STRESS AND COPING STRATEGIES AMONG RELATIVES OF MENTALLY ILL IN IBADAN METROPOLIS, OYO STATE, NIGERIA

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ABSTRACT
Mental illness of an individual does not just affect the patient, it may also be seen as a problem of the whole family. As primary care givers, families suffer from stress factors such as financial burdens, the neglect of other sibling and the interruption of the family routines. This work investigates the stress factors and coping strategies adopted by relatives of people living with mental illness in Ibadan Metropolis, Oyo state. The study adopted a cross-sectional research design involving 300 relatives of mentally ill individuals seen at the psychiatric unit of Ring Road State hospital, Ibadan. A purposive sampling was used to elicit information from respondents. Among other findings, it found that 59% of respondents were children of the mentally ill patients and 43% indicated that the emotional stress was the major stressor identified and creation of humour (29%) was the major coping strategy employed by the relatives. Furthermore, there were significant relationship between stressors, coping strategies and gender of the caregivers. The study recommends that the government health care providers and policy makers should organize public enlightenment programmes on mental health education. Health care providers should educate family members of mentally ill so as to enable them cope with stressors.
Keywords: *Stress, Coping strategies, mental illness, relatives.*

INTRODUCTION

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 (American Psychiatric Association, 1994; Charlson et al., 2016).American Psychiatric Association (1994) documented that alterations in thinking and behaviour contribute to a host of problems like distress, impaired functioning, disability, loss of freedom and heightened risk of death. In 2016 over 1 billion people were recorded to be affected by mental disorder worldwide and they are responsible for 19% of years lived in disability. (GBD, 2016).).Mental illness carries great social stigma especially linked with fear of unpredictable and violent behaviour (Rehm and Shield, 2019). Mental illness of an individual therefore, may be seen as a problem of the whole family. As primary care givers, families suffer from stress factors such as financial burdens, the neglect of other sibling and the interruption of the family routines Charlson et al., 2016). Stress therefore is the body's response to physical, mental, or emotional changes, situations, and forces. Stress can result from external factors (e.g., events, environment) or from internal factors (e.g., expectations, attitudes, feelings). Stress often occurs in response to situations that are perceived as being difficult to handle or threatening. Common causes for stress include illness, injury, fear, and anxiety.

When studying the adjustment of families of formerly hospitalized mentally ill relative, (Karnieli-Miller, 2013)found that families feel hopelessly burdened or trapped by the former patient's problems. In a study conducted by Chukwu et al (2019) on a support group of parents of mentally ill persons, it was found that parents often bear the burden of guilt and feelings of responsibilities for their child's mental illness. The term coping generally refers to expending conscious efforts to solve personal and interpersonal problems and seeking to master, minimise or tolerate stress (Weiten and Lloyd, 2008).Coping skills are methods a person uses to deal with stressful situations and this takes practice. Among these coping strategies are: spirituality, physical activities, relaxation techniques, friendship building, sleeping creating humour and engaging in hobbies. However, utilizing these skills becomes easier overtime. Most importantly, good coping strategies or skills make way for good mental health wellness. Coping responses are partly controlled by personality habitual traits and partly by the social environment (Carver, Charles; Connor-Smith, Jennifer, 2010).

Family members are often reluctant to discuss their mentally ill member with their friends because they do not know how people will react due to myths and misconception that surround mental illness. This bearing of burden by members of the family of those having mental illness results in stress. Reliance on the families of people with a mental illness inevitably results in some form of burden experienced by carers (Karp (2000).Being a caregiver for someone with mental illness can create considerable costs for families and often involves the family unit in a long-term stress that threatens the physical, social and mental wellbeing of all family members (Pickett-Schenk et al. 2000). Previous studies have been done but most of the studies examined were often directed to meeting unmet needs of the mentally ill rather than incorporate the needs of the family as a whole. There is then the need to investigate the stress factors and coping strategies adopted by relatives of people living with mental illness. This study investigates the stress experienced and coping strategies adopted by relatives of people living with mental illness in Ibadan Metropolis, Oyo state. Nigeria. This involves; investigating the stressors experienced by relatives of people living with mental illness, investigating how relatives of people living with mental illness cope with their stressors and exploring factors determining the adoption of their preferred coping strategies.

