FAMILY SUPPORT AND CLINICAL CORRELATES AMONG PATIENTS WITH SCHIZOPHRENIA IN A NEUROPSYCHIATRIC HOSPITAL IN NIGERIA

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ABSTRACT
In developing countries, families play a central role in caring for the mentally ill. However, the assessment of the level of family support in relation to the sociodemographic and clinical factors of schizophrenia patients have not been well researched. This study is a furtherance of the management schizophrenia patients by assessing their level of perceived family support and its relationship to their socio-demographic and clinical variables. It is a cross-sectional descriptive study of 100 patients with schizophrenia attending the outpatient clinic of a specialist psychiatric hospital, for follow up care. Diagnoses were based on ICD-10 Diagnostic criteria for research. The questionnaires administered to the participants consists of clinical and socio-demographic factors and self-rated 20-item Perceived Social Support-family scale. Most participants had strong family support (96%) while the rest had weak family support. The unmarried participants were associated with higher family support scores than the married. (Mann Whitney U=548.00, p=0.03). There was no relationship between family support and age or duration of illness and treatment. It is important to strengthen the existing family support and to utilize it in the management of patients with schizophrenia. This will reduce the burden on families and contribute to better outcome measures among schizophrenia patients.

Keywords*: family support, schizophrenia.*

INTRODUCTION
The family is the most elementary societal group with bonds of kinship or marriage and is universal (Simpson, 2006). It may also be extended through marriage of more than one wife (polygamy), or through shared residence of two or more married couples and their children in most West African countries (Afolabi, Abioye-Kuteyi, Fatoye, Bello &Adewuya ,2007).
Family members appear to be the most significant source of social support and reason for most of the association between social support and health (Afolabi *et al*., 2007). They play a crucial role in caring for the mentally ill and in several ways, they are the main care providers (WHO 2001). The cultural standards of social closeness, support and social link greatly contribute to patient's wellbeing. In the absence of adequate social support from government, welfare of psychiatric patients depends vastly on the collaboration of the family (Fatoye, Ayeni & Oladimeji, 2006).
Loyalty to family is strong in Nigeria. This traditional view is however changing as a result of family members moving from rural communities to urban areas in search of work or educational prospects. This has led to family breakdown and separation. (Bhugra, 1989). A patient who gets satisfactory family support is more likely return to normal psychosocial functioning. This psychosocial well-being is a function of patient's perception of the care and support received. The perception of these patients is likely to differ across ethnic groups as a consequence of cultural difference and changing degrees of experience with discrimination and stigmatisation. There are however, inconsistent findings on the outcome of social support on the psychosocial functioning of psychiatric patients (Fatoye *et al.*, 2006).
Nigeria is a customarily diverse country and its various parts are different in their access to mental health services (Ayonrinde, Gureje & Lawal, 2004). This form opinions in the minds of

family members that may either promote or negatively impact family support. The opinions about causative factors of mental illness are also associated with the experience of family stigma (Bhugra, 1989). Mental disorders are entrenched in the social milieu of individuals and a lot of social factors affect the onset, course and outcome of these disorders. The social and emotional situation within the family also plays a crucial role occurrence of mental disorders. Association between mental disorders like schizophrenia and depression and the family environment have been previously established (Kuipers, 1990). These links have been said to be an important risk factor for relapses especially in schizophrenia

Assessment of the level of family support will assist mental health professionals to identify the possible factors that influence family support positively or negatively. The findings are likely to be modified by the diverse cultural values and family structures in the study setting.

Literature Review

The definition of family is not limited to the traditional family, but also comprised the agreed societal rules and expectations specifying right and unbefitting ways to behave in a society (Abu-Laban & Abu-Laban, 1994). Intergenerational bonds also exist based on lineage or biological ancestry. These are known as one's kinship group (Murdock, 1949). All these customs influence the characterisation of the family.

Quite a number of studies on family support have focused on the capability of family members to alleviate and cushion the impact of psychosocial stress on mental health. (Cassel, 1976). The provision of family social support also varies with gender, relationship between giver and receiver, social-cultural context and personality features of the giver. (Dakof & Taylor, 1990). Family social support also refers to coping resources (emotional and physical), perceived to be provided by the family (Becker, Lesse & McCrone, 1998). The problems of measuring number of contacts as an indicator of family support are that it is likely that the actual numbers are not important. Also, some social ties could be a source of stress. This observation led to various studies that have tried to measure the quality of contacts as well as their number (Henderson, 1984). By extension, it was not the family social support itself but the belief in the support that is vital (Armstrong, 1997).

