminologies and expressions they may not encounter in spoken language, stimulating language development beyond what might be obtained through toy-play or other parent-child interactions (Chang et al, 2015; Mukhtar, 2019).

Campbell et al (2018) argue that every time two or more people are together, there is a communicative exchange and such communication relations are foundational for creating healthy relationships. Emotionally receptive parenting is a key feature of healthy relationships and is associated with helpful developmental outcomes for

children (Meybodi et al, 2017). Securely emotionally involved infants develop necessary trust in their parents and can discover and gain knowledge freely (Pamela et al, 2019; Woodhouse et al, 2019).

Parental discipline is an important part of parenting. Successful discipline requires a strong parent-child bond (Theodoritsi et al, 2018). When parents control their children, they are aiming to support and raise them for self-control, self-direction, and their capability to care for others (Woodhouse et al, 2019). Vivian et al (2016) showed that conflicting discipline, parents' pessimistic emotion, and mental health are related to a child's difficulties in emotion regulation. However, parent teachings on interventions can change the parenting practices that support children's emotional performance (Madigan et al, 2018).

Children require care that enables them to promote their capacity to flourish and ensures their existence and safety from physical and psychological mistreatment (CDC, 2019). To achieve this key parenting competency, investing in women's education is critical. Research data (NCCS, 2019) highlight the strong correlation between mother's education and earlier preventive care initiation. An assessment of increased educational attainment and its effect on child mortality showed that 59% of the reduction in child mortality can be attributed to the better education of women (WHO, 2020).

The fundamentals of effective parenting programs in a health institution consist of parents being treated as partners with providers, focusing on intervention to the desires of parents and children, and inclusion of fathers (National Academies of Sciences, 2016). Findings from research by Gordon (2019; Chung, 2019) suggest that the level of therapeutic commitment with parents, empathic relations and parents' feelings of being valued are related to the contribution and development of parenting competency.

2.3 Parenting and Achievement of Sustainable Development Goals

Worldwide parents are the principal caregivers, preparing their children for a cheerful, satisfying and fruitful life (United Nations, 2019). They take part in a vital role in achieving sustainable, societal, financial and cultural growth (World Vision, 2020).

A growing body of evidence shows that the societal and financial losses associated with unattended maternal mental health conditions are overwhelming (United Nations, 2019). Mental health places an enormous burden on individuals, families, and society. It has intense impacts on people's financial and societal well-being. In 2010 alone,

depression cost an estimated US$800 billion in lost economic productivity and these expenditures are anticipated to double by 2030 (World Bank Group, 2018) putting the 2030 Agenda and the SDGs at a stick.

Although most people with a mental illness can be in employment, mothers living with mental disorders, are likely to become jobless (WHO, 2019). The working environment provides opportunities for promoting self-esteem, equal opportunity and wellbeing for mothers with mental disorders (SDGs, Goal 10; reduced inequality). Increasing mothers' ability to work, also, promotes economic development and inclusion (Goal 8; decent work and economic growth). Goal 11-sustainable cities and communities; will be achieved through innovation and investments on secure and cost-effective houses, particularly for children and women, affordable health services, clean water provisions and building resilient communities and wealth, mainly in slum areas where most of the families live.

In Kenya and many other countries, there is a social stigma attached to mental illness (Nyayieka, 2018). Families with mental health issues do not seek treatment regularly since they are scared, embarrassed, fear losses of social status or the marriage prospects of their family members will lessen (Kanyoro, 2018). To address this, PPDKenya, (2018) has embraced SDGs Goal 17; partnerships to achieve the goal. It has helped build awareness among communities and counseled families on maternal mental health. The project's community-based interventions facilitate women suffering from mental illness to seek treatment. The project provides mothers with livelihood support, social therapy, and economic empowerment while supporting their families.

Focused policies and strategies intended at nurturing women's health and well-being throughout their life are the foundation of healthy societies and are essential for realizing the 2030 agenda and SDGs (Civil Society Report, 2019). Studies have shown that many maternal mental illnesses and lifestyle behaviors affect children, amplify poverty and negatively impact on societies (NCCS, 2019). For instance, childhood diarrheal diseases, anemia, malnutrition can damage brain development and function, slow down intellectual and physical growth (CDC, 2019). All have a long-term impact on children's cognitive development, behavioral disorders, discontinue full-time education early and have poorer educational outcomes, higher rates of joblessness and lower job security (UNICEF, 2020).

Maternal mental disorders can cause poverty by preventing full involvement in economic and social activities. This may hinder the achievement of SDGs, Goal 1; Eradicating poverty, and Goal 4; quality education. Mental health and psychosocial wellbeing are imperative for children's learning and school attendance. Quality education can support and protect mental health through knowledge and life skills, provision of safety and significant social interactions (United Nations, 2020).

Maternal mental health threatens economic affluence and increases poverty. This has harmful impacts on children, for instance, a higher possibility of not being vaccinated or improper treatment for childhood diseases (PPDKenya, 2018). Poor maternal nutrition before and throughout pregnancy, as a result of mental disorders, contribute to poor intrauterine growth, resulting in low birth weight, predisposing the child to metabolic disorders and the threat of non-communicable chronic diseases in the future. These problems could be worsened by HIV and malaria (UNDP, 2020).

Promoting mental health and well-being for mothers is essential for health and social performance at an individual level, the social and economic well-being of societies (Global Mental Health, 2018). Mother's mental health and wellbeing lead to earlier protective care initiation to save lives, reduce child mortality; hence working towards the SDGs Goal 3; to end preventable deaths of newborns and under 5 children by 2030. This includes immediate and exclusive breastfeeding, skilled attendants for antenatal, delivery, and postnatal care, access to nutrition and micronutrients, family information on danger signs in a child's health, immunizations, and SDGs Goal; 6, improved access to water, sanitation, and hygiene (World Vision,2020).

Policies that support the economic empowerment of women, enabling them to live better and self-reliance life could simultaneously improve the health and mental well-being of future generations; make contributions to ensure that development is socially and economically inclusive (CDC, 2019). The WHO (2020) definition of mental health; a state of wellbeing where individuals realize their potential, be able to deal with normal challenges in life, be capable of working productively and contribute to their community; sums up much of what is required if we are to attain the SDGs, Kenya Vision 2030 and achievement of Kenya big 4 agenda which consists of food security; affordable housing; manufacturing and affordable healthcare for all (Mwita, 2020).

2.4 Factors that Facilitate Effective Parenting

Tchernegovski et al (2018) indicated that double focus that considers the needs of the parent and their children can be strengthened through practices that emphasize parental empowerment through adequate social and workplace support.

2.4.1 Support for Mothers with a Mental Disorder

Mentally ill mothers, given appropriate support and treatment, education and training can become competent parents (Royal College of Psychiatrists, 2019). Wade et al (2019) suggest that some parents may require guidance to develop the confidence to safely communicate with their kids concerning their conditions. McFarland and Fenton (2018) highlighted the support needed by some parents, which includes role modeling, practical help, as well as emotional support in child caring.

Charlotte et al (2019) in his research indicated that offspring of mothers with mental illness tend to be looked after by foster parents i.e. grandparents, aunties, step-parents and other family members. When this alternative is appropriate, the fast decision-making process is crucial, especially for kids whose social, behavioural and emotional growth may be greatly hindered when they subjected to abusive or neglectful childcare for a long period (Pamela et al, 2019).

Practitioners need to assess whether common parenting stresses negatively impact on mental health (Ruud et al, 2019). According to Queensland Health (2017) assessment protocol demands a holistic examination of the mothers' capability to fulfill the needs of their children, the influence of wider community, familial factors and the development of the child. Clinicians must be able to recognize the strengths of the family, safety, and well-being of a child and the dangers that can be alleviated through necessary support (Ruepert and Maybery, 2016).

Organizing family support groups can be beneficial to family members by meeting and sharing their experiences. Research by McFarland and Fenton, (2018), revealed that parents treasure the opportunity to come together with other mentally ill parents. According to Laura et al (2018), multi-family interventions prevent relapses, reduce feelings of isolation and stigma, and improve family cohesion.

Health specialists working with antepartum and post-partum mothers should be sensitive to the indicators of mental ill-health and take care of their psychological well-being (PPDKenya, 2018). In their view, Petrowski and Stein (2016) suggest that health

care providers should involve and support fathers to give emotional and practical aid to their partner, to lessen the effect of perinatal mental disorders on young ones (Mental Health America, 2019). If a mother has acute mental disorders and requires hospitalization, she must access her baby (PPDKenya, 2018). If she is deprived of this rigorous care and isolated from her baby, it may traumatize her and hinders vital early bonding (Royal College of Psychiatrists, 2019).

2.4.2 Support for Children of Mothers with Mental Disorders

Good preventive measures aid the development of children's resiliency, reduce them from exposure to adverse manifestations of their parent's illness, increase family stability, and strengthen the capacity of the parent to fulfill the needs of their children (Charlotte et al, 2019; Grove et al, 2015). According to Foster et al, (2018), giving age-appropriate accurate information to children improves their understanding that mental illness is not infectious; it's not their fault, increases empathy for their parents, learns how to deals with fears and misperceptions and develops the courage to share their experiences.

Interventions that encourage families' communication assist all individuals to widen their understanding of the effect of mental disorders (Diane et al, 2019; Sadia et al, 2019). Holding supportive discussions among family members can help parents know the experiences of their children. This may have a positive outcome on childcare, and help them feel less isolated and worried (Elizabeth and Jody, 2018). Further (Queensland Health, 2017), family communications increase the willingness to ask for support whenever necessary, builds self-confidence and improve relations among members of the family.

According to Maybery and Reupert (2018), programs to support children of mentally ill parents, to learn about mental disorders, coping strategies, and social interactions may be necessary. Tartakovsky (2018), adds that kids may prefer to receive information when parents are present so that they can assist them makes sense of mental disorder. Tabak et al (2016), suggest that children must have access to a mentor to act as an advocate and discuss their parent's condition and reach them during a crisis.

2.5. Parenting in the Context of a Chronic Mental Disorder

There are limited qualitative studies conducted in the field of the feelings and experiences of mothers living with mental disorders (Mental Health America, 2019).

This concurs with Murphy et al (2018), that mothers' views concerning their childrearing encounters have been overlooked. Moreover, Rampou et al (2015) argue that women suffering from mental disorders seem to desire a chance to express their fantasies, sorrow, and fear concerning parenthood.

2.5.1 Challenges

Mothers with chronic mental health problems have stressful life experiences and often impairs the development of their children (Murphy et al, 2018). They encounter distinctive problems and challenges, attached to the needs of managing both mental health problems and parenting (Sonia et al, 2018). According to Hancock et al (2018) in his research on "Understanding the challenges of individuals experiencing timely mental health recovery", mentally ill mothers have high chances of being single, unemployed, divorced, and separated. They encounter high degrees of family victimization, strife, and stigma. Women with chronic mental disorders are among the most unsupported and susceptible in societies (Husain et al, 2016). They often face challenging circumstances including lack of social support, poverty, discrimination, lack of health and parenting information, inadequate housing, trauma (Murphy et al, (2018).

In her article on "Tips for parenting with a Mental Disorder", Tartakovsky (2018) indicated that parents suffering from mental disorder have increased problems of irritability, decreased energy, sustaining attention, difficulty in concentrating, irregular sleep, moodiness and easily worried. In their study, Salzmann-Erikson and Kallquist (2019) on the encounters of having a mother living with recurring mental disorders showed that most of the parents' experienced that the sickness made them incapable of meeting their personal and children needs. At times, children may assume the duties of maintaining the household, caring for the parent or siblings at a tender age as a response to the reduced ability of some parents. Such environmental may result in children developing behavioural disorders (Sadia et al, 2019).

According to Graham (2018), anxiety and depression impinge on about 20% of women during the initial year following childbirth. Depressed mothers have low chances of interacting with their kids actively (PPDKenya, 2018). As a result, there is no stimulation, and the infants tend to fall back in maturity, language development, and emotional behavior (Petrowski and Stein, 2016). This might raise the vulnerabilities to poor maternal-infant bond, infanticide and suicide (PPDKenya, 2018). Foster et al

(2018) indicated that consistency is important for children; however, this may be compromised due to the ebbs and flows of mental disorders.

Kumantha (2019) speaking to the Star in an interview, said that mothers with depression might be emotionally unavailable, withdrawn, and apathetic to their kids. This may make them encounter problems recognizing the needs of the children as well as react to cues, battle with sticking to daily schedules like taking kids to school, mealtimes, bedtimes, overlook their hygienic and physical requirements, face difficulties in supervising and disciplining their children, as well as fail to seek healthcare, hence putting them in poor conditions.

According to Charlotte et al (2018), women suffering from mental disorders may experience hallucinations associated with their kids, have distorted views of their children, and may believe they are medically unwell, are obsessed or have special powers. They may respond to the hallucinations, neglect or physically abuse the children.

According to 'Queensland Health' (2017) mothers suffering from severe mental disorders have low tendencies of raising childcare problems as they ascribe any problems to deficient associated with the illness, afraid of negative perception, or loss of custody of their children. However, Silvia et al (2018) indicates that these parents may report diminished confidence, low self-esteem, dampened nurturance, stigma and social isolation. Mothers may develop feeling of self-blame, pushing them to worry about their childcare capabilities, conceal their mental illness, and end up developing the feeling of being unfairly judged as ineffective parents (Murphy et al (2018).

In some instances, parents may encounter guilt and shame concerning their childcare problems and the effects of their sickness on kids (Tanaka et al, 2018). This is because the inherent stigma in the community have negative beliefs and attitudes that mentally-ill mothers are bewitched and have become useless, making them perceive themselves as less capable parents (Nakku et al, 2018). He adds that discriminating attitudes towards affected mothers and their children, among medical care staffs, as well as inadequately trained health workers are some of the factors thought to hinder access to mental care for mothers. According to Sonia et al (2018) stigmatization is ascribed to ethnocultural and socio-economic features of the environment. The cultural value of

collectivism causes biases towards mentally ill mothers, in particular with regards to child-rearing and marriage (Ruud et al, 2019).

In Kenya and Africa as a whole, mental health issues are attributed to either witchcraft or spiritual problem (Kanyoro, 2018; Nyayieka, 2018). In their study on parenting journeys of mentally ill parents in Uganda, Murphy et al (2018) found out that the majority of families take their perinatal family members with mental illness to a witch doctor. Osman, (2016, in Al Jazeera Media Network, 2019) narrates how well-wishers took a young mother with mental illness to Mathari Hospital after a local radio station covered her story. The mother was being prayed for by religious leaders, in the hope that only God will protect her.

Ndetei (2016, in Al Jazeera Media Network, 2019) argues that, many societies see the mental disorder as a bad omen and a curse; chain those with illnesses for a long period, leading to deeper psychological trauma. According to Musyimi et al (2016), a huge gap concerning public awareness exists and he advises public leaders to expend in creating awareness to help combat stigmatization.

Single mothers living with mental disorders may find it hard to exercise their childcare role (Tartakovsky, 2018). Theodoritsi et al (2018) in his article on how financial, psychological and social influences the mental health of single-parent families, argue that single mothers experience high degrees of depression, stress, and anxiety, lacks social support, encounter socio-economic problems, leading to feelings of isolation and low self-esteem. Additionally, raising children through the single-parent family may be accompanied by serious psychological health issues for the kids, including externalizing disorders, anxiety, and depression (Karibi and Karen, 2019).

2.5.2 Experiences of Children of Mothers with Chronic Mental Disorders

Parental mental disorders and child maltreatment are strongly correlated. Parenting difficulties can result in kids suffering from emotional neglect and abuse (Bell et al, 2018). Mothers may experience inappropriate intense anger around their kids, have tremendous mood swings that leave their children hyper-vigilant, frightened, and confused (Diane et al, 2019). Tchernegovski et al (2018) argue that children of mentally ill mothers may be subjected to contextual and familial stressors including isolation, marital discord, and housing instability. According to the Royal College of Psychiatrists (2020), some children become anxious, withdrawn and find it tough to focus on their

school work. Also, they can have physical health problems, and struggle with their education, especially when they live in poverty, poor housing or have an unstable life (Pamela et al, 2019).

Children may find it difficult to talk about their parent's problems especially when they have no details of their illness. This may hamper them from seeking help (Jones et al, 2016). They feel guilty about their parent's illness, and can be preoccupied with fears of becoming ill themselves. Some show signs of severe emotional problems (Diane et al, 2019). According to the Royal College of Psychiatrists (2019), there is a perceived stigma and need to keep secrets. Some parents may keep their illness secret to their children. This makes it more difficult for the children to control their feelings as they have the desire to know details concerning the mental illness of their parents.

Access to preventative programmes for children is difficult due to their unwillingness to take part because of actual and perceived stigma, lack of discussions by health professionals with children about mental illness and the need for children (Laura et al, 2018). Nonetheless, there are still inadequate primary health care services to support the desires of the mentally ill mothers and their children (Nilsson et al, 2015).

2.5.3 Clinicians' Reactions Towards Mothers and their Children

Reupert et al (2015) in his research on “family-centered health practice, for clinicians in the primary care settings”, found that clinicians believe they have a deficient of knowledge and skills and may face anxiety when interviewing the mother about the safety of their children. Bondarenko et al (2017), adds clinicians' responses may be different from their apparent behaviour. They may act caringly in support of a person's mental health, though they are experiencing frustration or viewing the person negatively. Tchernegovski et al (2018) argue that clinicians' feelings of guilt, sympathy, fear, anger, and shame towards child wellbeing and childrearing are common aspects of counter-transference towards parents and children.

In her observation, Tungpunkom et al (2017) noted that health care workers utilized many defensive approaches to safeguard themselves from the mental loads of experiencing child neglect and abuse. Such approaches were over-simplified intervention strategies (that does not consider the distressing family conditions) and over-identification with mothers (that permits medical practitioners to keep away from watching the child's hardships). However, Mulligan et al (2019) argue that the mothers'

needs and that of their children are always contradicting, making it hard for clinicians to harmonize both aspects, particularly in an institution that prioritizes the mental health of parents.

