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Appraisal Of Social Support Systems In Mitigation Of Stress Experience Among Relatives Of People Living With Mental Illness In Ibadan

Dr Abimbola Afolabi
Department of Social Work,
Faculty of Education,
University of Ibadan, Nigeria
08035627992
drafolabiabimbola@gmail.com/ afolabi.abimbola@dlc.ui.edu.ng

Abstract
Mental illness is a global public health problem with Nigeria ranking high in the occurrences of depression and suicide. People with mental illness suffer stigma which extends to their families too by association. The relatives as a result face stress and less social support. There have been previous studies on mental illness experiences of patients and interventions were often directed to meeting unmet needs of the mentally ill with less focus on the social support given to the family of the mentally ill patients. Hence, this study examined the social support system to mitigate the stress of relatives of people living with mental illness. The study is cross-sectional and descriptive. A total of copies of questionnaires were distributed and retrieved from purposively selected relatives who are caregivers of patients with schizophrenia who attended the psychiatric unit of the Adeoyo State Hospital, Ringroad, Ibadan. Data collected was analysed at univariate and bivariate levels using SPSS. The majority (56%) were males while most (20.3%, 61) of the respondents were in the age range of 50-59 years of age. The majority (59%) of the caregivers are children to the patients. Physical, emotional, psychological and physical stressors are experienced by the relatives and the sources are workplace, religious institutions, friends and community. The respondents experienced stigma in form of unfriendliness (85.8%), criticism (98%); difficulty in association (96%); desertion (87.7%) and non-involvement in social gatherings (86.7%). Family, government, non-governmental organisations provided support for the relatives of patients with mental illness. There is a significant relationship between respondents' gender and their perceptions about social interactions with significant others. Relative of a family member living with mental illness experience burden due to all forms of stress incurred while taking care of their loved ones. The family also experienced stigmatisation as a result of their relationship with patients living with mental illness. They do not enjoy support from their family members but the government. Non-Governmental Organizations provide them with emotional, physical and informational supports. Government and other stakeholders should ensure that policies and programmes that are formulated and implemented are targeted at reducing stigma, burden and stress experienced by caregivers of patients with mental illness.

Keywords: Burden; caregivers; mental illness; social support; stress.

Introduction

Mental illness is a public health problem. According to WHO (2017), an estimate of 450 million people suffers one form of mental disorder or the other. The organisation also estimated that 25% of the population will suffer mental illness at some point in their lives. In Nigeria, it is estimated that one out of 4 persons suffers mental illness (Wang, Aguilar-Gaxiola, Alonso, 2007). Nigeria has

the continent's highest cases of depression and rank 15th in the global figure for suicide (Aljazeera, 2019). According to American Psychiatric Association, mental illness is the term that refers collectively to all diagnosable mental disorders which are health conditions that are characterized by alteration in thinking, mood or behaviour associated with distress and/or impaired functioning. schizophrenia, depression, bipolar, and anxiety disorders (American Psychiatric Association, 2013). Mental illness carries great social stigma especially linked with fear of unpredictable and violent behaviour. African society also has a peculiar attitude towards the mentally ill person and this is evident in the rejection, scornful disposition and negative perception of the mentally sick individual (Mohammed and Mohammed, 2008). Mental illness is generally linked to violent behaviour; hence people do not want to be told they have mental health challenges or to be associated with people living with mental illness. A 2019 survey conducted by Africa Policy Initiative (API) and EpiAFRIC on mental health in Nigeria revealed that there is low awareness about mental health and it is believed to be caused by drug abuse, possession by evil spirits and brain malfunctioning with the majority battling with mental illness taken to the spiritual houses for healing. According to Crocetti, Spiro, and Siassi (2004), and Dave (2002), it was because mental illness was defined in such narrow and extreme terms that the public feared, rejected, and devalued people with mental illnesses. Nunnally (2001) found that people were more likely to apply a broad range of negative adjectives such as dangerous, dirty, cold, worthless, bad, weak, and ignorant to a person labelled as insane or neurotic than to an average person.

Among the Yoruba which is largely concentrated in the southwestern part of Nigeria, people who suffer from one mental disorder or the other are usually referred to as "Were", and they believe that the pregnancy of such people was possessed by spirit pranksters most often referred to as "emere". Surviving children manifest various forms of mental illness ranging from manipulative stereotyped historic dissociative disorder to real schizophrenia (Ilechukwu, 2007). Most Nigerians believe that mental illnesses are afflictions caused by supernatural causes (Udoh, 2002).

The family has a major influence on compliance with suggested treatment regimes and the recovery process, thus, the family is the basic unit of care. In many parts of the world, people have been influenced by "Familism". Familism is a concept in which an individual is accustomed to placing family honour, continuation, prosperity and stability more than individual interests. The family unit is therefore regarded as the most important cohesive unit in a society. Hence, a close relative of someone with mental illness is in a difficult and delicate position for they are both "marked" (Farina, 1998). As such, the mental illness of an individual becomes a problem for the whole family.

In caring for the needs of mentally ill patients, families are faced with lots of challenges (Zang, Conner, Meng, et al., 2021) which can be daunting unless support is provided. Families are faced with financial burdens, increased risk of physical morbidity, low self-esteem, stigma, discrimination and various forms of psychological distress such as anxiety and depression (Dyck, Short, & Vitaliano, 1999; Perlick,Rosenheck, Jf, & Sirey, 2001; Evridiki, Andreas, Haritini, & George, 2010; Shah., Wadoo, & Latoo, 2010; Möller-Leimkühler, & Wiesheu, 2012). These can affect the way they care or respond to the needs of the patients living with mental illness. When studying the adjustment of families of formerly hospitalized mentally ill relative, Doll (1976) found that families feel hopelessly burdened or trapped by the former patient's problems. In a study conducted by Dincin, Selleck and Streicker (1978) on a support group of parents of mentally ill persons, it was

found that parents often bear the burden of guilt and feelings of responsibility for their child mental illness.

