

Variations in Family Attitudes towards Coping with People Living with Mental Illness

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Abstract

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BACKGROUND: The major challenge faced in Nigeria regarding the care of people living with mental illness are a stigma, caregiver burden and financial aid. This has led to high premature deaths and has also hindered the attainment of Sustainable Development Goal 3 target 4. In an attempt to find lasting solutions to increased mortality caused by mental illness, it is important to evaluate family attitudes towards people living with mental illness.

AIM: To examine variations in family attitudes towards coping with people living with mental illness in Nigeria.

SUBJECTS AND METHODS: Thirty In-Depth Interview (IDI) were conducted among caregivers of people living with mental illness (those presently receiving treatment and those recovering). During all the interview sessions, field notes were taken. Responses from interviewees were transcribed and analysed with the aid of 'systematic-content analysis.

RESULTS: It found out that family members of people living with mental illness or caregivers usually suffer from stress and stigma, which affects adherence to treatment.

CONCLUSION: Caregivers must have sufficient knowledge and support to assume the responsibilities of caring for the mentally ill, leading to recurrence. The caregiver remains in contact with professional healthcare workers and helps the mentally ill with decision-making and matters affecting their daily life.

Introduction

Mental health, as non-communicable disease, is an indispensable part of a person's capability to carry on with an actual existence of self-actualisation, capacity to maintain social interactions and to resolve everyday decisions [1]. Mental illness clarifies the syndrome that is usually portrayed by mood deregulation and behaviour of both men and women [2], and it is inextricably linked to development. However, the Sustainable Development Goals (SDGs) showed that by 2030, prevention and management of mental health and well-being would lead to a 33% decline in premature death due to non-communicable diseases (NCD). To achieve the Sustainable Development Goals (SDGs), effective management of

people living with mental illness is very crucial. To achieve this, it is not possible to over-emphasise the role and attitudes of family members or caregivers in managing people living with mental illness.

Caregiver refers to someone who provides unpaid care and support to any member of the family or relative, acquaintance or neighbour who has been diagnosed with mental illness. The function of a caregiver has been recognised as vital, both functionally and economically. A fundamental part of caregiving is the ability to be an excellent communicator with a person living with mental illness (who has recovered or who is recovering).

The majority of household caregiving is normally provided by parents (mothers and fathers), spouse or husband, or relatives. Members of mentally ill households or relatives usually feel stigma pain [3],

[4], [5]. Not only for people with mental illness, but also their families, mental illness is traumatic. Many studies have found that caregivers of mentally ill people suffer from stress, face a significant burden and receive poor assistance from mental health professionals in general. [6]. Disability and the severity of symptoms are the most important indicator of burden. Effective management, therefore, represents the first step towards reducing the burden. High emotional pressure can reflect the family's hard work in helping the patient and is interfered with by controlling attitudes, stigma, burden and the perception of the caregiver of mentally ill people [7].

As medical care expands to find better approaches to help manage people living with mental illness, caregivers play an important and ever-growing role. Caring for mentally ill people requires untiring work, vigour, understanding, and an undeniable impact on the daily life of caregivers. Caregivers are at high risk for various challenges to physical and mental health. They sometimes suffer from an alarming level of constant concern, anxiety, frustration, depression, and risky behaviour. They neglect their care and are more likely to die than non-caregivers of equivalent age. [8]. Social support in Nigeria is considered to be of great value about the problem of caring for people with mental illness [9].

Mental health care behaviour in African indigenous society is often influenced by the household decision-making process in mental illness management [10]. In general, mentally ill people's relatives decide where to seek their help. The belief system of the roots of mental illness influences the opinion of a family about the probable cause of mental disorders experienced in society by a family member. [11]. First of all, mental retardation is diagnosed much earlier than serious mental illness in family life. Mentally disabled people are usually diagnosed at birth or early childhood. As a result, most mentally ill siblings have always known that they have significant disabilities with their brother or sister. Their formative years included satisfaction and difficulties in living with a visible "family difference" [12], and many siblings were involved in parental surrogacy, especially sisters [13], [14].

