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An Exploratory Study on the Psychological Experiences of Families of People Living with Schizophrenia under Forensic Care at Mathari Hospital, Nairobi County, Kenya

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Abstract:
Family members of People living with schizophrenia under forensic care (PLWSUFC) find themselves in a multifaceted situation. Families are considered important in increasing the patients' chances of living a well-functioning life after discharge from psychiatric facilities. In Kenya, scanty evidence exists on exploration of the psychological experiences of such families facing a paradox. The aim of this study was to explore the psychological experiences of families with a relative under forensic care in Mathari Hospital having committed a crime under the influence of schizophrenia. The study was guided by the Rational Emotive Behavioral Therapy. This qualitative study used phenomenology research design and recruited a sample size of 14 participants an open-ended question was asked during the semi-structured in-depth interviews and recorded. The audio recorded interviews were transcribed verbatim and data analyzed thematically. The findings from the study revealed that families of PLWSUFC at Mathari Hospital, suffered negative emotions which were: rejection, unresolved anger, ambivalence, denial, despair fear and unrequited love, The study recommends that counseling psychologists develop appropriate psycho education programs for families in this situation. Such programs are envisioned to improve families' psychological well-being, better management of the patients and reduce recidivism.

Keywords: *Family members, People living with schizophrenia under forensic care (PLWSUFC), exploring the psychological experiences*

1. Introduction

Families of PLWSUFC face a double peril. Hörberg et al (2015) explained that they have a mental illness and a criminal act to contend with often without preceding awareness. This brings distress to any family given the chronic nature of schizophrenia. This condition as reported by Ghoreishi et al (2015) presents in explicable symptoms which may include; psychotic behavior, anxiety, paranoia, delusions, withdrawal and suicidal tendencies. Besides, its onset brings sudden responsibility of caregiving to the family.

Further, Hanlon (2013) observed a high occurrence of schizophrenia diagnosis in forensic population and that people living with schizophrenia were predisposed to violence. These findings attributed the predisposition to violence to the neurological deficits and impaired ability in persons with schizophrenia to limit thoughtless violent tendencies. Dixit (2016) provide another explanation for the possible predisposition to violence in persons with schizophrenia. That is, that schizophrenia impaired the reality testing of a person rendering them with distorted insight of self, environment and the world.

Families, besides having to deal with a chronic condition which may predispose their loved one to violence, are reported to be at times the victims of the violence meted by PLWSUFC. For example, Brown and Birtwistle (2011), have documented that families of persons with schizophrenia were in some occasions the target of overt psychosis of the schizophrenia sufferer as they carried out the care giving roles. Findings from Karim, Ali, and Deuri (2015), enlightened that where the persons living with schizophrenia were having hallucinations, there were instances they could outwardly accuse the family of possibly causing the hallucination and delusions. An earlier study by Schultz (2007) concurred by stating that auditory hallucinations were purportedly more frequent in persons with schizophrenia. Dixit (2016) stated that during the auditory hallucinations a person living with schizophrenia can be instructed by the imaginary voices to attack other people (including family members) perceived to be a threat to self.

Families of people living with schizophrenia face more distress due to the perception about the mental disorder. Unfortunately, according to Birchwood and Cochrane (2013) there was the lack of a mutual understanding on the cause of

schizophrenia. This has resulted to myths and misconstructions being framed about this mental condition rendering the schizophrenia patients mysterious to their family members and the public eye. Where people living with schizophrenia engaged in violent acts, Hörberg, et al (2015) submitted that important legal and health consequences followed. The persons end up being referred for treatment under the forensic Psychiatric care instead of being taken to prison. This position complicates experiencesof families, as Rowaert (2017)described, PLWSUFC are not held responsible for the crimes and are regarded as persons in need of treatment.

The forensic care is thus geared towards protection of society on one hand and on the other hand observes the rights of the mentally ill. The aim for the treatment is to avert new crimes and evade acts of violence by the patient and consider the protection of the citizens. Further aims of forensic treatment according to Neil, (2012) are to improve the patient's well-being processes and to enable, if possible, the patient to return to a regular life after treatment back in the community.