Caring for someone with mental illness usually create considerable costs; direct and indirect f families and often exerts pressure on the physical, social and mental wellbeing of all fami members (Pickett-Schenk et al. 2000). People with mental illness usually face stigmatization ar are often perceived to be impulsive, violent, and a source of unpredictable risks. Hence, the publ tends to avoid interaction with them (Wong, Davidson, Anglin, et al., 2010). This negative attituc towards them may be extended to their caregivers. According to a study conducted by, caregive of persons living with mental illness experience affiliate stigma among caregivers of persor (Zhang, Subramaniam, Lee, Abdin, & Chong, 2018) leading to them limiting their interaction an communication with others as a result of the embarrassment and stigma they face. The caregiver may also find it difficult to attend social engagements due to the limited time at their disposa (Wong, Lam, Chan, & Chan, 2012).

Previous studies have been done but most of the interventions examined were often directed t meeting unmet needs of the mentally ill with less focus on the social support given to the family o the mentally ill patients. This study, therefore, examined the social support system of relatives o people living with mental illness. Social support refers to the information resources provided by a network of individuals and social groups, as well as the degree of an individual's satisfaction with the support he/ she receives from others (Lino, Portela, Camacho, Atie, & Lima, 2013).

Methodology

This study was descriptive and cross-sectional. Quantitative methods were employed in collecting data from the study population which includes the relatives of people seen at the psychiatric unit of the Adeoyo State Hospital, Ring road, Ibadan. From the data collected from the hospital, the incidence of schizophrenia cases seen at the psychiatric unit of Ring Road State Hospital, Ibadan, Oyo State between January 2015 and December 2015 was ascertained to be seven hundred and forty-one (741) and recorded.

Table 1: The incidence of schizophrenia at the psychiatric unit of Ring Road State Hospital, Ibadan, Oyo state between January 2015 and December 2015.

	Male	Female	Total
1ST QUARTER	114	88	202
2ND QUARTER	74	56	130
3RD QUARTER	118	110	228
4TH QUARTER	115	66	181
TOTAL	421	320	741

Sample size and sampling technique

Yaro Yamani's sample size selection formula (Yamani, 1967, p.886) was used to calculate the sample size thus:

$N = N/1 + (N (e)^2$

Where N = population size
n = sample size
e = the level of precision

$n = N/1 + (N (e)^2$
$n = 741 + (1482(0.05)^2$
$n = 741/1+3.705$
$n = 741/4.705$
$n = 157.49$
$n = 157$

The minimum sample size from the population then is three hundred and fifteen (315) relatives of schizophrenic patients. Assuming a 10% attrition rate, the final sample size was calculated thus:

Attrition rate = 10/100 ×157
Attrition rate = 1/10×157
Attrition rate = 15.7
Attrition rate = 16
Hence, final sample size was 157 + 16 = 173

After the sample size was calculated, a 10% attrition rate was added for any form of error that may occur when filling and retrieving the questionnaires.

Each case of mental patients was purposively selected based on the consent of their relatives to answer the questions highlighted on the questionnaire. For each case, two relatives were approached and questionnaires were self-administered. Hence, 346 copies of the questionnaires were made. However, it is only 300 copies of questionnaires that were administered. The remaining copies could not be administered due to the reluctance of relatives to partake in the research.

Validity and Reliability

Face and content validity were done on the questionnaire before it was administered. The items on the instrument were scrutinized by the researcher's supervisor and other experts on methodology in the Faculty to ensure congruency with the research problem. The face and content validity were ascertained that the instrument measures the defined properties intended. Similarly, the reliability of the questionnaire was done by the test re-test method.

Administration of instruments

The questionnaires were personally administered by the researcher with the assistance of psychiatric nurses, psychiatric doctors and social workers at the psychiatric unit of Ring Road State Hospital, Ibadan, Oyo State. The data collection was carried out between 1st February and 15th June 2016. These relatives filled the questionnaires within the hospital premises after the medical practitioner had attended to the ill family member.

Data analysis

The data obtained were edited and cleaned to eliminate inconsistencies that could undermine validity and reliability. Data generated from pre-coded, open-ended and fixed choice questions were entered using Microsoft Access Software to minimize data entry error and to ensure effective data management. These data were finally exported and analyzed using the Statistical Package for Social Sciences (SPSS). Frequency counts, tables, bar charts, pie charts, simple percentages were calculated for the respondents' demographic characteristics. The research questions were tested using chi-square and correlation analysis.

RESULTS

Socio-demographic Characteristics of the respondents

Table 2 indicates that the most represented aged group (20.3%, 61) of the respondents in the study were in the age range of 50-59 years of age. These are people of advanced age who are likely to have time at their disposal to care for patients. The table also revealed that most of the respondents (36.3%) were married while 25.7% were single, 24% of respondents were separated while very few (8%& 6%) of respondents were divorced and widows. More than half of the respondents (174, 58%) practised Islam while 36% (108) affiliated with Christianity religion. The ethnic group distribution shows that Yoruba people form the largest population (83.3%) of the respondents. Igbos, Hausas and others are also part of the research work. This distribution can be attributed to the locality of the research work which is predominantly a Yoruba speaking place.

The gender of the respondents was fairly distributed among both sex, 168 (56%) were male while 132 (44%) were female. This shows that there are more male respondents than females during the data collection on the field. This is different from what has been reported in previous studies on caregiving experiences of relatives of patients with mental illness. A study on family caregivers' experiences of involuntary psychiatric hospital admissions of their relatives showed 19 out of the 31 respondents interviewed was females. Literature has reported on the characteristics of people who attend mental health support groups. The figures are such that middle-class females who have higher than average educational levels constitute a higher percentage than their male counterparts (Borkman, 1997; Mannion et al, 1996; Norton et al, 1993). This finding from this research on the age distribution of people who care for their relatives living with mental illness differs from previous ones. This difference may be due to environmental factors. Having more males in this study could be a result of the nature of the sickness of the relatives they are taking care of. People suffering from mental illness are perceived to need 'strong' hands in handling which men are generally believed to have. However, this is just an assumption and not a fact from empirical findings.