Access to better treatment for people with mental illness, including medication prescriptions, psychosocial interference and services for reintegration, is a key factor in relieving the burden of caregivers. Emergency management readiness, the provision of legally delegated community treatment to prevent hospitalisation and the support of an informed balance [15] are also necessary. People with mental illness are suffering from episodic crises that can undermine family and household stability. Therefore, in society, the course of mental retardation is better accepted than mentally ill people. Women are often caregivers of the family. Women seek health care more frequently for their children and themselves. The challenge of family responsibility in advanced and

non-industrialized countries to help people with mental illness is a collective problem. Different health and social systems in different countries may affect a family's duty to care.

Families may be responsible for taking care of persons with mental illness in a convincing manner of the facilities, resources and care available to persons with mental illness and their caregivers. Knowing the detailed lifestyle that could affect the burden of family caregivers and the techniques that transmit these issues in the care of a mentally ill member of the family can be an important part of developing an all-inclusive family-centred care ideal. According to [16], households are the main sustainable caregiver and a valuable supply for mentally ill people despite differences in needs and concerns between individuals and ethnic groups. Studies in the UK have shown that caregivers have some collective needs. Expressive support, assistance with seclusion, recognition of reliable and suitable services, evidence and recognition of their role and impact in helping caregivers [17]. It is the responsibility of extended Arab families to arrange their members to prevent or retard the effects of parental loss and psychological disorder [18]. Instead of unfamiliar persons, the violent behaviour of mentally ill people is most often directed towards families, caregivers and acquaintances. Regrettably, Nigeria does not have statistics on the percentage of population attributable risk (PAR per cent) that would indicate the proportion of mental illness-related violence.

In addition to the above, it is worthy to note that in reducing premature death caused by mental illness, the attitudes of caregivers are often neglected in the study of the management of people living with mental illness. This is because it is necessary to examine the attitudes of caregivers to manage mental illness; as has already been established, it is prone to the stigma that can lead to a relapse and ultimately affect the rehabilitation process of mental illness. This study, therefore, examines variations in family attitudes/caregivers in the management of mentally ill people in Nigeria. The study also investigates whether the treatment of mentally ill people has been a positive exploration in pursuing and achieving the Sustainable Development Goals (SDGs) target 3.4.

Subjects and Methods

This study utilised In-Depth Interview (IDI) to examine the variations in family attitudes towards coping with people living with mental illness in Nigeria. Interviews are the most common source of qualitative data for health scientists. Interviews allowed for in-depth analysis to explain attitudes of caregivers, who are family members and coping strategies towards people living with mental illness in a view to reduce

premature death among men as listed in the Sustainable Development Goals (target 3.4). The choice of these methods was necessary to enhance the realisation of the objectives of this study.

Framework analysis was used to analyse the data. In the work of [19], the framework analysis focuses on real-life findings using a method of content analysis that summarises and classifies responses into themes [20]. Also, framework analysis is suitable for applied research that deals with practical methodologies to solve problems, in particular, health issues.

Hospitals and Local Government Areas (LGAs) in Ogun State have been selected intentionally. Four Federal and State-owned hospitals were purposively selected. The selection criteria for psychiatric hospitals are 1. The presence of psychiatric patient facilities and services and 2. Availability of psychiatric patients.

The multistage sampling procedure was adopted to purposively select Ogun State due to the presence of a first-generation Neuropsychiatric Hospital. The state was clustered into six dialectical groups and purposively selected three LGAs with psychiatric healthcare facilities. People living with mental illness could not be interviewed because they were not mentally stable. Family members or people in selected psychiatric hospitals who care for mentally unstable people (now suffering plus those who recovered) who are Yoruba descendants in Ogun State were randomly selected, screened, recruited and interviewed in their clinic days after obtaining informed consent. Caregivers under 18 years of age were excluded. Caregivers who had been or is currently in a marital relationship were the target group of interest. At the commencement of the interview, the basic characteristics such as gender, marital status, level of education and religion were assessed.