A healthcare practitioner from Australia interviewed by Rupert et al (2015) claimed that the main focus should be on "understanding the parent and then childrearing takes care of itself." This concurs with, Reupert and Maybery (2016) arguments that it's hard for clinicians in mental health institutions to sustain a two focus that put into consideration the parents' experiences and needs of their children. Nonetheless, Murphy et al (2018) indicated that parenting anxiety is common to all mothers, and health care workers have a duty of aiding families to mitigate parenting anxiety and build resilience.

2.6 Theoretical Framework

Bowlby's Attachment Theory

The theory of attachment was developed by Bowlby (1907-1990), to understand the discomfort experienced by infants when separated from their mothers (Fraley, 2020).

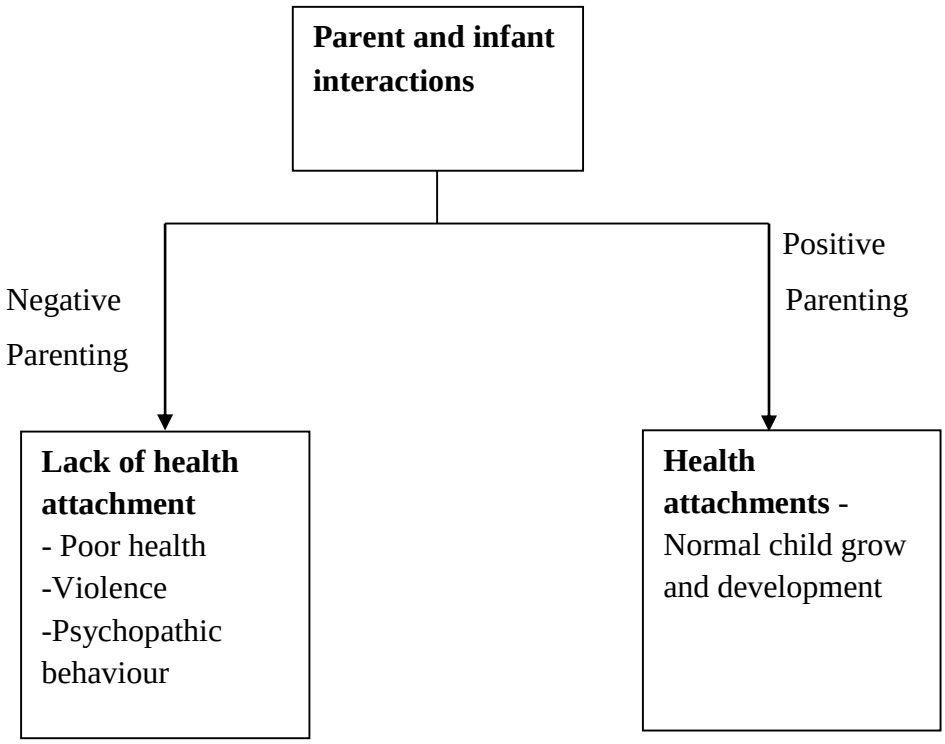

Figure 1: Bowlby's Attachment Theory (1907-1990) focuses on differences between children who lack health attachment and those who have health attachments.

Bowlby noted that separated infants would extremely cry, scream, and cling anxiously to stop the separation from their parents (Ackerman, 2020). He considered these behaviors to be reinforced through natural selection and strengthened by the child's likelihood of survival and control proximity of caregivers (Cherry, 2019). Bowlby designated these behaviors as "attachment behavioral system," which directs individuals' habits of establishing and sustaining relationships throughout life (Crandall et al, 2016; Rothman et al, 2020).

Bowlby argues that children explore the proximity of mother, accessibility, and attentiveness. If they realize that the mother is available, they feel appreciated, safe, and confident. However, if they recognize that the caregiver is absent, they become worried, feels discouraged and experiences deep disappointments, despair, and depression (McLeod, 2018; Rosmalen, 2020).

Research indicates that disappointment in forming safe attachments in the early days of life can have harmful behavioral consequences all through in life (Crandall et al, 2016). Children diagnosed with post-traumatic stress disorder, conduct disorder or oppositional defiant disorder, commonly exhibit affection problems, probably owing to early neglect, trauma or abuse (Berry and Danquah, 2020). Maternal mental disorders have a direct influence on parenting, which affects the child's developmental stages (Theodoritsi et al, 2018; Ruud et al, 2019). According to Hussain et al (2016), household and social circumstances affect and are also affected by maternal mental disorders, influencing parenting and child wellbeing directly.

2.7 Conceptual framework

Parents feel pleasure in the achievements of their children. Exclusively, they desire to be good parents and they would like the best outcomes for their children. Woefully, the desires to offer the best parenting do not always turn into real practice (Crandall et al, 2016; Girme et al, 2020). Although the majority of parents with mental disorders do not always abandon or maltreat their children, many struggles in employing warmth, responsive care-giving (positive parenting) and forming strong attachments with their children (Foster et al, 2018).

Researchers found that mothers with mental disorders have significantly lower decision-making and are mostly accused of child maltreatment (Jones et al, 2016). Parents, advocate for support to plan and change their behavior, respond aptly to

children's cues, control emotions, solve the problem, and make decisions (Graham, 2018; PPDKenya, 2018). Throughout child livelihood, better maternal cognitive regulations are coupled with helpful responses to a child's needs, improved maternal sensitivity, warmth, caring expression and confidence (Maybery and Reupert, 2018).

Mothers with mental disorders require effective interventions. Exploring and understanding their parenting experiences may help to explain how parents employ parenting skills, determine how and when to intervene, and the support systems necessary for strengthening child protection and preventing child and adolescent emotional and behavioral disorders.

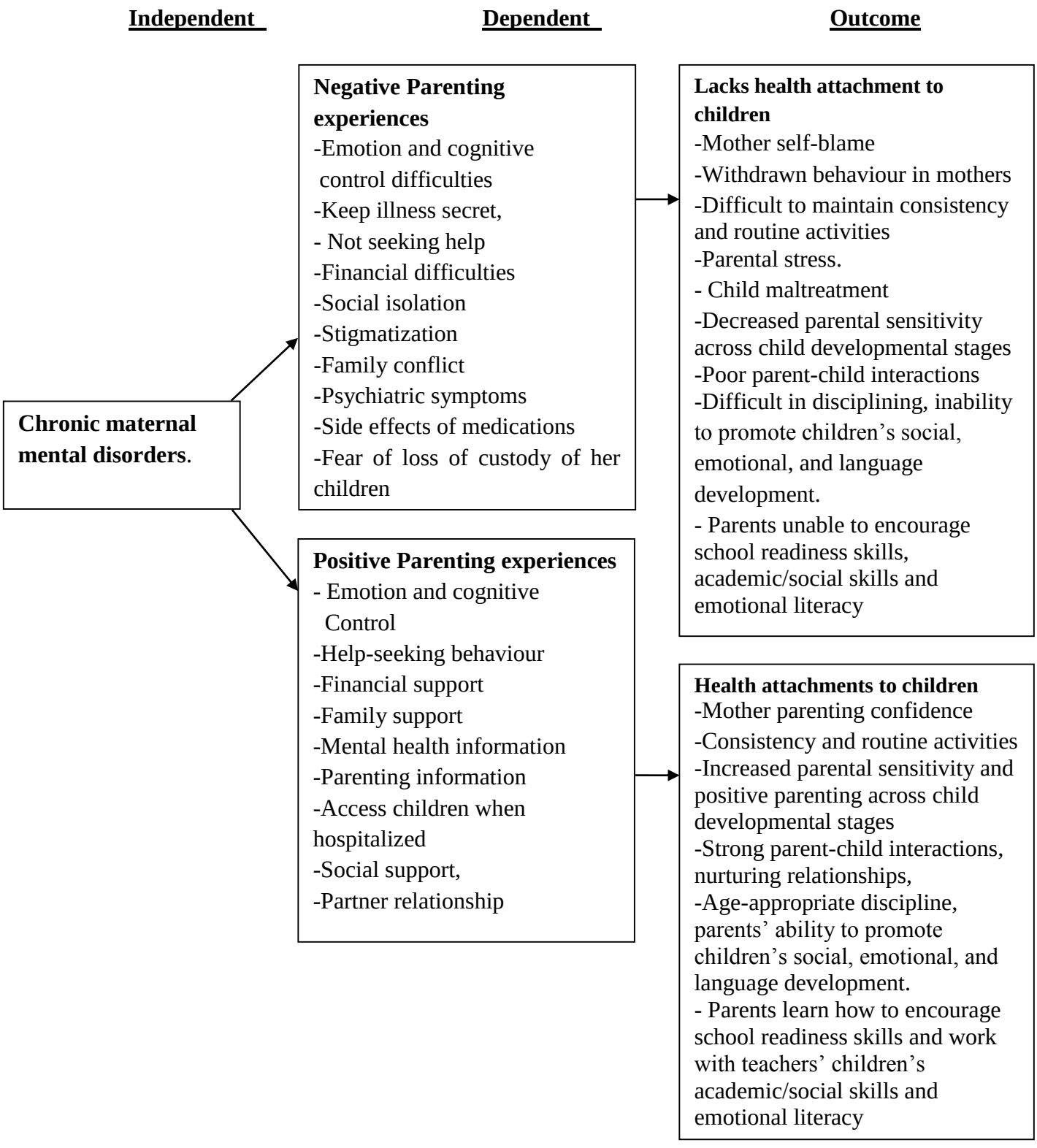

Figure 2: Conceptual framework of chronic mental disorders and parenting experiences.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Study Site

This study was conducted at the mental health outpatient clinics of Mathari Hospital, Nairobi. Mathari is a Kenya only National, Teaching and Referral Psychiatric hospital with a bed capacity of 700. It has five (5) male psychiatric wards, three (3) female psychiatric wards, a rehabilitation centre for drug and substance abuse illness, as well as an outpatient psychiatric department. It has three (3) sections of MSU for mentally ill lawbreakers.

Mathari Hospital is a centre for integrated services, including laboratory, maternal and child health clinic, child and adolescent psychiatric clinic, pediatric clinic, TB clinic, diabetic clinic, dental services, radiology, physiotherapy, general outpatient services, comprehensive care centre, Medically Assisted Treatment (MAT) clinic for heroin abuser and Clinic for Substance Abuse Treatment (CSAT).

The hospital runs mental health clinics weekly (on Tuesdays) in all wards. There are three (3) female wards where the study was conducted, and an average of thirty (30) outpatients were attended in each ward on clinic day. Usually, the mental health status of the patients is evaluated by the psychiatrist. The nurse gives "health talk" to the clients in the morning before the clinics start, keeps the register of attendants and maintains the queue.

The rationale for choosing Mathari Hospital is that being the only national, teaching and referral psychiatric hospital, it has the greatest number of patients from different backgrounds, all over the country, has a diverse range of mental disorders, skilled health care personnel and best facilities of care. It is strategically situated along Thika road, about 3 Km from Nairobi city centre, opposite Muthaiga police station and Muthaiga Golf Club.

It was important to carry out the study to discover the child-rearing experiences of mothers attending the mental health clinics at Mathari hospital. It is expected that the results will persuade the hospital management to develop a policy that considers the availability of the children during the mental health evaluation of their parents, manage the problems related to child-rearing, raise public awareness about needs for mothers and child mental health protection. This will elevate the hospital to be the center for

excellence in providing quality mental health services based on the respect for individuals and maintaining their dignity.

3.2 Study Design

This is a qualitative research design. It utilized a descriptive phenomenological approach. Similar designs have been used by researchers in nursing and midwifery to understand the meaning of lived experiences of patients, families and professionals (Annelie et al, 2019). Beard et al (2019) and Rampou et al (2015), used similar designs to explore perception of mothers living mental illness. Dusseldorp et al (2020) used similar designs to describe the impact of nurse practitioner care on patients with chronic conditions and Juevesa et al (2020) described the managers coping mechanisms to burnout using similar designs.

3.2.1 Phenomenology

A phenomenology is an approach to qualitative research that seeks to explicate the essence, meaning, and structure of an individual or group of people's life experiences about a certain concept (Neubauer et al, 2019). Phenomenology provides room to explore individuals' experiences and perceptions in their natural settings without predetermined criteria (Annelie et al, 2019). The types of phenomenology include Transcendental phenomenology which focuses on the essential meaning of participant's experiences; Hermeneutic phenomenology reflects on lived experiences with interpretation by the researcher; and Existential phenomenology concentrate on individuals' experience as it considers people's values, emotions, and relationships (Daley, 2017).

The transcendental phenomenology approach applies to this research work. It concentrates on exploring in-depth, explicating the essence of the participants' lived experiences. It is invaluable when analyzing lived encounters that are emotionally laden, complex, and sensitive such as parenting with mental illness, as well as when describing an individual's personal view. Phenomenology allows the respondent to look back and offer an in-depth description of their encounters with the investigator remained attuned to and empathetic to their own stories (Annelie et al, 2019), harmonizing both the subjective and objective perspectives to knowledge. It allowed the investigator to thoroughly unearth and describe the way certain encounters can

influence mentally ill mothers in their parenting responsibility, the way they understand the experiences and how these encounters make essence in their life.

3.3 Target Population

The target populations were all mothers with chronic mental disorders who had dependent children and were attending mental health clinics at Mathari hospital.

The current study adopted a definition of chronic mental disorders in mothers to mean a mother identified with schizophrenia, bipolar disorders, and major depressive disorders.

3.4 Eligibility Criteria

The most important tasks were the selection of participants who had experience in parenting with mental illness and were willing to share their thoughts and experiences.

3.4.1 Inclusion Criteria

1. Mothers identified with schizophrenia, bipolar disorders or major depressive disorder and have had the disease for a period of ≥ 12months as this indicates the chronicity of the disease.
2. Had dependent children below 18 years of age at the period of study. These are the children who requires constant care from their parents.
3. Have been in remission (mentally stable) in the preceding two months with a MMSE score of
4. ≥ 24 points (see appendix 2).
5. Attending the mental health outpatient clinics at Mathari hospital.
6. Those who accepted to participate through written informed consent.

3.4.2 Exclusion Criteria

1. The mothers who may have developed emotional discomfort during the interview.
2. All mothers with co-morbidity associated with substance use since the use and misuse substances have models influencing the mothers' parenting capabilities, and the focus of this study was on recurring mental disorders.

3.5 Sample Size Determination

Sample size adhered to the principle of data saturation. In-depth interviews were conducted to obtain data on parenting experiences. The data saturation reached at the

15th interview hence making a sample size of 15 participants. Many studies in descriptive phenomenology demonstrate that data saturation is typically achieved with sample sizes of 7 to 15 participants (Aguinis and Solarino, 2019). However, other researchers have indicated that a sample size of 30 participants is sufficient (Hennink et al, 2017; Sim et al, 2018). For qualitative research, a guiding principle would be to sample until data saturation is attained (Saunders et al, 2018; Vasileiou, 2018); which is a level where all study questions have been rigorously looked at in detail and no new themes or concepts show up in succeeding interviews (Sim et al, 2018; Wiley, 2019).

3.6 Sampling Method

Sampling in qualitative research is a deliberate selection of specific data sources from which data are collected to address the research objectives (Gentles et al, 2015; Palinkas et al, 2016). According to Moser and Korstjens (2018) purposeful sampling is a logical and powerful technique for recruiting information-rich participants for in-depth study which yields insights and in-depth understanding; and it is appropriate strategy for descriptive phenomenological studies (Aguinis and Solarino, 2019). In this study, the participants purposely selected were mothers who had knowledge and experiences on parenting with mental illness. They had 'lived experiences' about the phenomena being explored.

The researcher purposively sampled the three (3) female wards in the hospital because they are the only ones where female patients are admitted and where one is likely to find mothers with dependent children (children below 18 years). Then at the ward level, mothers with dependent children are the rich sources of data. They were therefore, be selected purposively and interviewed until data saturation was reached. In each ward, data was collected until saturation was reached.

3.7 Recruitment procedures

The researcher informed the medical superintendent and the nurse in-charge of the Mathari hospital about the intention to carry out the study in the facility through a letter and asked for permission to access the participants. The nurse in charge of the hospital informed the nurse-charges of the female wards and the health records department-incharge to expect the researcher on the pre- and clinic days through a memo.

The researcher verbally informed the nurses in female wards, about the study goals and the intention to identify and recruit the participants from the mothers attending clinics.

This enabled them to offer support in the identifications of a quiet location in the ward. Before the clinic day, the researcher verbally notified the health record personnel about the study so as to avail the records of those scheduled for the clinic and the approximate number of the patients expected to attend the clinic were noted.

At the ward level, the researcher availed himself every clinic-day early enough before the clinic began, talked with the mothers who were waiting, those who met the criteria and were willing to participate were be selected, given time to reflect and scheduled a meeting date for interview, whether in the hospital or at home or a place where the client was comfortable. Their contacts were taken for communication purposes. Those who opted to come to the hospital a day that was not the clinic day, their fare was reimbursed.

The files of the participants were scrutinized to determine the diagnosis, and the period they have lived with the illness. A Mini-Mental Status Examination was performed to ascertain their mental status, and those who scored ≥24 points and met the inclusive standards were asked to give informed consent and interviewed. Recruitment continued until saturation occurred.

3.8 Data Collecting Instruments

Data on the parenting experiences of mothers with mental disorders were obtained via semi-structured interviews using an interview guide (see appendix 3). An interview guide was adapted from a "structure for important practices centered on family (Engage, Assess, Support, Educate-EASE)"; a feasible structure for reinforcing recovery when consumers of mental health are parents (Foster et al, 2018). The modification was made to include biographical information such as participants' number of children, age, marital status, employment status, educational level, religion, and residences, as a base for building therapeutic relationship, establishing bond, collaboration and trust during the interview.