Table 2. Socio-demographics characteristics of respondents

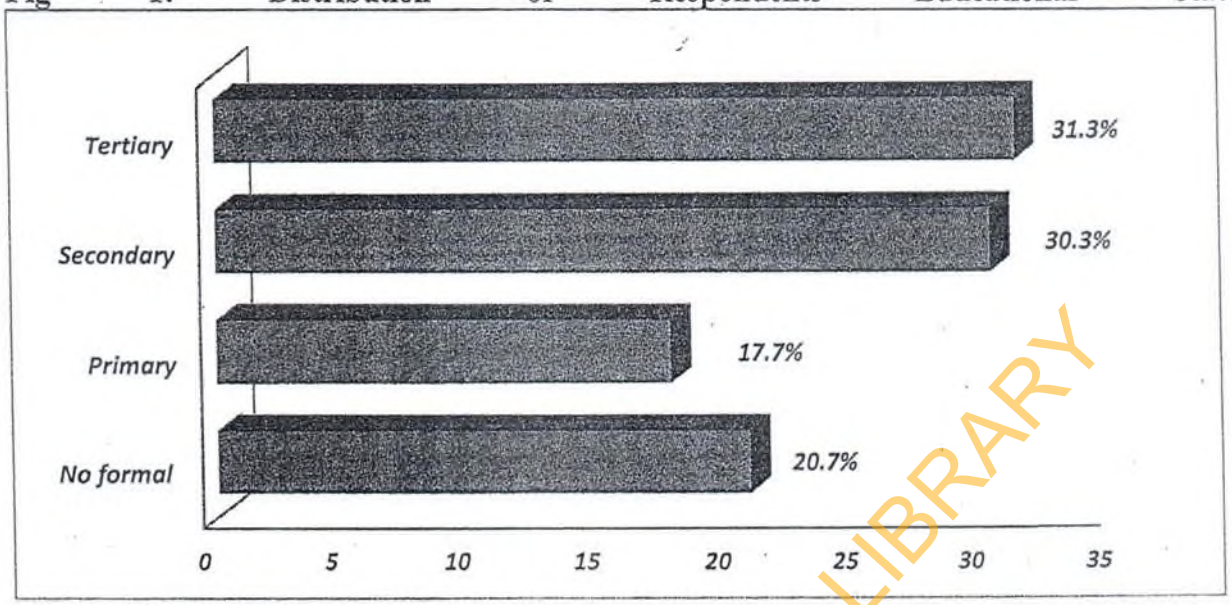
Variable	Frequency	Percentage
Age range (in years)		
20 – 24	20	6.7
25 – 29	39	13
30 – 34	34	11.3
35 – 39	58	19.3
40 – 44	27	9
45 – 49	34	11.3
50 – 59	61	20.3
55 – 59	9	3
>59	18	6

Sex		
Male	168	56
Female	132	44
Marital Status		
Single	77	25.7
Married	109	36.3
Separated	72	24
Divorced	24	8
Widowed	18	6
Religion		
Christianity	108	36.
Islam	174	58
Traditional	11	3.7
Others	7	2.3
Ethnic distribution		
Yoruba	250	83.3
Igbo	42	14.0
Hausa	5	1.7
Others	3	1.0
TOTAL	**300**	**100.0**

Educational Status of Respondents

The distribution of educational status of respondents in figure 2 shows that 20.7% of respondents have no formal education. 17.7% of respondents have completed Primary school, 30.3% of respondents completed their Secondary school and 31.3% of respondents completed their tertiary school. This implies that majority of respondents were learned and few of the respondents have no formal education.

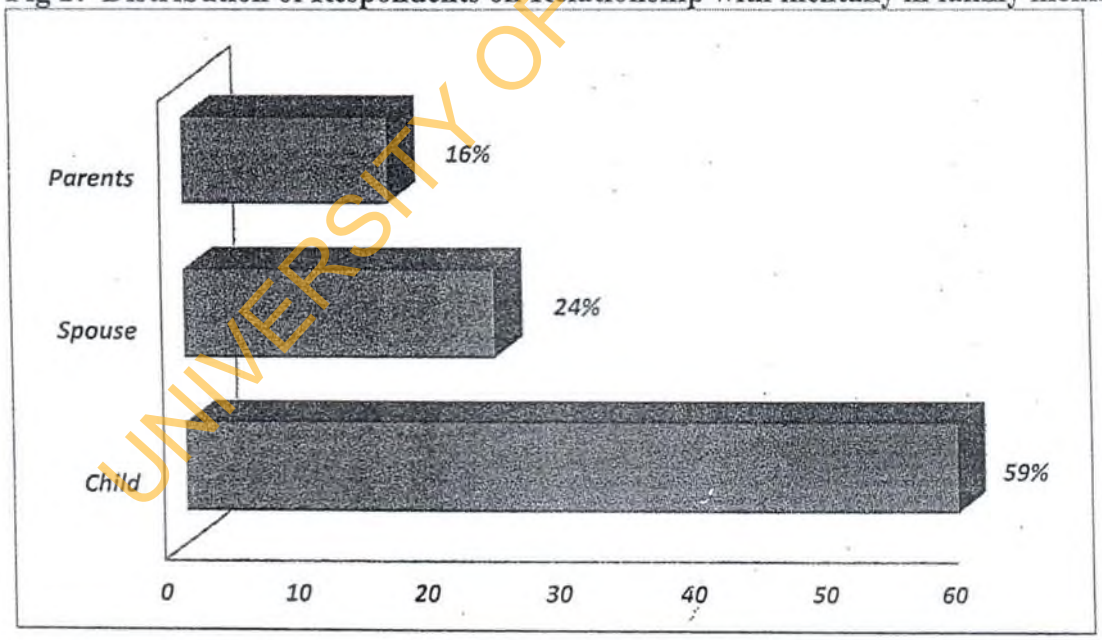
Fig 1: Distribution of Respondents Educational Statu



Relationship of Respondents with Patients

Various relationships with the mentally ill family member were established from the research work. Children of mentally ill relatives constituted the largest group (59%) while parents are the smallest group (16%). This implied that the caregivers are close family members.