The clinic hall at the various psychiatric hospitals, which is void of distractions was chosen for the interviews. These locations allowed interviewees to be easily accessible, comfortable and to freely discuss health issues. Thirty Interviews were conducted across the three Local Government Areas in the state. The few respondents were due to a limited number of mentally ill persons (invited persons). Volunteers were interviewed. However, the number of interviewees was manageable, and there was enough data. Each of the interviews lasted 50 to 90 minutes. Discussions continued until new information was made available and the theoretical saturation was achieved. The interviews were moderated by a social worker who was selected to avoid partiality and misconception of health conditions. Discussions were held in Yoruba (local southwestern language, Nigeria).

Nonetheless, some individuals used Pidgin English or a combination of Yoruba and English. The

in-depth interview guide was adopted from the Caregiver Burden Inventory, Orientation towards mental illness scale (OMI) [21], [22] cited by [23]. Interviewees were asked about their experiences and knowledge of care given to people living with mental illness as well as coping strategies in reducing premature deaths among men.

The socio-demographic characteristics of the interviewees (marital status, mentally ill relationship and level of education) have made the findings more representative and contributed to the creation of contrasting beliefs. The interviewees reviewed the notes to ensure the validity and integrity of the data were correct.

Other researchers who did not participate in the study but had qualitative expertise also examined the transcriptions. Transcripts were read without numbers to discover themes, confirm that the transcripts follow the same approach to transcription and eliminate bias in the identification of themes. It should also be noted that the analytical results were submitted to non-participating colleagues and women who considered the findings of the research to be appropriate.

Statistical Analysis

During all the interview sessions, field notes were taken. Responses from interviewees were transcribed and analysed with the aid of 'systematic-content analysis' Qualitative data were thematically, and content analysed [19]. The field notes and transcripts were read severally to have a proper understanding of the data. In classifying, repeated answers and mutual themes, 'scissors and paste' approach was used [24], [20], [19]. Transcript data that have been revised repeatedly and field notes have enhanced the identification of the concepts. Concepts have been coded and systematised into categories for each transcription and then combined. The topics have been further refined by more concepts, divisions or combinations [20]. Answers from interviewees that could not be grouped directly into themes discussed and subsequently re-grouped between reviewers. The importance of the answers and the links to other topics were discussed.

A Microsoft Excel sheet document that details the answers to each question was generated. Each of the question was inserted on detached sheets within an Excel sheet. In the used excel sheet as created, five columns were labelled, the first column was interviewees' identification number (ID); the second column was for coding; the third column or responses of the interviewees; the fourth column was for the themes of the coding categories while the fifth (last) column was for analysis of the questions. Afterwards, the responses were cross-tabulated by socio-demographic characteristics for easy appraisals and evaluations. The results were buttressed with existing

literature. Analysis of data adapted the qualitative research review guidelines (RATS). RATS stress the importance of research questions. It also criticizes the suitability of methods while ensuring transparency and consistency of the interpretive approach [25]. Data presentation and research findings were used with consolidated criteria for reporting qualitative research (COREQ) [6].

Ethical Consideration

At the commencement of the interviews, the aim of the study was made known to the interviewees, and their consents sought and obtained to be part of the study. They were also assured of the confidentiality of data, and the place of the interview was made free of interference as much as possible. Participants' permissions were also sought before recording the interviews on tape. Approvals from Aro Neuropsychiatric Hospital, Abeokuta with approval Number PR003/16 and Federal Medical Centre, Abeokuta with approval number FMCA/470/HERC/05/2016 were obtained from institutional ethical boards.

Results

A total of 30 caregivers of mentally ill people were interviewed with a response rate of 100%. Of these, 73% were females, and 27% were males. Findings showed that 23% were under 29 years of age, those in age categories 30-39 were 33%, the highest proportion was 40 years and above with 43%. Most (83%) of the participants were married, while 17% were separated. The distribution of religion showed that the respondents in Nigeria practised the two main religions. The study found that a greater proportion of respondents practised Christianity (67%) while 33% practised Islam. It is also worthy to note that 57% of the participants had secondary education, while 43% of the participants had tertiary education. Surprisingly, 50% had relations with parents, while 17% had a relation with siblings.

Perception of mental illness

Caregivers indicated the causes of mental illness. Few caregivers used the right terminology for the disease. However, experienced medical and social workers' facilitators helped to classify the disease described by participants. The most common causes of mental illness described by participants were: hereditary (*'were Iran'*), a mental illness that one is born with (*'were amutorunwa'*). A small number also mentioned mental illness due to affliction (*'were afise'*).

