Attitude of Care-Givers towards Mental Illness, Social Support and Coping Strategy as Predictors of Relapse among Mental Patients

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Abstract

This study investigates the extent to which the attitude of care-givers affect relapse among mental patients. It also examines the influence that social support has in preventing relapse in mental patients, and explores the effective coping strategy in the prevention of relapse among mental patients. Eighty people including forty mental patients and forty care-givers participated in the study. The participants were selected using purposive sampling technique. Three standardized research instruments were used to collect data namely Berlin Social Support Scale, Cope Orientation of Problems Experienced Inventory and Attitude towards Mental Illness Scale. Findings from this study showed that attitude of care-givers do not influence the rate of relapse among mental patients. Also, it was found that avoidance-focused and emotional-focused coping strategies have influence on the rate of relapse of mental patients, but problem-focused coping strategy does not. Moreover, findings revealed that social support does not have significant influence on the rate of relapse among mental patients.

Keywords: Attitude, Care-giver, coping strategy, Mental illness, Mental patients, Relapse, Social support.

1. Introduction

Mental illness is the term used to describe a broad range of mental and emotional conditions. Mental illness also refers to mental impairment other than mental retardation, organic brain damage, learning disabilities and drug dependence. The term psychiatric disabilities is used when mental illness significantly interfere with the performance of major life activities such as learning, thinking, sleeping, eating and communicating with others.

Mental illness is treatable and symptoms of mental illness often can be controlled effectively through medication and/or psychotherapy, but sometimes the symptoms of mental illness may go into remission and for some people, it causes continuous episodes that require ongoing treatment. Untreated mental illness can disrupt an individual's personal, social, educational and work activities and in some cases may lead to suicide. Knowledge about mental illness is very poor in the Nigerian community; this channels the pattern of attitude of people towards mental illness (Awaritefe & Ebie, 1975). For instance, the widespread belief that use of drugs is the cause of mental illness may be regarded as good, in view of its possible restraining effect on the use of illicit or psychoactive substances. However, since this is only true for a very limited number of mental illnesses, and since the public often views the use of substance as a moral failing, this belief may translate to a notion of mental illness as being self-inflicted. Such a view is more likely to elicit condemnation rather than understanding or sympathy (Weiner, Perry & Magnusson, 1998). Also, almost one in ten thought mental illness might be a divine punishment. Such view, apart from further implying that people with mental illness might in some ways be deserving there lot, have important implications for the seeking of medical care by persons affected, even those that are currently receiving treatment might have their situation exacerbated by such attitude. A supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and that help would be more likely to be obtained from spiritualists and traditional healers.

Views about mental illness, most times determine pattern of attitude that will be exhibited by individuals towards the mentally ill. Due to the misunderstanding and myths surrounding the mental illness, the mentally ill are sometimes stigmatized and may be labeled in stereotypical names such as madmen, morons, lunatic, maniac and psycho. In the contemporary Nigerian settings, there are various proverbs and general saying that points to the stigmatization of the mentally ill. Word like, craze person is often used to qualify them or anything relating to them. Once institutionalized, many families refuse to take back their mentally ill family members even after recovery from the illness, forcing these people to totally lose trust in others and their conditions take a turn back into its worse. According to the World Health Report (2001), stigma and discrimination are the main obstacles facing the mentally ill and it is the shame and fear of these that prevents the mentally ill from seeking help and care for their disorders. Stigma is known to create a hidden burden among the mentally ill, ultimately resulting in reluctance to seek help and delay in rehabilitation. Due to the prevalence of stigmatization of the mentally ill, people with serious mental illness often experience difficulty in developing and maintaining social relationships outside of the contact they have with professionals and family members (Davidson, Haglund & Stayner, 2001). Their interactions with others can be limited and they often have smaller social networks than people without mental illness (Baker, Jodrey, Intagliata & Straus, 1993), and their networks are often largely comprised of mental health or social service professionals, family members and peers with psychiatric conditions (Angell, 2003). Pickens (1999) indicates that people with psychiatric illnesses tend to have smaller networks than people without psychiatric disorders. The networks of those with psychiatric illnesses also tend to include more family members.