Fig 2: Distribution of Respondents on Relationship with mentally ill family member

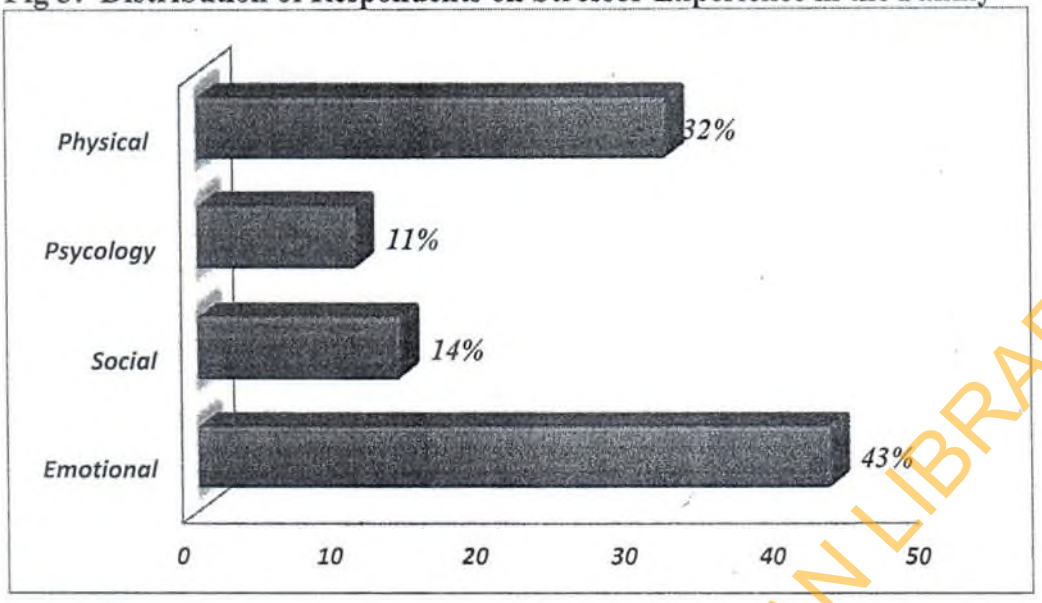


Family-Induced Stress Experienced By Relatives Of The Mentally Ill Patients

The relatives of people living with mental illness have experienced physical, social, emotional and psychological stress and the source of this stress is from the members of their family. This study

found that most respondents experienced emotional stress most (43%) closely followed by the experience of physical stress which is reported by 32% of the respondents.

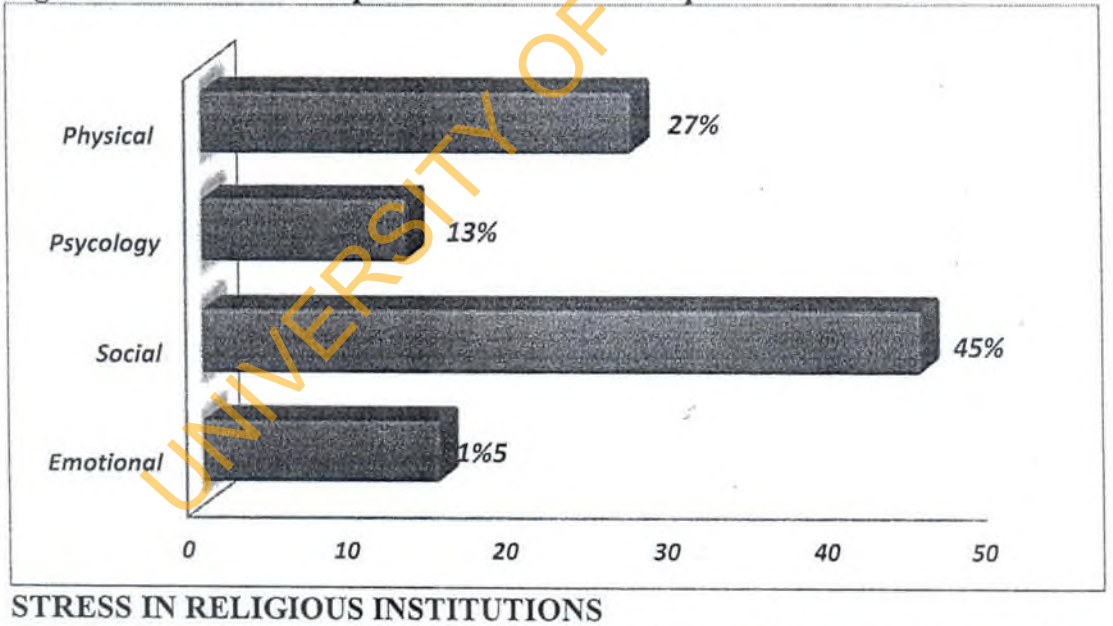
Fig 3: Distribution of Respondents on Stressor Experience in the Family



WORK PLACE STRESS

From the research work, it was found that relatives of people living with mental illness experienced social stress most (45%) in the workplace. On the other hand, they experienced psychological stress the least (13%) in the workplace.

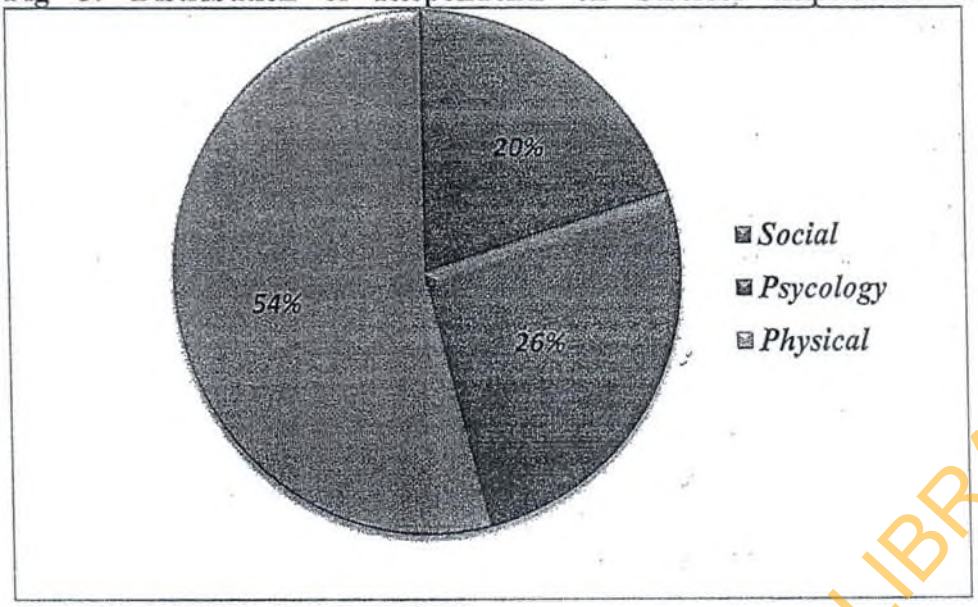
Fig 4: Distribution of Respondents on Stressor Experience at WORK



STRESS IN RELIGIOUS INSTITUTIONS

Religion institutions may have been thought of as stress-free but research has found that social, physical and psychological forms of stress are experienced by these relatives. The largest (54%) population of the respondents in the research work reported they experienced a physical form of stress the most in the religious institutions.