Compared with objective family social support, perceived family social support is said to be mainly cognitively mediated. That is, support functions by influencing one's assessment of stressfulness of a situation (Cohen & Mckay, 1984). Potentially stressful events would be assessed as less stressful or even of no negative effect if support affected interpretation of the threat. Therefore, a measure of perceived accessibility of family social support would be more a sensitive indicator of its buffering effects than objective presence of that support (Blazer, 1982)

In Nigeria, a study on the Perception of social support role of the extended family network by patients with schizophrenia and affective disorders, reported that age and duration of illness were significantly negatively correlated with perceptions of social support from the extended family (Ohaeri, 1998).

The influence of family support on patients with psychiatric disorders have also been investigated by other studies. One of these studies showed that family support (assessed by family involvement), was significantly associated with family participation in treatment, post-discharge appointment but not with medication adherence. A limitation of this study is the fact that family support was assessed during hospitalization not at home. The advantages of the sick role during hospitalization may have confounded the study (Adeponle *et al.*, 2009).

A Study in western cultures have also examined the relationship between family support and quality of life among 83 patients suffering from schizophrenia, schizoaffective disorder, bipolar disorder, depression and other psychiatric conditions. Family support was found not to be

associated with the subcomponents of quality of life. The study did not fully assess transportation, finance or physical health of patients (Sharir, Tanasescu, Turbow & Mamman., 2007).

In a more recent study to review psychosocial interventions designed to promote positive family environment for schizophrenia patient, brief family interventions were associated with better understanding in family members of these patients (Okpokoro, Adams & Sampson, 2014). This shows the potentials that are inherent in family members and useful in the management of these patients. A qualitative study has shown that family support appears to be useful in reducing the stigma on communities in which schizophrenia patients live (Erna Erawati & Budi Anna Keliat,2015). This helps in the rehabilitation and re-integration of these patients.

The findings in these studies may reflect underlying individual, family and regional differences that might have affected the perception of family support and its usefulness in improving quality of life.

METHODOLOGY

Study Design

It is a cross-sectional descriptive study. Participants were schizophrenia patients attending the outpatient clinic at Federal Neuropsychiatric Hospital Kware, Sokoto Nigeria.

Setting

The Federal Neuropsychiatric Hospital Kware, Sokoto is a tertiary specialist psychiatric hospital located in Kware local government area of Sokoto State, North-west Nigeria. The hospital attends to patients with mental disorders mostly from Sokoto, Kebbi, Zamfara and Niger states. These are mainly Hausa–speaking states. It also provides services for patients from Niger and Benin Republic.

Ethical Consideration

Ethical approval for the study was obtained from the Health Research Ethics Committee of the Federal Neuropsychiatric Hospital Kware, Sokoto. Code: FNPHK/ADM/SUB/809/VOL.1

Patients found to be having low family support will be offered access to appropriate social intervention and family therapy.

Instruments

(a). The Perceived Social Support Family Scale: This is a 20-item validated measure of family support. It is a self-report scale developed by Procidano and Heller in 1983. Scores range from 0 to 20. Scores equal to or greater than 11 points are said to have strong family support, scores 7 to 10 have weak family support while scores equal or less than 6 points have no family support. The perceived social support–family scale has good reliability and validity. (Procidano & Heller, 1983) and an alpha coefficient of 0.90.A Hausa version was developed through forward-backward translation.

(b). Proforma Questionnaire: A questionnaire for data on socio-demographic factors like age, sex, marital status etc. was also developed.

Selection of Participants

Participants were recruited by convenience sampling based on the inclusion and exclusion criteria. This was because it was difficult to determine when these patients will come for follow-

up care and many do not adhere to the scheduled appointment date. Informed consent was gotten from all participants before the administration of the instrument**s.**

Inclusion Criteria

1. Patients must meet ICD-10 Diagnostic Criteria for Research as documented in the medical files

2. The patients must be mentally stable.

Exclusion Criteria

1. Patients with delusions, hallucinations or absence of insight will be excluded from the study.
2. Patients with co-morbid conditions or serious physical illness. E.g. Blindness and cardiovascular diseases will be ineligible for the study.