In summary, families of PLWSUFC: first, face a prolonged uncertainty as Nedopil, et al (2015) stated, forensic care by principle is not time bound. They also stated that the nature of offences committed by PLWSUFC may go against the principle of recovery, and provided an example that when a person killed it might never be possible to recover from killing someone. Third, Drennan and Wooldridge (2014) found out that families of PLWSUFC not only faced stigma due to the mental health problem but also had to deal with repeated prolonged contacts with the criminal justice system. In addition, Neil (2012) observed that many forensic patients might have a range of pre-existing social disadvantages such as family problems, educational failures and poor work records.

Family is unquestionably important in the care, recuperation and relapse prevention of the patients. While several researches have focused on the family experiences of people living with schizophrenia in other care contexts, little has however been done towards understanding the emotional experiences of families of PLWSUFC at the Kenya's Mathari Hospital. The current study therefore tried to identify the emotional challenges that families with the two-fold stigma face. Consequently, it outlined areas where counseling psychologists could focus on and support families towards their psychological well-being. The exploratory study on the experiences of the families of the PLWSUFC was guided by the Rational Emotive Behavior Therapy (REBT). Specifically, it was guided by Ellis summary that people got disturbed not by things but by the view, they took of them.

Families of PLWSUFC being at risk of psychological problems and having had no room to express their experiences (Gillespie, 2019 &Ise Aselo et al 2016) motivated this study to explore their psychological experiences in the complicated setup. The purpose for this qualitative study was to understand the psychological experiences of families of PLWSUFC at the Mathari Hospital in order to assist counseling psychologists come up with strategies to support such families. The study sought to answer the question: What were the psychological experiences of families of PLWSUFC at Mathari Hospital? This study aimed at contributing to the body of knowledge to counseling psychology with regard to psycho education on mental health awareness. As well as developing interventions programs to support families in order to reduce the families' negative experiences. Families are often the 'forgotten victims'(Matthews, 1983) within the penal system. The study acknowledges the trauma and challenges associated with having a family member mentally ill and confined, it was thus important to illuminate the experiences of those who are often voiceless within the criminal justice system yet play a role inreduction of readmission and recidivism.

1.1. Scope and Delimits of the Study

The current study was conducted in the forensic unit of Mathari Hospital - in Nairobi County. The study employed a qualitative phenomenological study design in order to understand families' subjective experiences with regard to schizophrenia diagnosis and a forensic record in their relatives.

The study focused on the families of persons with schizophrenia under forensic care who were able to go visit their relative at the Mathari Hospital Nairobi within the data collection period. That excluded families who were not able to come to the hospital during the study period and also excluded families whose patients had been diagnosed with other mental disorders. Further research with broader sample of respondents would contribute to a better understanding of the topic under study

The greatest limitation to this study was the difficulty in reaching family members of persons with schizophrenia under forensic care in a limited timeframe. That there are generally few visits to the forensic patients meant that the pool of family members to recruit for interview was small. To address this, the researcher had to bend the data collection timeframe taking longer than initially planned for.

This present study did not include some variables such as family members' profession, level of income, and place of residence. The study location was limited to one forensic set up if repeated in different hospitals a wider perspective of the topic may emerge. The study focused on family members of PLWSUFC who had come visiting in the hospital. Therefore, the findings cannot be generalized to family members who did not visit the hospital nor to family members of persons with other mental illnesses. The study used the phrase family member which can be different in meaning and application; it would be constructive for future exploration to narrow down to specific groups in the family. Last, in as much as the necessary efforts were made to be unbiased, there is a chance that the investigator's approach and insights may have had a sway on the data collection process.

2. Method

The present qualitative study engaged a phenomenological study design. This type of research design tries to find an understanding of the lived experiences in their own natural settings (Creswell, 2013). Creswell (2013) explained that

qualitative phenomenological research explores the meanings, values, and beliefs of participants in relation to a phenomenon in order to develop new understandings of topics where little is known. The present study was carried out in a National Teaching and Referral public hospital offering specialized psychiatric treatment in Nairobi Kenya. The Mathari hospital is located along Nairobi Thika Super highway, West of Nairobi and directly opposite Muthaiga police station. The hospital attends to both civil and forensic psychiatric patients.

The researcher recruited participants using purposeful sampling technique. With this technique, participants who met certain pre-determined criterion considered important for the study were selected. The study worked with a sample size of 14 participants which fitted in Creswell (2007) recommendation of between 5-25 participants for Qualitative phenomenological studies. The sample size was also determined by the criterion given by Morse (1994) of informational redundancy. Data was collected by means of in-depth-interviews following an interview guide. The respondents were asked semi-structured, open-ended questions in an informal conversational format (Polit& Beck 2008). The open-ended questions served the purpose of giving the participants the liberty of responding as extensively as they could.