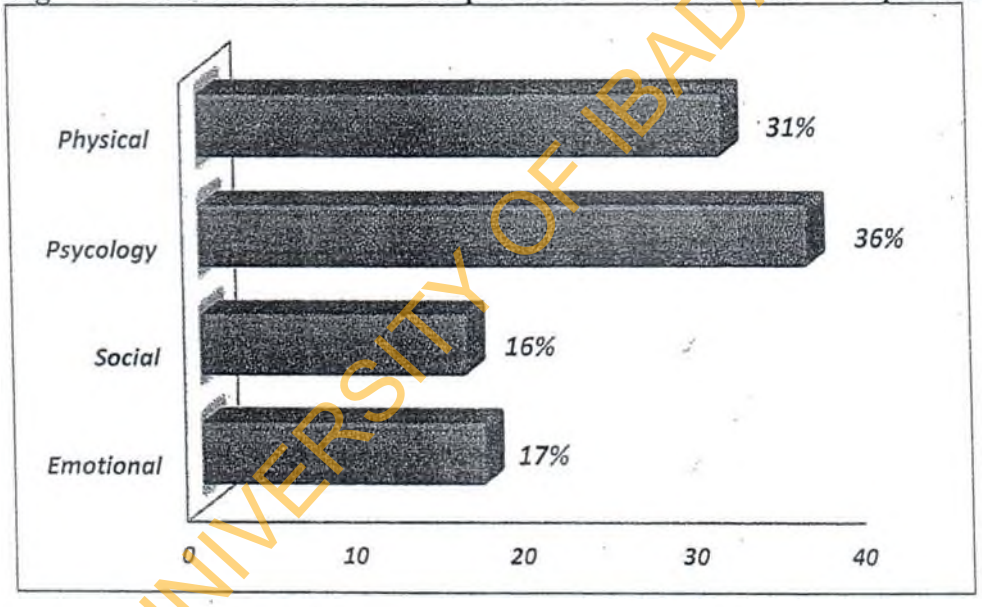
Fig 5: Distribution of Respondents on Stressor Experience at Religion Institute



STRESS IN THE COMMUNITY

Figure 7 shows that psychological stress is experienced by the majority (36%) of the respondents whereas the social form of stress is experienced the least (16%) by these relatives.

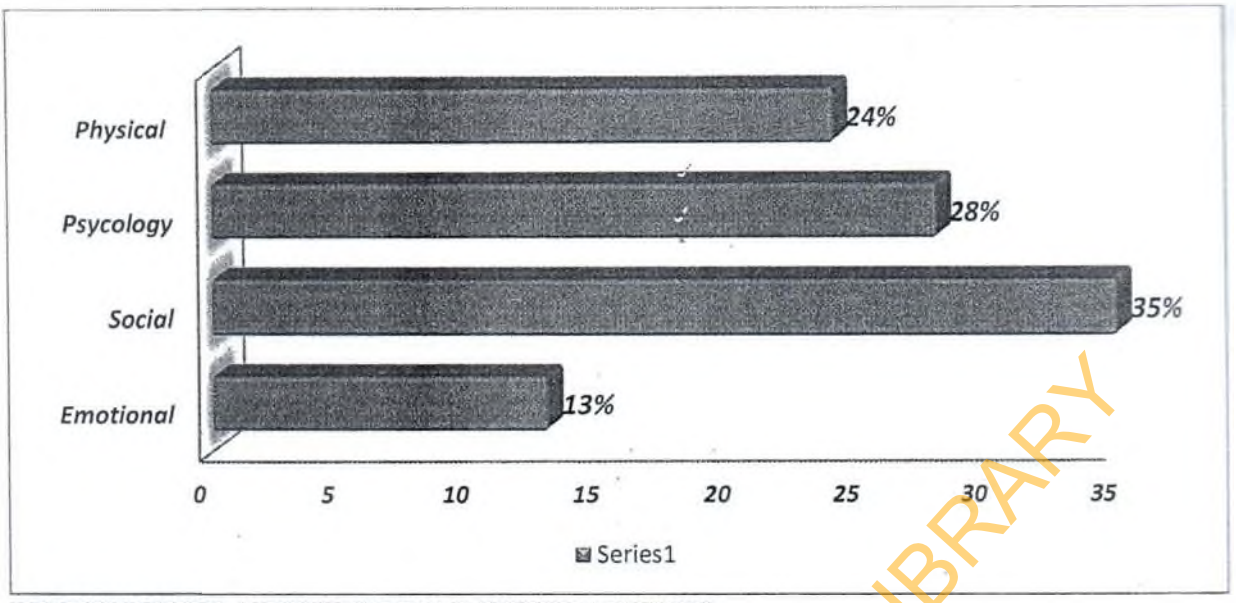
Fig 6: Distribution of Respondents on Stressor Experience at Community



STRESS WITH FRIENDS

Friends who are supposed to be a succor for their friends who have family members living with mental illness also give these relatives some form of stress. These forms of stress include physical, psychological, social and emotional. The highest (35%) number of respondents reported they experienced social stress most and the lowest (13%) population reported they experienced emotional stress most.

Fig 7: Distribution of Respondents on Stressor Experience with Friends



PERCEPTION ABOUT SOCIAL INTERACTION

Questions were asked about how relatives (caregivers) of the mentally ill perceive their relationships with people while taking care of their loved ones in psychiatric hospitals. The majority (42.3%) of the participants agreed their family members avoided them. Two hundred and ninety-four (98%) of the study participants stated that they faced criticism, stigma and discrimination from these family members while 85.3% agreed they were unfriendly and 96% reported that the people find it difficult to associate with them publicly.

Furthermore, two hundred and sixty-three (87.7%) said that the family members deserted them due to the mental illness of their family member while two hundred and sixty-two (87.3%) of these respondents said that the family members were too busy to assist in the care of their loved ones living with mental illness.

