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Till Health Do Us Part? Maternal Ethical Exit and Moral Loneliness: An Autoethnographic Account from Urban South Africa

Till Health Do Us Part: An Urban South African Autoethnography of Maternal Ethical Exit and Moral Loneliness

Nokwanda Yoliswa Nzuza
University of KwaZulu-Natal, South Africa

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Abstract
Mental illness within families reshapes care, moral responsibility, and everyday life, particularly in African contexts where mental health support is limited, and caregiving remains gendered. Drawing on African feminist scholarship, this paper uses ethically masked autoethnography to examine how care, danger, and maternal ethical decision-making unfolded within an urban South African household affected by severe mental illness. The analysis shows how mental illness reorganised domestic life, transformed caregiving into vigilance and risk management, and redistributed ethical responsibility. It explores how maternal responsibilities were renegotiated when endurance became unsafe for children and institutional, familial, and religious supports failed. The paper makes one primary conceptual contribution: maternal ethical exit, which theorises withdrawal from co-residence not as abandonment but as an ethical reconfiguration of care oriented toward protection under conditions of danger. It also uses moral loneliness as an analytical formulation for the experience of carrying consequential ethical responsibility without adequate shared witnessing, validation, or collective support, bringing this formulation into dialogue with African feminist anthropology, family caregiving, severe mental illness, and maternal decision-making. Drawing on African feminist anthropology, feminist ethics of care, the anthropology of mental health, and scholarship on everyday religion, the paper argues that care cannot be reduced to sacrifice, endurance, or continued proximity. It further demonstrates how spiritual rupture and ancestral reorientation emerged as forms of moral grounding amid institutional collapse. Methodologically, the paper shows how relational masking, selective disclosure, and reflexive restraint can enable autoethnographic inquiry into intimate suffering while reducing risks to those represented.

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Introduction

Mental illness within families produces disruptions extending beyond the individual experiencing distress, reshaping everyday life, caregiving practices, and moral responsibility. In many African contexts, where mental health systems are under-resourced and crisis-oriented, families become primary sites through which illness is managed and risk contained. This is particularly relevant in urban South Africa, where mental health services remain episodic and fragmented rather than structured around sustained family support (Petersen et al., 2016; Lund et al., 2018; South African Department of Health, 2023). While broader African feminist scholarship frames the analysis, the institutional context is specifically urban South Africa, where caregiving is shaped by local mental health infrastructures and gendered expectations of family responsibility.

Psychiatric anthropology demonstrates that severe mental illness redistributes responsibility across households, transforming family members—particularly women—into informal psychiatric caregivers responsible for monitoring risk, coordinating treatment, and managing the moral consequences of illness (Kleinman, 1988; Jenkins & Carpenter-Song, 2008; Das, 2015). While caregiving may confer moral legitimacy, expectations of care can also constrain ethical choice. Within many gendered moral frameworks, women's commitment to care is measured through endurance and the preservation of family continuity despite suffering. When mental illness introduces unpredictability or danger into household life, mothers face difficult ethical dilemmas: remaining may expose children to harm, while leaving may attract stigma or accusations of moral failure. Separation from an ill partner may be interpreted not as relational breakdown but as evidence of inadequate femininity, failed caregiving, or abandonment of familial responsibility. It is within this context that the paper develops the concept of maternal ethical exit—withdrawal from co-residence as an ethical reconfiguration of care when continued proximity becomes unsafe. Rather than signalling abandonment, maternal ethical exit conceptualises departure as a care-centred response oriented towards protection.

Kinship is theorised in anthropology as a set of practices through which care, responsibility, and moral belonging are enacted (Carsten, 2000). Yet contemporary scholarship also documents the fragility of kinship support under conditions of economic precarity and social change (Ferguson, 2013). In prolonged crisis, responsibility for care may become increasingly individualised rather than collectively shared. This paper conceptualises this condition as moral loneliness: the experience of carrying consequential ethical responsibility without meaningful shared witnessing, validation, or collective deliberation. For mothers, such individualisation intensifies the ethical difficulty of making decisions about care, safety, and family continuity under conditions of uncertainty.

Religion and spirituality also shape experiences of mental illness and caregiving in African contexts. While faith practices often provide moral explanation and hope during crisis, prolonged suffering may produce spiritual rupture and prompt reorientation towards alternative forms of moral grounding (Das, 2015; Luhrmann, 2020). Despite growing scholarship on mental illness and caregiving in Africa, limited attention has been paid to maternal ethical decision-making as a situated practice shaped by intersecting demands of care, danger, and moral expectation. Much existing literature focuses on caregiver burden, stigma, or institutional shortcomings, understating the moral reasoning through which caregivers negotiate danger, obligation, and responsibility. Few studies attend to how ethical decision-making is lived and remembered from within intimate household contexts, particularly where children are present and where disclosure carries ethical risk.

This paper addresses these gaps through ethically masked autoethnography, using lived experience as an analytic site through which broader social and moral processes can be examined. Rather than offering a confessional account, it situates personal narrative within African feminist anthropology, psychiatric anthropology, feminist ethics of care, and scholarship on everyday religion. It asks: How does severe mental illness reorganise everyday care practices? How are maternal ethical responsibilities negotiated when endurance becomes unsafe for children? And how are moral and spiritual frameworks reworked when institutional, familial, and religious supports fail?