Theoretical Framework

The theory adopted for this study is the Family System theory, it is also known as the system model theory. The pioneers of family system theory are Nathan Ackerman, Jay Haley, Donald Jackson, Virginia Satir, Murray Bowen and Lyman Wyne. These pioneers started their work in 1950 although their work primarily began in the area of schizophrenia, which quickly spread to the entire field of mental illness. Family system theories make us to see abnormal behaviour as the product of habitual relationship patterns, usually within the family. These theories recognize the importance of the family in determining the psychosocial and emotional well-being of each member. By the 1970s, these theories were applied to specific patterns of abnormal behaviour, Coyne, 2000 suggested that depression might be the product of a spiral of complementary dominance and submission responses. Bowen's theory was developed during his work with schizophrenic families. He began seeing distinctions in affective states and cognitive processed that led to his scale of differentiation.

This early work was based on psychoanalytic theory and applied to an approach that defined the family as a system operated by the principles as other system such as societies, corporations, or institutions. Bowen further believes that a person current behaviour was caused by a transference process that inappropriately applied to the past history and behaviours to present situations. Bowen noticed that "stuck togetherness" was the family's defense against crisis or tension. They would pull together when they felt stressed and isolate themselves from outside influence to restore balance. This system was described as a delicate balance a change in one member would affect all other members. In this system the smallest unit (consisting of

three people) was called the triangle. Bowen felt that dyads (two people) who could not handle stress would bring a third person to stabilize the unit. In a state of calm, there are two comfortable sides of the triangle and one conflict.

In summary, the family system theory is important to this study as it will enable family members of mentally ill to look at dysfunctional behaviour in the family in terms of lack of differentiation of family members, repression of individuality and the inability of spouses to differentiate from their parents past behaviours. It is also deduced that while one member of the family may have symptoms, the disturbance is not merely in the symptomatic person but in the family unit as a whole. The family is seen as a system in which the whole is more than the sum of its parts.

METHODOLOGY

The study adopted a cross-sectional research design. The incidence of schizophrenia cases seen at the psychiatric unit of Ring Road State hospital, Ibadan, Oyo State was ascertained to be seven hundred and forty-one (741) and recorded. The study population was two relatives (spouse and children) each of all the incidences of schizophrenia. This then gives a total population of one thousand, four hundred and eighty-two (1482).Using Yaro Yamani's sample size selection formula, sample size was three hundred and fifteen (315). Assuming a 10% attrition rate, the final sample size was 315 + 32 = 347. Purposive sampling technique was used by using only relatives of patients with schizophrenia.. This was done by including two members from the family of each patient with schizophrenia who have accompanied the patient to the outpatient clinic. These family members also reside with mentally ill relative.

This study adopted well-structured questionnaire which sought responses from relatives of mentally ill was used. The first section sought responses on demographic characterises of the respondents. The section has 10 questions. The second section has 14 questions which sought responses on stressors experienced by relatives of people living with mental illness. The third section also had 14 questions and sought responses on relatives' coping strategies with stressors. The last section which has 14 questions sought responses on factors determining coping strategies adopted by family members of people living with mental illness. The face and construct validity of the instrument were ascertained by other experts in the field and the reliability of the questionnaire was done by test re-test method and the following alpha values were obtained: stressor experience 0.72, coping strategies 0.74, and preferred choice 0.91.

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, during which time all documented patients had opportunities of attending follow up appointments. These relatives filled the questionnaires within the hospital premise after the medical practitioner had attended to the ill family member. The Ethical approval was gotten from an ethics board before commencement of the study, informed consents were obtained from the participants and data collection was done with adherence to ethics of explaining the purpose of the study to each respondents and asking their permission to be involved in the study by answering questionnaire and ensuring confidentiality of respondent's responses. The data generated from the field with the help of questionnaire were checked, cleaned, coded and analysed using the statistical Package for the Social Sciences(SPSS version 20).The data were analyzed at both descriptive and inferential levels and presented in frequencies, Percentages, chi square and correlation analysis at0.05significance level of acceptance or rejection.