Cohen & Syme (1992) researched on the attitude of mental health professionals towards mental illness using 1194 participants. The result showed that 45% showed some level of authoritarianism (the belief that persons with mental illness are inferior to normal people and therefore require coercive handling), 25% showed benevolence (kindness to the mentally ill, thereby leading to parent-like treatment towards them) and 30% showed social restrictiveness (persons with mental illness should be distanced from the society because they are dangerous). Similar results had been found on large samples by Taylor & Dear (1980). Mental health professionals who endorse authoritarian attitudes towards their clients are likely to rob them of their power over treatment (Link, Cullen & Frank, 1987). They further showed that citizens were likely to stigmatize persons labeled mentally ill, even in the absence of any aberrant behavior. In the same vein, Link, Phellan & Bresnahan (1999) posed a modified labeling theory where they concluded that although a psychiatric label does not lead to mental illness, but it is certainly associated with negative societal reactions that in turn exacerbate the course of the person's disorder.

In an attempt to examine attitude towards mental illness from the cultural point of view, three paradigms that attempt to explain the prominence of stigma were identified. These include socio-cultural perspective (stigmas developed to justify existing social justices), motivational biases (stigmas developed to meet basic psychological needs) and social cognitive view (stigmas developed due to products of human cognitive structures) (Corrigan & Phellan, 2004). Stigmatizing attitudes has also been found to bring about discrimination against persons with mental illness.

Citizens are less likely to hire persons who are labeled mentally ill, less likely to lease them apartment and more likely to falsely press charges for violent crimes against them (Socall & Holtgraves, 1992). Stigmatizing attitudes also lead to poor treatment. Socall & Holtgraves (1992) asserted that psychiatric symptoms tend to produce stigmatizing reactions than those associated with labels alone. Moreover, poor social skills that are a function of psychiatric illness also lead to stigmatizing reactions.

Mohammed, Zubair, Isa & Muktar (2008) conducted a research on the perception and beliefs about mental illness among adults in Karfi, Northern Nigeria. The result shows that 34% of the respondent belief that the use of psycho-active drugs causes mental illness, 18% believed is wrath from God, hence the attitude or perception of mental illness has no direct influence on relapse on the mentally ill if the causes persist. Kua (1993) found in his study that patients believed that they are possessed by spirits and that their problem is being caused by black magic, evil spirit and poverty, and felt there care-givers and doctors could not help. Rekha (2003) found that attitude of care-givers towards mental patients is the lowest cause of their relapse (15%) while financial problem and improvement in symptoms has the highest percentage (41% and 28% respectively).

For people with serious mental illness, perception of adequate social support are associated with several psychological benefits, including increased self-esteem, feelings of empowerment, functioning, quality of life and recovery, while the absence of social support appears related to greater psychiatric symptom, poorer perceptions of overall health, and reduced potential for full community integration (Corrigan & Phelan, 2004). Several psychosocial programs have being developed to directly and indirectly foster social relationship of people with psychiatric conditions (Harris & Bergman, 1985). These programs are often non-traditional, in that social support is provided by non-professionals such as community volunteers or members of self-help and mutual support. Review of the evaluation of these programs suggests an association with improvements in several aspects of psychological health and functioning. Use of these natural supports may also be more mutual and normalizing, less expensive and lead to greater community integration than social skills programs provided by rehabilitation professionals. But despite the support being given the mentally ill, individual coping with their situation is also essential (Goldberg, Rollins & Lehman, 2003).

A vital positive coping strategy that families living with mental illness can have is utilization of social supports. Accessing social support is an adaptive problem focused strategy. Social support in this context can be described as an exchange of information by individuals. This provides emotional support, esteem support and network support. Social support may be social networks such as churches, friends and extended family or they may be formal networks such as health care or educational institutes. As mental health treatment options decrease, families are given the responsibility of transitioning their mentally ill relative from inpatient psychiatric treatment to outpatient. The coping strategy of family members and also the patient may influence the prognosis of the illness. Identification of the family members and patient coping strategy may aid in helping prevent relapse.

Moreover, the importance of social support in the prevention of relapse cannot be over-emphasized. Davidson & Stayner (1997) studied the relevance of social support in bipolar disorder. They found out that poor social support may increase the risk of relapse in bipolar disorder. The result further showed that a low level of social support is significantly more common in bipolar patients who relapsed during a one year follow up. They concluded that perceived social support is associated with a higher risk of relapse in bipolar disorder.