Table 1: Socio-Demographic Characteristics of In-Depth Interview Participants

Selected Characteristics of Caregivers	Frequency	Percentage
Gender		
Male	8	26.7
Female	22	73.3
Total	30	100.0
Age in years		
18-29	7	23.3
30-39	10	33.3
40 and above	13	43.3
Total	30	100.0
Marital Status		
Single	-	-
Married	25	83.3
Separated	5	16.7
Total	30	100.0
Educational Level		
No Education	-	-
Primary Education	-	-
Secondary Education	17	56.7
Tertiary Education	13	43.3
Total	30	100.0
Religion		
Christianity	20	66.7
Islam	10	33.3
Traditional	-	-
Total	30	100.0
Relation to Patients		
Parent	15	50
Spouse	10	33.3
Sibling	5	16.7
Total	30	100.0
Local Government Areas		
Abeokuta North	10	33.3
Abeokuta South	12	40
Sagamu	8	26.7
Total	30	100.0

Source: Author's Computation.

A caregiver aged 30-39 expressed that *'breaking a family taboo is the primary cause of mental illness. In Yorubaland, it is called 'two idle'*. Another married caregiver, aged 40 years and above pointed out that mental illness is due to insufficient rehabilitation. Other causes of mental illness as experienced are described in the following excerpts:

"Omo on mejo ko'gbodo ya were bi koni taye ninun" (Translated thus; "No mental illness shall affect a child of eight years or less without supernatural causes") (Caregiver, Married, Islam, Spouse).

"The cause of mental illness in the life of my son is as a result of substance/drug abuse" (Caregiver, Separated, Christian, Parent).

Attitudes towards people living with mental illness

Answers from a married caregiver whose husband had a mental illness (30-39 years of age) said that the stigma attached to the disease humiliates him. A caregiver said that "a kind of label is a psychiatric hospital because it is isolated." While one participant stated that stigma is a major obstacle to recovery, it can limit the social functioning of family members and mentally ill people.

A man aged 40 years and above indicated that caregivers' self-stigma is a psychological challenge. An extract of another caregiver in the same age group indicates:

"I have avoided making friends because my younger sister is mentally ill" (Caregiver, Single, Islam,

Sibling).

Many caregivers avoided being identified with the mentally ill people they care for due to public stigma.

'I worried that people would find out about the illness' (Caregiver, Female, Married, Spouse).

'I worried that neighbours would treat me differently' (Caregiver, Male, Islam, Parent).

Most caregivers believed that self-stigma could hurt the mentally ill seeking treatment, adherence and rehabilitation.

'I find it very difficult to give my husband his drugs; this has affected him from recovering fast' (Caregiver, Female, Christian, Spouse).

My daughter was involved in the murder; I took her to a mental home. She was found to have a mental illness. Her health condition is improving, but I'm afraid to take her home so as not to commit murder (Caregiver, male, Christian, Parent).

'My family has a mental illness. No one is willing to marry my daughter because they all believe that it is hereditary (Caregiver, female, Christian, Parent).

Limitations to the utilisation of mental healthcare services

In addition to the main topics identified, the results showed that caregivers faced challenges in the use of mental health services. Most participants indicated that access to and use of mental health services was problematic in the mental illness recovery and rehabilitation process. The general impression was that "financing was a major impediment to the use of mental health services."

"The drugs prescribed by the professional healthcare workers are too expensive." (Caregiver, Single, Sibling).

"To make sure my daughter was treated, I had to lend money to relatives and friends (Caregiver, Separated, Parent).

There was consensus, especially among older caregivers, that the distance is also a major barrier to the utilisation of mental healthcare services. Few of their responses are as follows:

"The biggest obstacle to hospital use is distance. I had to stay in a hotel so my son could receive adequate treatment at the time". (Caregiver, Female, Married, Parent).

"This child is my third child to go to this psychiatric hospital. The hospital is far from where I live." (Caregiver, male, Married, Parent).

Some caregivers pointed out that while the mental hospital is far away, the services offered are

too costly. (Caregiver, Female, Married, Parent).