The interview guide consisted of four sections which include biographical information, use of mental health facilities, experiences of parenting with mental disorders and experiences of family and social relationships. It incorporated various open-ended questions to inspire the mothers' to completely reveal their encounters in parenting with mental illness. All interviews were audio recorded using a Sony ICD PX333 digital voice recorder. The duration of the interview was 45 to 60 minutes.

According to Foster et al (2018), in a phenomenological study it is important to know that whereas the majority of life encounters might be shared or similar, every single family and parent is extraordinary, with objectives applicable to the present and past situations, family, and cultural context. Using an interview guide in exploring the participants' experiences on parenting, an in-depth individual interview produced rich information regarding the way mentally ill mommies make sense of their mental health problems and associated motherhood.

The primary goal of EASE is to reinforce the capacity of clinicians, to deal with major parents' psychosocial needs as well as improve relational recovery in communities and families with mentally ill parents (Emerging Minds, 2016). One practical standard that is family-centered and applies to EASE is gathering important details about parents' strengths, resources, vulnerabilities, relevant support needs for family members and children (Goodyear et al, 2015).

Components of EASE

1. **Engage:** This is creating a collaborative bond and trustworthy sense in the succeeding interview with an individual (Grant et al, 2018). Mentally ill parents require a careful relationship that might promote open dialogue on family life, parenting, and the effect of mental disorders on their kids (Hine et al, 2018).
2. **Assess:** This entails pinpointing clients as parents caring for children, the current parent-child relationship, such as whether the kids are leaving with their parents, parenting requirements, partner involvement, and basic family ties (Foster et al, 2018).
3. **Support:** This involves the extension of empathy and emotional support concerning family ties and parenting needs (Foster et al, 2018). Parents may gain support from the community, access proper professional services, and identify peer support groups (Naughton et al, 2017).
4. **Educate:** This entails improving parents' awareness of the effect of childcare on their mental health, and the effects of maternal mental disorders on children and the entire family (Foster et al, 2018). Parents may develop help-seeking behavior, and child protection (Grant et al, 2018).

3.9 Methods of Data collection

Semi-structured, one-on-one interviews were employed to obtain qualitative data. The researcher-built rapport, clarified the study goal and gained informed consent. Participants were then interviewed in an identified private place. However, family members were allowed and assisted in the interview if the client was willing. These interviews were audio recorded using a Sony ICD PX333 digital voice recorder, with participant permission, to allow for subsequent transcription. Different emotional responses and any other observations were documented on the field notes. The researcher transcribed the recorded interview verbatim. The participant's narratives were analyzed into themes.

3.10 Data analysis

In a descriptive phenomenology, the researchers often bring their perspectives, experiences, values, beliefs, and identity to the data collection and analysis process (Annelie et al, 2019). Before data analysis the researchers assume phenomenological attitude. They do bracketing. In other words, the researchers to put aside their perceptions of a phenomenon and give meaning to a participant's experiences (Neubaueret al, 2019; Wirihana ,2018). The concept of "bracketing" comes from Husserl's (1936-1983) epoché in which the researchers allows themselves to be present to the data without positing its validity or existence (Christensen et al, 2017; Turley et al 2016).

In this research, the researcher assumed the phenomenological attitude. He set aside his experiences and presuppositions about mothers with mental disorders; allowing reality from the participants' perspective, and then applied Caulfield (2020) six-step process, phenomenological approach to analyze the transcribed data. The six steps were as follows:

1. **Familiarization**: Horizonalization process is the initial step during data analysis (Annelie et al, 2019). The researcher transcribed every interview verbatim before the data analysis. He read interview transcripts several times, made comprehensive notes to familiarize with the data. Statements in the transcripts that offer information about participants' experiences was pinpointed. Different emotional responses and phrases were also outlined at this initial stage. Member checks was conducted, whereby participants were asked to review their interview transcript and omit or edit any given details.

2. **Coding**: Using these detailed notes, the researcher created short phrases equivalent to different codes. Each code described the understanding, feelings, and experiences of the participant articulated in that part of the transcript.
3. **Generating themes**: The created codes were compared throughout interviews, pinpointed the patterns among them and began generating themes pertinent to the study goals.
4. **Reviewing the themes**: The generated themes were reviewed, identified and merged the similar ones. Themes with distinctive meanings were unaltered to enhance the diversity in the description of the data.
5. **Defining and naming of the themes**: Defining and naming of the themes were done by stating precisely the importance of each theme, defining how it helped in understanding the data, providing a clear name of each theme.
6. **Writing up**: Finally, the themes were manually converted into a descriptive record illustrated by verbatim quotes to explain and reflect the essence of the themes in participants' perspectives.

3.11 Trustworthiness

The philosophy of trustworthiness as expressed by Lincoln and Guba (1985, in Nowell, 2017) was applied. Trustworthiness is a terminology in qualitative research that corresponds to internal and external validity, reliability and objectivity in a quantitative approach (Trochim, 2020). This includes measures of credibility, transferability, dependability, confirmability, and authenticity.

1. Credibility:

This included triangulation, extended consultation, persistent observation and discussion for 45- 60 minutes with the recruited participants. The researcher's authority as a psychiatric clinician with over 20 years of experience, with a post-basic psychiatric nursing training and research methodological preparation, tactfully and skillfully used open-ended questions to increase credibility. Piloting the interview schedule before the commencement of data collection, peer-reviewing by supervisors qualified at masters and doctoral level, verbatim transcription and audio-recording of interviews further increased the credibility of this study.

2. Transferability:

The researcher recorded details of the study approach and design, sampling methods, sample size, and study outcomes, the features of the participants that were in direct correspondence to the study questions.

3. Dependability:

The researcher attained dependability by ensuring that the whole research process was well-recorded, logical, and traceable. The supervisors qualified at masters and doctoral level monitors and examines the study process and outcomes. An audit trail of records was maintained including consent letters, audio recordings, field notes, transcriptions, and thesis report.

4. Confirmability:

This was achieved through establishing an audit trail to make sure that sources of data were traceable, indicating how interpretations, constructs, and themes were reached. The researcher did bracketing; reserving any preconceived views and beliefs regarding mothers with mental disorders, demonstrating that the study outcomes described the reality from the participants' perspective.

5. Authenticity:

This was established through clarifying and paraphrasing during the interview, via member checking to validate and ensure credibility and genuineness about data interpretation and participants' experiences. Audio-recording and verbatim transliteration was done and verbatim quotes was incorporated in data analysis. Field notes enabled the investigator to make comments on non-verbal cues, impressions, and behaviors that could not be covered via the audio-recordings.

3.12 Ethical Considerations

1. Autonomy:

Autonomy and voluntary participation were observed. Autonomy constitutes the right to full disclosure as well as the right to self-determination. Since mental disorders affect a person's cognitive functions, a Mini-Mental Status Examination (MMSE) was conducted before a patient was allowed to participate in the study to ensure that the aspect of voluntary participation was observed. Competent participants provided written informed consent.

The MMSE is a commonly used set of questions for screening cognitive function (Willacy, 2017; Roco, 2019). It tests the individual's orientation, short-term memory (retention), attention, short-term memory (recall), and language. Competence to give consent is determined by a score of ≥ 24 on MMSE (Wagoro, 2008; 2016; Wagoro and Duma, 2018). Participants were interviewed in an identified private place. However, family members were allowed and assisted in the interview if the client was willing. The relative were informed of the interview procedures and were allowed to witness the interview process by filling a consent (witness) form.

The participants were informed about the goals of the study, types of data and data collection approaches. Anonymity and confidentiality were guaranteed and engagement was willful. The opportunity to get out of the study without ramifications, how the study findings could be availed to the participants, value of the study, any associated risks, how the information will be utilized, and time commitment expected from participants were explained. The researcher gave the participants 45-60 minutes to understand information about the study and made voluntary choices.

2. Beneficence:

The participants benefited by finding an opportunity to verbalize their parenting experiences in conducive conditions. Through reflection, analysis of their emotional disorders and parenting experiences could make them develop new perspectives. Such self-exploration and self-awareness were encouraging for mothers and could make them develop resilience. The obtained data was shared through presentations, conferences, and publications to increase social awareness and the importance of supporting mothers and their children. The participants who opted to come to the hospital for the interview a day that was not the clinic day, their fare was reimbursed.

3. Non-maleficence:

It was improbable that any physical or emotional harm could occur to the participants if the interviews were conducted respectfully and sensitively. However, the researcher envisaged that a distressful or traumatic event could cause some discomfort to the participant. If at any point the participant felt discomforted or upset, she was allowed to stop the interview and resume when she felt comfortable again. If she felt that she could not continue to take part in the research, she was be given a chance to pull out. The investigator made observations and stopped the interview if the participant

appeared too sick to proceed. If during the interview the participants experiences emotional distress or anxiety, the details were be revealed to the medical team for the participants' safety, protection of the children and any household members. As part of protection from harm to participants, the protocol was reviewed and approved by KNH/UoN-ERC and Mathari hospital administration. The study was conducted within the dictates of the approved guidelines.

4. Justice:

Inclusion and exclusion criteria ensured that all the participants were fairly, justly, and equitably treated. Confidentiality was maintained throughout the study to ensure that there was no intrusive to participants' lives. Information from the participants was kept confidential, anonymity was upheld, involvement was willfully, and one could pull out from the interview without ramifications at any time. In the process of sharing the study findings, quotes were used as illustrations but the participants were not identified.

3.13 Storage of personal data

To prevent data loss, a digital voice recorder was employed to tape the interviews. Audio recordings were stored in password-protected computers. The transcribed information was stored safely, a place only accessible to the researcher.

3.14 Dissemination Plan

Copies of research findings were submitted to the Ethics and research unit, Mathari hospital and the UoN-School of Nursing Sciences, which were later made available to the University library. The results were also presented in appropriate academic and scientific conferences, and also published in mental health journals.

CHAPTER 4: RESULTS

4.1 Introduction

The purpose of this qualitative study was to explore the lived parenting experiences of mothers living with chronic mental disorders. This chapter highlights the findings of the study based on the specific research objectives which were to explore lived parenting experiences, find out the challenges in parenting and establish the available support systems that facilitates parenting for mothers with chronic mental disorders attending mental health clinics at Mathari hospital.

The findings are presented using the themes and subthemes converted into a descriptive record illustrated by verbatim quotes to explain and reflect the essence of the parenting experiences in participants' perspectives.

This chapter also includes the demographic profile of the participants presented using tables. A total of 15 participants were recruited. Interviews were conducted up to 15th interview when data saturation occurred and no new themes were generated.

4.2 Demographic Profile of the Participants

This section highlights the demographic profile of the participant including: age, marital status, occupation, level of education, employments status, religion, residents, clinical diagnosis, years of living with mental disorders, current number of children and at first episode of mental disorders.

A sample of 15 participants aged 22-52 years were interviewed. Eight of the 15 mothers were aged between 30 and 39 years, three were between 40 and 49 years old, two were between 20 and 29 years of age and two were between 50 and 59 years. Six of the 15 mothers were married, four were single, three were separated, one was windowed and one was in a cohabitation relationship.

Nine of the 15 mothers had tertiary level of education which includes middle level college (4), university level (3) and vocational training college (2), four had primary level of education and two had secondary level of education. Five participants reported having a self-employed business, four were casual workers, two were in formal employment by the government, two were house wives and two were not in any form of employment. Of the 15 participants, twelve were of Christian faith, two were of Islamic faith and one reported to be a Pagan.

Eight mothers were diagnosed with schizophrenia, three with bipolar II disorder, three with bipolar I disorder and one with major depressive disorder. The 15 participants, had lived with mental disorders for between 2-22 years. Eight of the mothers had lived with mental disorders for between 11 to 20, six for between 1 to 10 years and one for between 21 to 30years.

Five mothers had no children on the first onset of mental disorders, four mothers had 2 children, two mothers had 4 children, two mothers had 1 child, one mother had 5children and one mother developed psychosis associated with pregnancy and child birth at 3months gestation during the first pregnancy and has since then lived with mental disorders. At the time of study, all the15 participants had dependent children below 18 years. Seven mothers had 2 dependent children, six mothers had one child, one mother had 5 children and one mother had 4 children.

Eleven mothers reported to be always in close contact with their children, and are actively involved childcare, three mothers indicated that at times they are with their children and other times with their relatives, especially during the first few months of remission. They indicated that their children were with their relatives within nearby or far in rural areas; but they easily accessed the children and participated in child rearing. Only one mother who reported that has never been in close contact with her child. Her close relatives took the child from her and later took the baby to children home.

Eight participants indicted that they lived in their own houses, six in rented houses and one lived in government houses. Ten of the participants lived with their relatives and five lived with their spouses. Seven of the participants came from Nairobi metropolitan and its environs, five from Kiambu and its surroundings, two from Thika and one from Kenol-Murang'a, representing different cultural and social background in the country.

The table 1 summarizes the social demographic characteristics of the participants which includes level of education, employments status, religion, residents, people they stay with and the housing status.

TABLE 1: SOCIAL DEMOGRAPHIC CHARACTERISTICS

Pn	Level of education	Employments status	Religion	Residents	Stay with who	House status
P1	Standard 8	House wife	Islam	Eastleigh	Husband and children	Rented
P2	University	None	Christian-catholic	Kiambu	Mother and children	Own
P3	Middle level college	None	Christian-PCEA	Kikuyu	Sister and my 2 children	Own
P4	Form 4	Casual worker	Christian-catholic	Limuru	Husband and children	Rented
P5	Middle level college	Business lady	Christian-EAPCA	Nairobi-Bahati	Sister	Rented
P6	Vocational training college	Business lady	Christian-Anglican	Kiambu-Thindigua	Mother, brothers, sisters and my child.	Own
P7	Vocational training college	Casual worker	Christian-PCEA	Ruai	Parents, brothers, and my child.	Own
P8	University	Casual worker	Christian-Full Gospel	Kibera	Sister	Rented

P9	Middle level college	Teacher	Islam	Kawangware	Two young children and my 2nd born Daughter.	Rented
P10	Form 4	Housewife	Christian- Full Gospel	Ruiru	Husband and two young children.	Own
P11	Standard 8	Casual worker	Christian- PAG	Githunguri	My four children	Own
P12	Middle level college	Hospitality	Christian- Catholic	Kenol	Husband and her two children.	Own
P13	University	Business lady -Hawker	Pagan -	Kiambu	Grand mother	Rented
P14	Standard 8	Business lady	Christian- Catholic	Nairobi- NYS	Husband and her one child.	Government house
P15	Standard 8	Business lady -Veg. vendor	Christian-PCEA	Thika	Mother	Own

Key

Pn= Participants

The table 2 summarizes the participants' demographic profile of family and clinical characteristics. This includes age, marital status, clinical diagnosis, years of living with mental disorders, current number of children and the number of children at first episode of mental disorders, contact with their children and the persons who cares for their children when they are hospitalized.

TABLE 2: FAMILY AND CLINICAL CHARACTERISTICS

Pn	**Age**	**Marital status**	**Clinical Diagnosis**	**YLMD**	**Number of children at first episode/ Ages (yrs.)**	**Current Number of children/ Ages (yrs.)**	**Contact with children**	**Care of children when I am hospitalized**
P1	38	Married	Bipolar II disorder - Since age 25 years - Has had several visits to mental health clinics since 2007. - Admitted twice in a psychiatric ward in the last one year.	13	2 children. Ages: 2, 1month	5 children. Ages: 15, 13,10,6,2	At times	-My husband -My sister -My co-wife
P2	35	Separated	Bipolar I disorder - Since age 27 years - Has had several visits to mental health clinics since 2012.	8	2 children. Ages: 4,2	2 children. Ages: 12,10	Always	-My mother -Father to my children

			- Admitted once in a psychiatric ward in the last one year.					
P3	38	Separated	Schizophrenia - Since age 27 years - Has had several visits to mental health clinics since 2009. - Last admission was 2018.	11	2 children Ages: 4,1	4 children Ages: 15,12,9,5	3rd and 4th born- always. 1st and 2nd born- rarely.	**- 3rd and 4th** born- My sister. **-1st and 2nd** born- Stays with their father.
P4	36	Married	Schizophrenia - Since age 30 years - Has had several visits to mental health clinics since 2014. -Admitted once in a psychiatric ward in the last one year.	6	2 children Ages: 10,4	2 children Ages: 16,10	Always	-My husband
P5	37	Single	Bipolar I disorder - Since age 21years	16	None	1 child Ages: 3	At times	- My parents

			- Has had several visits to mental health clinics since 2004. - Admitted three times in a psychiatric ward in the last one year.					
P6	43	Single	Schizophrenia - Since age 28 years - Has had several visits to mental health clinics since 2005. - Admitted once in 2007 in a psychiatric ward	15	None	1 child Ages: 8	Always	-Mother, siblings take care of the child when going to the clinic or work.
P7	44	Single	Depression - Since age 22 years - Has had several visits to mental health clinics since 1998. - Last admission was 2018.	22	None	1 child Ages: 17	Always	-Mother, -Brothers
P8	29	Single	Bipolar II disorder - Since age 26 years	3	None	1 child Ages: 2	Never	Children home

			- Has had several visits to mental health clinics since 2017. - Admitted four times in a psychiatric ward in the last one year.					
P9	52	Married	Schizophrenia - Since age 40 years - Has had several visits to mental health clinics since 2008. - Last admission was 2018.	12	4 children. Ages: 18, 16,12,1	5 children. Ages: 30, 28,24,13,11	Always	-My 2nd born daughter
P10	50	Married	Schizophrenia - Since age 37 years - Has had several visits to mental health clinics since 2007. - Last admission was 2009.	13	5 children Ages: 18, 15,11,4,1	5 children Ages: 31, 28,24,17,14	Always	-My husband -My 2nd born daughter -My sister

P11	41	Window	Schizophrenia - Since age 35 years - Has had several visits to mental health clinics since 2014. - Admitted twice in a psychiatric ward in the last one year	6	4 children Ages: 19, 16,11,7	4 children Ages: 25, 22,17,13	Always	-Themselves
P12	38	Married	Bipolar II disorders - Since age 18 years - Has had several visits to mental health clinics since 2000. - Last admission was 2014.	20	None	2 children Ages:5,2	Always	-My mother -My sister
P13	22	Cohabitation	Schizophrenia - Since age 17 years - Has had several visits to mental health clinics since 2017.	3	Three months Pregnant	1 child Ages: 3 ½	At times	-My mother

			-Admitted five times in a psychiatric ward in the last one year.					
P14	32	Married	Bipolar I disorder - Since age 30 years - Has had several visits to mental health clinics since 2018. - Last admission was 2018.	2	1 child Ages: 3	1 child Ages: 5	Always	-My husband -My mother
P15	32	Separated	Schizophrenia - Since age 18 years - Has had several visits to mental health clinics since 2008. -Admitted twice in a psychiatric ward in the last one year.	12	1 child Ages: 1 month	2 children Ages:12,13	Always	-My mother

Key

Pn = Participants

YLMD = Years of Living with Mental Disorders

4.3 Lived Experiences of Mothers Living with Chronic Mental Disorders

Lived parenting experiences in the context of this study is defined as child rearing empirical knowledge, attitudes, expectations, perceptions and practices, gained through involvement in childcare. Mothers use a variety of coping skills to achieve control and survive through various actions and behavior; that covey their lived experience of handling mental and emotional disorders.