Hamilton (1998) studied some men and women diagnosed for schizophrenia and had relapsed for a number of times, they found that lack of social support was not significant to their rate of relapse. Susan, Barbara, Nirvana, & Petlick (2000) found a highly negative correlation between social support and relapse of patients with dementia. Their study showed that the patient's care-givers were showing symptoms of chronic stress which could have affected the social support given to the patients. DiMatteo (2004) found an interaction effect of social support and quality of life in the prevention of relapse. Crawford, Jonge, Freeman & Weaver (2004) opined that both users and providers have reported that delivery of care to people with severe mental illness should be a service priority. Killaspy (2006) studied on the impact of social support on rate of relapse with patients who received support from different sources. He found out that despite having received all the support, few patients (26.4%) thought that the support was actually helpful as they still experience difficulties in optimal performance. Active coping, perception of severity of disability, and social support were found to be significant predictors of depression (Zea, Belgrave, Townsend, Jarama & Banks, 1996). These three were associated with increase depression, stress, and severity of disability.

Social support is also associated with the psychological well-being of students with high levels of stress (Zea, et al, 1996). Gottlieb (1985) found that lack of social support is associated to stress, depression and mental health problems. For instance, lack of social support showed a positive association with psychosomatic symptoms and high levels of perceived social support were associated with low levels of depression. High levels of social support were associated with faster and more extensive recovery of function after a stroke, and that social support is an important prognostic factor in recovery (Gordly, 1996).

Cohen & Hoberman (1983) concluded that social support buffers against stressful life events, increases adherence to medical treatments, and improves recovery from mental illness, among other health promoting effects. They also found that for people with serious mental illness, perception of adequate social support are associated with several psychological benefits, including increased self-esteem, feeling of empowerment, functioning optimally, quality of life and recovery, while the absence of social support appears related to greater psychiatric symptoms, poorer perception of overall health and reduced potential for full community integration. Studies had also proved that the presence of a socially supportive person reduces cardiovascular reactivity in socially threatening situation (Quigley, 2003). It was noted that males and females had different preferred source of social support. Studies have demonstrated that being integrated into social networks and receiving high levels of social support are important for mental health and well-being particularly for women (Alarie, 1996). Social support improves quality of life, promote mental health and help to cope with the abusive (Mitchell, Hargrove, Collins, Thompson, Reddick, & Kaslow, 2006).

The term coping has several definitions. Folkman & Lazarus (1980) defined coping as any response to external life strains that serves to prevent, avoid or control emotional distress. They see coping as a dynamic process where individuals work through situations and events. They asserted that it is the transaction between the individual and the environment that enabled one to cope. Coping performs two major functions namely, regulating stressful emotions and altering the distress person-environment. These strategies to achieve these include cognitive distraction, seeking emotional support, emotional regulation and cognitive restructuring. Some family members use positive coping strategy to help manage their situation, such as positive thinking and the utilization of appropriate social support while some families use negative coping strategies such as avoidance behaviors, negative thinking and substance abuse. Some families find it difficult to deal with the stigma associated with mental illness and this negatively influences the coping ability of family. Some family members with mentally ill relatives use avoidant strategies to cope with their situation. Avoidance is an emotion-focused coping strategy that family members use when they overestimate the threat of the illness or underestimate their own coping ability. Avoidance may include removing oneself physically from a situation or refusing to discuss or even think about the issue or situation. Families may also totally avoid their mentally ill relative and cut off any contact.