Coping Strategies towards People Living with Mental illness

Several preventative coping strategies in minimising premature deaths among men as listed in the Sustainable Development Goals (SDGs) were described in the interviews. These approaches were used to manage caregivers' attitudes towards the mentally ill. A popular response from the interviewees was that instituting family support groups and counselling caregivers by professional healthcare providers will be of great importance in dealing with self-stigma among caregivers of mentally ill people.

Primary themes of coping strategies included counselling caregivers by professional healthcare workers, seeking government support in the treatment of people living with mental illness and establishment of family support groups to eradicate or minimise self-stigma among caregivers of mentally ill.

Seeking Counselling from Professional healthcare workers

Across all discussion, seeking counselling from professional healthcare worker was one of the essential steps in coping with the mentally ill. Majority of the participants complained of the need to be counselled. The general perception was that professional healthcare workers were 'divine helpers' in the treatment of mental illness, especially as it relates to the recovery process and rehabilitation. Interviewees thought that health workers were trained discreetly. The following are extracts from some of the respondents in all age groups: *'Hiding anything from medical personnel will be of no help to me. They are here to help me. Their counsel me go a long way' (Caregiver, aged 18-29).*

'Professional healthcare workers are highly respected in this country and are held in high esteem, for me I need their advice so that my wife will get well as quick as possible' (Caregiver, aged 30-39).

'Counselling caregivers will go a long way. It will help to guide me whenever there is a relapse' (Caregiver, aged 40 and above).

Seeking government support in the management of the mentally ill

The analytical results revealed a popular approach to coping among caregivers seeking government support in treating people with mental illness. Virtually all the caregivers described this coping strategy as very important. Other comments in support of this response indicated that 'the best option is government intervention in the treatment of mental illness. A caregiver (aged 30-39) indicated that 'the

drugs are too expensive to purchase, hence the need for subsidy. However, another participant (in age 40 and above) believed that *'if the government can create more psychiatric hospitals in every state in the country, it will be easier to have access to the psychiatric hospitals*. Almost a quarter of all participants indicated that they expected support from the government in the management of these health problems. In this connection, another caregiver (18-29 years old) considered government assistance in reducing premature mental illness deaths. *'for me, I want the government to reinforce the National Health Insurance Scheme (NHIS)*.

Establishment of family support groups

The next strategy for coping with the mentally ill was the establishment of family support groups. Most caregivers reported that family social support could help them feel worthy. Discussions highlighted that family support groups are vital means for families who have a loved one with mental illness, knowing that other caregivers had the same knowledge is a relief to families who often speak about mental illness to relatives, friends and neighbours. Having been told that other caregivers have been able to work out the same health issues can inspire hope. A caregiver aged 37 reported that *'having social groups is the best way to ease stress'*. Another caregiver aged 29 indicated that *'learning from the experience of other caregivers will assist in speedy recovery of the mentally ill'*. This was supported by three caregivers who stated that sharing of knowledge by other caregivers is very important.

Discussion

This study provides evidence on the levels of support and unpaid caregivers attitudes towards PLWMI with the view of reducing premature deaths among men. These findings go beyond existing studies on the attitudes of caregivers and the management of mental health and wellness. In addition to adding to the knowledge base on family/caregiver attitudes, the results also helped achieve goal 3.4 of the Sustainable Development Goals (SDGs), which states that by 2030, premature mortality from non-communicable diseases should be reduced by one-third through prevention and treatment, and mental health and well-being promoted. This study dealt exclusively with different attitudes of family/caregivers in managing people living with mental illness. Amongst the important contributions of this research is the discovery that caregivers experience financial and social burden. Caregivers, who undergo undesirable levels of severe burden, are responsible for caring for people living

with mental illness [26]. To take care of PLWMI, caregivers need support and understanding. Also, PLWMI dominates caregivers, which can lead to an increase in distress and its inability to deal with the crisis [23]. In [13]'s work, unwanted quality of life for caregivers can lead to poor quality of care and a deterioration in their quality of life. Failure to deal with the situation could lead to the possibility of PLWMI being abused, leading to a further deterioration of the disease.