To explore the lived parenting experiences, the following questions were asked: What are your parenting experiences in trying to be the best parent possible? What are your feelings of being with your children?

The participants explained their experiences in many ways that could be merged into three themes as follows: "Being a trustworthy mother, challenges in parenting roles and perceived support systems." These lived parenting experiences are summarized in table 3.

TABLE 3: PARENTING EXPERIENCES

	Main Themes	**Sub-themes**
1.	**Being a trustworthy Mother**	- Fulfillments and confidences of being a mother - Joy of being a mother - Being a reliable and responsible mother - Emotional support for the children
2.	**Challenges in parenting roles**	- Inadequate financial resources - Parenting inadequacy due to psychiatric symptoms - Decreased parenting ability due to side effects of medication - Lack of readily available childcare support - Fear and distress about separation - Stigmatizations - Children emotional wellbeing: Mothers' perceptions - Single motherhood
3.	**Perceived support systems**	- Support from the family and community - Desire for knowledge on mental health and parenting - Improving parenting skills - Hospitalization and parenting support needs - Mother-child friendly services when hospitalized.

4.3.1 Fulfillments and Confidences of Being a mother

Motherhood is an importance stage in life for all women irrespective of their mental health status. All the participants endorsed motherhood as "very important period" and recognized their role as mothers to be of major importance. P2 said: "*Mental illness cannot reduce our ability to be good mothers…we are responsible to our children…we love them."* They reported that motherhood improved their self-esteem. Children motivated them with genuine love and warmth that brings experience joy to motherhood. They motivated them to take their medication and enhanced them to seek help for their mental health needs. The participants explained that motherhood is full of sacrifices, overwhelming, fulfilling, and wonderful. It is satisfying spending quality time with the kids, talking to them and fulfilling their desires. This strengthens mother-child bonding. Motherhood improve communication within the family especially between spouses or partners and this makes parenting more satisfying. Motherhood brings confidence and gratification in every success of the child. Each milestone the child achieves is an evidence of good upbringing.

This was exemplified in the following excerpts. P4: *"I am a trustworthy and satisfied parent… I always endeavor to be a good mother…the best possible. I feel good when I see my children grow. I want to love my children unconditionally, spend quality time together and empower them to feel secure, as I take my medication."*

4.3.2 Joy of Being a Mother

Motherhood is very essential. All participants indicate that they were proud of being a mother. They felt that parenthood is an importance stage in life that bring joy, honor, respect and responsibility. P5 said: *"I feel proud of being a mother, happy since everything is going on the right way. I feel complete as a mother. This is a stage I really longed for. My child stays with my parents at rural areas. I communicate with my mother often to know the state of my child. When I go home, I stay with the child and learn issues of parenthood from my mother…she does it well."*

The participants strongly expressed their joyous feeling of parenthood period. The mothers feel respected, valued and are capable of bringing up health children with bright future, if they are offered some little support. P13 narrated: *"Parenthood period makes mothers honored. My child knows has two main supporters, my mother and I, he is so fond me. I love my child more than ever…. There is nothing I cherish in this world than my child. I*

am mother…I live for my child… I am so lucky. As a mother, I feel excited, have high hopes for my child."

P6 said: *"I expect my child to grow well…have bright future. When you are mother... first of all you get responsible, secondly you fear God…because you are there to pray for the safety of your child…being mother in an opportunity, God has given you…and I believe you should use every opportunity given wisely*."

All participants felt that are capable of being reliable mothers. They expressed their reliability and responsibility to their children just like any other trustworthy mother would do. P14 lovingly said: "*Motherhood is joyous…I really rejoice of being a mother to my children. They are so… special to me…I cannot stay without them…it's like a lady's handbags or police and his gun… we cannot be separated."*

Another mother P12, devotedly added: "*I am mother of two children…some people thought that I cannot bear children and make a family because I take medication. I have a feeling like any other woman…I'm a human being…not a mentally ill patient. I am very happy when I'm caring for my children… I love them…and I'm planning to get more…may be five"*.

4.3.3 Being a Reliable and Responsible Mother

The key sentiments for all the mothers included that of being trusted, trying to be the best mother possible… and giving the best care to their children. They put emphasis on maintaining the family cohesion, creating a safe and stable environment, prioritizing the routine activities, being available for the children, and working hard to meet their needs. This was accentuated by P13: *"Try to exist as possible for your kids… Parenting is being trusted taking the responsibility … being the supreme being … you are God to them. Give them nutritious food, adequate sleeps, security, warm clothing, appropriate guidance, necessary socialization and education."*

P2 explained: *"I stay with my children all the time. I provide all care and protection for them. I emphasize on discipline and good moral values. I share with their father… although we separated… about the children needs, as a mother would always do. I give them the best I can… I love them… they trust me."*

However, they acknowledged that, because of the mental illness, their relatives made a rigorous effort to be practically involved in caring for them and their children. They

affectionately explained the role played by their relatives to keeps the family together. P1 narrated: "*I take my medication well and this helps me to play my parenting role properly…. I always learn parenting from relatives… I have accepted my sickness... my sister and my co-wife teaches me how to take care and support my children. My husband gives contributions for the welfare of the family as well."*

4.3.4 Emotional Support for the Children

The participants expressed the importance of creating a strong emotional connection with children, creating an environment that encourages open communication; to ensure that their children understand that they could rely on them for emotional support. P2 said: "*I always emphasize on quality parent-child time and interaction… I'm very close to them, I watch at them as they play with other kids... at times I play with them... You are responsibility to them…your protection, your provisions. Although I separated with their father, … I usually allow the children to visit him for their emotional gratification".*

The participants indicated that the children emotional needs are different and they are supposed to be prioritized, respecting and promoting individuality in each child. P1 explains: *"Children are important to me; they are God's gift.…one of my children is a slow in learner… and I handle her individually…take her for counseling."*

Some mothers indicated that it is important to have appropriate and assertive communication with the children. P5 narrated: *"At appropriate age, it's important to share about mental health problem with your children. It promotes understanding and improves their emotional well-being. It encourages them to participate in the care of their mother… and seek help when their mother is sick".* This was supported by P4 who said: *"My children visit me when I am hospitalized, I explain why I was admitted… They feel encouraged when they see my positive progress. They are aware that I attend the clinic. This knowledge promotes and satisfies their emotional wellbeing.".*

On the same vein P7 described the importance of parent-child interaction in maintaining cohesive family. *"I usually spare time to talk to my child, encourage him to be self-reliance, because my mental health state makes me not to be financially stable. He understands that I usually develop episodes of mental illness… He helps in house cores… and encourages me attend the clinic."*

4.4 Challenges in Parenting Roles from Mothers' Perspectives

Mothers living with mental disorders experiences a lot of challenges which includes balancing between managing their mental health problems and the needs of their children, decreased energy, guilty, feeling of inadequacy, fear and distress about children's custody, inadequate financial resources, psychiatric symptoms, effects of medication, lack of social support, and stigmatization.

To find out the challenges in parenting role from mothers' perspectives, the following questions were asked: What are your feelings about managing your illness, children and your partner? What are the challenges that are of concern to you as a mother? What are your experiences of being a mother regarding the relationships with the relatives, friends and other members of the society? What activities did you give up regarding childcare due to mental health problems? How does your mental ill-health interfere your parenting roles? P10 replied: "C*hallenges due to mental illness, makes it be difficult to the parent you want to be."*

4.4.1 Inadequate Financial Resources

The participants narrated their challenges concerning inadequate financial resources to meet their own and their children's basic needs such as food, clothing, shelter and education. This challenge was aggravated by lack of employment, low income from the small self-employed business. P1 said: *"I have a lot of financial stress…because I do not have money. My husband has little source of income. I only give my children what I can afford. I'm not able to buy enough food and clothes for them and like other children."*

Money is essential enable the participants to go for clinic appointments and buy medications. Lack of money to attend the clinics usually leads them suspending their appointments. P7 explicated: *"Sometimes I don't have money to go for clinic appointments…most of the time I don't buy medication because of financial difficulties, and I have to wait until I get help from my relatives. At times it is difficult for me to meet the medical bills of my children when they are sick."*

Maintaining a job is often difficult, and balancing a job with family life is a great challenge. The mothers who could be gainfully employed, could not be able to secure a job due mental disorder. Most of the mothers depended on their small businesses for their financial gain or support from relatives. P4 explained: "*For now, I don't have a stable job… I stopped*

working due to mental illness… I cannot meet my needs and that of my children. I usually do any casual job available…but I tell you… it's difficult to sustain my financial needs."
P2 expounded: *"I have tried to find a job but it's very difficult…even with my good grades, my former employer dismissed me because of mental illness. I am also afraid I may get sick while working…because working while you are sick is very stressful."*

Most mothers indicated that due to financial difficulties, they are unable to offer quality education to their children. P7 said: "*My child would like to be like his age mates in the village who he sees to have good clothing, school uniform, good education… But at times I don't have money for school fees and…he has to forgo school.*"
P5 adds that: "*I don't have a steady job… I struggled to pay for my school fee…my father struggles too… financial difficulties made drop out of school… not completing my tertiary education."*

Some participants said that the children's biological fathers do not support them financially. P13 said the following: *"And the dad* [father of the child] *is just there… he comes from rich family… He refused to take responsibility. I have even gone to court. He was represented by three (3) lawyers…I had one none. I withdrew the case. I have gone to FIDA, children offices… so that he helps his kid, but all in vain. It is now difficult for me to buy food and pay school fee for the child."*

Some of the participants narrated how they struggle to get a house due to financial constraints. P13 continued to say the following: *"Currently my mother and my child are homeless. The landlord chased her away due to house rent. My rented room is also likely to be locked. I have arrears for several months. My father does not offer support, because my mother and I, could not be suffering like this…without shelter…and financial difficulties."*

Some mothers regretted how poverty has made her and her children suffer in the hands of their family members. P15 said: *"If were financially stable, I would rent a house far from home, so as to protect my children from my relatives, who usually mistreats them. I believe I won't be admitted hospital again…because there will be nobody to beat and stress me…and my children will stable…. and attend school well."*

4.4.2 Parenting Inadequacy due to Psychiatric Symptoms

All participants described how the psychiatric symptoms, particularly during acute episodes of mental illness, interfered with their parenting role. P9 said: "*This disease drains all the power; sometimes I feel so…weak, stressed and confused … I feel tired and exhausted and difficult to perform my house chores …and I can sleep the whole day… I don't have attention to the kids."*

Some mothers acknowledged assaulting their children. P2 had the following to say: "*Mental illness disorganizes the mind… violent and aggression behavior scares the children. Sometimes I get so... angry with anybody, I beat my children unnecessarily… very badly indeed, and they fear me. It's difficult to provide care and protection that time…but I love them."*

Some mothers narrated how they could obey commands due to mental illness and put their children at risk. P10 narrated: *"I could leave young child anywhere in the society without any care, because holy spirits and angels could command me to go to villages and markets to preach. At times I could leave my house early, and go to a far place... I could come back in the evening tired and exhausted. My children could be taken care of by the neighbours."*

Another mother (P1) said: *"I could move out of the house and stay outside…I do not want to talk to anybody… The young child lacks time to call me mum…mum. I am not able to teach the children how to talk, walk, and using the toilet…. It interferes with mother-child bonding."*

4.4.3 Decreased Parenting Ability due to Side Effects of Medication

The side effects of psychotropics interfered with the parenting abilities, as reported by most of the participants. The side effects include hand tremors, heaviness of the tongue, drilling of saliva, sedation and fatigue. They felt that medication interfered with the way of talking, reduced their concentration and slowed them down in their daily activities. P10 said: *"The medication makes me feel somehow lazy, my head feels heavy, my hands shake… have difficulty in talking. Other times I feel drowsy and …like sleeping all the times. This makes me have difficult to perform my daily activities and taking care of my children."*

In order to prevent the side effects, some mothers through psychiatric consultation changed their antipsychotics from typical to atypical with less side effects and others reduced the dosages of their medication. P12 explained: *"The medicines used to make me feel sleepy*

and drowsy. I was afraid that the employer may dismiss from work…. This could be very difficult for me to care of my children… the doctor changed the medicine. Nowadays, I take one tablet and it is okay."

Some mothers stopped their medication and sought alternative care as elucidated by P9: *"Most of time I prefer not to take medication, and be prayed for by the religious leaders… medication make me feel sleepy, and I cannot cook for my kids, clean their clothes, or assist them with their homework."*

4.4.4 Lack of Readily Available Childcare Support

Some mothers reported having no alternative care for their kids. This could make them fail to turn up for their clinic appointments. They explained that this could make them discontinue their medication leading to relapses. P11 said: *"When admitted in the hospital or attending the clinic my kids are left alone. My relative cannot help them. They all go to look for any casual work available to sustain themselves. They cook their own food…they don't depend on anybody."*

P12 said: *"My mother and sister in-laws are very illogical… There they cannot take care of my children when I have busy schedules. Sometimes they* [children] *accompany me to the clinic for my appointments. Other times I miss clinic…I don't know where to leave them."*

4.4.5 Fear and Distress about Separation

Some mothers expressed their fear and distress about potential and actual separation from their kids and the consequences of not being available for them. Obsessions of fear and custody loss of children caused anxiety and worries among many participants. P2, explained: *"When I am admitted to the hospital, I don't know what my kids are told by the relatives. I may want to take care of my children in a certain way, but my relatives want another way. So, I have no say to my kids' life, I am afraid that they might take my children away from me."*

Those who had lost custody to their children described it as a misfortune and disappointments. P3 described: *"I feel distressed because my in-laws divide the children between me and my husband.*

I am afraid… I have two… but the other two will not know that I'm their mother. I am always scared…they might come for the others claiming that I am an incompetent mother."

P8 explained the following: "*It is very disappointing; my brother went with my baby…and he says that he took her to a children home. He separated me with my baby. I want my child to stay with me. I want her to call me mum…mum… She should not call other people mommy."*

4.4.6 Stigmatizations

The participants reported that public holds perception that the mentally ill individuals are socially undesirable. Stigmatized persons may internalize perceived prejudices and develop negative feelings about themselves and causing self-stigmatization. Information gathered from the mothers indicated that the messages delivered by family, friends and the society made them feel labeled, judged, ignored, isolated and rejected.

Although it is expected that the society and families would support their sick members some mothers claimed that they were cruelly treated by their close relatives, the community including the law enforcing agencies. P15 narrated: *"My brother beats me in front of my children…my mother just watches… He says that I am a mad woman… My children cry… they say that when they grow up, they will take me to a peaceful place…* [pausing for while]. *They are very stressed and they perform poorly in school."*

P8 said: *"The beating from my bother…. always put me in agony…it makes me be admitted in hospital all the time…you can see* [pointing at the scars on the legs] *….my brother destroyed my brain. He has refused me to see my baby… he took her to children home."*

P11 had the following to say: *"My in-laws insult me…they say that I bewitched my husband. They mistreat my children. They steal crops from my samba... When I report this to the chief… like other members of the society…he also insults me…kwenda huko, wewe mwenda wazimu…* [go away, you mad woman]. *I wonder how can I bring up my children well…in such a society...."*

P12 said: *"My in-laws believe in witch crafts…and say people with mental disorders are useless. They stopped talking to me…many a times, they tell their son* [my husband] *…to chase me and my children away from their compound."*

Another mother P13, described: *"I have got very few true friends…. because when I recover…and go to the market for shopping, some people would say…wee wazimu, umekuja …toa nguo… tuone uchi wako tena…* [you mad woman, you have come…remove

yours clothes…we see your nakedness again…]. *I feel shattered …My child would feel embarrassed."*

Some mothers expressed feeling of alienation form the family and the society as narrated by P2: *My husband was cheating on me; my in-law could not listen to me…they even brought a woman to him to marry. I was stigmatized…Being seen as if I cannot do anything on myself. That time they had poisoned my kids mind… They feared me… I could not to guide them on anything… even the school work. I felt alienated and disowned."*

Some mothers reported the trust and confidence with their family members and the society diminished as explained by P3: "*The stress in life has made me to think differently about other people. I don't like mixing with some family members, relatives, friends, workmates and some people in the society… because they will lough at you, stigmatize, humiliate and ignore you."*

P5 further added: *"My people feel like am a burden to them, they see me like I'm a curse to them, a bad omen to them. They Make me feel as if am not worthy to exist among them…In work places…they make difficult for you to work, and may make you lose job. In business, people who are close to you, they make you lose customers."*

Some participants lamented that some family and community members may not protect mother with mental disorders from assailants. They may protect the perpetrator and punish the already traumatized victim. P13 had the following to say: "*I don't visit my grandmother nowadays… because I went there for my child to greet her…my uncle raped me in presence of my young child. After reporting …everybody was against me…everyone thought I was lying…they pushed me away with my child… they said I'm crazy and my child will take after me* [Mental illness] …*I felt 'blue'...* [I felt hopeless… worthless…]."