Some families use religious and spiritual support as means for coping with caring for a mentally ill relative. The use of spirituality is seen as a positive emotion-focused coping strategy. The importance of coping strategy has also been emphasized in psychiatry. Folkman & Lazarus (1980) found that emotion and problem focused coping approaches can facilitate stability among mental patients. Emotion-focused coping can take a range of forms such as seeking social support, and acceptance and venting of emotions (Carver, Scheier & Weintraub, 1989). Although emotion-focused coping styles are quite varied, they all seek to lessen the negative emotions associated with the stressor, thus emotion-focused coping is an action-oriented (Admiral, Korthagen, & Wubbels, 2000). Problem-focused coping appears to be the most adaptive coping style as it is associated with reduced psychological distress while avoidant coping appears to be the most maladaptive as it is associated with increased distress (Bouteyre, Maurel, & Bernaud, 2007). Clinically depressed participants experience less improvement and greater dysfunction when they engage in avoidant coping (Billings & Moos, 1984). Holahan, Holahan, Moos, Brennan & Schutte (2005) showed that avoidant coping is positively associated with depressive symptoms in a ten year longitudinal study. They found that individuals that engaged in avoidant coping at baseline were more likely to experience chronic and acute stressors when measured four years later and to exhibit depressive symptoms ten years later. Avoidant coping has also been associated with increased psychological distress in non-clinical populations such as the general population (Wijndaele, Matton, Duvigneaud, Nefevre, Bourdeaudhuij & Duquet, 2007). Wijndaele, et al (2007) showed that problem-focused coping is the most effective at reducing psychological distress in the general population.

Problem-focused coping appears to be effective simply because it removes daily stressors. Although daily stressors are only small, they have been associated with lowered mood (Wolf, Elston, & Kissling, 1989).

Sullivan (1993) conducted a qualitative study of coping strategies employed by people with serious mental illness. He reported that 19 out of 40 participants identified spiritual beliefs as integral to their recovery. The participants believed that spirituality provided meaning to the unpredictability of their illness. Their congregation, prayers and belief in a benevolent God combined to provide social support. Cultural factors also determine coping strategy. Culture relates to how people cope with everyday problems. In particular, the stress and anxiety of maintaining an image reinforced by the cultural community can have deleterious effects on coping behaviors and health, such as in the case of the cultural stereotype of the strong black woman (Matthew, Dimsdale & Nelesen, 2005). Aldwin & Revenson (1987) posited that the predominance of one type of coping strategy over another is determined by personal styles and by type of stressful events. Kemp, Green, Hovanitz & Rawlings (1995) found that coping skills such as avoidance and separation strategies including problem avoidance, self blame and social withdrawal were related to higher levels of distress. Crockett, Iturbide, Torres, McGinley, Raffaelli & Carlo (2007) found that seeking social support was an effective coping strategy for students experiencing high levels of stress, as students reported fewer anxiety and depressive symptoms when they received social support, as opposed to students who did not receive social support.

This study investigates the extent to which the attitude of care-givers affect relapse among mental patients, and explore the influence of social support in prevention of relapse in mental patients. It also examines the effective coping strategy in the prevention of relapse among mental patients.

2. Hypotheses

(1) There will be a significant influence of attitude of care-givers on the rate of relapse among mental patients.
(2) There will be a significant influence of coping strategies on relapse among mental patients.
(3) There will be a significant influence of social support on relapse among mental patients.

3. Participants

The participants were made up of 80 people (40 patients and 40 caregivers). They include 20 in-patients and their care–givers, and 20 out-patients and their care-givers. They were drawn from the Federal Neuro-Psychiatric Hospital, Uselu in Edo State of Nigeria using purposive sampling method. The criterion for the selection of the participants includes.

(i) Patients should have been diagnosed using the ICD 10.
(ii) In-patients should have relapsed twice or more and out-patients should not have relapsed since granted leave, for at least six months.
(iii) Patients should have a key member of the family as care-giver during the course of illness and treatment.
(iv) Patients should be relatively stable, in terms of good judgment and insightfulness.

From the twenty in-patients, two had the diagnosis of paranoid schizophrenia, nine had substance related diagnosis, three had severe depression, one had hebephrenic schizophrenia, one had mania, and four had bipolar affective disorder. Six of the cases were profound since they have relapsed four times. Thirteen of them had Senior Secondary School Certificate (SSCE), four had University Bachelor degrees while three had National Certificate in Education (NCE) as their educational qualifications. Thirteen were single, six were married while one is widowed, and their age ranges from 37 years to 68years. Their first episode was 2007-2009. Their care-givers were all close relatives.