The participants were interviewed in the Boardroom at the Hospital's forensic unit. The board room was set an hour before the interview. The researcher availed an audio recording device whose operation was tested in advance to minimize failure. Data was audio recorded during the interviews with the participant's consent, and data correctly captured. The researcher gave participants ample time to express themselves and focused them where they seem to extremely digress. The researcher concentrated mainly in directing the interviews and capturing everything that was said (both verbally and non-verbally). The interviews which were carried out on different days took an average of 40 minutes each. The interviews were listened to and transcribed verbatim taking notes of the key words, phrases and statements. The gathered data was stored digitally as well as in the note books

The data generated was thematically analyzed. The choice of technique was informed by Braun and Clark (2007) who recommend it for analyzing qualitative phenomenological research data. In addition, Guest Macqueen and Naney (2012) explained that it permits the subjective acknowledgement of participant's understandings, feelings and insight as the most central objects of study.

In the current study, authorization was obtained from the Tangaza University College Ethics Committee as well as from the National Commission for Science Technology & Innovation (NACOSTI). The Hospital granted permission to the researcher to access contacts of potential participants from the hospital records and carry out the interviews in the Hospital's premises. The participants gave their consent to be recorded and quoted for study purpose. Confidentiality of the participants was guaranteed. All the data collected was safely kept and used exclusively for purposes of the present study. The researcher abstained from injuring participants psychologically, morally or physically. For this study the researcher had anticipated distress on participants after interviews on emotive lived experiences. Hence psychosocial support was available free of charge to participants to deal with any emotional needs during and after the interviews.

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3. Results

The table presents the demographic of the participants

No.	Participant's Gender	Participant's Age	Patient's Offence	Victim Of Offence	Participant's Relationship to Patient	Period Stayed in Hospital
P1	Male	64	Murder	Mother	Father	6 years
P2	Male	29	Murder	nephews	Son	4 years
P3	Male	46	Murder	mother	Brother	8 years
P4	Male	29	Murder	Mother	Father	5 years
P5	Female	59	Creating disturbance	Mother	Mother	2 years
P6	Female	59	Attempted Murder	Mother	Mother	18 months
P7	Male	35	Murder	Wife	Cousin	I year
P8	Male	26	Infanticide	Her baby	Brother	2 years
P9	Female	55	Infanticide	Her baby	Mother	2 ¾ years
P10	Female	45	Arson	husband	Sister	5 years
P11	Male	49	Grievous harm	wife	Brother	6 years
P12	Female	61	Murder	daughter	Wife	1 ½ years
P13	Female	54	Murder	Daughter	Mother	8 months
P14	Female	56	Murder	Husband	Mother	3 years

Table 1

The study interviewed 14 participants both male and females whose age ranged from 26-64 years. Two of the participants were fathers to the patients, five were mothers to the patients, four were siblings, one cousin, one spouse and one an offspring of a patient. Each of the patients the participants had come to visit had a schizophrenia diagnosis and under forensic care. Out of the 14 patients, 8 had murdered, 2 had killed their infants and the remaining 4 caused grievous harm, arson, attempted murder and created disturbance respectively. The victims of the offenses committed by the

patients in the study were all family members. The participants' anonymity was ensured by concealing their identity through the assigning of labels as P1 to P14

The research question sought to know what the participants experienced psychologically as a result of the mental disorder and offending behavior of their relative. From the responses seven themes emerged.

3.1. Rejection

The participants in this study experienced rejection. Their relatives' psychotic behavior together with negative media reporting left them feeling excluded from their previous social cycles. Some extracts from participants that depicted a feeling of rejection was: 'Since my brother murdered our mother, our neighbors do not visit our homestead (distant stare), the villagers prefer using alternative routes and avoid anywhere near our compound. The welfare committee stopped taking any contribution from us for any communal event such as funerals and nobody from our family is ever invited to any of the meetings since this act happened.' P3 46 years male