RESULTS

Socio-demographic Characteristics of Respondents

Table 1 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. 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 female during the data collection on the field. Also majority of respondents (36.3%) were married, 25.7% were single, 24% of respondents were separated while very few (8%& 6%) of respondents were divorced and widow. More than half of the respondent (174, 58%) practiced Islamic while 36% (108) affiliated with Christianity religion.

Table 1. 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 – 54	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
TOTAL	**300**	**100.0**

The distribution of educational status of respondents in figure 1 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 respondents have no formal education.

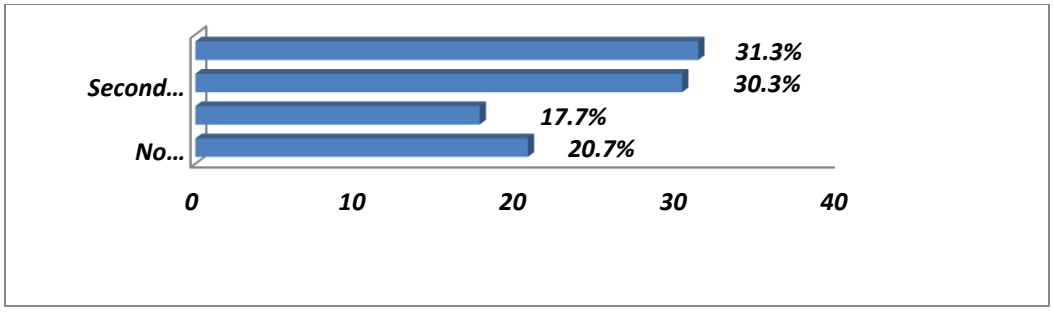

Fig 1 Distribution of Respondents Educational Status

It was observed in the research that one hundred and sixty-six of the respondents which is the highest (55.3%)group reside in low density areas. The lowest (19.3%) totalling fifty-eight reside in medium density areas. Various relationships with the mentally ill family member were established

from the research work. Children of mentally ill relative constituted the largest group (59%) while parents are the smallest group (16%). 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 placeIn discussing distribution of the structure of household, the research work found nuclear family to be the highest population amongst the respondents used for the study. Those that belong to the extended family are one hundred and forty-three (47.7%).

Table 2: Socio-economic characteristics of the respondents

Variable	Frequency	Percentage
Population Density of Residence		
Low Density	166	55.3
Medium Density	58	19.3
High Density	78	35.5
Relationship with the patient		
Parent	48	16
Spouse	75	25
Child	177	59
Ethnicity		
Yoruba	250	83.3
Igbo	42	14
Hausa	5	1.7
Others	3	1
Household Structure		
Nuclear	146	48.7.
Extended	143	47.7
Others	11	3.7
TOTAL	**300**	**100.0**

Stress experienced by relatives of people living with schizophrenia

The relatives of people living with mental illness experienced physical, social, emotional and psychological stress in the family. This study found that most respondents experienced emotional stress most (43%) closely followed by experience of physical stress which is reported by 32% of the respondents.

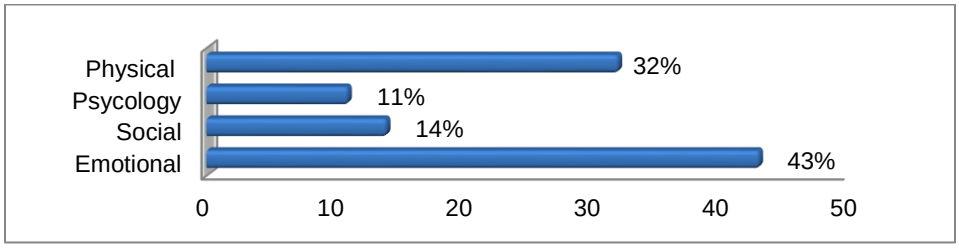

Fig 2: Distribution of Respondents on Stressor Experience in the Family

COPING STRATEGIES WITH STRESSORS

Table 3 has shown responses on the impact of different coping strategies with stress. There are several coping strategies but the ones reported include avoidance, creation of humour, mental health education, spiritual help, seeking help from others, use of alcohol and other drugs. Creation of humour was rated highest (29.3%) form of coping strategies the respondents employed to cope with stress faced because of the family member with mental illness. Use of alcohol and other drugs are the least (11%) reported form of coping strategies.