Some mothers indicated that they have been accustomed to the ignorance of the society. They have neglected and abandoned them. P11 narrated: *"It's like a normal thing for people to fear and run away from me in the community…. I am used to them… whatever they take me …it's upon them…but it's very sad for them to mistreat me and my children."* P10 described her ordeal in the community: *"The society thinks that I'm possessed by the demons. They segregate me and my children …and avoids greeting me. My husband ran away from home and rented a house far away."*

The participant reported that self-stigma decreased their self-esteem and increased self-doubt and shame. They felt embarrassed about having a mental illness. These feelings limited their societal relationships and impaired parental roles. P5 elaborated:
"I don't share my mental health problems with my child because he is young; but I would also not like to share with him even if he is grown up. I believe I will be cured by the time he is grown up. According to how mental illness is taken in society, I don't want him to hate me and himself."

Another mother P2 added: *"The society take mentally ill person like a person who has been bewitched, not presentable in public, and cannot be married and have children. I don't want my children to take me like other people..."*

P6 said: *I gave up married…because of the way society takes mental illness. I fear telling any prospective partner that I take medicine… I am afraid to disclose my mental health condition to anybody outside my family."*

4.4.7 Children Emotional Wellbeing: Mothers' Concerns

The participants expressed their concerns about negative effects of mental illness on emotion wellbeing of their children. Some mothers blamed themselves for not being available for their children, especially when they are hospitalized. P2 said: *"My children are concerned that my illness will prevent me from caring for them. They do not understand why they are always with their grandmother or other relatives. They may feel neglected and denied motherly love."*

Other participants were worried that their children performed parenting roles on their behalf at tender age. P9, said: "*I feel sorry for not having time with my kids. I'm usually in and out hospital all the time; when I'm supposed to be working and caring for my children. My older children helps me and supports the young ones. I suppose it is too tough for them."*
Some mothers expressed their concern that the exposures of their children to episodic bouts of mental disturbances may put them into risk for cognitive, social and developmental problems as indicated by P14: "*My children are aware that I suffer from mental disorder…. The cry in disbelief... as they see me being dragged to hospital…. They really think a lot…they are very stressed…. It seems as if they will also suffer from mental illness in future."*

P1 said: *"My relatives will not allow my children visit me in the hospital. They will get disturbed,*
when they learn that I have mental disorders. They will segregate themselves to avoid being ridiculed by their agemates…and they may not regard me as their mother."

Some participants explained that family conflicts increase the parental-child discord and hence increasing the risk for behavioral and emotional difficulties in children. P15 elaborated: *"Family discord …caused hatred among the family, mother-child interaction diminished and I could not guide and control them in their developmental stages."*

P10 also had the following to say: *Occasional family disharmony leaves the children with no role model…they suffer emotional problems because they miss parental support. They feel lonely, neglected…and they learn bad behavior…my older child is now becoming naughty."*

4.4.8 Single Motherhood

The participants reported diverse reasons for single motherhood which includes being widowed, separated or never married. These mothers conveyed as experiencing financial and housing insecurity, parenting stress, partially due to lack of financial support from a partner. Mothers also described lack social support, and disciplining their children as great hinderance in child rearing. P13 clarified: *"The greatest challenge is that, I am single mother. I've no stable job. So, I feel like…it's just a burden, because my child lacks a father figure in his life… his father rejected him and refused accountability. My child has gone thrice to children home… I fear that my child when he grows up and learns the father; he will despise him..."*

Another mother, P2, said: *"Disciplining a child as a single mother quite difficult. My sister at times discourages me from disciplining and guiding my children. She says action may make themhardy. I feel torn in between… I'm supported to bring up well-disciplined children, at the same time my contribution towards children rearing is not recognized."*

4.5 Perceived Support Systems for Mothers and their Children.

Mothers with mental disorders usually expresses their desires for acknowledgement and support in parenting roles. They require knowledge on parenting practices necessary for the growth and development of their children. They need health education on how to improve their parenting skills, understanding how to manage their mental health problems and their

children to know their parents' illness. They desire emotional and childcare support when they are sick and mother-child friendly environment when they are hospitalized.
To establish the perceived and actual support systems that facilitate in parenting roles, the following questions were asked: What support would you require to enable you manage your illness and care for your children? How do family members, relatives, friends and other members of the society treat you and your children? How would you like them treat you?

All the participants expressed their desire to be treated with respect and dignity and offered support by the family members and the society. This was exemplified in the following excerpts. P5 said: *"I would like them* [families and society] *to understand that it's because of illness that I behave differently… give me support because when I'm out of illness I behave like any other woman. They should take me like a mother who is responsible for her life, and well-being of her children."*

4.5.1 Support from the Family and Community

The participant expressed their gratitude for the support the receive from their relatives and the society. They felt recognized and this enabled them to remain mentally stable and perform their parenting roles with ease. P6 narrated: *"My relatives support me financially to enable me come to clinic, buy medicine and offer good education for my child. They understand that this is a disease that comes and goes and can be controlled. They involve me in family and society activities… like now I am the treasurer of a welfare group in our village."*

Fathers or partners are significant sources of support for mothers living with mental disorders. P4 explained: *"My husband offers support for the children. He knows I am a responsible mother and respect me. He is concerned about my health. He encourages me to take medication."*

P3 said: "*My husband and I separated, and we rarely talk, however he sends money to buy food, clothes and school fee for my children to my sister."*

The participants described the importance of cohesiveness in a family in support of their parenting roles, as exemplified by P5: "*My relatives take my children positively. My mother provides shelter, my brothers pays the NHIF card for me and my kids, my sister feeds them*

and take them to hospital when they are sick, my grandmother is very kind and supportive. My children… cannot suffer."

Another mother, P7 said: "*My relatives supports and helps my child to visits me when I am admitted; I am so… close with him… I don't miss any step in his growth and development."*

Some participants acknowledged the religious organizations for their support. P9 said: *"My religion gives me some casual works, helps me buy my medication, supports me with food to feed my children, and pay the school fee for them."*

4.5.2 Desire for Knowledge on Mental Health and Parenting

The participants expressed their desire for them and their families to acquire knowledge on mental health, how to recognize of mental illness, their treatments and prognosis. P1 enquired: "*I want to know what my illness is, one time I was told that I have schizophrenia, another time it was bipolar disorders. I want to know more about them."* Another mother, P11 asked: *"I want to know about my condition so that can tell my children and close relatives where I suffer from."*

Some of the mothers reported that their current medication makes them unable to perform their parenting roles. P9 inquired: *"I want understand why my medication was changed because the one I'm taking now makes me feel drowsy and fatigue…"* Another mother P6, wanted to know course of treatment of her condition: "*I want to know whether taking medicine is for life time or not. I have taken for 15 years now. My child keeps on asking."*

In further quest for knowledge, mothers preferred their family members to know about their mental health conditions. P12, said: *"The idea to talk to mothers and their children in hospital should be embraced; it should extend even during clinic days. Let our children know mental illness is not as bad as people think, it's a disease that can be controlled and cured."*

P4 emphasized: *"It is important to involve fathers or partners in health education on mental health problems, family relationships and parenting so that they can support mothers in taking medication and child-rearing."*

Some mothers wanted to know whether there are laws protecting and safeguarding the rights of persons with mental disorders. They also wanted to know the role of the governments in care of mothers and their children in the communities. P7 queried: *"what*

are rights of mothers living with mental illness… and what are the rights of their children…?

Some mothers wondered if the government could organize community based mental health programmes to sensitize people on mental health issues; aimed at improving parents' awareness of the effect of childcare on their mental health, and the effects of maternal mental disorders on children and the entire family. This would help the parents to develop help-seeking behavior, and child protection. P12 said: *"If people with mental health knowledge…can make a routine to have a mental health education programme in the communities … it can reduce stigma and myths about mental health and causes of mental illness…this can help the mothers and their children to seek help easily... I don't know how the government can do that…it can be a good thing."*

4.5.3 Improving Parenting Skills

All mothers testified that partner support played an important part in their ability to manage their daily lives and improving their parenting skills. P13 said: "*I really fear that my child will end up being a bad character in his life…I fear quarrelling or beating him. I beat him once…thoroughly… and the buttocks were very swollen… and my partner took him to hospital…he was admitted."*

Some mothers expressed their difficulties and worries in disciplining their children, suggesting that they required help. P5 explained: *"When the demand for children is too much, I feel as if I am denying them their rights. Denying him playing with items, he gets annoyed... Our parents used to cane us but they don't want see my child cry. I feel… I need to learn more on how to discipline a child if I have to bring up children as well as our parents did."*

Another mother P2, said: *"I tell my kids when they are doing wrong. But sometimes when I discipline them, the relatives think I'm becoming mentally sick. This brings a lot of differences and misunderstanding between me and my relatives. I feel I need…help."*

Some mothers expressed their difficulties in childrearing due many hospital admissions. P13 narrated: *"It is difficult to provide adequate care to the child because I'm in and out of the hospital. I don't have time to monitor my child…he does not listen to me…he has no respect for me… he is becoming spoilt, such that he can abuse you… I need a lot of help"*

4.5.4 Desire for Mother-Child Friendly Services when Hospitalized

When mothers are hospitalized, they usually express the desire for recognition and appreciated as mothers by health care providers. They articulated the need for emotional and childcare support, and mother-child friendly services when hospitalized.

To further establish the perceived and actual support systems that can facilitate in parenting roles, while the mothers are hospitalized, the following questions were asked:

What are your feelings about being hospitalized? What would your children say if they visit you in the hospital when you are admitted? What are your feelings about the care given to you and your children by the health care providers, when they visit you in the hospital? How would you like health care provider to treat you and your children?

P1 articulated her feelings: "*Health workers only give medicine. They do not talk about parenting with mental illness…when the relatives visit the patient in the ward, the children are left outside while the relatives enter. Mothers feels very sad, they miss to talk and touch their children."*

P11 commented: *"Health workers should allow us talk to our children …we are mothers. They should give us and our children…counselling about mental health. They should provide a safe environment where we can talk with all our family members freely."*

P2 expressed her concerns: *"My family usually visit me when I am hospitalized, they are … not informed about my progress… At times my 10 years old child is locked outside by health workers, while my husband and my 16 years old child enters the ward compound. My son feels anxious...other family members are dissatisfied for they are denied a chance to know my condition."*

Another mother P5 commented:
"If my child visits me in the hospital when I'm admitted, I think he will be very worried, he may think that I am in a prison because of the way they lock the doors and prevents children to see their mothers. I guess, he would ask the health workers to open the gate for me so that he can feel the warmth of the mother…and then ask them to explain my condition."

The participants expressed their concerns regarding the whereabout of their children during the periods they are admitted in the hospital. They expressed the necessity for a mother-child friendly arrangement to allow their children to visit them. P8 made the request:

"Those with young children, the health workers should ask the relatives to bring the them to the hospital so that mothers can see, talk and play with them. We want to bond… and breastfeed those who are still breastfeeding."

P15 suggested: *"We can move outside the ward in sheltered place* [pointing at the shade outside the ward] *... be given adequate time to be with our children ... this will make us be satisfied and recover faster… They* [health workers] *should teach the big children about our mental health conditions, so that they are able the help us… and meet the desire of knowing our conditions.*

Some mothers felt that hospitalization separated them from their children. P1 explained: *"When I am hospitalized, I wonder the whereabout my children.... who is cooking for them... I wished if the small one could be brought to stay with me in the hospital so that I can bath him."*

Another mother P13, said: *"My child has gone to children home thrice because there was nobody to stay with him when I was admitted in the hospital, I think it would be better if we can be allowed to stay with our children in the hospital until we are discharged."*

Some mothers testified that they have always desired to be released from the ward to go home and check on their children: This was exemplified in the following excerpts. P10 testified: *"When I am hospitalized… I kept on asking the nurses and doctors to parole me, to go and check on my children. I ask them to call… to know about their safety."*

CHAPTER FIVE: DISCUSSION, CONCLUSSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of this qualitative study was to explore the lived parenting experiences of mothers living with chronic mental disorders. This chapter discusses the key findings from the study based on the research questions which were to sought answers for; what were the lived parenting experiences, the challenges in parenting and perceived support systems that facilitates parenting for mothers with chronic mental disorders attending mental health clinics at Mathari hospital. The discussion is linked to the literature and entangled on participants' many responses which were summarized into three main themes; which includes lived parenting experiences of "being a trustworthy mother, challenges in parenting roles and perceived support systems." The chapter also includes conclusions and recommendation based on the research findings.

In this study chronic mental disorders include schizophrenia, bipolar disorders, and major depressive disorder. This aligns with the WHO (2020) facts that these disorders present with re-occurring and persistence of symptoms; with schizophrenia being characterized by distortions in thinking, perception, emotions, language, sense of self and behaviour. Bipolar disorders consist of both manic and depressive episodes separated by periods of normal mood. Manic episodes involve elevated or irritable mood, over-activity, rapid speech, inflated self-esteem and a decreased need for sleep. Major depressive disorder is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, tiredness, and poor concentration.

5.2 Discussion

5.2.1 Lived Parenting Experiences of "Being a Trustworthy Mother"

The participants had lived with mental disorders which include schizophrenia, bipolar disorders, and major depressive disorder for between 2-22 years, with an average two dependent children below 18 years. This concurs with WHO (2019) report that approximately 85% of persons living with mental disorders in third world nations are parents with one or more dependent children.

The participants in this study had wide range of experiences and knowledge on parenting with mental disorders. The study revealed that 14 out of 15 mothers were in close contact with their children and actively involved childcare. This was exemplified in the following excerpts, P6: *"Parenting is providing the basic needs to the children, feeding them, giving*

them warm clothes, ensure they sleeps well, giving age appropriate discipline, teaching good moral values, socialize them in the environment, teach the young ones how to talk, taking them to hospital when they are sick, taking them to school and assisting in school work."

This explanation corresponds with Connolly et al (2017) and Parenting for Brain (2020) who described parenting as the process of educating and bringing up children from infancy up to adulthood, aspiring to realize the child's developmental, psychological, physical, and emotional needs. The mothers were aware of the aims of parenting which includes; ensuring children's health and protection, preparing them for life as fruitful adults and transmitting cultural values (Tanaka et al, 2018).

The participants considered motherhood as very unique period in woman life time. They felt gratified, respected, and valued for being mothers. They were ambitious of bringing up health children with bright future. Similarly, Pamela et al (2019) stated that parenthood is a normative life encounter for the majority of people. It defines the meaning and roles of adulthood. When parents fail in their parenting roles, they face unending humiliation and shame (Foster et al, 2018). As most of the participants indicated, motherhood brings joy, honor and responsibility. They preferred the society to treat them as mothers responsible for their own life and those of their children. They argued that they have feelings like any other human being when they are out sickness, they are responsible just like any other woman in the society. In the same way, American Psychiatric Association, (2019) reported that motherhood is a normalizing life experience for women suffering from mental disorders, and prefer referring to themselves as parents than as patients. The majority described parenthood as promoting their confidence, growth and development. This corresponds with Tartakovsky (2018) finding that mothers suffering from mental disorders, indicated that their children gave them joy and motivated them to take their treatment, even though it is stressful.

Mothers in this study expressed their reliability and responsibility to their children just like any other trustworthy mother would do. This is analogous to CDC (2019) report that parents are vital assets for children in supervision and support of positive emotional health and well-being. People with mental disorders can be competent mothers, free of relapses if given proper combination of psychotherapy, pharmaco-therapy and family involvement. Increased awareness can lead to better information on mental illness, prevention of mental

disorders and promotion of psychosocial well-being of mothers and their children (Royal College of Psychiatrists, 2020).

Mothers expressed their confidence in parenting roles. They endeavor to be the best mother by treating their children, in the best way possible. They emphasized on maintaining the family cohesion, creating a safe and stable environment, prioritizing the routine activities, being available and creating a strong emotional connection with their children. Comparatively, Tanaka et al (2018) indicated that, good parenting is characterized by nurturance, responsiveness, consistency, autonomy, warmth, and appropriate developmental supervision at all stages of development.

Worldwide parents are the principal caregivers, preparing their children for a cheerful, satisfying and fruitful life (United Nations, 2019). They take part in a vital role in achieving sustainable, societal, financial and cultural growth (World Vision, 2020). Similarly, this research reveals that with some little support, mothers living with chronic mental disorders can develop adequate parenting skills and abilities to meet these vital functions and therefore cannot be exempted from parenting roles.

5.3 Challenges in Parenting Roles from Mothers' Perspectives

Mothers with chronic mental health problems encounter distinctive problems and challenges, attached to the needs of managing both mental health problems and parenting (Mental health foundation, 2020; Sonia et al, 2018). Equivalently, mothers in this research reported having difficulties in meeting their needs and those of their children such a controlling their emotions and responding to their children cues.

According to Hancock et al (2018) mentally ill mothers have high chances of being single, unemployed, divorced, and separated. They encounter high degrees of family victimization and strife. Women with chronic mental disorders are among the most unsupported and susceptible in societies (Husain et al, 2016). Equally, this research revealed that mothers with mental disorders often face challenging circumstances such as lack of social support, poverty, parenting inadequacy due to psychiatric symptoms, decreased parenting ability due to side effects of medication, fear and distress about separation from their children and stigmatization. Similarly, Murphy et al (2018) showed that mothers with mental disorders face discrimination, lack health and parenting information, prone to inadequate housing and trauma.