Drawing on lived experience in urban South Africa, this paper makes two conceptual contributions. First, maternal ethical exit theorises withdrawal from co-residence as a care-centred ethical response under conditions of danger. Second, the paper uses moral loneliness as an analytical formulation for understanding the experience of carrying ethical responsibility without adequate shared witnessing or collective support. By foregrounding motherhood as an ethical practice rather than a naturalised role, the paper reframes exit from co-residence not as moral failure but as a care-oriented response grounded in protection, responsibility, and survival.

Literature Review and Theoretical Orientation

This study is situated at the intersection of African feminist anthropology, psychiatric anthropology, feminist ethics of care, kinship studies, and the anthropology of religion. These bodies of scholarship provide the theoretical framework for examining how care, moral responsibility, and maternal decision-making are negotiated within households affected by severe mental illness. Rather than treating these perspectives separately, the review brings them into dialogue to show how gender, kinship, institutional insufficiency, and spirituality collectively shape caregiving under conditions of danger.

Mental Illness, Family Life, and Relational Care

Anthropological scholarship has long challenged biomedical approaches that locate mental illness exclusively within the individual. Psychiatric anthropologists have demonstrated that mental illness is lived through relationships, social worlds, and moral expectations (Kleinman, 1988; Jenkins & Carpenter-Song, 2008; Das, 2015; Drake, 2015). Illness reshapes household dynamics, redistributes responsibilities, and reorganises everyday routines, affecting not only those diagnosed but also those who share domestic and emotional life with them.

Within families, caregiving frequently becomes the primary mechanism through which mental illness is managed. Family members monitor symptoms, respond to crises, coordinate treatment, and absorb the emotional and practical consequences of illness, often with limited institutional support in African contexts (Petersen et al., 2016; Lund et al., 2018). Existing research has largely focused on caregiver burden, stigma, treatment adherence, and emotional strain. While these studies make important contributions, they often frame caregivers as support providers rather than moral actors negotiating competing responsibilities, particularly when protecting children may require disrupting family continuity.

Mental Health Care, Household Responsibility, and the South African Context

Mental health care in South Africa is shaped by substantial gaps between formal policy commitments and the availability and continuity of care experienced by households. The South African mental health policy framework recognises the importance of community-based and integrated mental health services, yet families frequently remain central to the practical management of severe mental illness. Research from low- and middle-income settings similarly demonstrates that limited-service capacity,

uneven access, and gaps in continuity of care can shift substantial responsibility for mental health care from formal institutions to families and communities (Lund et al., 2018; Petersen et al., 2016).

This redistribution of responsibility is particularly significant for understanding the ethical dimensions of household caregiving. When institutional care is intermittent or insufficient, family members may become responsible for monitoring symptoms, managing crises, facilitating treatment, maintaining household stability, and protecting other family members. The household consequently becomes an important site in which the consequences of institutional insufficiency are absorbed and negotiated. In this context, caregiving is not simply a private expression of familial commitment; it is also shaped by the availability, or absence, of wider systems of support.

South African scholarship further cautions against assuming that family and kinship networks automatically provide sustainable forms of collective care. While kinship may function as an important resource during periods of illness and crisis, responsibility can be unevenly distributed, particularly along gendered lines (Ferguson, 2013; Mbedzi et al., 2024). The result is that responsibilities imagined as collective may become concentrated within particular household members. For mothers caring within households affected by severe mental illness, this can create a situation in which decisions concerning safety, children, treatment, and household continuity are experienced as intensely personal decisions even though the conditions producing those decisions are structural.

The South African context is therefore not treated in this study as a geographical backdrop to an otherwise universal account of maternal decision-making. Rather, the institutional and relational conditions surrounding mental health care help constitute the ethical problem examined here. Maternal ethical exit emerges within this context as a response to the redistribution of responsibility that occurs when formal and kinship supports cannot adequately sustain safe household care. The concept therefore draws attention not only to a mother's decision to leave, but also to the social and institutional conditions under which that decision becomes an ethical responsibility.

African Feminist Perspectives on Care, Motherhood, and Endurance

African feminist scholarship provides an important lens for understanding how caregiving responsibilities become gendered and moralised. African feminists have consistently challenged portrayals of women as naturally caring, self-sacrificing, or endlessly resilient, arguing instead that such expectations emerge from historically and socially produced relations of power (Oyěwùmí, 2016; Tamale, 2020).

Within many African societies, motherhood remains a significant source of social recognition and moral value. Mothers are often expected to sustain family cohesion, absorb emotional strain, and prioritise collective wellbeing over personal safety. While these expectations may provide social legitimacy, they can also operate as disciplinary norms that normalise women's suffering and restrict ethical choice. The expectation that women should remain committed to caregiving regardless of personal cost often obscures the structural conditions that make caregiving difficult and dangerous.

African feminist scholars also caution against romanticised representations of kinship and communal support. Although African families are frequently portrayed as collective systems of care, responsibility is often distributed unevenly, with women carrying disproportionate emotional and practical labour during periods of illness and crisis. By foregrounding these inequalities, African

feminist scholarship enables a critical understanding of motherhood as a socially and ethically negotiated practice rather than a fixed identity.