TABLE 3: COPING STRATEGIES WITH STRESSOR

Coping strategies		
	FREQUENCY	**PERCENTAGE**
Avoidance	39	13
Creation of Humour	88	29.3
Mental health education	47	15.7
Spiritual Help	59	19.7
Use of Alcohol and other drug	33	11
Seeking help from others	34	11.3
TOTAL	300	100

FACTORS CONTRIBUTING TO COPING STRATEGIES

Figure 3 has shown various factors contributing to the choice of coping strategies. It was obviously shown that gender of respondents was the most (30%) considered factor contributing to the choice of coping strategy made. Cultural affiliation (13%), severity of illness (12.3%), duration of illness (11.7%) and age (10.3%) are factors considered to be contributing to the choice of coping strategies at about the same rate whereas social support is the least considered.

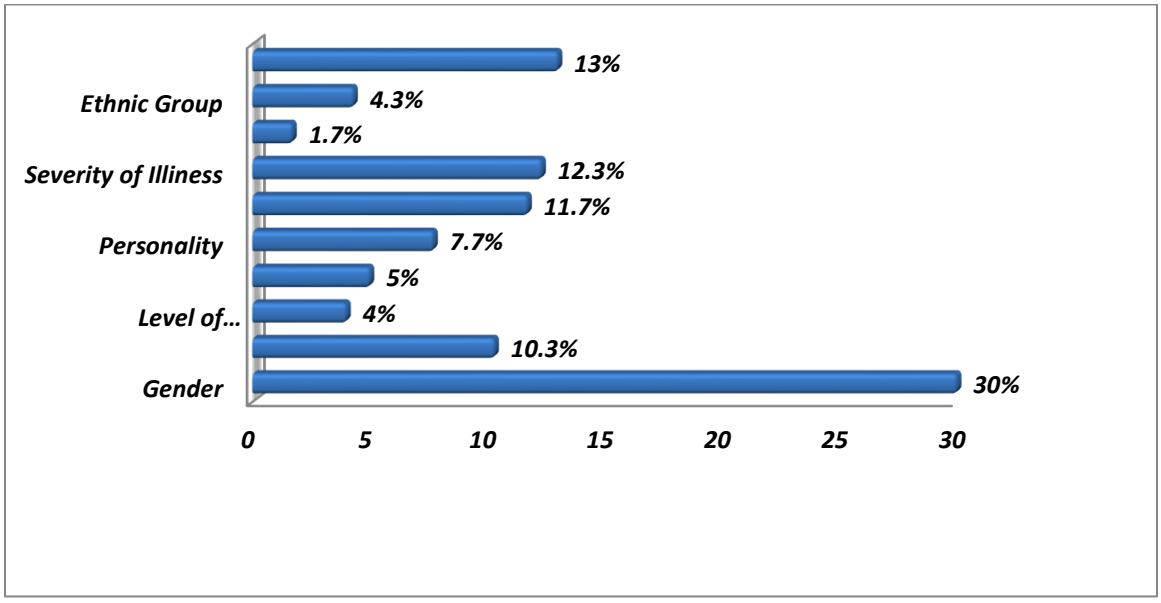

Fig 3: Distribution of Respondents on the Factors that contribute to the choice of coping strategies

Relationship between coping strategies and age as a stressor

Table 4 shows, there is a significant relationship between respondent's Age and their coping strategies adopted. Since the p-value (0.001) for the Chi-square test is less than 0.05. This means that, age of respondents influence their coping strategies adopted. The tables and figures have also identified various coping strategies with seeking spiritual assistance, seeking help/social support and seeking mental education having higher responses. The study examined relationships between levels of expressed emotions in 44 parents of individuals with schizophrenia and the coping strategies they used. It is also similar to the submission that research consistently show humour and comedies are often associated with enduring negative stereotypes about social groups (Ford & Fergusson, 2004; Thomas and Essex, 2004).