5.3.1 Inadequate financial resources

Mother with mental disorders usually have problems in functioning in the workplace. They reported experiencing trouble in concentrating, socializing; and therefore, job security was low. In accordance with Newman, (2020), due to episodic bouts of mental disturbances, absences from duty, mothers with mental disorders may not be able to keep a jobs hence poor income and financial instability. In addition, many women with a mental illness are likely to be single parents (Gao et al ,2020; Tartakovsky, 2018), therefore they lack support of a partner's income.

Maternal mental disorders threaten economic affluence and increases poverty (PPDKenya, 2018; Theodoritsi et al, 2018). This has harmful impacts on mothers and their children. Findings from this research, indicates that lack of income influenced mothers' ability to buy medication, access health services leading to frequent relapses and hospitalizations. Mothers reported to have challenges in buying basic needs for family such as food, clothing and paying children's hospital bills. This indicates that there is higher possibility of children not getting vaccinated or improper treatment for childhood diseases.

Although most people with a mental illness can be in employment, mothers living with mental disorders, are likely to become jobless, intensifying the chance that they will live in poverty (WHO, 2019). Nevertheless, the working environment can provide opportunities for promoting self-esteem, and wellbeing for mothers with mental disorders. Increasing mothers' ability to work, can promotes economic growth and development.

5.3.2 Parenting Inadequacy due to Psychiatric Symptoms

According to WHO (2019) depressed mothers may have reduced responses to the needs of a child, and may fail to care for themselves. Mothers with mental disorders might be emotionally unavailable, withdrawn, and apathetic to their kids. Comparatively, mothers in this research described how the psychiatric symptoms, particularly during acute episodes of mental illness, interrupted their parenting roles affecting the children's health. This includes maltreating and neglecting their children. Similarly, Kumantha (2019) reported that mothers with depression may have difficulties in recognizing the needs of the children, fail to seek healthcare, hence putting them in poor health conditions.

Tartakovsky (2018) indicated that parents suffering from mental disorder have increased problems of irritability, decreased energy, and sustaining attention, difficulty in concentrating, irregular sleep, moodiness and easily worried. This research revealed, that

other symptoms that significantly interfered with parenting roles includes: restlessness, feelings of hopelessness and worthlessness, inability to carry out daily duties, indecisiveness and loss of interest in activities previously enjoyed.

Some mothers reported leaving their children anywhere in the society, in a risky environment due to commanding auditory hallucinations. Correspondingly, Charlotte et al (2018) findings showed that women suffering from mental disorders may experience hallucinations associated with their kids, and have distorted views of their children. They may respond to the hallucinations, neglect or physically abuse the children.

5.3.3 Decreased Parenting Ability due to Side Effects of Medication

Mothers reported the side effects of psychotropics interfered with their way of talking, reduced their concentration and slowed them down in their daily activities affecting their childrearing abilities. The medication made them feel sleepy, dizziness and fatigue; and therefore, requiring some assistance on their parenting roles. This report corresponds with Seeman (2018) statements that, effects of psychotropics drug such as sedation, dizziness, clouded thinking, tardive dyskinesia, increased appetite, sleepwalking, client beliefs and attitudes toward their drugs, can affect their problem solving, decision-making, and behavior. Thus, playing a critical role in child custody determinations.

5.3.4 Lack of readily available childcare support.

Mothers recognizes the need for family and community support in child-rearing. However, the everyday encounter of not having suitable and willing available childcare support obstructed the mothers' capacity to attend the clinic appointments. This similar to Theodoritsi et al (2018) arguments that financial resources and lack of alternative childcare arrangements influences a mother's ability to access healthcare services. Some mothers were accompanied by their children the clinic, while others missed clinic appointments and failed to buy medication, increasing the chances of relapse, significantly interfering with parenting roles.

5.3.5 Fear and distress about separation

Mothers reported concerns that their mental disorders jeopardize the custody of their children. Stigma and fear of losing child custody resulted in delaying needed treatment so as to remain attached to their children. Similarly, according to 'Queensland Health' (2017) mothers suffering from mental disorders have low tendencies of raising childcare problems as they ascribe any problems to deficits associated with the illness. They are afraid of

negative perception, or loss of custody of their children. Equivalent to Silvia et al (2018) findings, these parents reported diminished confidence, low self-esteem, dampened nurturance, stigma and social isolation and feeling tremendous self-blame, pushing them to worry about their childcare capabilities, conceal their mental illness, and end up developing the feeling of being unfairly judged as ineffective parents.

5.3.6 Stigmatizations

The participants reported that the society holds perception that the mentally ill individuals are socially undesirable. Information gathered from the mothers indicated that the messages delivered by family, friends and the community made them feel labeled, judged, and rejected. Comparatively, Panthee and Maharjan (2019) reported that, stigmatized persons may internalize perceived prejudices and develop negative feelings about themselves and causing low self-esteem and decreased quality of life. In some instances, parents may encounter guilt and shame concerning their childcare problems and the effects of their sickness on kids (Laura et al, 2018; Tanaka et al, 2018).

Although it is expected that the society and families would support their sick members, some mothers claimed that they were cruelly treated by their close relatives and the community. Similarly, Nakku et al (2018) indicated that mother with mental disorders are negatively viewed in the society. This could be associated with the inherent stigma in the community. The community holds negative beliefs and attitudes that mentally-ill mothers are bewitched and have become useless, making them perceive themselves as less capable parents.

5.3.7 Children Emotional Wellbeing: Mothers' Concerns

Many mothers expressed their concerns about negative effects of mental illness on emotional wellbeing of their children. These concerns interrelate with Bell et al (2018) view that parenting difficulties can result in kids suffering from emotional neglect and abuse. Mothers reported that irritability, failure to respond to their children needs caused by mental disorders, may make them develop intense fear, and refuse to associate with them. Correspondingly, Diane et al (2019) reported that mothers may experience inappropriate intense anger around their kids, have tremendous mood swings that leave their children hyper-vigilant, frightened, and confused.

Some mothers were worried that their children performed parenting roles on their behalf at tender age. They blamed themselves for not being available for their children, especially

when they are hospitalized. In accordance with the Royal College of Psychiatrists (2020), children may assume the duties of caring for the parent or siblings as a response to the reduced ability of some parents. Such environmental may result in children developing emotional and behavioural disorders such as anxiety, withdrawal and find it tough to focus on their school work. Also, they can have physical health problems, and struggle with their education, especially when subjected to marital discord, housing instability, poverty, and unstable life (Pamela et al, 2019; Tchernegovski et al, 2018).

Some mothers reported not willing to disclose their mental health problems to their children due fear and stigma associated with mental disorders. This aligns with the Royal College of Psychiatrists (2020), that there is a perceived stigma and need to keep mental illness secrets. This makes it difficult for the children to control their feelings as they have the desire to know details of their parents' illness. Similarly, Jones et al (2016) reported that, children may find it difficult to talk about their parent's problems since they have no ideas; and this may hamper them from seeking help. They feel guilty about their parent's illness, and can be preoccupied with fears of becoming ill themselves (Diane et al, 2019).

5.3.8 Single motherhood

The reasons for single motherhood are diverse, including being divorced, widowed, separated or never married (Raising children network, 2020). Research shows that a stable and emotionally health two-parent family is ideal for a kids' well-being because it provides financial stability and emotional resources.

The participants in this study described financial instability, lack social support, stress in day today activities and disciplining their children as great hinderance in child rearing. Correspondingly, Malachi (2020) reported that single mothers living with mental disorders may find it hard to exercise their childcare role, which can give rise to behavioral problems in children. Similarly, Theodoritsi et al (2018) argue that single mothers experience high degrees of depression, stress, and anxiety, lacks social support, encounter socio-economic problems, leading to feelings of isolation and low self-esteem.

Additionally, raising children through the single-parent family may be accompanied by serious psychological health issues for the kids, including externalizing disorders, anxiety, and depression (Karibi and Karen, 2019). Contrary, some studies have identified the resiliency of single parenthood families if they have adequate resources and financial stability (Tartakovsky, 2018).

If the reason for single motherhood is divorce or separation, the children suffers from adjustment problems and feeling of being ashamed (Malachi,2020). Moreover, this research revealed that, if the partner stops offering support, the children may suffer resentments and hold painful memories of parents' divorce. Comparatively, if single parenthood is due spouse's death; whom she was financially or functionally dependent, it becomes harder for the mother to bear all responsibilities. This may set in a motion of cascading negative events that may deteriorate psychiatric symptoms and ultimately culminate in physical illness. Similarly, Tikotzky et al (2020) reports that, children undergoing grieving moments, their range of overwhelming emotions such as sadness, anger, confusion, anxiety may be worsened by the mothers' moods.

Guiding children through grief while the mother is also grieving can be very difficult. Particular attention should therefore be given to prevention, detection, and early intervention of mental disorders in single mothers.

5.3.9 Lack of health and parenting information

When mothers are hospitalized, they usually express the desire for recognition and support by health care providers about their parenting concerns. However, they portray uncertainties whether health professionals would be willing to provide such supports. Matching with Nilsson et al (2015) findings, there is inadequate primary health care services to support the desires of the mentally ill mothers and their children.

The participants recalled that health workers never asked them about their children's welfare despite always expressing the desires to see or talk to them. Correspondingly, Silvia et al (2018) reported that mental health professionals view the "health talks" with patients concerning childcare as less significant; and the needs for children are regarded as not important. Similarly, this research revealed mental health workers do not offer childcare support and mother-child friendly services when the mother is hospitalized. Probably, according to Reupert et al (2015) this could be due to the clinicians believe that they have deficient of knowledge and skills and may develop anxiety when caring for the mother and their children. Similarly, Bondarenko et al (2017) reported that clinicians may act caringly in support of a person's mental health, though they are experiencing frustration or viewing the person negatively. Equally, Nakku et al (2018) found that there are negative views towards mothers suffering from mental disorders, even among health care workers. Discriminating attitudes towards affected mothers and their children, and inadequately

trained health workers are some of the factors thought to hinder access to mental care for mothers.

The finding of this research corresponds with Mulligan et al (2019) arguments, that the mothers' needs and that of their children are always contradicting, making it hard for clinicians to harmonize both aspects, particularly in an institution that prioritizes the mental health of parents. Nonetheless, Murphy et al (2018) indicated that parenting anxiety is common to all mothers, and health care workers have a duty of aiding families to mitigate parenting anxiety and build resilience.

5.4 Perceived Support Systems for Mothers and their Children.

The participants fondly, appreciated the support they received from the family and the community in their childrearing activities. This brings into line Beard et al (2019) report that, family support has constantly assisted mothers living with mental illness to manage their challenges and promote parenting roles. Similarly, Charlotte et al (2019) indicated that offspring of mothers with mental illness tend to be looked after by foster parents i.e. grandparents, aunties, step-parents and other family members.

This research revealed that mothers with mental disorders required health education on effective childrearing practices, understanding the management of their problems and the children to know mental health conditions of their parents. Similar finding by Royal College of Psychiatrists (2019) indicated that if mothers with mental disorders, are given appropriate support, treatment, education and training can become competent parents. Wade et al (2019) suggested that some parents may require guidance to develop the confidence to safely communicate with their kids about their conditions. Some mothers indicated that they required practical help and emotional support in child caring. Correspondingly, McFarland and Fenton (2018) highlights that some parents needed role modeling in their parenting activities.

The participants expressed the need to improve their parenting skills and mother-child friendly environment when they are hospitalized. Some mothers reported that health workers deny them access to their children. The children are kept out of the ward as the relatives enters. This, opposes Queensland Health (2017), protocol this is the time when the health care professionals should take a chance to directly observe the parent-child relationship and offer support.

The participants reported feeling sad, irritable, anxious, confused and dissatisfied when they are denied contact to their children. The health care providers may perceive this as psychotic symptoms and impulsively administer tranquilizers to calm down them and at times keep them in seclusion room. This contradicts the Queensland Health (2017) protocols that clinicians must be able to recognize the strengths of the family, safety, and well-being of the mother and her children; and the dangers that can be alleviated through necessary support. Similarly, PPDKenya (2018) reported that, if a mother has acute mental disorders and requires hospitalization, she must access her baby. Comparatively, the results of this research support Royal College of Psychiatrists (2019) view that if a mother is deprived access and care; and isolated from her baby, it may traumatize her and hinders vital early bonding.

The participants suggested that organizing family support groups can be beneficial to family members by meeting and sharing their experiences. Equivalently, the research by McFarland and Fenton, (2018) which revealed that parents treasure the opportunity to come together with other mentally ill parents. According to Laura et al (2018), multi-family interventions prevent relapses, reduce feelings of isolation and stigma, and improve family cohesion.

Partner support can be explicitly important. The support they provide is described by mothers as critical to their well-being and ability to cope with difficult situations. Similarly, articulated Beard et al (2020) reported that women who have a supportive partner are more likely to avoid symptoms of depression and anxiety after childbirth and have less parenting stress during the early years' child life. Consistently, Petrowski and Stein (2016) suggested that health care providers should involve and support fathers to give emotional and practical aid to their partner.

Mothers expressed the need to educate the society on how to effectively manage stress, prevention of mental illness which is a widespread problem in the country. This research revealed stigma and discrimination is prevalent in the society. Similarly, Mutiso et al (2018) indicated that low awareness and negative societal attitude toward mental disorders may hinder accessibility to mental health services. To address this, PPDKenya, (2018), creates awareness, building resilient and wealth communities and counsel families on maternal mental health. The project provides mothers with livelihood support, social therapy, economic empowerment and facilitate them to seek mental health treatment.

Similarly, the World Vision Kenya in partnership with Ministry of Health, has been training community health volunteers to address common mental health problems in the communities (World Vision Kenya,2018). Comparatively, some of participants in this research reported having learned stress management tactics to handle mental problems arising from life challenges such as conflicts, unemployment, violence and relationship issues from the religious their leaders. This has helped them to build a social support network, improve the wellbeing of their families and children.

5.5 Strengths and Limitations

Strengths:

The research rendered rich information on the parenting experiences of mothers living with chronic mental disorders.

1. The interviews were conducted until the saturation was reached at 15 participants. They provided qualitative data which contained rich descriptions relating to parenting experiences of mothers living with mental disorders. Mothers described all relevant experiences and therefore the data represented world view of each participant.
2. The study involved a sample of mothers from Nairobi metropolitan and its environs, Kiambu and its surroundings, Thika and Kenol-Murang'a; who had attended mental health clinics in the hospital. Therefore, the applicability of results to all mothers living with mental disorders is considered to be appropriate; since their experiences were unique to individual experiences, based on their unique parenting experiences, from different cultural and social backgrounds.
3. The age range of participants was broad. They had dependent children of diverse ages and had wide experiences of parenting with mental disorders. Mothers narrated their experiences from first episode of mental illness to the up-to-date. This implies that the analysis was based on an extensiveness of recollected experiences explicit to mothers living with mental disorders.

Limitations:

1. The study concentrated on the parenting experiences of mothers only and did not consider the views of the entire family system.
2. Although partners were not on the attention of this study, their support is perhaps critical in the lives of mothers living with mental disorders and could have briefly presented.

5.6 Conclusions

The perceptions and experiences of mothers living with chronic mental disorders validated and significantly extended the knowledge of existence of parenting with mental disorders. Their views expounded several factors contributing to how mothers make essence of motherhood and child-rearing.

Based on the findings of this study, the researcher draws the following conclusions:

1. Motherhood is an importance stage in life for all mothers living with chronic mental disorders. It brings gratification, joy, honor, respect, confidence and responsibility.
2. Mothers living with chronic mental disorders are in close contact with their children and actively involved childcare.
3. Mothers living with chronic mental disorders experiences and challenges, attached to the needs of managing both mental health problems and parenting.
4. Mothers living with chronic mental disorders face challenges which includes:
    - Inadequate financial resources, unemployment, poverty
    - Parenting inadequacy due to psychiatric symptoms
    - Decreased parenting ability due to side effects of medication
    - Lack of social support
    - Fear and distress about separation from her children
    - Stigmatizations, discrimination, family victimization, strife,
    - Single motherhood: never married, divorced or separated
    - Lack of health and parenting information
    - Inadequate housing and trauma
5. Mother living chronic with mental disorders can be competent mothers, free of relapses if given proper combination of psychotherapy, pharmaco-therapy and family involvement.
6. Mothers living with chronic mental disorders, if offered support can develop adequate parenting skills and abilities to meet vital life functions and therefore cannot be exempted from parenting roles
7. Spouses or partners are essential part of a mother's world. They need to be supported to increase their capability of supporting mothers in child-care and reduce parenting stress.

8. Increased awareness can lead to better information on mental illness, prevention of mental disorders and promotion of psychosocial well-being of mothers and their children.

5.7 Recommendations

The finding from the study provided some insight which needs further exploration and action in order to provide adequate parenting support for mothers living with chronic mental disorders, help the health care providers to improve their knowledge on parenting with mental illness and create public awareness on mental health and support for mother and their children.