Feminist Ethics of Care and the Limits of Endurance

Feminist ethics of care provides a complementary framework for understanding moral decision-making within intimate relationships. Care ethicists challenge abstract models of morality that prioritise universal rules or detached rationality, emphasising instead relational responsibility, attentiveness to vulnerability, and responsiveness to particular circumstances (Held, 2005; Tronto, 2013).

Importantly, feminist care scholars distinguish between care as a moral ideal and care as a lived practice embedded within unequal relations of power. Care is not inherently benevolent; it may also involve exhaustion, obligation, sacrifice, and constraint. Kittay (2019) argues that caregiving frequently occurs within conditions of dependency and asymmetrical responsibility, requiring caregivers to negotiate competing obligations with limited support.

These insights are particularly relevant in contexts of severe mental illness. Caregiving may initially be understood as remaining present and enduring hardship. However, care ethics also recognises that protection sometimes requires establishing boundaries, interrupting harmful situations, or refusing forms of care that reproduce harm. Ethical responsibility is therefore not reducible to endurance alone. This perspective provides a foundation for maternal ethical exit, which conceptualises withdrawal as a possible form of care when continued proximity places children or caregivers at risk.

Kinship, Relational Failure, and Moral Loneliness

Kinship is theorised in anthropology as a set of practices through which care, responsibility, and moral belonging are enacted (Carsten, 2000). Yet contemporary scholarship documents the fragility of kinship support in contexts shaped by economic precarity and social change (Ferguson, 2013). In prolonged crisis, care may become individualised rather than collectively shared. Within the present study, this condition is understood through the concept of moral loneliness, referring to the experience of bearing consequential ethical responsibility without adequate shared witnessing, validation, or collective support. For mothers, such conditions may intensify the ethical strain of decision-making under uncertainty.

Research on families affected by severe mental illness demonstrates that caregiving extends beyond the management of symptoms. Relatives may assume responsibilities for treatment coordination, crisis management, everyday functioning, emotional support, and protection, often within contexts where formal mental-health services are limited or difficult to access (Jenkins & Carpenter-Song, 2008; Petersen et al., 2016; Lund et al., 2018; Mbedzi et al., 2024). Such responsibilities can generate substantial emotional and practical strain. However, accounts of caregiving that focus primarily on burden, exhaustion, or burnout may not fully capture the ethical dimension of having to make consequential decisions about safety and family wellbeing.

Moral loneliness is useful here because it draws attention to the relational conditions under which ethical responsibility is carried. It differs from caregiver burden, which foregrounds the demands and costs of caregiving; from burnout, which concerns the effects of prolonged strain; and from social isolation, which refers more broadly to diminished social connection. Moral loneliness concerns the experience of having to determine what ought to be done when responsibility remains, but the

relational and institutional resources through which that responsibility might ordinarily be shared have contracted.

This distinction becomes particularly important when kinship networks that might ordinarily distribute responsibility become unavailable or withdrawn. African kinship cannot be assumed to operate as an automatically supportive or uniformly collective system. Responsibility may instead become unevenly distributed, with particular family members—often women—assuming disproportionate practical and emotional labour (Ferguson, 2013). In the context examined here, institutional insufficiency and the contraction of kinship support progressively narrowed the circle within which decisions about safety, care, and family continuity could be negotiated.

The paper uses moral loneliness as an analytical formulation for the experience of carrying consequential ethical responsibility without adequate shared witnessing, validation, or collective deliberation. Rather than claiming the term as a wholly original concept, the analysis specifies its relevance within the particular configuration examined here: severe mental illness, gendered caregiving, institutional insufficiency, contraction of kinship support, and maternal responsibility for children's safety.

Moral loneliness therefore provides an important conceptual condition for understanding the central argument of this paper. It helps explain how a mother may come to experience responsibility for safety and care as something that must be carried largely alone. It does not, however, explain the specific form of response developed in this study. That question is addressed through the concept of maternal ethical exit.

Marital Exit, Safety, Migration, and Material Conditions

Marital and relationship dissolution is well established as a process shaped by relational, social, economic, and safety-related conditions. Recent research on sub-Saharan Africa demonstrates that union dissolution is a significant feature of family life rather than an exceptional departure from marital continuity. Using Demographic and Health Survey data from 34 sub-Saharan African countries, John and Nitsche (2022) found substantial variation in the timing and prevalence of union dissolution across the region, with many first unions ending during the early years of marriage. Their findings are important for situating marital exit within the broader realities of African family life rather than treating separation as inherently anomalous or morally deviant.

Research also demonstrates that marital exit may be associated with migration, prolonged absence, and changing economic relations. Agadjanian and Hayford (2018), for example, show that the relationship between men's labour migration, women's autonomy, and union dissolution in rural Mozambique is complex and depends partly on the economic circumstances surrounding migration. Migration can therefore alter the material and relational conditions within which marital commitments are sustained. More broadly, research on divorce and economic wellbeing demonstrates that relationship dissolution can produce substantial economic consequences, particularly for women and lone mothers (Leopold, 2020). These findings caution against understanding marital exit simply as an individual decision detached from material circumstances.