3.2. Unresolved Anger

In the present study five participants stated that they were angry at the blame people apportioned them as if they were the cause of the patients' actions while three were angry with the patients. They expressed their feelings as follows:
'My daughter is just a difficult character to handle, before this attempted murder whereby she just jumped on me and tried to strangle me, she has been full of drama (biting her lower lip). She burned down a room I had rented her to ashes, has been in engaged in several fights (Shaking her head and a frown on her face) I regret giving birth to her I really wish she did not exist''P6 59 years female

'I am blamed for having bought my brother drinks and giving him money, even my own mother says that had he been sober and broke, he would have not murdered his wife. you see the blame (Bites lower lips).' P11 49 years Male

3.3. Ambivalence

Family members had concurrent conflicting reactions, beliefs and feelings towards the patients that were both negative and positive. In this study 5 out of the 14 participants had love and concern for the patients but equally angry and ashamed by what their loved ones did. They wished the forensic detention would come to an end but also were not sure of re-integrating with the patients. Some of what they expressed were as follows:
'I sympathize with my son who had always been calm and friendly, but how can I forgive him for killing his mother 'I am really torn in between, his siblings wonder why I even bother to visit him, but he is my first born' P1 64 years male

3.4. Denial/Unreasonable

Almost all the participants interviewed had not come to terms with the diagnosis of their forensic patients, they still held on to their initial perception even where disclosure had been done. Below are some of the sentiments voiced by five participants:

'He fakes illness to avoid taking responsibilities. How can a mentally ill person know the time for meals, know-how to ask for money? Where did he get schizophrenia from? Nobody in my family or his father's family has it. This disorder thing is a cover-up for his irritating conduct' P5 43

3.5. Despair

All participants in this study expressed the feeling of being hopeless and helpless and believed that they were on their own where nobody cared about them. Some of the participants in this study said: 'In as much as I wish my mother well,my uncle and family can never forgive her nor accept her back.She killed three of his children.My father has since remarried and relocated with his other wife. I do not know who to turn to,I am alone in matters to do with my mother' P2 29 years male

3.6. Fear

Fear was the most verbalized psychological experience quoted by all the participants in this study. The fear experienced was as a result of witnessing the violent acts committed by their relatives living with schizophrenia or witnessing the hostility meted at their relatives after the offensive acts under the influence of schizophrenia. 'I feel so scared of my husband. His eyes turned unusually red and almost popping out. He ran after our last-born daughter, like someone chasing a huge wild animal. Till today, (Pointing the ground with the two index fingers) when I see anybody running, my heart beat races'. 'I come visiting him but I am not able to look at him in the eye. I shake with fear but I try not to show him' P12 61 years female.

3.7. Unrequited Love

In this study five participants expressed that the love and care they gave to the patients was often one sided and unappreciated: 'He has a list of demands. Whenever I arrive his main interest is in what I have brought for him. I have never heard him say a simple –thank you. One feel wasted but what do you do? I have learnt to relate with him that way but to say the truth, it's not easy' P11 49 years male

The data analysis in this study revealed that most family members of persons living with schizophrenia lacked awareness about the mental illness. As a result, they survived on myths and misconceptions about the condition. The study

established that families of PLWSUFC mainly endured negative psychological experiences as was manifested in the seven themes that emerged.

4. Discussion

The current study revealed that family members of persons with schizophrenia and under forensic care at the Mathari Hospital had predominantly negative psychological experiences. These findings confirmed what Rowaert (2017) stated, that families of mentally ill offenders experienced more stress than those mentally ill individuals with no judicial involvement. Families of mentally ill offenders had to deal with both mental health services and judicial system.Research findings from Hebert (2013) Mitosis (2012) and Naser (2016) implies that faced with the dual challenge, families experienced feelings of guilt, shame disbelief, fear, anger and grief. Chen (2014) indicated that it was entirely normal for families to experience intense emotional turmoil when a loved one is diagnosed with a serious mental illness. Schmid et al (2009) explained that the reason for distress in families of persons with schizophrenia was the chronic nature of the illness and the attached stigma to the mental illness.

The present study elicited seven themes which reflected the psychological experiences of families as a result of their relative having committed a crime under the influence of schizophrenia and thus receiving forensic care.

4.1. Rejection

According to DeWall (2011) rejection is a feeling of shame,sadness or grief because of non acceptance by others.This is displayed by others having little desire to include them in groups,their presence being ignored or being actively expelled from a group or existing relationship.