Based on the findings of this study, the researcher recommends the following:

Recommendations for mental healthcare institutions and policy makers

1. Mental health institutions need to provide procedure and guidelines on risk assessments for mothers and their children while the patient is hospitalized and during the clinic follow up and offer family-centered psycho-education.
2. Mental health institutions should put into place policies that enable mothers admitted in the hospital to have access to their children. The contacts should occur in consideration for the child emotional support and therapeutic benefit of the mother. This should take place in an appropriate and safe environment.
3. Mental health institutions should organize continuous education programs emphasizing on a holistic approach to the care of mothers with mental disorders. Their training should include learning how to support mothers' parenting roles, how to protect children who are at risk for harm, patient referral systems and ethical issues.
4. Mental health institutions should organize family support programmes for mothers with chronic mental disorders within the institution and extended to the communities. Organizing family support groups can be beneficial to family members by meeting and sharing their experiences. Multi-family interventions prevent relapses, reduce feelings of isolation and stigma, and improve family cohesion.
5. The ministry of health should initiate mental health education programme in the communities; to be delivered by community health workers under the supervision of national and county health teams. This will help to create awareness on mental

health, curb down the stigma and discrimination, build resilience in the societies and encourage parents to develop help-seeking behaviour and child protection.

Recommendation for future research

1. A further research to explore the understandings of the families of mothers living chronic mental disorders is desirable.
2. A study is necessary to provide a detailed understanding of the roles of partners in the lives of mothers living with chronic mental disorders.
3. A research to explore the experiences of fathers living with chronic mental disorders in regard to parenting is also important.

- This would lead to a better understanding of the experiences of families of a member living with chronic mental disorders; and identification family support needs.

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APPENDICES

APPENDIX 1: CONSENT FORM- ENGLISH VERSION

Study title:

Parenting experiences of mothers living with chronic mental disorders at Mathari hospital.

Investigator:

Francis Njagi Kabugua

Part I: Information sheet.

I'm a post-graduate student at the University of Nairobi seeking to attain a Masters of Science degree in Nursing (Mental Health and Psychiatric Nursing). One of the necessities of this programme is to do a survey of the student's preference.

Purpose of the study:

There is an increasingly support for mental health services to take part in family-oriented mental health exercises, for prevention of mental disorders and advancement of psychosocial prosperity of mothers and their children.

This research will generate evidence-based data to inform the hospital management board concerning the value of organizing services to fulfill the desires of the mothers and their children when mothers are hospitalized during acute periods of illness, convalescent period, during mental health clinics follow up in the hospital and in the community. The community will benefit from psycho-education, parenting skills, social support in mitigation of the stigma,

The aim of this study is to discover and specify the parenting experiences of mothers with chronic mental disorders visiting Mathari hospital for follow up. This will help to gather information that might have positive impact on parenting, the outcomes and experiences of children, and enlighten the institution how to develop family support plan.

You have been chosen to be involved in the study since you are a mother of children below 18 years, attending the mental health clinic and you have lived with the disease for some time.

Voluntary participation:

Involvement in the study is non-compulsory and you can decide to discontinue your participation at any time during the interview without any victimization, should you choose to.

What the study involves:

In order to collect the information, I have developed an interview schedule. You are one of the clients being asked to participate in the study by engaging in an in-depth interview; this will take about 45-60 minutes.

Risks and how they will be mitigated:

There are no foreseeable social, physical or psychological risks in taking part in the study.

Benefits:

No individual benefits. However, the participants who will opt to come to the hospital for the interview a day that is not the clinic day, their fare will be reimbursed. The hospital management will use the results of this inquiry to come up with strategies that provide effective, individualized family-focused mental health services, formulate programmes to reorient services to meet the desires of mothers in child rearing, increase levels sense of worth and readiness to seek assistance when necessary. This in return will improve the relationships between family members and bring up health children.

Protection of information and maintenance of confidentiality:

Your identification is not required during the interview. The details you provide are for the purpose of study. Anonymity and confidentiality will be guaranteed. No direct reference will be made to you during presentation and in publications. The information you provide cannot be traced back to you.

Communication of the results:

Copies of this research finding will be submitted to the Ethics and research unit, Mathari hospital and the UoN-School of Nursing Sciences, which will be later made available to the University library. The results will also be presented in appropriate academic and scientific conferences, and also published in mental health journals.

Study authorization:

The study has been authorized by the school of nursing sciences.

Contacts:

If you have any question, you are at liberty to get in touch with the investigator and supervisors at any time on the contacts given below:

Investigator:

Name : Francis Njagi Kabugua

Phone No. : 0721835856

Email : fnkabugua@yahoo.com

Supervisor 1:

Name : Dr. Miriam Wagoro,

Phone No. : 0722 737 356

Email : carole@uonbi.ac.ke

Supervisor 2:

Name : Dr. Irene Mageto,

Phone No : 0724205419

Email : imageto@gmail.com

Part 2: Informed consent- for Participant:

I being a mother of children below 18 years of age and attending the mental health clinics at Mathari hospital, and having been explained the purpose this study, I understand and willingly agree to participate. I accept that I shall not be compensated for involvement in the study, that participation is non-compulsory and that I can decide to discontinue the participation at any time without reprimand. I have been given the opportunity to talk about all my concerns with the investigator and I am contented.

I hereby give informed consent to take part in the study titled, "Parenting experiences of mothers living with chronic mental disorders at Mathari hospital".

Participant: Signature …….Date……

Investigator: Signature……..Date…….

Part 3: Informed consent- for Guardian (Witness):

I am the guardian of the client attending the mental health clinics at Mathari hospital. My client is willing to be accompanied during the interview. I have been explained the interview procedures and the purpose the study by the researcher. I understand and willingly agree to witness the interview processes and assist in the interview where need be.

I accept that she will not be compensated for involvement in the study, that participation is non-compulsory and that she can decide to discontinue the participation at any time without reprimand. I have been given the opportunity to share all my feeling with the investigator and I am contented.

I hereby give informed consent to witness the interview processes for my client in the study titled, "Parenting experiences of mothers living with chronic mental disorders at Mathari hospital".

Guardian: Signature …….Date……

Participant: Signature …….Date……

Investigator: Signature……..Date…….

NYONGEZA

NYONGEZA YA 1: FOMU YA KIBALI –TOLEO LA KISWAHILI

Mada ya masomo:

“Ujuzi wa ulezi wa akina mama walio na ugonjwa wa kiakili katika hospitali ya Mathari.”

Mchunguzi wa habari:

Francis Njagi Kabugua

Sehemu ya 1: Karatasi ya habari

Mimi ni mwafunzi katika chuo kikuu cha Nairobi. Nimehitimu nikapata shahada ya kwanzwa kazi ya uuguzi. Ningali naendelea na masomo ili kupata shahada ya pili ya uuguzi wa afya ya kiakili.Katika utaratibu wa masomo hii inahitajika mwafunnzi kufanya utafiti anayopendelea.

Lengo la utafiti wangu:

Kuna ongezeko kuu la kushikilia afya bora ya akili katika familia ili kuzuia shida za ugonjwa wa kiakili, kujikimu kimaisha na kuboresha hasa afya ya akina mama na watoto wao.

Utafiti huu utasaidia kupeana miundo misingi katika hospitali inayohusu dhamana za kupanga jinsi wanavyopeana huduma ili kuhakikisha mahitaji ya akina mama na watoto wao, hasa wakati akina mama wanapolazwa hospitalini wakiwa wagonjwa mahututi, wakati wanapoendelea kupona, na wakati wa kutembelea kliniki ya aya ya kiakili kutazamwa jinsi wanavyoendelea kupona. Jamii itafaidika na masomo ya afya ya kiakili,ulezi mbalimbali,na makazi ili kuzuia unyanyapaa wa kijamii.

Lengo la utafiti huu ni kuvumbua na kubainisha ujuzi kamili wa malezi wanayopata wazazi walio na ugonjwa wa kiakili kwa muda mrefu wanapoendelea na kuzingatia matibabu katika hospitali ya Mathari. Hii itasaidia kupata habari inayofaa ya ulezi ,matokeo na uzoefu wa watoto na kuwezesha kituo hiki kuendeleza na kushikilia afya kwa jamii.

Umechaguliwa ili kusaidia utafiti kwani wewe ni mama mlezi wa watoto walio chini ya miaka 18, anayetembelea hospitali hii ya wagonjwa wa kiakili na umeishi na huu uwele kwa muda mrefu.

Kujitolea kwa hiari:

Kuhusika kwa huu utafiti sio lazima na unaweza kutoendelelea wakati wowote, wakati tunapoendelea na hakuna atakayekuuliza.

Kinachohusika kwenye utafiti huu:

Ili kupata habari ya utafiti huu nimeamua kutumia mbinu ya Mwongozo wa Maswali ya Mahojiano.Wewe ni mmoja wa wale wataulizwa kuhusika katika utafiti kwa mahojiano ya kina. Mahojiano yatachukua muda wa dakika 45-60.

Tahathari na jinsi ya kuzizuia.

Hakuna njia zozote zinazoonekana au zinazofikiriwa kama tahadhari katika utafiti huu.

Manufaa.

Hakuna manufaa hata moja ya kibinafsi.Hata hivyo wahusika watakaojitolea kuja hospitalini ili kujibu maswali siku ambayo sio ya kliniki, watarejeshewa nauli yao. Kamati husika hospitalini itatumia matokeo haya ili kutafuta njia mwafaka za kuweza kupeana matibabu bora ya jamii kwa wagonjwa waliolemewa kiakili ,kutafuta mipangilio ili kuwawezesha kupata matarajio yao ya malezi na kujiinua kama wazazi ili wapate kutafuta usaidizi wanaohitaji, na wakati unaofaa. Basi hii itasaidia uhusiano kati ya familia na ulezi bora wa watoto.

Kukingwa na kuhifadhi siri ya habari hii:

Kujitambulisha kwako hakuhitajiki wakati wa mahojiano.Kujitambulisha kwako si muhimu katika mahojiano haya.Yale utakayopeana ni ya kutumika tu kusaidia utafiti wetu.Kutoa habari ya uliyoyasema na kuhifadhi siri ni hoja ambalo ni lazima lihifadhiwe. Hakuna wakati wowote utatanjwa. Kwa mfano, wakati wa kuripoti utafiti na kuuandika.

Mawasiliano ya matokeo ya utafiti:

Nakala za utafiti zitawasilishwa kwa kitengo cha maadili ya utafiti, hospitali ya Mathari na chuo kikuu cha Nairobi-shule ya uuguzi na kisayansi ambayo itarudi kuwa tayari kwa maabara ya chuo kikuu cha Nairobi. Mtokeo vilevile yatawasilishwa kwa mikutano ya kiasomo ya kisayansi na kuchapishwa kwa jarida za afya ya kiakili.

Idhini ya utafiti:

Kusoma huku kumeruhusiwa na chuo kikuu cha Nairobi -shule ya uuguzi na sayansi.

Waasiliani:

Ikiwa una swali unaweza kuwasiliana na wahusika waliopeanwa hapo chini:

Mtafiti:

Jina : Francis Njagi Kabugua

Nambari ya simu: 0721835856

Barua pepe : fnkabugua@yahoo.com

Msimamizi wa 1:

Jina : Dr. Miriam Wagoro,

Nambari ya simu: 0722 737 356

Barua pepe : carole@uonbi.ac.ke

Msimamizi wa 2:

Jina : Dr. Irene Mageto,

Nambari ya simu: 0724205419

Barua pepe : imageto@gmail.com

Sehemu ya 2: Kibali cha mhusika:

Mimi nikiwa mama wa watoto walio na umri chini ya miaka kumi na minane na huwa natembelea kliniki ya wagonjwa wa kiakili katika hospitali ya Mathari, nimeelezewa kuhusu utafiti na nia yake. Naelewa na nimejitolea kushughulishwa katika utafiti huu.Nimekubali sitafidiwa kwa kuhusishwa katika utafiti huu ,tena sio lazima nijihusishe katika utafiti na ninaweza kuchagua kutoendelea kuhushika bila kulazimishwa au kuulizwa na yeyote. Nimepewa nafasi kuongea na mtafiti kuhusu hisia zangu na nimeridhika.

Kwa hivyo napeana kibali cha kuendelea na utafiti huu kwa mada, "Ujuzi wa ulezi wa akina mama walio na ugonjwa wa kiakili katika hospitali ya Mathari."

Mhusika: Sahihi ……..Tarehe……..…

Mtafiti : Sahihi……...Tarehe…….

Sehemu ya 3: Kibali cha shahidi -Mlezi:

Mimi ndiye mlezi wa mgonjwa wa kiakili anayetembelea kliniki ya hospitali ya Mathari. Mhusika wangu amejitolea niandamane naye wakati wa mahojiano.Nimeelezewa kuhusu mpangilio wa mahojiano haya na sababu za kuufanya utafiti huu.Naelewa na nitajitolea kuwa shahidi wakati wa mahojiano haya niko tayari kujitolea wakati usaidizi wangu utahitajika.

Nakubali ya kwamba hatafidiwa kwa kuhusika katika utafiti huu, na kukubali kuhusika sio lazima, na anaweza kuchagua kutoendelea wakati wowote bila kuulizwa.Nimepewa nafasi kuzungumza hisia zangu na mtafiti na nimeridhika.

Mimi hapa napeana kibali kama shahidi wa mahojiano haya kati ya mhusika wangu na mtafiti katika utafiti kwa mada, "Ujuzi wa ulezi wa akina mama walio na ugonjwa wa kiakili katika hospitali ya Mathari."

Mlezi : Sahihi … ……..Tarehe……..…

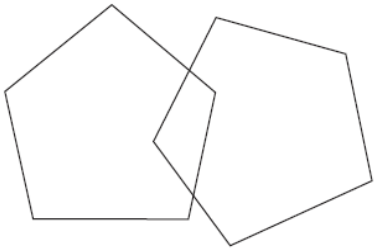
Mhusika: Sahihi … …….Tarehe……..…

Mtafiti : Sahihi … ……..Tarehe…….……

APPENDIX II: STANDARDIZED MINI-MENTAL STATUS EXAMINATION (SMMSE)

		EXAMINATION	TIME FRAME	POINTS
1. ORIENTATION				
I Temporal Orientation	a	***What year is this?***	10 sec	1
	b	***Which season is this?*** or ***What is the approximate time?***	10 sec	1
	c	***What month is this?***	10 sec	1
	d	***What is today's date?***	10 sec	1
	e	***What day of the week is this?***	10 sec	1
II Spatial Orientation	a	***What country are we in?***	10 sec	1
	b	***What province or county are we in?***	10 sec	1
	c	***What city/town are we in?***	10 sec	1
	d	***IN HOME – What is the street Address of this house?*** ***IN FACILITY – What is the name of this building or ward?*** ***IN GENERAL- What is this place?***	10 sec	1
	e	***IN HOME – What room are we in?*** ***IN FACILITY – What floor are we on?*** ***IN GENERAL- Where are we now?***	10 sec	1
2. REGISTRATION		**SAY:** ***I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.*** Say the following words slowly at 1-second intervals **- BALL/ CAR/ MAN**	20 sec	3

3. ATTENTION AND CALCULATION		***Spell the word WORLD. Now spell it backwards.*** OR***Subtraction***: 100-7=93-7=86-7=79-7=72-7=65.	30 sec	5
4. RECALL -Short Memory		***Now what were the three objects I asked you to remember?***	10 sec	3
5. LANGUAGE AND PRAXIS (9 POINTS)				
I. Naming of Objects	A	**SHOW** wrist-watch. **ASK:** ***What is this called?***	10 sec	1
	B	**SHOW** pencil. **ASK**: ***What is this called?***	10 sec	1
II. Repeat		**SAY:** ***I would like you to repeat this phrase after me:*** "NO IFS, ANDS OR BUTS"**.**	10 sec	1
III. Reading and obey		**SAY:** ***Read the words on the page and then do what it says.*** Then hand the person the sheet with CLOSE YOUR EYES on it. If the subject reads and does not close their eyes, repeat up to three times. Score only if subject closes eyes	10 sec	1
IV. Writing a complete Sentence.		**HAND** the person a pencil and paper. **SAY:** ***Write any complete sentence on that piece of paper.*** (Note: The sentence must make sense. Ignore spelling errors)	30 sec	1
V. Three(3) Stage Command		**ASK** the person if he is right or left- handed. Take a piece of paper and hold it up in front of the person. **SAY**: ***Take this paper in your right/left hand*** (whichever is non-dominant), ***fold the paper in half once with both hands and put the paper down on the floor*** . Score 1 point for each instruction executed correctly. Takes paper correctly in hand Folds it in half	30 sec	 1 1 1

	Puts it on the floor		
VI. Copy the diagram (***Figure 3: Two pentagons with an intersection***)	**PLACE** design, eraser and pencil in front of the person. **SAY**: ***Copy this design please.***  Allow multiple tries. Wait until person is finished and hands it back. Score only for correctly copied diagram with a 4- sided figure between two 5- sided figures.	1 min	1
	TOTAL POINTS		**30**

Interpretation of the MMSE		
Severeness	24 to 30 18 to 23 0 to 17	No cognitive deterioration Mild cognitive deterioration Severe cognitive deterioration

Note: This tool is given for use in British Columbia with authorization by Dr. William Molloy 2008. Cognitive deterioration -Recognition, Diagnosis and Management in Primary Care: Standardized Mini-Mental State Examination (2014)

APPENDIX III: INTERVIEW GUIDE - ENGLISH VERSION

	QUESTIONS	PROMPTS
1.	Introduction I would wish to begin by knowing a little about you. Could you tell me a little about yourself?	**A) Social demographic characteristics** 1. Tell me your age 2. Tell me your level of education 3. What is work do you do? 4. Tell me your religion 5. Where do you stay? -Who do you stay with? -Own or rented house?
2.	Let me know a little bit more about your family.	**B) Family characteristics** 1. What is your marital status? 2. Tell me about your children. How many are they? 3. Tel me their ages. 4. Tell me where they live. 5. Do they go to school? 6. Who provides care to them? 7. How often are you in contact with your children? 8. How is the relationship between you, your children and your partner?
3.	Let me know about your mental health problems. What is your diagnosis?	**C) Some clinical and ill-related characteristics** 1. When did you first notice these problems? 2. What did you do then? 3. What do you think has caused these problems? 4. First episode of illness-Did you have children? -How old were the children? 5. When was your last admission in the hospital? 6. Approximately how many times were you admitted within the last one year? 7. Who attends to your kids while you are admitted in the hospital?