Safety provides another important basis for understanding relationship exit. Recent South African research is particularly relevant. Mabunda et al. (2025) found that women leaving abusive relationships in Gauteng often described leaving as a process involving multiple decisions and turning points, rather than as a single event. For many participants, escalating violence and concern for their

children's safety were central to the decision to leave. Similarly, research on women escaping domestic violence identifies safe housing as a central component of the process of leaving, highlighting the material and structural conditions that shape women's capacity to achieve safety after exit (Stulz et al., 2024).

These studies demonstrate that leaving an intimate relationship can constitute a protective and relationally consequential practice. They also show that exit is rarely simple: women may have to negotiate safety, children, housing, economic insecurity, social relationships, and the possibility of continuing consequences after separation. The present study therefore does not treat exit as an inherently emancipatory act or assume that leaving automatically resolves the difficulties generated within an intimate relationship. Instead, it asks what happens to maternal responsibility when withdrawal from co-residence becomes necessary for protection.

Moral Loneliness and Maternal Ethical Exit

The paper uses moral loneliness as an analytical formulation for the experience of carrying consequential ethical responsibility without adequate shared witnessing, validation, or collective deliberation. Rather than treating moral loneliness as a wholly original concept, the analysis specifies its relevance to a particular caregiving configuration: severe mental illness, gendered responsibility, institutional insufficiency, contraction of kinship support, and concern for children's safety.

Moral loneliness describes a relational and institutional condition in which responsibility remains concentrated while the resources through which ethical decisions might ordinarily be shared are inadequate. In the context examined here, this condition developed as institutional responses remained episodic and kinship support became increasingly limited. The result was not an absence of relationships, but an absence of meaningful participation in the practical and moral labour of deciding what should be done.

The paper distinguishes this condition from maternal ethical exit. Moral loneliness describes the condition of ethical responsibility carried without adequate shared support; maternal ethical exit describes a maternal reconfiguration of care in response to conditions in which continued co-residence becomes unsafe. The relationship between the concepts is neither causal nor automatic. Moral loneliness helps illuminate the relational and institutional conditions under which the ethical problem of remaining or leaving becomes particularly acute; maternal ethical exit names the specific reorganisation of maternal care that may follow when withdrawal from co-residence becomes necessary for protection.

This distinction allows the paper to use moral loneliness without presenting it as a second original conceptual contribution. The primary contribution is maternal ethical exit: a formulation for understanding how withdrawal from unsafe co-residence may constitute a reconfiguration, rather than an abandonment, of maternal responsibility.

Conceptual Framework and Contribution

Existing scholarship offers important insights into caregiving, mental illness, family life, relationship dissolution, and ethical responsibility. However, there remains limited conceptual language for describing how mothers negotiate the ethical meaning of withdrawal from co-residence when continued proximity to severe mental illness becomes incompatible with the protection of children or the caregiver herself.

Building on the distinction established above, the paper's primary conceptual contribution is maternal ethical exit. The concept specifies how maternal responsibility may be reorganised when continued co-residence is no longer compatible with protection. Moral loneliness provides the contextual lens through which the relational and institutional conditions surrounding this ethical problem can be understood.

The contribution is therefore not to argue that women's departure from unsafe or unsustainable relationships is itself new. Existing scholarship has already demonstrated that relationship exit may be shaped by violence, migration, economic insecurity, prolonged absence, and concerns about women's and children's wellbeing. Rather, the paper identifies a specific ethical configuration in which departure is understood through the continuing obligations of motherhood. Withdrawal from co-residence may alter the spatial and relational form of care without terminating maternal responsibility.

This framework extends African feminist anthropology and the anthropology of care by shifting attention away from the amount of suffering a mother can endure and towards the forms of care that become ethically necessary when endurance itself becomes dangerous. It therefore treats maternal agency not simply as the capacity to remain or leave, but as the situated capacity to reorganise responsibility under conditions of danger, uncertainty, institutional insufficiency, and relational collapse.

Religion, Spiritual Rupture, and Moral Reorientation

The findings also extend anthropological debates on religion, spirituality, and moral life. Existing scholarship demonstrates that religious practice often intensifies during periods of suffering and uncertainty (Das, 2015; Luhrmann, 2020). This study supports that observation while also illustrating how prolonged crisis may produce spiritual rupture. Prayer initially functioned as a source of comfort and hope. Over time, however, continued suffering unsettled confidence in established forms of spiritual support. Rather than leading to religious abandonment, this rupture facilitated moral reorientation. Within the author's experience, ancestral acknowledgement emerged as a source of continuity and grounding during a period characterisedby institutional failure, kinship withdrawal, and moral isolation. In this account, this reorientation reflected an effort to locate ethical direction, continuity, and relational connection under conditions of uncertainty. These findings support anthropological arguments that spirituality may be lived in flexible, adaptive, and relational ways rather than through rigid doctrinal boundaries (Ashforth, 2011; Nwoye, 2021).