Of the twenty selected outpatients, four had the diagnoses of paranoid schizophrenia, eight had substance related diagnoses, two had severe depression, three had bipolar affective disorder, two had hebephrenic schizophrenia, and one had panic attack. Their first episode was 2009-2011. Nine of them had Senior Secondary School Certificate (SSCE), eight had University Bachelor degrees while three had National Certificate in Education (NCE) as their educational qualifications. Ten were married, nine were single and one was divorced. Ten were males and ten were females with age range of between 25 years and 60 years. Their care-givers are all close relatives to the patients.

4. Instruments

Three instruments were used for this research namely, Berlin Social Support Scale, Cope Scale and Attitude towards Mental Illness Scale. Data were also gathered through interviews during psychotherapy sessions.

4.1 Berlin Social Support Scale

Berlin Social Support Scale was developed by Schulz & Schwarz (2004). It has six subscales which are Perceived available support, Need for support, Support seeking, Actual received support, Provided support and Protective buffering. The Cronbach Alpha for internal consistency for the subscales are as follows, Perceived available support 0.83, Provided social support 0.75, Need for social support 0.83 and Protective buffering 0.82

4.2 Cope Scale

Cope Orientation of Problem Experienced Inventory (COPE) was developed by Carver, Scheie & Weintraub (1989) to measure individual's style of coping. It is a 5-item self-report questionnaire that measures styles of coping employed by people in traumatic situation. Participants are to rate a 4-point Likert scale ranging from 1 (I usually don't do this) to 4 (I usually do this a lot). The COPE has three subscales, each measuring a coping strategy such as problem focused coping strategy, emotional focused coping strategy and avoidance coping strategy. The scale has test-retest reliability of 0.86

4.3 Attitude towards Mental Illness

Attitude towards mental illness scale was developed by Ng & Chan (2000). It consists of 34 items scored on a 5-point Likert scale. The items measures specific aspects of expected behavior which includes separatism, stereotyping, restrictiveness, benevolence, pessimistic prediction and stigmatization. It has a test-retest reliability of 0.79

5. Procedure

The researchers seek for and granted permission from the appropriate authority before data were collected. Access was granted to the patients at the wards (male ward, male annex, female ward, female annex, drug ward and also the village ward) and also to the psychotherapy sessions and ward rounds. Access was equally granted to the files of the participants. This enabled the researchers to get more information about the participants. The researchers gathered the data with the assistance of the Nurses (at the wards and at the OPD), visiting Health workers and Social workers.

The instruments were administered sectionally. Since all the participants were relatively stable, and educated, they were able to fill the instruments. Some were administered by the researchers after group psychotherapy sessions, thereafter the nurses at the wards helped in administering the session for the care-givers. Some were administered at the village ward which is a form of institutionalization that also has the care-givers on ground. Some were administered after wards round, and some were administered after assessment.

For the out-patients, the instruments were administered when they came for appointments with their doctors, usually they do come with a relative (care-giver), and hence the researchers were able to access the care-givers also. During psychotherapy session and ward rounds, files are always on ground for the researchers to access more information. Thereafter, the instruments meant for each patient and care–givers were attached together for easy identification.

6. Statistical Method

Multiple regressions analysis was used to analyze the data collected for this study. It was also used to test the hypotheses.

7. Results

Results of the data analysis are presented in tables below.

Table 1: Summary table of Regression analysis showing the influence of attitude of care-givers on rate of relapse among mental patients

Variables	R	R2	F	P	B	t	P
Positive Attitude	.19	.04	.72	>.05	-0.94	-.57	>.05
Negative Attitude					-0.175	-1.05	>.05

The result in Table 1 shows that there is no significant influence of attitude of care-givers on rate of relapse among mental patients. The result indicate that attitude of care-givers does not in any way influence the rate of relapse among mental patients.

Table 2: Regression analysis summary table showing the influence of coping strategies on relapse among mental patients

Variables	R	R2	F	P	B	t	P
Avoidance focused	.49	.24	4.29	<.05	-0.34	-2.29	<.05
Problem focused					0.09	0.56	>.05
Emotion focused					-0.32	-2.12	<.05

Result in Table 2 shows that there is a significant joint influence of coping strategies on rate of relapse. It further shows that there is a significant individual influence of avoidance focused coping strategy (beta = -0.34) and emotional focused coping strategy (beta = -0.32) on rate of relapse, but the influence of problem focused coping strategy (beta = 0.09) is not significant on the rate of relapse. With this result, there exists an influence of two out of the three coping strategies on the rate of relapse.