4.	What are your feelings about managing your illness, children and your partner? What are your feelings about being hospitalized?	**D) Hospitalizations** 1. Do you share with your children about your mental health problems? 2. What would your children say if they visit you in the hospital when you are admitted? 3. What would you say are the concerns of your children regarding your mental health? 4. What are your feelings about the care given to you and your children by the health care providers, when they visit you in the hospital? 5. How would you like health care provider to treat you and your children?
5.(a)	- Let me know regarding your encounters of being a mother. - What are your Parenting experiences in trying to be the best parent possible?	**E) Parenting with mental illness.** 1. What do you understand "by taking care of children?" 2. How does your mental ill-health interfere your parenting roles? 3. What are your concerns regarding emotional wellbeing of your children? 4. What are your feelings about meeting the needs of your Children? 5. What are the challenges that are of concern to you as a mother? 6. What support would you require to enable you manage your illness and care for your children?
	Are there instances you have self-doubt and questioning your parenting roles?	7. What are your feelings of being with your children? 8. Do you feel that you always provide adequate care to your children? 9. What mistakes do you fears making when caring for your children? 10. What assistance do you feel is necessary to support you in your parenting role?
6.	What are your experiences of being a mother regarding the relationships with the relatives, friends and	**F) Experiences of relationships in the family and the community.** 1. Have mental health problems changed relationships between you and others? 2. What has changed? 3. Would you prefer some people not to know?

	other members of the society?	- Who should not know? - Why? 4. How do family members, relatives, friends and other members of the society treat you and your children? 5. How do you feel about it? 6. How would you like them treat you?
7.	What activities did you gave up regarding childcare due to mental health problems?	**G) Participation in Activities** 1. Have others discouraged or stopped you from doing something because of the mental health problems? - Could you give me examples? - How do you feel about it? 2. Have others encouraged or persuade you to do something because of the mental health problems? - Can you give me examples? - How do you feel about it? 3. Have you ever hesitated or gave up doing something because of the mental problems? - Can you give me examples? - How do you feel about it?
8.	Closing Remarks We have come to the end of the discussion. Thank you so much for taking the time to speak with me today.	**H) Closing questions** 1. Is there anything more you would like to tell me that we have not discussed? 2. Do you have any questions about all what we discussed?

NYONGEZA YA 3: MWONGOZO WA MASWALI YA MAHOJIANO - TOLEO LA KISWAHILI

	MASWALI	**M ASWALI YA KUKUMBUSHA**
1.	Utangulizi Ningeomba kwanza nijue machache kukuhusu wewe. Unaweza kuniambia machache kukuhusu wewe?	**A) Tabia za Kijamii** 1. Una miaka mingapi? 2. Niambie kiwango chako cha elimu 3. Huwa unafanya kazi gani? 4. Dini yako ni gani? 5. Unaishi wapi? –Mnaishi na nani? -Nyumba yenu au ya kupanga?
2.	Naomba nijue mambo machache kuhusu familia yako	**B) Kuhusu jamii** 1. Hali yako ya ndoa? 2. Niambie kuhusu watoto wako.Ni wangapi? 3. Wana umri gani? 4. Wanaishi wapi?. 5. Wanaenda shule? 6. Nani huwapa mahitaji yao? 7. Mara ngapi huwa na hao watoto wako? 8. Je,uhusiano wako na watoto, na mpenzi wako huwa namna gani?
3.	Ningetaka kujua hali yako ya afya kiakili iko namna gani? Je, unajua ugonjwa wako?	**C) Mambo yanayohusu ugonjwa wa kiakili** 1. Mara ya kwanza kujua shida hizi ilikuwa lini? 2. Ulifanya nini wakati huo? 3. Unadhani hizi shida zimesababishwa na nini? 4. Mara ya kwanzwa kuwa na hizi shida -Ulikuwa na watoto? -Walikuwa na umri gani? 5. Ulilazwa hospitali lini mwisho? 6. Kwa kimo umelazwa mara ngapi kwa muda wa mwaka mmoja hivi ? 7.Ni nani huwa anawashughulikia wanao wakati umelazwa hospitalini?

4.	Je hisia zako na vile unavyojipanga na ugonjwa ,wanao na mpenzio ni zipi? Unahisi vipi wakati umelazwa hospitalini?	**D) Kuwa Hospitalini** 1. Huwa unazungumza na wanao kuhusu ugonjwa wako wa kiakili? 2. Wanao husema nini wanapokutembelea hospitalini ukiwa umelazwa? 3. Unaweza kusema nini kuhusu wanavyochukulia wanao juu ya hali yako ya kiakili? 4. Unahisi vipi jinsi unavyoshulikiwa na wahudumu wa afya na vile wanavyoshughulikia wanao wanapokutembelea hospitalini? 5. Je matarajio yako kwa wahudumu wa afya jinsi wanavyokushughulikia na kushughulikia wanao ni yapi?
5.(a)	- Naomba nijue hali yako ya ulezi wa wanao kama mzazi. - Huwa unajihisi namna gani katika juhudi zako kuwa mlezi mwema?	**E)Ulezi na ugonjwa wa kiakili** 1. Waelewa vipi "kuchunga watoto?" 2. Ni vipi shida ya akili huadhiri hali ya ulezi kama mzazi? 3. Wafikiria vipi kuhusu hisia za watoto wako? 4. Huwa wahisi nini kuhusu jinsi ya kukidhi mahitaji ya watoto wako? 5. Ni changamoto zipi zinazokukumba kama mama? 6. Ungependa usaidizi upi ili kuweza kujipanga na ugonjwa na vilevile kuchunga watoto wako?
b)	Kuna yale yanayukufanya kutojiamini na kujiuliza maswali kuhusu ulezi wako kama mzazi?	7. Hisia zako za kuwa pamoja na wanao ni zipi? 8.Unaona kama unapeana mahitaji yanayotosheleza watoto wako? 9.Ni makosa yapi huwa unaogopa kuyafanya unaposhughulikia wanao? 10. Ni usaidizi gani ungependekeza kupewa ili kukusaidia katika ulezi wako?
6.	Je, uzoefu wako kama mama kuhusu jamii yako, marafiki na jamii yote kwa jumla uko namna gani?	**F) Maisha na uhusiano wa familia na jumuia.** 1. Je shida zako za akili zimebadili uhusiano wako na wengine? 2. Ni nini kimebadilika? 3. kuna watu ungependa wasijue shida yako? - Ni akina nani ungetaka wasijue? - Kwa nini? 4. Je, watu wa familia, marafiki na watu wa jamii yote kwa kijumla wanakuchukuliaje pamoja na watoto wako? 5. Huwa unahisi vipi kuhusu hayo?

		6. Ungependa wakushughulikie vipi?
7.	Ni kazi zipi ulijiuzulu za ulezi kwa ajiri ya ugonjwa wa akili?	**G) Ushiliki katika shughuli za kazi** 1. Watu wengine wamewahi kukusimamisha au kukuonyesha ya kwamba ni vigumu kuendelea na shughuli fulani kwa ajili ya ugonjwa wa akili? - Unaweza kupeana mfano? - Unahisi vipi kuhusu hayo? 2. Je wengine wamewahi kukusihi ufanye jambo fulani kwa sababu ya shida ya akili? - Unweza kupeana mfano ? - Unahisi vipi kuhusu hayo? 3. Umewahi kukosa au kuchelea kufanya jambo kwa sababu ya ugonjwa wa akili? - Unaweza kupeana mfano? - Unahisi vipi kuhusu hayo?
8.	Maoni ya mwisho. Tumefika mwisho wa majadiliano . Asante sana kwa kutumia muda wako kuongea nami.	**H) Maswali ya kufunga** 1. Kuna jambo lingine lolotete ungependa kuongeza ambalo hatukujadili? 2. Unaweza kuwa na swali kuhusu yale tumezungumzia?

APPENDIX IV: APPROVAL FROM KNH-UoN ERC TO CONDUCT THE RESEARCH

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/248

6th August 2020

APPROVED
06 AUG 2020
KNH/UoN-ERC

Francis Njagi Kabugua
Reg. No. H56/11194/2018
School of Nursing Sciences
College of Health Sciences
University of Nairobi

Dear Francis

RESEARCH PROPOSAL – PARENTING EXPERIENCES OF MOTHERS LIVING WITH CHRONIC MENTAL DISORDERS ATTENDING MENTAL HEALTH CLINICS AT MATHARI HOSPITAL (P132/02/2020)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above research proposal. The approval period is 6th August 2020 – 5th August 2021.

This approval is subject to compliance with the following requirements:

a. Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b. All changes (amendments, deviations, violations etc.) are submitted for review and approval by KNH-UoN ERC before implementation.
c. Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d. Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e. Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
f. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
g. Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

For more details consult the KNH- UoN ERC website**http://www.erc.uonbi.ac.ke**

Yours sincerely,

PROF. M. L. CHINDIA
SECRETARY, KNH-UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Director, CS, KNH
The Chairperson, KNH- UoN ERC
The Assistant Director, Health Information, KNH
The Director, School of Nursing Sciences, UoN
Supervisors: Miriam C.Wagoro, School of Nursing Sciences, UoN
Irene G. Mageto, School of Nursing Sciences, UoN

APPENDIX V: APPROVAL FROM MATHARI HOSPITAL TO CONDUCT THE RESEARCH

FRANCIS NJAGI KABUGUA
SCHOOL OF NURSING SCIENCES
UNIVERSITY OF NAIROBI,
P.O BOX 19676-00100,
NAIROBI.

17th August 2020.

CMED/ 19/08/20.
Allow the above officer to start data collection. The file will be discussed in the next Training & Research Meeting.

THE MEDICAL SUPERINTENDENT,
MATHARI N. TEACHING & REFERRAL HOSPITAL,
P.O BOX 40663-00100,
NAIROBI.

Dear Sir / Madam,

RE: APPLICATION TO CONDUCT A STUDY IN YOUR INSTITUTION

I'm a post-graduate student at the University of Nairobi seeking to attain a masters of science degree in mental health and psychiatric nursing.

I kindly request for permission to do research on "Parenting Experiences of Mothers Living With Chronic Mental Disorders Attending Mental Health Clinics at Mathari Hospital".
This is part of my post-graduate academic requirements.

Attached herein please find the proposal and approval letter from Kenyatta National Hospital/University of Nairobi Ethics & Research Committee (KNH/UoN-ERC).

I would be grateful if my request is considered.

He should leave all these documents plus the CMED

MATHARI NATIONAL TEACHING & REFERRAL HOSPITAL
Sept 19 AUG 2020
P. O. Box 40663, Nairobi
FOR: MEDICAL SUPERINTENDENT

Dr. V

Yours faithfully,

Francis Njagi Kabugua
MScN Student

MATHARI HOSPITAL

CLEARANCE TO UNDERTAKE RESEARCH IN MATHARI HOSPITAL

TO: IN-CHARGES (ALL FEMALE WARDS) Date 19/08/2020

This is to inform you that (name/no. of students)

FRANCIS NJAGI KABUGUA

From (Name of training institution)

UNIVERSITY OF NAIROBI

Has/have been cleared by the office of the Medical Superintendent to undertake research at Mathari hospital.

Please accord them/him/her the necessary support.

Thanks

MATHARI NATIONAL TEACHING & REFERRAL HOSPITAL
C.M.E.D.
Date: 19/8/20
Sign:
P. O. Box 40663, NBI.

In-Charge C.M.E.D

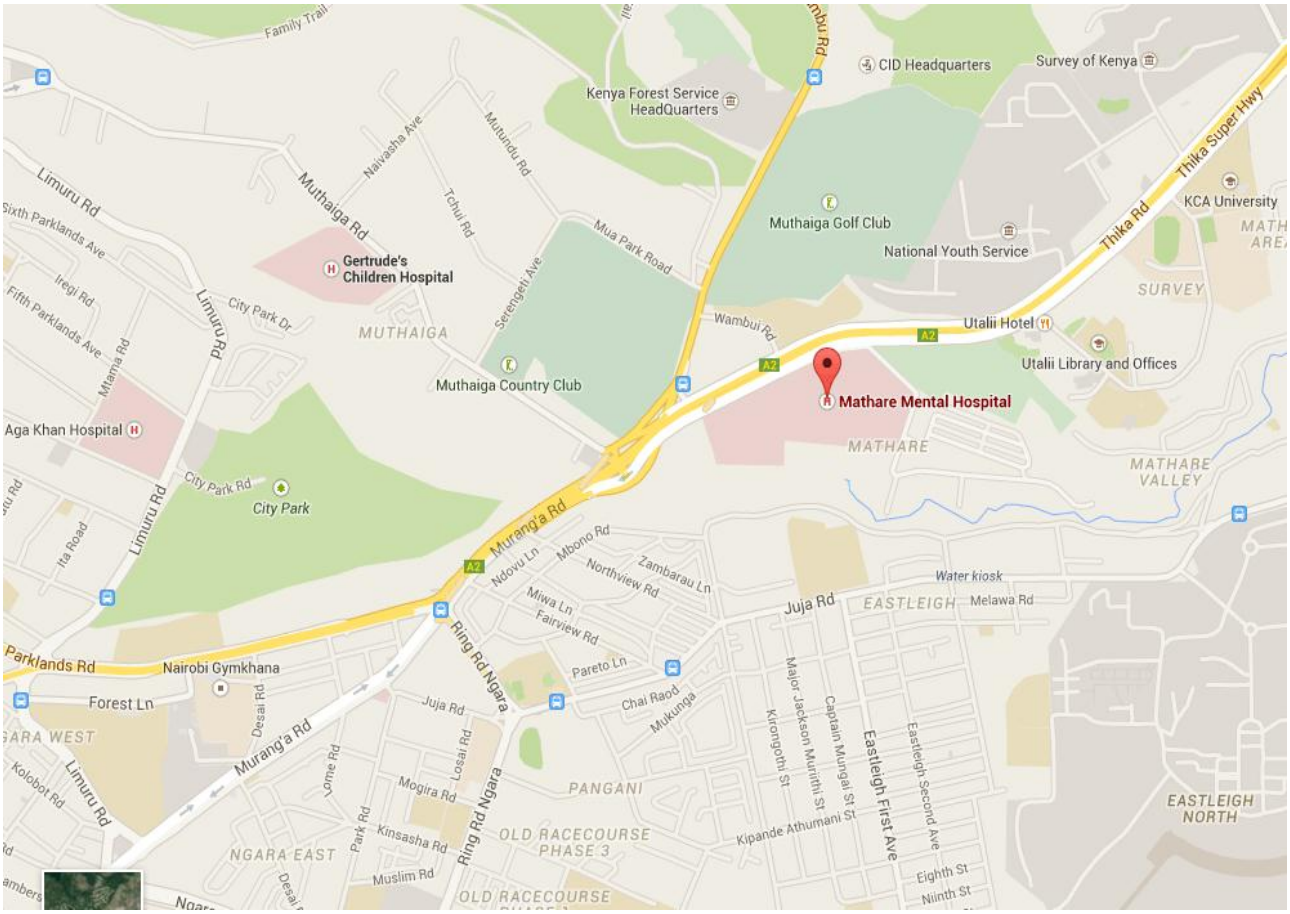
APPENDIX VI: THESIS WORK PLAN

ACTIVITY	DEC 2019	JAN 2020	FEB 2020	MAR 2019	APR 2020	MAY 2020	JUN 2020	JUL 2020	AUG 2020	SEP 2020	OCT 2020	NOV 2020	DEC 2020
Proposal development													
Presentation of proposal to school of nursing sciences for guidance and approval													
Presentation of proposal to KNH/UoN/ERC for approval													
Making corrections and amendments													
Collection, analysis and presentation of data													
Report writing, presentation of draft to school of nursing sciences													
Oral defense of thesis at the school of nursing sciences													
Corrections of the thesis													
Submission of final complete thesis													

APPENDIX VII: STUDY BUDGET

DESCRIPTIONS	QUANTITY	PRICE PER PIECE (KSHS)	TOTAL PRICE (KSHS)
Personnel resources			
Travel expense for the researcher	4 days	500	2000
Reimbursement- clients who travel to hospital for interview	15 persons	200	3000
KNH/UoN/ERC fee	1	4,000	4,000
Stationery			
Printing papers	5 rims	600	3,000
Note books	1	30	30
Erasers	1	10	10
Pencils	1	30	30
Bilopens	1	20	20
Voice recorder	1	5,000	5,000
Proposal development			
Internet services	90 hours	60	5,400
Proposal typing and printing	80 pages	40	3,200
Proposal binding	2 copies	200	400
Interview guide	3 pages	50	150
Final Thesis Preparation			
Typing of preliminary results	1 copy	1,000	1000
Photocopies	2 copies	500	1000
Typing and printing of final copies	6 copies	1,5 00	9,000
Publications			
Publication fee	1 Publication	50,000	50,000
Totals			**87,240**
Contingencies (10% of total cost)			**8,724**
Grand totals			**95,964.00**

APPENDIX VIII: MATHARI HOSPITAL LOCATION MAP



APPENDIX IX: TURNITIN ORIGINALITY REPORT

PARENTING EXPERIENCES OF MOTHERS LIVING WITH CHRONIC MENTAL DISORDERS AT MATHARI HOSPITAL

ORIGINALITY REPORT

Atieno M C W

13%	11%	6%	7%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1. hsag.co.za
   1%
   Internet Source
2. www.earlychildhoodworkforce.org
   1%
   Internet Source
3. www.formsbank.com
   1%
   Internet Source
4. bmcpsychiatry.biomedcentral.com
   <1%
   Internet Source
5. documents.worldbank.org
   <1%
   Internet Source
6. e-space.mmu.ac.uk
   <1%
   Internet Source
7. Submitted to Eiffel Corporation
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   Student Paper