TABLE 4: Relationship between coping strategies and age as a stressor

	20-24yrs	25-29yrs	30-34yrs	35-39yrs	40-44yrs	45-49yrs	50-54yrs	55-59yrs	60-64yrs	Total
Avoidance	6 2.0%	3 1.0%	5 1.7%	8 2.7%	2 .7%	6 2.0	8 2.7%	1 .3%	0 0.0%	39 13.0
Creation Of humor	5 1.7%	7 2.3%	4 1.3%	18 6.0%	6 2.0%	12 4.0%	23 7.7%	2 .7%	11 3.7%	88 29.3%
Mental Health Education	4 1.3%	13 4.3%	9 3.0%	6 2.0%	5 1.7%	3 1.0%	3 1.0%	4 1.3%	0 0.0%	47 15.7%
Spiritual Help	2 .7%	8 2.7%	8 2.7%	10 3.3%	4 1.3%	7 2.3%	15 5.0%	0 0.0%	5 1.7%	59 19.7%
Use of Alcohol and other drug	3 1.0%	2 .7%	4 1.3%	12 4.0%	3 1.0%	5 1.7%	3 1.0%	1 .3%	0 0.0%	33 11.0%
Seeking Help from Others	0 0.0%	6 2.0%	4 1.3%	4 1.3%	7 2.3%	1 .3%	9 3.0%	1 .3%	2 .7%	34 11.3%
Total	20 6.7%	39 13.0%	34 11.3%	58 19.3%	27 9.0%	34 11.3%	61 20.3%	9 3.0%	18 6.0%	300 100.%

$X^2 = 75.428$**DF=40 P-VALUE (0.001)**

Relationship between coping strategies adopted and gender

From the Table 5 below, there is a significant relationship between respondent's Gender and their coping strategies adopted. Since the p-value (0.000) for the Chi-square test is less than 0.05. This means that, respondents gender influenced their coping strategies adopted.

TABLE 5: Relationship between coping strategies and gender

COPING STRATEGIES WITH STRESSORS	*MALE*	*FEMALE*	*Total*
Avoidance	35 (1.7%)	4 (0.3%)	39 (13.0%)
Creation Of humor	24 8.0%	64 1.3%	88 29.3%
Mental Health Education	32 0.7%	15 5.0%	47 15.7%
Spiritual Help	27 9.0%	32 0.7%	59 19.7%
Use of Alcohol and Other Drugs	30 10%	3 1.0%	33 11.0%
Seeking Help from Others	20 6.7%	14 4.7%	34 11.3%
Total	168 56.0%	132 44.0%	300 100%

$X^2 = 69.351$ **DF=5 P-VALUE (0.000)**

Factors influencing the preferred coping strategy adopted

From Table 6 below , there is a positive significant relationship between respondent's Gender and their choice of coping strategies. Since the p-value (0.000) for the Chi-square test is less than 0.05. This means that, respondents gender influenced their choice of coping strategies.

TABLE 6: Relationship between factors influencing the preferred coping strategy and gender

FACTORS	MALE	FEMALE	TOTAL
Age	31 10.3%	0 0.0%	31 10.3%
Level of Education	12 4.0%	0 0.0%	12 4.0%
Place of Residence	15 5.0%	0 0.0%	15 5.0%
Personality	23 7.7%	0 0.0%	23 7.7%
Duration of Illness	5 1.7%	30 10.0%	35 11.7%
Severity of Illness	23 7.7%	14 4.7%	37 12.3%
Social Support	5 1.7	0 0.0%	5 1.7%
Ethnic Group	13 4.3%	0 0.0%	13 4.3%
Cultural Affiliation	39 13.0%	0 0.0%	39 13.0%
Total	168 56.0%	132 44.0%	300 100.0%

$X^2 = 239.351$ **DF=9 P-VALUE (0.000)**

DISCUSSION OF FINDINGS:

This study was conducted to investigate the stress factors and coping strategies adopted by relatives of people living with mental illness. The inclusion criteria are: the type of mental illness must be schizophrenia, the relative must reside with the mentally ill family member and he/she must be a parent, a sibling or a child ofthe mentally ill relative. The descriptive research design was adopted for the study and the research questions were tested using chi-square, percentages, bar charts and pie charts. The research has found male respondents to be 56% of the total respondents' while the females constitute 44%. Most previous studies on mental distress has been more on females. 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 higher percentage than their male counterparts (Borkman, 1997; Mannion et al, 1996; Norton et al, 1993). This finding from this research on age distribution of people who care for their relatives living with mental illness differ from previous ones. This difference may be due to environmental factors.