TABLE 3: PERCEPTION OF SOCIAL INTERACTION (1)

Avoidance		
	FREQUENCY	**PERCENTAGE**
Agreed	127	42.3
Disagreed	169	56.3
Undecided	4	1.4
TOTAL	300	100
Criticism		
Agreed	294	98
Disagreed	6	2
TOTAL	300	100
Unfriendliness		
Agreed	256	85.3
Disagreed	37	12.3
Undecided	7	2.3
TOTAL	300	
Difficult association		
Agreed	288	96
Disagreed	12	4

TOTAL	300	100
Desertion		
Agreed	263	87.7
Undecided	5	1.7
Disagreed	32	10.7
TOTAL	300	
Difficult understanding		
Agreed	278	92.7
Undecided	9	3
Disagreed	13	4.3
TOTAL	300	100
Busy significant others		
Agreed	262	87.3
Undecided	9	3
Disagreed	29	9.7

Table 4 is a continuation of the perception of caregivers about their interaction with family members who are not immediate. The table revealed that 84.7% of them said that their extended family members did not render assistance in the care of their family members living with mental illness. Only forty (13.3%) of the respondents disagreed that their significant others did not involve them in social outings. 96.3% of the participants in this research work agreed that their extended family members felt uncomfortable living with them because of the mental illness of their family members. This implied that the respondents do not have a good relationship with their extended family members while caring for their sick loved ones.

TABLE 4: PERCEPTION RESPONSES 2

Rendering any assistance		
	FREQUENCY	**PERCENTAGE**
Agreed	254	84.7
Undecided	18	6
Disagreed	28	9.3
TOTAL	300	100
Non-involvement in social outings		
Agreed	260	86.7
Disagreed	40	13.3
TOTAL	300	100
Uncomfortability		
Agreed	289	96.3
Undecided	3	1
Disagreed	8	2.7
TOTAL	300	
Unhappy with joint business		

Agreed	258	86.0
Undecided	19	7.7
Disagreed	23	6.3
TOTAL	300	

Table 5: Relationship between Perception of social interaction and socio-demographics Characteristics

Variable	Perception		Total	Chi-square (X^2)	P-value
	Poor	Good			
Gender					
Male	152 (50.7%)	16 (5.3%)	168 (56.0%)	8.031	0.005
Female	103 (34.3%)	29 (9.7%)	132 (44.0%)		
Marital Status					
Single	67 (22.3%)	10 (3.3%)	77 (25.7%)		
Married	95 (31.7%)	14 (4.7%)	109 (36.3%)		
Separated	60 (20.0%)	12 (4.0%)	72 (24.0%)		
Divorce	18 (6.9%)	6 (2.0%)	24 (8.0%)	2.721	0.606
Widowed	15 (5.0%)	3 (1.0%)	18 (6.0%)		
Educational level					
No formal	52 (17.3%)	10 (3.3%)	62 (20.7%)		
Primary	46 (15.3%)	7 (2.3%)	53 (17.7%)	3.000	0.960
Secondary	78 (26.0%)	13 (4.3%)	91 (30.3%)		
Tertiary	79 (26.3%)	15 (5.0%)	94 (31.3%)		
Structure of household					
Nuclear	124 (41.3%)	22 (7.3%)	146 (48.7%)	3.12	0.043
Extended	121 40.3%)	22 (7.3%)	143 (47.7%)		
Others	10 (3.3%)	1 (0.3%)	11 (3.7%)		
Residence					
Low Density	143 (47.7%)	23 (7.7%)	166 (166%)	0.44	0.800
Medium Density	49 (16.3%)	9 (3.0%)	58 (19.3)		
High Density	63 (21.0%)	13 (4.3%)	76 (25.3%)		
Total	255 (85.0%)	45 (15.0%)	300 (100%)		

Table above shows that there is a significant relationship between respondents' gender and their perceptions about social interactions with significant others. Since the p-value (0.005) for the Chi-square test is less than 0.05. This means that gender of respondents influences the perceptions From the table, there is no significant relationship between respondents' Marital Status and their perceptions about social interactions with significant others. Since the p-value (0.606) for the Chi-square test is greater than 0.05. This means that marital status of respondents does not influence their perceptions. There is no significant relationship between respondents' educational Status and their perceptions about social interactions with significant others. Since the p-value (0.960) for the Chi-square test is greater than 0.05. This means that educational status of respondents does not influence their perceptions. Also, there is no significant relationship between respondents' Structure of Household and their perceptions about social interactions with significant others. Since the p-

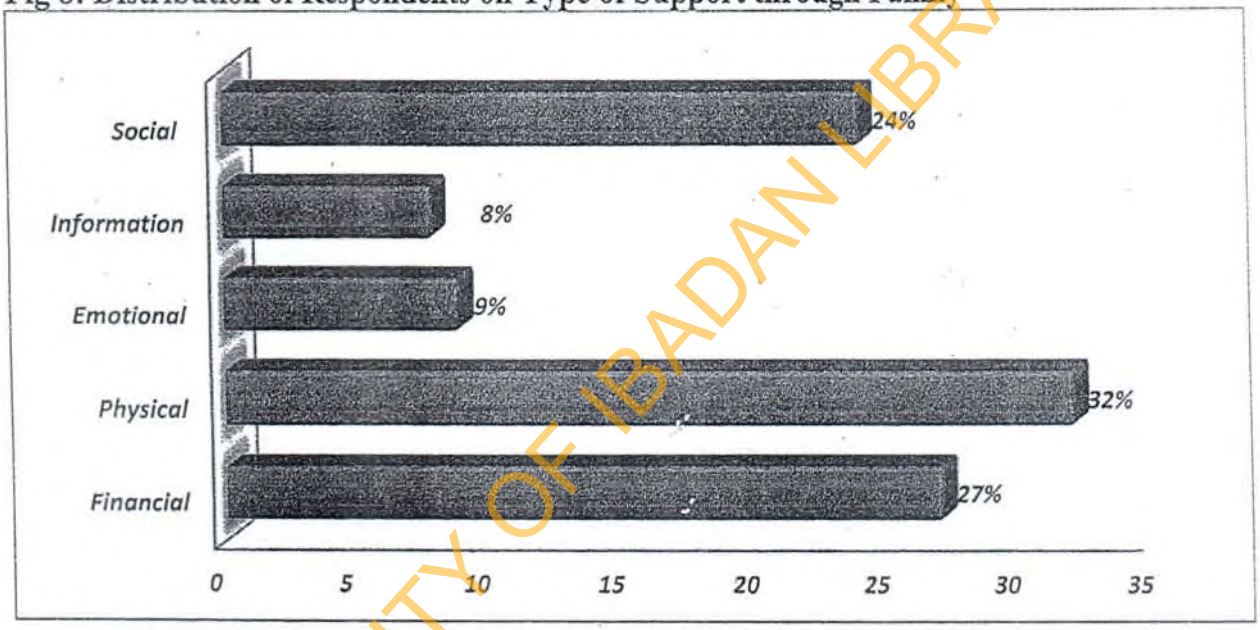
value (0.043) for the Chi-square test is less than 0.05. This means that Structure of the Household of respondents influence their perceptions.