It was also discovered that caregivers were not willing to disclose the patients' mental illness and being ashamed or embarrassed by it. As a result of stigma experienced by the caregivers, they avoided social gatherings or been seen with the mentally ill. This is likely to happen because been seen with the mentally ill; the caregiver is at risk of stigma and discrimination by friends, colleagues or the populace in the society. In the works of [27], stigma in caregivers is on the increase and needs to be eradicated.

It was also discovered that caregivers had to travel miles to get access to mental healthcare services in Nigeria. In the work of [28], women have more frequent access to mental health facilities, receive more treatment, and have a higher rate of psychiatric hospitalisation than men. These variations may affect women's diagnosis and therapy. These variations can have an impact on diagnosis and therapy for women. The results of the study confirm the previous work carried out by [29], which showed that access to mental health services is increasing closely with the health centres. This proximity is necessary to reduce the transport rate and the thoroughness of access to modern health services from a distance.

Limitation of the Study

The study's limitation includes the use of a purposive sample of medical facilities that restrict the generalizability of results. The limited number of interviews may also be a study limitation. The study appraised the attitudes of caregivers towards PLWMI in Nigeria. Responses of attitudes of professional healthcare workers towards PLWMI were neglected. Another significant limitation of the study is the language barrier. The service of a knowledgeable Yoruba interpreter was employed by the principal investigator. This is to allow the Yoruba interpreter to interpret the information provided by the caregivers in the Yoruba Language so as to have rich and in-depth information. On the contrary, some complications with the translator could have existed with the fact that the translator spoke both Yoruba and English Language as some words could have been lost in transition. In view of the above, the reliability of the gathered empirical material may have been negatively affected by the issues mentioned; the research was strengthened by the fact that an appreciable number

of literatures were compared with the interviews conducted. Finally, this study only established responses by caregivers and the key socio-demographic characteristics, the type of mental illness been experienced were not collected.

In conclusion, this study has added to the knowledge about caregivers' attitudes toward PLWMI. This study concludes that the rehabilitation process and management of PLWMI is crucial to the achievement of target 3.4 of the Sustainable Development Goals (SDGs). The non-availability of mental healthcare services and the poor utilisation of psychiatric hospitals in Nigeria which include but not limited to stigma, finance and distance should be urgently addressed by the government. The study recommends that the government find lasting solutions to the challenges of PLWMI by providing support and adequate healthcare facilities to reduce thirty - three per cent of premature death from non-communicable diseases through prevention, management and promotion of mental health. The existing policy document on mental health, formulated by the Government of Nigeria in 1991, which includes a promotion, advocacy, prevention, rehabilitation and management.