The study found majority (72%) of the relatives of people living with mental illness that participated in this study reported that the duration of the mental illness was more than three months. This duration of mental illness of their family member had effect on their carers and the

duration contributed to the choice of coping strategies. This is in conformity with previous research which indicates that long term care giving in mental health is associated with stress and emotions such as shame, embarrassment, feelings of guilt and self-blame (Ohaeri, 2003). The study found that majority (82.3%) of the respondents confirmed that the care of their family member living with mental illness gave them stress as shown in table 16.There is strong positive significant relationship between family and religion place of stress among the respondents. There is a negative relationship between family place of stress and others. This implies that family place did not have the same effect like others and only religions have the same pattern with family place of stress. There is a strong positive significant relationship between works and friends place of stress while works place of stress shows negative relationship with others place of stress. This implies that work and friends shows the same effects.

Furthermore, there is a significant relationship among community, religion institution and friends place of stress. This implies that they have the same contributions. The finding is likened to a preliminary exploratory study (Wintersteen and Rasmussen, 1997) which found that a group of 25 fathers coping with the mental illness of an adult child exhibited emotional stress that was largely unrecognized and unacknowledged by mental professionals. In addition, fathers tended to utilize more isolating strategies for coping with their adult children's mental illness. This was also particularly the case with the Canadian sample that included 40 members of schizophrenia support group (Thompson, 2002). This finding is also similar to that of a Swedish multi-centre study where 162 relatives of patients in acute psychiatric wards following both voluntary and compulsory admissions were interviewed concerning psychological factors related to stigma. A majority of the relatives' psychological factors of stigma by association (Ostman and Kjellin, 2012). Furthermore, another study that was conducted to look into on Moroccan families of patients with schizophrenia by Nadia, Fortiha, Soumia and Driss, 2004, found 86.7% reported psychological suffering.These findings are also in conformity with clinical observation and early empirical research which showed that assuming a care giving role can be stressful and burdensome (Biegel, 1991). Also, in care giving, objective stressors lead to psychological stress and impaired health behaviours which stimulate physiologic responses resulting in stress and mortality (Vitaliano, 2003).

The study found that there is a significant relationship between respondent's age and their coping strategies adopted. The study also identified various coping strategies with seeking spiritual assistance, seeking help/social support and seeking mental education having higher responses. The findings are similar to those most frequently used strategies which are seeking spiritual help and social support in a study conducted in by Hall in the year 2000. The study examined relationships between levels of expressed emotions in 44 parents of individuals with schizophrenia and the coping strategies they used. It is also similar to the submission that research consistently shows humour and comedies are often associated with enduring negative stereotypes about social groups (Ford & Fergusson, 2004; Thomas and Essex, 2004).

Conclusion

It is no gain saying the fact that being a relative of a family member living with mental illness attracts a lot of stress and require the need to adopt strategies to cope with the stressors. The study concluded that social and physical forms of stress occur more at work place than all other forms of stress. On the other hand, physical stress occurs most in religion institutions while psychological and physical occur at the same rate in the community. Relatives of people living with mental illness experience social stress most among friends closely followed by psychological and physical stress.

Several coping strategies were identified but music, seeking help and mental health education top the list. Factors that determined their preferred coping strategies found gender of the respondents playing a most vital role in their choice making.The study also established that there is a strong positive relationship between family and religion institutions. This shows that people

experience similar stressors in both families and religion institutions. It also established that there is no relationship between respondents' family care and their work.

Recommendations

Based on the above findings, the following recommendations are made:

- Health practitioners especially social workers should carry out health education on coping strategies for relatives of mentally ill.
- The government should make adequate provision 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 with a view to reducing stress of people living with mental illness and their family members.

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