SOURCES OF SOCIAL SUPPORT FOR RELATIVES

Family support

Family which is the first agent of socialization provides support to their members in various forms. Family in this study referred to spouses and children; that is immediate family members. The family support documented by Figure 8 includes social, emotional, physical, financial and provision of information. Physical support has been identified to be enjoyed most (32%) in the family. Provision of information is identified to be the least enjoyed by these relatives of people living with mental illness.

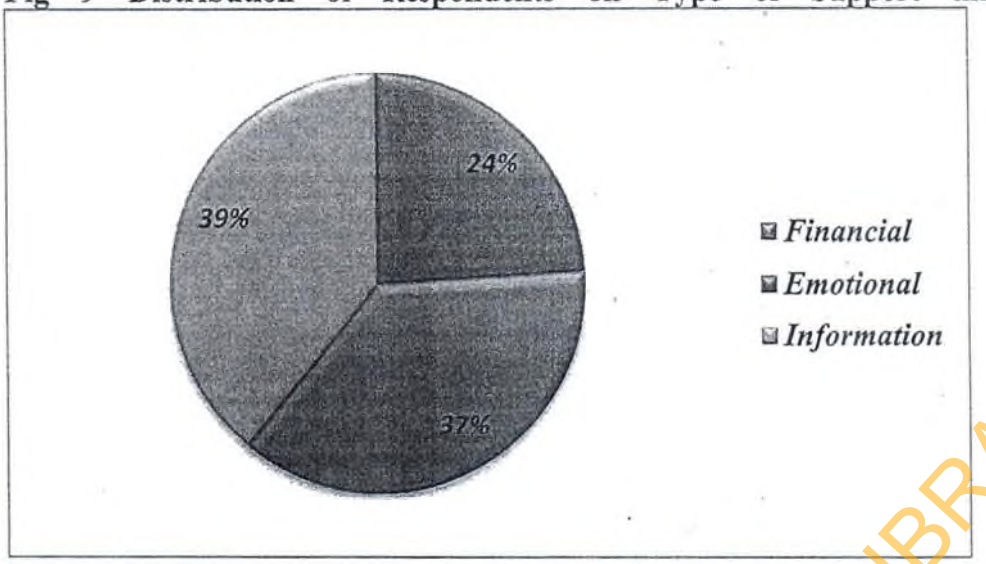
Fig 8: Distribution of Respondents on Type of Support through Family



GOVERNMENT'S SUPPORT

The government provides three major forms of support as documented in figure 9. The Government provides informational support which is the support that has been enjoyed by the largest (39%) part of the respondents. The government through their various personnel provide emotional support and this was reported by 37% of the respondents. Lastly, Government has been reported to provide financial support by 24% of the total respondents.

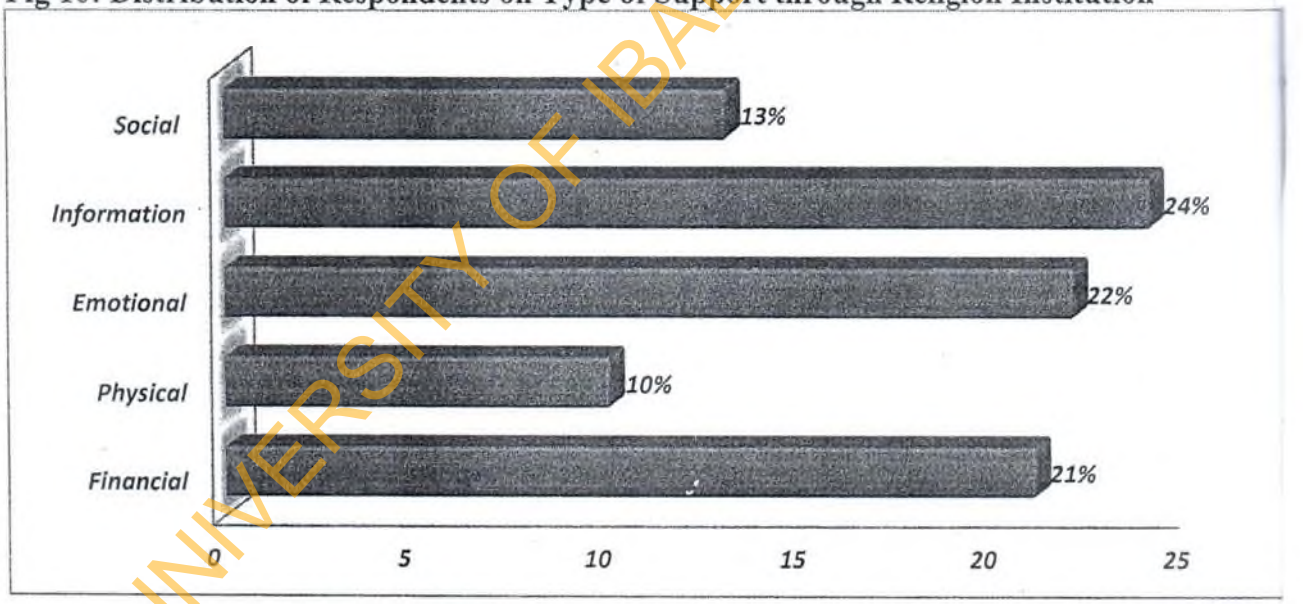
Fig 9 Distribution of Respondents on Type of Support through Government



RELIGION INSTITUTIONS' SUPPORT

Religion institutions apart from preaching and praying also provide some form of support to their members. The relatives of people living with mental illness enjoy the provision of information most (24%) in these religious institutions. The physical form of support is enjoyed the least (10%).

Fig 10: Distribution of Respondents on Type of Support through Religion Institution



NON-GOVERNMENTAL ORGANISATION (NGO) 'S SUPPORT

Non-Governmental Organisation provides different types of support. Figure 13 documented the least (20%) form of support being the provision of information. The highest (28%) form of support is shown to be a provision of emotional support.