Methodology

This study uses ethically masked autoethnography to examine how severe mental illness reshaped caregiving, maternal responsibility, and ethical decision-making within an intimate household in urban South Africa. The methodology describes the research design, positionality and reflexive practice, the generation of retrospective narrative data, the ethical safeguards used to protect those implicated in the account, the approach to analysis, and the strategies used to establish trustworthiness. Together, these methodological choices enabled the study to examine intimate moral experience while limiting the potential for harm to individuals represented in the narrative.

Research Design

This study employs autoethnography as its primary methodological approach. Autoethnography enables researchers to examine personal experience as a site through which broader cultural, social, and moral processes can be understood (Ellis et al., 2011; Adams et al., 2015). Rather than treating

lived experience as merely anecdotal, it situates personal narratives within wider theoretical and social contexts, allowing intimate experiences to illuminate broader questions of power, care, and responsibility.

Autoethnography is particularly suited to examining family life shaped by severe mental illness because the ethical and relational dimensions of caregiving unfold within intimate domestic spaces that are difficult to access through conventional qualitative methods. Situated experience constitutes the primary site through which changing conditions of risk, responsibility, and maternal obligation are examined. Consistent with African feminist commitments to centring women's lived experiences, the study uses personal experience as an analytic resource rather than confession, while connecting intimate experience to broader questions of mental health care, gendered responsibility, kinship, institutional insufficiency, and the ethics of care (Ellis et al., 2011; Adams et al., 2015).

Positionality and Reflexive Practice

The analysis is informed by a reflexive consideration of positionality and its influence on knowledge production. Within African feminist scholarship, positionality is understood not as bias to be eliminated but as a condition of knowledge production requiring explicit engagement and reflection (Collins, 2000; Berger, 2015; Harding, 2015).

Data Generation

The primary data consisted of retrospective self-narratives generated through sustained reflexive writing and memory work. The narrative material was developed through repeated engagement with significant episodes of caregiving, household instability, encounters with mental-health services, experiences of danger, negotiations concerning family responsibility, and the eventual reorganisation of domestic life. These experiences were written and rewritten over time as their ethical significance became clearer. The data therefore comprise not a single retrospective account but a body of reflexive narrative material developed through repeated engagement with remembered events and experiences. Particular attention was given to everyday caregiving practices, bodily and emotional responses, spatial arrangements within the household, moments of uncertainty, attempts to obtain assistance, and decisions concerning safety and responsibility.

Memory was treated neither as a transparent record of events nor as an objective reconstruction of the past. Instead, it was approached as an interpretive process through which experiences were retrospectively organised and given meaning (Ellis, 2020). The analysis therefore attends both to the experiences recalled and to how their significance was understood differently over time. This approach is particularly important for the present study because the concept of maternal ethical exit did not arise from a single event or predetermined decision. It emerged through retrospective examination of a cumulative process involving changing perceptions of risk, caregiving responsibility, institutional insufficiency, kinship withdrawal, and the protection of children.

Ethics and Relational Masking

Given the intimate nature of the experiences examined and the involvement of other individuals, this study is guided by an ethics of care that prioritises protection, relational accountability, and minimisation of harm. Ethical responsibility extends beyond institutional requirements to include consideration of consequences for those connected to the narrative (Held, 2005; Tronto, 2013). The study employs relational masking: identifying details, timelines, locations, and relationship markers have been selectively altered, condensed, or omitted to protect anonymity while preserving analytic integrity (Saunders et al., 2015; Tolich, 2016).

The narrative is written from the perspective of caregiving and cannot represent the internal experiences of the person living with mental illness. The analysis avoids diagnosis or speculation, focusing instead on relational and ethical consequences. Children are represented indirectly through observed changes in everyday life, protecting their privacy and future autonomy. These safeguards shaped what could be disclosed, how experiences were reconstructed, and the degree to which particular events could be described; ethical restraint therefore became integral to the production of knowledge.

Data Analysis

Analysis proceeded through iterative reading, writing, reflection, and engagement with theory. Rather than employing formal coding, the study adopted an interpretive thematic approach (Braun & Clarke, 2021). The analysis moved recursively between narrative material and theoretical literature, allowing concepts and themes to emerge through sustained dialogue between lived experience and scholarly interpretation. Five interrelated themes were developed: caregiving under conditions of danger; institutional cycling and ethical burden; kinship withdrawal and moral loneliness; spiritual rupture and ancestral reorientation; and maternal ethical exit.

Trustworthiness and Methodological Contribution

Trustworthiness was approached through reflexive transparency, theoretical coherence, and sustained engagement with the narrative material. The study understands qualitative quality in terms of credibility, resonance, and conceptual contribution (Ellis et al., 2011; Tracy, 2020). The study contributes methodologically by demonstrating how autoethnography can examine intimate experiences of mental illness without reproducing harm. Through relational masking, selective disclosure, and reflexive restraint, the paper illustrates how ethical responsibility can strengthen qualitative inquiry.

Findings: Care, Danger, and Maternal Ethical Decision-Making

The findings are organised around five interconnected themes illustrating how care, danger, and ethical responsibility were negotiated within an intimate household shaped by severe mental illness. Although presented separately, these themes overlapped in everyday life, revealing how caregiving was progressively transformed by uncertainty, institutional insufficiency, kinship withdrawal, and concern for children's wellbeing.