Hypotheses

1. There will be no significant association between family support and socio-demographic factors of patients with schizophrenia

2. There will be no significant association between family support and clinical factors of patients with schizophrenia

Procedure

Participants were enlisted consecutively through individual contact as they came for follow-up care at the out-patient clinic; on every clinic day. Patients that satisfy the inclusion and exclusion criteria were educated on the nature of the study and the estimated amount of time needed for participation. Patients were told that their participation is simply voluntary with no that there are no disadvantages for non-participation. Informed consent was gotten from all participants before administration of the questionnaires.

Data analysis

Data was analysed using Statistical Package for the Social Sciences Software Version 16. Descriptive statistics were calculated for the variables. For categorical variables, the proportions were computed. For continuous variables, means and standard deviations (SD) were generated. The correlation between family support and other continuous variables were determined using Pearson Correlation Coefficient. While association between family support and categorical variables was determined using Mann-Whitney U test. Levels of significance was set at $p< 0.05$.

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RESULTS

The participants consist of 65% males and 35% males. Also, most of the participants were married (80%). Other details on sociodemographic factors can be seen on Table 1.

Table 1.
Sociodemographic/Clinical Factors of Participants (Categorical Variables)

Socio-demographic factors	Frequency	%
Gender		
Male	65	65%
Female	35	35%
Marital Status		
Married	80	80%
Unmarried	20	20%
Tribe		
Hausa	96	96%
Others	4	4%
Religion		
Islam	100	100%
Christianity	-	-
Education		
Formal	19	19%
Non-formal	81	81%
Employment status		
Employed	10	10%
Unemployed	90	90%
State of Residence		
Sokoto	82	82%
Others	18	18%

The mean age of participants was 31.31years while the mean duration of illness and treatment was 7.44 and 5.92 years respectively. Details are as shown in Table 2.

Table2

Sociodemographic/Clinical Factors (Continuous Variables)

Factors	Mean	S. D	Minimum	Maximum
Family Support Score	13.46	1.65	8	17
Age	31.31	11.31	16	65
Duration of illness	7.44	6.13	1	35
Duration of Treatment	5.92	5.39	1	35

Note: S.D is Standard deviation.

Most participants had strong family support (96%) while the rest had weak family support. Details are as shown in Table3.

Table3

Family Support Categories

FREQUENCY (%)	STRONG FAMILY SUPPORT	WEAK FAMILY SUPPORT	NO FAMILY SUPPORT
n (%)	96 (96%)	4 (4%)	---

The unmarried participants were associated with higher family support scores than the married. (U=548.00, p=0.03). Other sociodemographic factors were not associated with family support score. Details are as shown in Table 4.

Table4
Relationship Between Family Support Scores and Sociodemographic Factors

	Family Support Score (Mean Rank)	Z value	Mann-Whitney U	P value
Gender				
Male	49.96			
Female	51.50	-0.26	1102.50	0.80
Marital Status				
Married	47.36			
Unmarried	63.08	-2.21	548.00	0.03
Education				
Educated(formal)	55.63			
Uneducated	49.30	-0.88	672.00	0.38
Work Status				
Employed	51.45			
Unemployed	50.39	-0.11	440.50	0.91

There was no relationship between family support and age, duration of illness/treatment. Details are as shown in Table5.

Table 5
Relationship Between Family Support and Age, Duration of illness and Treatment.

	Mean (S.D)	Pearson correlation coefficient	P Value
Age	31.31(11.31)		0.35
FSS	14.74(12.96)	-0.10	
Duration of illness	7.44(6.13)		
FSS	14.74(12.96)	-0.11	0.27
Duration of Treatment	5.92(5.39)	-0.10	0.32
FSS	14.74(12.96)		

Discussion

This study was on family support and how it relates to the sociodemographic factors of patients with schizophrenias. In Nigeria, few studies have examined this level of family support and associated factors.