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References

- World Health Organization. Department of Mental Health, Substance Abuse, World Health Organization, World Health Organization. Mental Health Evidence, Research Team. Mental health atlas 2015. World Health Organization, 2015.
- World Health Organisation. Mental health: Maternal mental health, 2017. www.who.int/mentalhealth/maternalchild/maternalmentalhealth. Accessed 15th February, 2017.
- Larson JE, Corrigan P. The stigma of families with mental illness. *Academic psychiatry*. 2008; 32(2):87-91. <https://doi.org/10.1176/appi.ap.32.2.87> PMID:18349326
- Corrigan PW, Miller FE. Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*. 2004; 13(6):537-48. <https://doi.org/10.1080/09638230400017004>
- Olawande TI. Gender Differentials in the Perception and Treatment of Mental Illness among the Yoruba of Ogun State, Nigeria. Unpublished PhD Thesis, 2017. <https://doi.org/10.4172/1522-4821.1000384>
- Saunders JC. Families living with severe mental illness: a literature review. *Issues in Mental Health Nursing*. 2009; 24(2): 175-198. <https://doi.org/10.1080/01612840305301> PMID:12554427
- Ohaeri JU. The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*. 2003; 16(4):457-65. <https://doi.org/10.1097/01.yco.0000079212.36371.c0>
- Edition F. Diagnostic and statistical manual of mental disorders. Am Psychiatric Assoc. 2013.
- Esan OB, Kola L, Gureje O. Mental disorders and earnings: results from the Nigerian National Survey of Mental Health and Well-Being (NSMHW). *The journal of mental health policy and economics*. 2012; 15(2):77-82.
- Kaur N. Caregiving burden and social support among caregivers of schizophrenic patients. *Delhi Psychiatry Journal*. 2014; 17:337-42.
- World Health Organisation. Gender disparities in mental health. Department of mental health and substance dependence. Geneva: World Health Organisation, 2015.
- Mehrotra K, Nautiyal S, Raguram A. Mental health literacy in family caregivers: A comparative analysis. *Asian journal of psychiatry*. 2018; 31:58-62. <https://doi.org/10.1016/j.aip.2018.01.021> PMID:29414389
- Stoneman Z, Brody GH, Davis CH, Crapps JM. Role relations between children who are mentally retarded and their older siblings: Observations in three in-home contexts. *Research in Developmental Disabilities*. 1989; 10(1):61-76. [https://doi.org/10.1016/0891-4222\(89\)90029-2](https://doi.org/10.1016/0891-4222(89)90029-2)
- Wilson J, Blacher J, Baker, BL. Siblings of children with severe handicaps. *Mental Retardation*. 2001; 27(3):167-173.
- Awad AG, Voruganti LN. The burden of schizophrenia on caregivers. *Pharmacoeconomics*. 2008; 26(2):149-62. <https://doi.org/10.2165/00019053-200826020-00005> PMID:18198934
- Chan SW. Global perspective of burden of family caregivers for persons with schizophrenia. *Archives of psychiatric nursing*. 2011; 25(5):339-49. <https://doi.org/10.1016/j.apnu.2011.03.008> PMID:21978802
- World Health Organisation, 2017. Accessed Online www.who.int/mentalhealth/prevention
- El-Islam, MF. Arab culture and mental healthcare. *Transcultural Psychiatry*. 2008; 45(4):1-8. <https://doi.org/10.1177/1363461508100788> PMID:19091731
- Green J, Thorogood N. *Qualitative methods for health research*. London: Sage Publications Ltd., 2004:279.
- Amoo EO, Omideyi AK, Fadayomi TO, Ajayi MP, Oni GA, Idowu AE. Male reproductive health challenges: appraisal of wives coping strategies. *Reproductive health*. 2017; 14(1):90. <https://doi.org/10.1186/s12978-017-0341-2> PMID:28754166 PMCid:PMC5534028
- Novak M, Guest C. Application of a multidimensional caregiver burden inventory. *The gerontologist*. 1989; 29(6):798-803. <https://doi.org/10.1093/geront/29.6.798> PMID:2516000
- Prabhu GG. Mental illness, public attitudes and public education. *Indian J Clin Psychol*. 1983; 10:13-26.
- Mokgothu MC, Du Plessis E, Koen MP. The strengths of families in supporting mentally-ill family members. *Curationis*. 2015; 38(1):1-9. <https://doi.org/10.4102/curationis.v38i1.1258> PMID:26018195 PMCid:PMC6091649
- Olanrewaju FO, Omotoso F, Alabi JO. Boko Haram insurgency and the management of internally displaced women in Nigeria: A situational analysis. *African Population Studies*. 2018; 32(1): 4022-4033.
- Clark JP. Qualitative research review guidelines-RATS. *Peer review in health sciences*. 2003:219-35.
- Gupta MD, Gauri V, Khemani S. Decentralized Delivery of Primary Health Services in Nigeria. Africa Region Human Development Working Paper Series Washington, DC, The World Bank. 2003.
- Shibre T, Negash A, Kullgren G, Kebede D, Alem A, Fekadu A, Fekadu D, Medhin G, Jacobsson L. Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social Psychiatry and Psychiatric Epidemiology*. 2001; 36(6):299-303. <https://doi.org/10.1007/s001270170048> PMID:11583460
- Rhodes AE, Goering PN, To T, Williams JI. Gender and outpatient mental health service use. *Social science & medicine*. 2002; 54(1):1-0. [https://doi.org/10.1016/S0277-9536\(01\)00002-8](https://doi.org/10.1016/S0277-9536(01)00002-8)
- Omonona BT, Obisesan AA, Aromolaran OA. Healthcare access and utilization among rural households in Nigeria. *Journal of Development and Agricultural Economics*. 2015; 7(5):195-203. <https://doi.org/10.5897/JDAE2014.0620>