The respondents reported having had psychological difficulties because people in their social spheres discriminated them. For some respondents, former close associates withdrew their dealings with them. While for some their relations made them feel uncomfortable by making unpleasant remarks towards the criminal acts of their loved ones. The responses revealed that there was permanently destroyed family relationship; there were persons under forensic care that families did not wish to reconcile with and therefore not wanted back even upon recovery.

This feeling of rejection has been reflected in Harris et al (2015). The findings expounded that where the patient committed a crime, frustration and stress was high and destroyed the would-be connection between family and patient nurturing rejection. The responses also concurred with Neil (2012) that families of mentally ill offenders may feel rejected by society as if they were part of the crime their relative committed. Rejection brings about a lack of support and understanding from others making families feel isolated in the long run.

4.2. Unresolved Anger

All respondents in this study expressed anger at two levels. First, they were angry at the offensive behavior of the PLWSUC and second, they were angry at other members of the society who barred them from any social support and apportioned them the blame for their patient's predicament.

Park and Lee (2017) state that families experienced anger when faced with schizophrenia or other severe mental illnesses. The anger has been found to be dependent on various constructs especially the chronic nature of schizophrenia. Second, the condition brings a loss of dreams and resentment. Also, family members felt powerlessness in neither changing the situation nor reversing the lost expectations. From Schmid, et al (2009) it could be seen that the patients' expressions sometimes characterized by violence, confrontation and threats, aroused the feelings of frustration, disappointment, and humiliation. Where violent criminal acts were involved, families expressed a feeling of pain (Ghoreishi, 2015). Herbert (2013) recounted that offspring have grieved the parental or familial support they never received denying them the chance to live their lives consequently, internalizing resentment

4.3. Ambivalence

The finding from the present study corroborated Gillespie (2019)'s assertion that forensic care is complex. To begin with, persons who have offended under the influence of schizophrenia were seen as dangerous to the society and in need of care and treatment. Then, the forensic care was characterized by constrain and coercion that could compromise patient's dignity. The family members' task was contradictory, they were supposed to care, protect and connect with the patients at the same they had their needs as some were the victims of the patients' violent acts.

Likewise,Koschorke (2017) stated that mental illness and criminal acts may make family members feel confused about the changed behavior of their loved ones. The respondents in the present study were confused as they visited their relative in the hospital. On one side caring about a forensic patient felt like supporting the criminal act committed. They were castigated by the remaining relatives who did not see the significance of following up on patients who had committed crimes. On the other hand, disconnecting from the patient based on the individual's religious values or memory of the past shared with the patient felt inhumane to the family members who experienced ambivalence.

4.4. Denial/Unreasonable

From the results obtained in the present study, some family members refused to accept that a mental illness existed in their relatives' lives and acted as if it was not real. Despite disclosure by the mental health professionals these family members refused to openly acknowledge that there was a reality to address.

According to Bunston, Franich-Ray, and Tatlow (2017) denial occurs in the context where there is a prior lack of awareness and inadequate informational support. In the current study, the family members who were in denial focused

on either the comorbid substance abuse by the patients or on the misconceptions about mental illnesses depending on one's culture or religion. In a study on coping with schizophrenia, Chandrasekaran, Sivaprakash and Jayestri (2002) placed denial as the first emotional stage of response to schizophrenia, during which families deny the severity of the problem and hope that the loved will grow out of it.

4.5. Despair

The family members of the PLWSUFC at Mathari Hospital interviewed in this study expressed a loss of hope due to their inability to change the situation. Some participants had visited the patients for years but recovery seemed slow. Others were concerned about the minimal interaction they had with the hospital and could not guess when their relative would be discharged. However, there were also participants who felt that given the nature of the criminal acts of their patients, the patients remained irreconcilable to the society. According to Doyle, Quayle and Newman (2017), in instances where the patient had no positive results despite the forensic psychiatric care which is often characterized by long stay in a restricted environment, family members of a patient can despair. In addition, the health care professional can in some instances be judicial, whereby they do not listen and lack competence to address hopelessness, apathy, anger and sorrow, Erritty and Wydell (2013) described schizophrenia as one of the most elusive diseases known to man and unknown to medicine bringing the feelings of 'utter despair. When accompanied by a criminal behavior, schizophrenia brings about feeling of not having any hope left often causing worry and sadness to families of the sufferer (Karim et al, 2015). Despair is further brought by loss of role expectation, mourning of what could have been and the loss of potential achievement for the loved one. This being the case families have to overcome cycles of hope and despair