Table 3: Summary table of Regression analysis showing the influence of social support on relapse among mental patients

Variables	R	R2	F	P	B	t	P
Perceived available support	0.431	0.186	1.881	>.05	0.338	1.91	>0.05
Need for support					0.184	1.102	>0.05
Provided support					-0.326	-1.422	>0.05
Protective buffering					0.126	0.535	>0.05

The result from Table 3 revealed that perceived available support, need for support, provided support and protective buffering do not have a significant influence on the rate of relapse among mental patients. This shows that social support does not have significant influence on the rate of relapse among mental patients.

8. Discussion

The result of this study revealed that no significant influence was found in the attitude of care-givers on the rate of relapse among mental patients. The result revealed that care-givers may exhibit positive and negative attitude towards the mental patients, but the attitude does not have any influence on the relapse rate of the patients. Many factors could responsible for this. The factors could be the belief of the people on the causes of mental illness such as the belief in black magic and evil spirit. Therefore, as long as these causes persist, there will always be relapse among the mental patients.

Another plausible explanation of this finding is that people also attach mental illness to the use of psychoactive drugs; hence the possibility of relapse is high. The previous findings of Mohammed, et al (2008), Kua (1993) and Rekha (2003) supports the result of this study.

Findings of this study further showed a significant joint influence of coping strategy on the rate of relapse among mental patients. The result shows a significant joint influence of avoidance focused and emotional focused coping strategies on the rate of relapse, but the influence of problem focused coping strategy is not significant on the rate of relapse. Individual differences of the participants used for this study is a plausible explanation for the variations in their actual coping style. Personality type and type of stressor could also be a reason for this finding. This result supports the previous findings of Adwin & Revenson (1987).

Furthermore, social support does not have significant influence on relapse among mental patients. This is because the subset of social support namely, need for support, provided support, perceived support and protective buffering does not significantly influence the rate of relapse among mental patients. The plausible explanation of this finding is that giving social support by care-givers to the mental patients does not prevent relapse from occurring. The patients will still exhibit symptoms of mental illness. However, the disconnect could be that patients don't give care-givers the area where help is really needed by them. That is, the patients may report area of less priority rather than areas where urgent attention is needed. This applies to most of the participants in the present study because most of them clamor for discharge, and any void of that is seen as maltreatment rather than support from their care-givers, even when it is evident they are not fit to be granted leave. The previous finding of Killaspy (2006) corroborates the finding of this study. However, the previous finding of Baker, et al (1993) is not in agreement with the finding of this study.

From the interview with the participants, other reasons for relapse among mental patients were found. These are non-adherence to medication which most of the participants blamed on the side effect of the drugs on them; visiting religious and worship centres instead of the hospital for treatment. In doing this, they are often encouraged to stop medication and believe in faith. The clergies make them to belief their ailment is spiritual, hence medication can't work for it and most times the patients belief this. This leads to relapse most of the times. Also, the immediate environment could encourage relapse especially if the environment encourages behavior that could cause mental illness.

10. Conclusion

Based on the findings of the present study, the following conclusions are made.

    (i)   Attitude of care-givers towards mental patients, whether positive or negative, do not influence the rate of relapse among mental patients.

    (ii)   Significant individual influence of avoidance focused and emotional focused coping strategy exist on rate of relapse, but the influence of problem focused is not significant to the rate of relapse.

    (iii) Social support does not significantly influence the rate of relapse on mental patients.

11. Recommendations

Based on the findings of this study, the following recommendations are made.

First, mental patients should be engaged more in discussion to enhance knowing the areas of higher priorities. This will make it easier for mental health practitioners to give them necessary and adequate support.

Second, patients should be treated by professionals who understand relapse process of the illness. Patients should be trained to explore their relapse patterns, identify their high risk situation and to develop strategies to avoid or cope with these situations.

Third, aftercare should also be encouraged. Aftercare treatment could be more focused in terms of more directional care. This service should be encouraged and more people should be trained to do the job.

Fourth, mental health professionals must strive to disabuse the mind of the patients from giving their ailment spiritual undertone. This will enable them adhere strictly to their medication.

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