Caregiving Under Conditions of Danger

Caregiving gradually shifted from nurturance toward vigilance. Rather than being organised around emotional support or domestic stability, everyday life became structured by anticipation, monitoring, and risk management. The home functioned as a space where safety could not be assumed, and ordinary routines required constant adjustment. One evening, the house was quiet but unsettled. Movement in the next room shifted between pacing and stillness. Nothing overtly threatening occurred, yet uncertainty saturated the atmosphere. I listened closely, assessing whether remaining visible would preserve calm or whether withdrawal would be safer. The children were nearby. Every decision felt consequential despite the absence of obvious crisis.

In such moments, care was less about intervention than calculation. Presence and absence, movement and stillness, speech and silence acquired ethical significance. The body became an instrument of vigilance. Periods of calm did not eliminate vigilance. Sleep became fragmented, and ordinary activities were accompanied by heightened awareness. The cumulative effect was exhaustion. Over

time, caregiving became organised around endurance and risk management rather than reciprocity and well-being.

Institutional Cycling and Ethical Burden

When crises intensified, institutional intervention became necessary. Police involvement, emergency services, and psychiatric hospitalisation were mobilised when risk could no longer be managed within the household. However, these interventions rarely produced long-term stability. Intervention followed a cyclical pattern: acute crisis prompted institutional response, temporary containment was achieved, and responsibility returned to the household. The conditions generating crisis remained unchanged. The responsibility for initiating intervention rested primarily with me. Decisions to contact authorities or pursue hospitalisation carried significant emotional and moral consequences. I was expected to protect those within the household while also facilitating interventions that could be experienced as coercive or punitive. This dual position generated considerable ethical tension.

Yet, moments of crisis were not the only experiences shaping decisions. Periods of calm, apology, and vulnerability complicated simple distinctions between danger and care. Following hospitalisation, conversations sometimes revealed regret, confusion, or suffering that reminded me that mental illness itself was a source of distress. These moments complicated moral certainty and underscored the relational complexity of caregiving. Nevertheless, institutional involvement rarely reduced long-term responsibility, which repeatedly returned to the household.

Kinship Withdrawal and Moral Loneliness

Although kinship is often imagined as a source of collective support during crisis, sustained assistance from extended family networks remained limited. Support was sometimes offered in symbolic or moral forms but rarely translated into ongoing practical involvement. Requests for help were seldom rejected directly. More commonly, assistance was deferred, postponed, or redirected. Suggestions focused on patience, prayer, or endurance. Conversations ended without concrete support. Over time, responsibility settled increasingly within the household.

The absence of meaningful collective engagement transformed the experience of caregiving. Decisions about safety, intervention, and endurance were largely made alone. While others expressed concern, the practical and ethical burden of acting remained concentrated within the caregiving role. There were moments when the question was not whether something was wrong, but what I should do next. I remember sitting with the practical details of a decision—whether to seek intervention, whether the situation had become unsafe enough to justify disrupting the household, and what the consequences might be for the children. I could ask others for advice, but the decision itself remained mine. No one else was positioned alongside me in the moment of deciding, and there was no shared process through which the responsibility could be carried. I had to determine when concern had become danger and when protection required action.

This experience forms the basis of moral loneliness: the experience of carrying ethical responsibility without shared witnessing, validation, or collective deliberation. It emerges when expected sources of relational support remain absent during moments of significant ethical decision-making. After an intervention, others could ask whether things had improved, but the responsibility for deciding what happened when the next episode occurred remained with me. There was no clear point at which responsibility could be handed back to a family network or institution. I remained the person who had to judge whether to wait, seek help, intervene, or protect the children by changing the household arrangement.

Importantly, moral loneliness does not imply complete absence of social relationships. Rather, it describes the failure of available relationships to provide meaningful participation in ethical responsibility. Family members remained present in various ways, yet the practical and moral labour of decision-making remained individualised.

Spiritual Rupture and Ancestral Reorientation

Religion initially served as an important source of comfort and moral orientation. As instability intensified, prayer became increasingly central to daily life, woven into ordinary routines. For a time, these practices provided structure and reassurance.

However, prolonged crisis produced spiritual exhaustion. Prayer continued, but its capacity to provide comfort diminished. Repetition generated silence rather than certainty. During this period, forms of ancestral acknowledgement emerged as an alternative source of grounding. These practices were neither formal nor ritualised. Rather, they involved quiet moments of reflection, symbolic gestures, and an increasing sense of connection to continuity beyond the immediate crisis.

Unlike prayer, which had come to feel like speaking into silence, ancestral acknowledgement offered a different orientation. It provided a sense of relational continuity and protection that did not depend on resolution or intervention. Survival became imaginable not through rescue but through connection with something enduring. Rather than representing rejection of Christianity, this reorientation reflected an adaptive response to prolonged uncertainty.

Motherhood and Maternal Ethical Exit

The presence of children transformed how care and responsibility were understood. As conditions became increasingly difficult to manage, concern for their wellbeing reshaped the ethical framework through which decisions were evaluated. Initially, endurance appeared consistent with prevailing understandings of caregiving and motherhood. Over time, however, the limits of endurance became apparent.