4.6. Fear

Participants experienced fear because of the acts of violence done by their relative. This finding is supported by Pule (2016) who stated that family caregivers of forensic mental healthcare users who had committed crime against the family, could prolong their stay in the hospital. Families might fear the forensic mental healthcare users and not ready to receive them back when they are discharged from the specialist psychiatric hospital. Pule (2016) also stated that the fear was due to the fact that the vast majority of the victims of offenders living with schizophrenia are found among families.
Fear is also mentioned in Monyaluoe (2014) where families felt at risk of being injured or killed by the violent and aggressive mentally ill member. Especially, where families had been attacked by their mentally ill family member. Likewise, families feared the patient's unpredictable and socially unacceptable behaviour. According to Iseselo (2016) persons with serious mental illness often engaged in behaviours that are frightening, troublesome, disruptive or at least annoying and many relatives are obliged to control manage and tolerate these behaviours.

Families have been reported to be afraid of the patient's expression of threat, violence and provocative behavior (Ntsayagae, Poggenpoel, &Myburgh, 2019). Families in this context feared that the patient could lash out in violence. They were thus on the guard and experienced a nagging feeling that anytime a situation could occur. x

Families in addition to fearing the patients fear possible stigma. In many cases anything regarding mental illness has attracted negative publicity. Families then fear for patient's safety. The lack of knowledge about the causes of schizophrenia, its prognosis and treatment are also a cause of fear. It was generally frightening for families of PLWSUFC at Mathari hospital; they bore the challenge of bizarre behavior of their relative and faced prejudice due to misconception about mental illness and the aftermath of the criminal acts.

4.7. Unrequited Love

Some participants felt that the love they expressed to the patients was unreciprocated. The patients did not always appreciate efforts and instead blamed the family members for their predicament or just made endless demands. The long-term nature of forensic care is reported to result in a sense of powerlessness and lack of control to families when there is no result of their support in patient's development. Park and Lee (2017) stated that a parent's love and patience could be sorely tested by behavior that seemed hostile or uncooperative. In another study Mitsonis et al (2012)cited those parents and sibling of people living with schizophrenia lamented that they were racked by demands that would overtax a Mother Theresa.

5. Conclusion

This study set out to explore the psychological experiences of families of PLWSUFC at Mathari Hospital, Nairobi. The study was guided by the understanding that people were not affected by the events but rather by what they thought about the events. In the context, it was not about the schizophrenia or the criminal acts but rather what the families thought about the mental illness and criminal offence that informed their psychological experiences.

The data gathered revealed that families of persons with schizophrenia under forensic care had either limited information or misinformation about the illness. In the cases where there was comorbid substance abuse, the families focused on the substance abuse as the issue and ruled out the existence of any other mental illness. Due to these findings, the study attributes the negative psychological experiences by family members to the lack of awareness and the misconceptions.

The study is convinced that with creation of awareness both about schizophrenia and it being a risk to offending behaviour, families of persons with schizophrenia under forensic care would have less negative psychological experiences.

6. Recommendation

Having a relative diagnosed with schizophrenia and under forensic care elicits intense emotion to the family members especially where they ae the victims of the offence. Support for family members is recommended. This support could be in the form of creating awareness for family members about schizophrenia and its risk factors for offensive behavior. The results of this study indicated that family members had negative psychological experiences. Knowledge would empower family members manage their psychological well-being.

Mental health professionals need to encourage family members to form support groups. Such groups would provide them a platform and the opportunities to confront their negative experiences such as fear blame and rejection. Similarly, families can source for help from each other without fear of prejudice and stigmatization.

The study finally recommends professional assistance in the form of counselling for the families. As well as family therapy that is basically concerned with the relationship with the family members and attempt to deal with expression of emotional symptoms which as stated by Pule (2016) may signals serious emotional problems within the family

Counseling psychologists could carry out similar scholarly studies targeting families of PLWSUFC in the community using a qualitative phenomenological design for additional understanding of family members' psychological experiences. Future studies by counseling psychologists could explore the experiences of specific family members such as the experiences of siblings, parents or children of PLWSUFC unlike this study which used the term family in a general way.

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