The demographic distribution of subjects showed that most of the patients were young adults, within the age range 15-25yrs and 26-36yrs.This is similar to the findings in other studies done in Nigeria (Afolabi et al., 2007, Adewuya, 2007). This demographic structure as well as social, economic and political environments, places great demands on families (Afolabi et al., 2007). Also, majority of the participants were uneducated. This is because most of them were from the state of the study setting. The school enrolment is still generally low compared to other regions of the country especially for the females (UNICEF, 2002).

Majority of patients were married. This is similar to findings in the study carried out in Ilorin, North-central Nigeria (Adeponle, 2003) but different from that done in Lagos, South-western Nigeria (Adewuya, 2007). In western cultures (Diego & Henlen, 2007, Gupta *et al*., 2007) reported that the majority of patients with schizophrenia were divorced or separated from their spouses. In northern Nigeria, wives are not usually formally divorced due to mental illness. The usual pattern is for the extended family of patients to take responsibility for her care with necessary support from the husband, until she is well enough to return to him; more so that polygamy is common and culturally or religiously allowed for men (Weeks, 1984). For male patients with mental illness, his relatives may take over his responsibilities, such as upkeep of his children and wife. Marriages are also easily arranged by relatives for patients who are not able to do so; on their own (Akande, 1979).

The majority of the patients were unemployed. This is also similar to that found in other studies (Adewuya, 2007, Gupta *et al*., 2007). This unemployment is basically lack of a paid job as some of the patients were self-employed as farmers, which is a predominant occupation in northern Nigeria.

The majority of patients had strong family support. These findings are not surprising because a central belief of people from northern Nigeria revolves around family intervention. Although there are little national social welfare provisions and the financial burden on the family is huge, most family caregivers have a sense cultural responsibility to their mentally ill relatives, and in many families caring makes the emotional ties better. This has implication in respect of the outcome and quality of life of the patients. The effect of this strong family support on these parameters need to be investigated in further studies.

The unmarried were significantly associated with higher family support scores than the married. This may be explained by the support individuals are more likely to receive from their families when they are unmarried (single, widowed or separated). When they become married the extended family are likely to reserve the financial responsibility to their spouses alone. It is also possible that the burden of care is felt more when the patients stay with their spouses during an episode of the illness. This may lead to lower levels of perceived family support for the married.

There was no association between family support and gender, education and employment status. However female patients had higher mean score of family support than their male counterparts. The unemployed, uneducated and married group had lower mean score of family support than the employed, educated and unmarried respectively.

There was no correlation of family support with age, duration of illness or treatment. This is unlike that reported by Ohaeri (Ohaeri,1998) in which age and duration of illness was significantly, negatively correlated with perception of support from the extended family in both patients with schizophrenia and affective disorders. This study setting has quite a number of social welfare services that families of patients can access to support their wards. This may improve patient's perception of support from families and reduce burden on families. This

reduced burden may also enable the families to render support in other areas of need for the patient. These social interventions are fairly well funded and may explain the difference in the findings.

The above findings also show that the sociodemographic factors and clinical variables did not influence the level of perceived family support. These findings are contrary to quite a number of studies done in other parts of the country. The socio-cultural setting appears to have played significant role in the level of family support these patients receive. However, this also need to be investigated in further studies.

Conclusion

It is important to strengthen the existing level of family support in the study setting and to highlight the socio-cultural factors that might have contributed to the attainment of such level of support. This is necessary due to current population shift from rural to urban. This leads to family separation and acculturation. Furthermore, this predominant and good family support becomes more pertinent in view of the poor national social welfare and policies for individuals with mental disorders in this study setting.

Recommendations

1. Stakeholders in the community, religious and social groups should be educated on how to strengthen the existing family support and maximize the high level of this support for patients in this study setting.
2. The level of family support for schizophrenia patients should be assessed in other regions of the country for comparism and a more comprehensive assessment of family support in these patients.

Limitation

1. This study is hospital based and therefore may not be representative of the individuals with schizophrenia in northern Nigeria.
2. It is a cross-sectional study and therefore may not capture the changes in levels of the measurements over time.

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AUTHORS CONTRIBUTION

Shehu Sale: Design of Study
Adebayo Sunday Adebisi: Analysis of data and writing of manuscript
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