Fig 11: Distribution of Respondents on Type of Support through Non-Governmental Organization

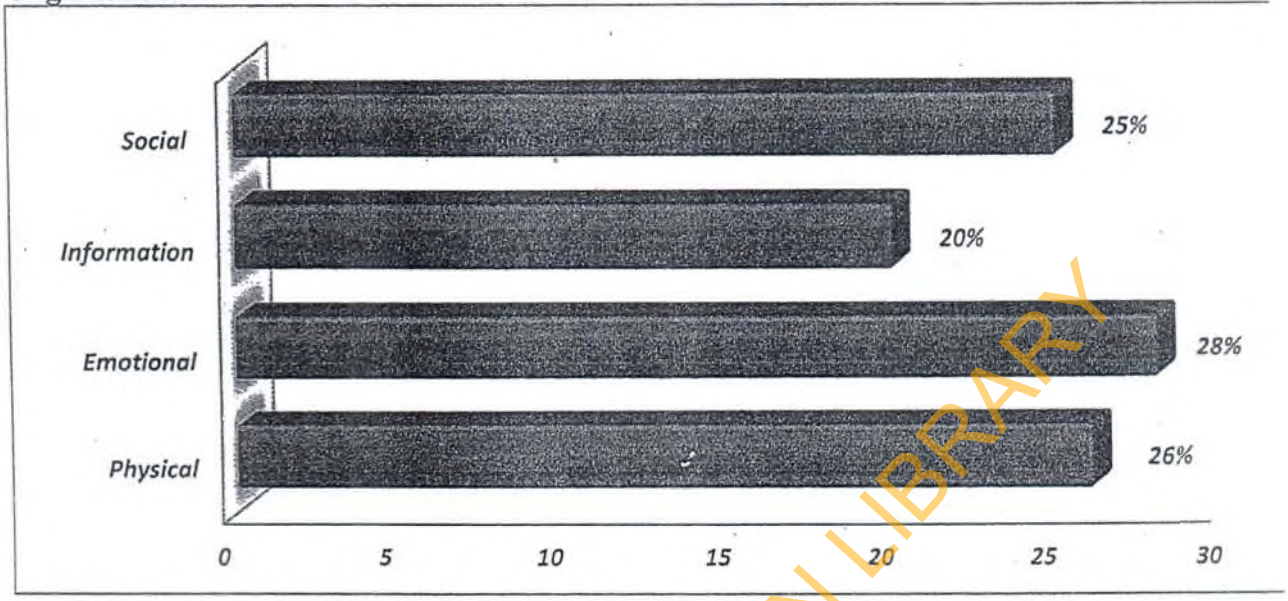


Table 6: SUPPORT AND PLACE OF SUPPORT

SUPPORT	FAMILY (%)	GOVERNMENT	RELIGION INSTITUTION	NGO
FINANCIAL	75	45	81	
PHYSICAL	86		25	67
EMOTIONAL	25	67	57	72
INFORMATIONAL	21	71	62	51
SOCIAL	65		33	67
TOTAL	272 (100)	183 (100)	253 (100)	275 (100)

DISCUSSION OF FINDINGS

This study examined stress and social support for relatives of people living with mental illness. The study revealed that caregivers/relatives of people with mental illness experienced psychological, social, emotional and physical stress from friends from family, community, friends, workplace and religious institutions. These stressors place a huge burden on them. The findings that caregiving for people with mental illness places a huge burden on the caregivers have been reported in the studies conducted elsewhere (Belina, Abegaz, Shibrie, 2010; Viana, Gruber, Shahly, Alhamzawi, Alonso, Andrade, et al., 2013; Hailemariam, 2015). Vianna, et al (2013) found out in their study that almost 40% of people who are primary caregivers of people living with severe mental health problems experience burden in their role of taking care of the patients. The study conducted by Belina, Abegaz & Shibrie (2010) in Ethiopia revealed that almost two-thirds (63.3%) of caregivers of patients with schizophrenia and bipolar-I disorder patients experience moderate to severe levels of burden. Similarly, the research conducted by Hailemariam (2015) showed that almost an overwhelming majority (99%) of the caregivers responsible for caring for mentally ill patients experienced moderate to severe levels of subjective burden.

On the perception of interaction with others, the study revealed that the relatives faced stigmatization in their relationship with others. They experienced avoidance, criticism, unfriendliness, difficulty in associating with people, desertion, difficulty in people understanding them, non-involvement in social gatherings, discomfort, non-assistance. This is similar to the findings of Girma, Möller-Leimkühler, Müller, Dehning, Froeschl, and Tesfaye, (2014) in Ethiopia that families of patients with mental illness reported stigmatization from the people.

Similarly, this study found that there is a positive significant relationship between respondents' gender and their perceptions about social interactions with significant others. However, there is no significant relationship between respondents' marital status; educational status; residence and their perceptions about social interactions with significant others.

On the social support given to relatives of people living with mental illness, the study found out that families or relatives of caregivers of people with mental illness did not support them. This has been reported in the study conducted by Magliano, Fiorillo, Malangone, Rosa and Maj (2006) on social support and quality of life of caregivers of mental illness patients. The study found out the caregivers of patients with schizophrenia experienced less social network, less support and a reduction in social contacts. Loss of friends and social networks by caregivers of patients living with mental illness was also reported by Grandón, Jenaro, & Lemos (2008). Similarly, according to 57, caregivers of people living with mental illness usually face stigmatization due to the kind of patients they are providing care for.

CONCLUSION AND RECOMMENDATION

Relative of a family member living with mental illness experience burden due to all forms of stress incurred while taking care of their loved ones. The stress is gotten from community, workplace and religious institutions. The family also experienced stigmatisation as a result of their relationship with patients living with mental illness in this case schizophrenia. They do not enjoy support from their family members but the government Non-Governmental Organizations provide them with emotional, physical and informational supports.

Based on the above, the following recommendations are made:

- Government health care providers and policymakers should organize public enlightenment programmes on mental health education. This will help to reduce stigma against mental illness, people experiencing it and their family members.
- The government should make adequate provisions to reduce environmental situations that create stress e.g. provision of adequate jobs, provision of social amenities or infrastructures (recreational centres, hospitals/health centres, rehabilitation homes and correctional homes e.t.c.).
- Government should incorporate stress prevention programmes into mental health care to reduce the stress of people living with mental illness and their family members.

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