The decision to leave did not emerge from a single event. Rather, it accumulated gradually through repeated experiences of vigilance, uncertainty, and concern for the children's safety. One evening, while moving through familiar routines, I became aware that ordinary activities required constant negotiation. Domestic spaces no longer felt predictably safe. Nothing dramatic had occurred, yet the threshold of what could be ethically tolerated had shifted. The realisation emerged quietly: care in its existing form could no longer provide adequate protection.

Leaving did not feel like abandonment. Instead, it appeared as a reconfiguration of responsibility. The objective was not withdrawal from care but the creation of conditions under which care could continue without reproducing harm. Responsibility continued after departure, but it was practised differently. The decision remained emotionally complex. Doubt persisted even after separation. Yet these uncertainties coexisted with recognition that prolonged vigilance, exhaustion, and risk had become normalised within everyday life. Care was no longer measured simply by the capacity to remain, but by the capacity to protect.

Discussion

This paper shows that caregiving within a household affected by severe mental illness cannot be adequately understood through moral narratives that equate care with endurance, sacrifice, or continued proximity. The findings demonstrate how care became progressively reorganised around

vigilance, risk management, protection, and difficult decisions concerning household continuity. These processes illuminate the conditions under which maternal responsibility may be experienced as increasingly individualised and the circumstances in which withdrawal from co-residence may become a form of care rather than its negation.

Rethinking Care Beyond Endurance

African feminist scholarship has long challenged assumptions that women's sacrifice is natural or inevitable (Oyěwùmí, 2016; Tamale, 2020). The findings suggest that caregiving under severe mental illness exposes the limits of such moral frameworks. When caregiving becomes organised around vigilance, fear, and risk management, endurance may cease to function as an ethical good. Remaining present does not necessarily reduce harm, nor does continued proximity automatically reflect responsible care. Feminist ethics of care offers an important corrective, emphasising attentiveness to vulnerability, responsiveness to harm, and responsibility for sustaining life (Held, 2005; Tronto, 2013). From this perspective, ethical action may require interruption rather than continuation, boundary-making rather than accommodation, and protection rather than endurance.

Relationship Exit, Safety, and the Reconfiguration of Family Life

As established in the literature, relationship exit can constitute a protective response to danger, material unsustainability, or prolonged separation (Barrios et al., 2021; Wood et al., 2021; Spring et al., 2021). Maternal ethical exit, however, identifies a more specific ethical configuration of withdrawal. It concerns a mother's reorganisation of co-residence and caregiving when continued proximity to a person experiencing severe mental illness becomes incompatible with the protection of children or the caregiver, while maternal responsibility itself remains intact.

The distinction is therefore not that maternal ethical exit involves leaving when other forms of exit do not. Rather, its specificity lies in what is being ethically reconfigured through the exit. In conventional accounts of marital dissolution, the analytical focus may fall on violence, relationship breakdown, migration, economic conditions, or the dissolution of the marital relationship itself. Maternal ethical exit instead foregrounds the moral problem of how a mother continues to enact responsibility for children when maintaining household co-residence is no longer compatible with their safety. Exit in this formulation is therefore not equivalent to abandonment of the marital or caregiving relationship. It is a reconfiguration of the conditions under which maternal care can be responsibly enacted.

This distinction is particularly important in contexts where the caregiver's responsibilities have become individualised through inadequate institutional support and weakened kinship networks. The ethical question is not simply whether the relationship should continue, but whether continued physical proximity remains compatible with the protective obligations of motherhood. Maternal ethical exit thus extends existing scholarship on relationship dissolution by bringing the ethics of maternal responsibility, child protection, severe mental illness, and the reorganisation of care into the analysis of relational exit.

The ethical stakes of exit are also evident in documented South African accounts of unsafe family relationships. Dekel et al. (2018), in a qualitative study of parents and caregivers convicted of child homicide in South Africa, examine the intersection of violence against women and violence against children within intimate and parenting relationships. Their findings illustrate the complex relationship between gender, power, intimate relationships, and violence. Research on couples affected by mental illness similarly demonstrates that the partner without mental illness may assume

increased household and caregiving responsibilities while experiencing stress, burden of care, isolation, and relational strain (Mokoena et al., 2019).

These accounts should not be interpreted as suggesting that women are responsible for violence because they remain in unsafe relationships. Rather, they demonstrate the ethical stakes of decisions concerning withdrawal, particularly where children's safety is implicated. They also show that leaving is not necessarily straightforward: women's capacity to exit is shaped by material resources, social support, and the conditions surrounding motherhood. Maternal ethical exit therefore concerns not simply the act of leaving, but the ethical reconfiguration of maternal responsibility when continued co-residence becomes incompatible with protection.

Maternal Ethical Exit as an Ethical Reconfiguration of Care

The findings complicate the assumption that maternal responsibility is necessarily expressed through physical proximity. In this account, responsibility intensified rather than diminished as the decision to leave became more consequential. The ethical problem was therefore not whether care should continue, but what form care could take once co-residence was no longer compatible with protection.

The decision to leave did not emerge from diminished responsibility but from heightened responsibility. Concern for children's wellbeing transformed the ethical meaning of caregiving. As risk accumulated and vigilance became normalised, care required asking whether continued co-residence remained compatible with protection. Maternal ethical exit refers to the reconfiguration of maternal responsibility through withdrawal from co-residence when continued proximity to a situation of severe mental illness creates unacceptable risks to children or the caregiver. The concept is specifically maternal because the decision to exit is shaped by the mother's responsibility to protect and sustain her children while negotiating the competing moral expectation to preserve household and family continuity. Exit therefore does not signify withdrawal from motherhood or care; rather, it constitutes a change in how maternal care is enacted when physical presence becomes incompatible with protection.

This formulation differs from dominant understandings of exit as abandonment. Abandonment implies withdrawal of responsibility. Maternal ethical exit, by contrast, involves continuation of responsibility through altered relational arrangements. Care persists after departure, but it is practised differently. The concept contributes to feminist scholarship by expanding understandings of maternal agency beyond narratives of sacrifice and endurance, demonstrating that care may involve creating distance when distance becomes necessary for protection.

The findings also show that maternal ethical exit emerged within conditions of moral loneliness. As institutional responses remained episodic and kinship support contracted, responsibility for assessing risk and protecting children became increasingly concentrated in the mother. Moral loneliness therefore helps explain the conditions under which exit became an ethically consequential decision, while maternal ethical exit identifies the reconfiguration of care that followed.

Mental Illness, Institutional Insufficiency, and Gendered Care

The findings further contribute to anthropological understandings of mental illness by highlighting its relational consequences. Rather than affecting only the individual diagnosed, severe mental illness reorganised household life, redistributed responsibilities, and reshaped moral expectations. Institutional responses were largely crisis-oriented, providing temporary containment but rarely addressing ongoing caregiving demands. Responsibility repeatedly returned to the household.

This dynamic reflects broader critiques concerning the transfer of care responsibilities from institutions to families (Petersen et al., 2016; Lund et al., 2018). However, the findings demonstrate that this transfer is not gender-neutral. Women, and particularly mothers, become primary managers of risk, safety, and moral responsibility. African feminist analysis illuminates how these responsibilities become normalised, with expectations that women will absorb hardship and maintain family stability frequently obscuring the unequal distribution of caregiving labour.

Spiritual Rupture, Ancestral Reorientation, and Moral Survival

Religion and spirituality also shape experiences of mental illness and caregiving in African contexts. Existing scholarship demonstrates that religious practice may intensify during periods of suffering and uncertainty, while prolonged crisis may also produce spiritual rupture and reorientation (Das, 2015; Luhrmann, 2020). These perspectives support an understanding of spirituality as lived through flexible, adaptive, and relational practices rather than rigid doctrinal boundaries (Ashforth, 2011; Nwoye, 2021).

Prayer initially functioned as a source of comfort and hope. Over time, however, continued suffering unsettled confidence in established forms of spiritual support. Rather than leading to religious abandonment, this rupture facilitated moral reorientation. Ancestral acknowledgement emerged as a source of continuity and grounding during a period characterised by institutional failure, kinship withdrawal, and moral isolation. This shift reflected a pragmatic effort to locate ethical direction and relational connection under conditions of uncertainty.

Implications for African Feminist Anthropology

Maternal ethical exit and moral loneliness offer new conceptual tools for understanding care under conditions of danger and institutional insufficiency. They challenge assumptions that caregiving is best understood through sacrifice, endurance, or proximity alone and instead emphasise the moral complexity of protection, boundary-making, and survival.

For African feminist anthropology, these concepts highlight the importance of examining how women negotiate ethical responsibility within contexts shaped by unequal distributions of care, fragile support systems, and competing obligations. Maternal decision-making cannot be reduced to either victimhood or agency but must be understood as a situated practice emerging within specific social, relational, and structural conditions. Ultimately, the findings suggest that care should not be evaluated solely by how much suffering can be endured. Care must also be understood through the difficult decisions made to protect life when endurance itself becomes dangerous.

Conclusion

This autoethnographic account examined how severe mental illness reshaped maternal caregiving in urban South Africa under conditions of institutional insufficiency and kinship withdrawal. The concept of maternal ethical exit captures the reconfiguration of maternal responsibility when continued co-residence becomes incompatible with protection, challenging frameworks that equate good care with endurance or proximity. Methodologically, the study demonstrates how relational masking and reflexive restraint enable autoethnographic inquiry into intimate suffering while limiting harm to those represented.

The findings have implications for mental health policy and practice. Mental health services should provide more sustained, family-centred support rather than relying predominantly on episodic crisis intervention. Greater attention is needed to caregivers and children living in households affected by

severe mental illness, including accessible psychosocial support, safety planning, continuity of care, and mechanisms for sharing caregiving responsibilities. Such approaches may reduce the concentration of risk management and protective responsibilities within individual caregivers.

Further research should examine maternal ethical decision-making across a broader range of households and contexts. Longitudinal and multi-perspective studies could provide a more comprehensive understanding of how perceptions of risk, caregiving responsibilities, family support, and decisions concerning co-residence change over time. Research involving children, caregivers, extended family members, and mental health professionals could further develop the insights generated through this autoethnographic account and assess the applicability of maternal ethical exit and moral loneliness across different social, cultural, and institutional contexts.

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