

Psychosocial and Demographic Factors as Predictors of Attitude Towards Mental Illness by Caregivers in Federal Neuropsychiatric Hospital Aro Abeokuta

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Abstract: This study investigated general health, self efficacy, social support and demographic variables as predictors of attitude to mental illness and care givers burden of psychiatric patients. For the study, five hypotheses were tested, one was confirmed, while four were partially confirmed. The study used 200 participants (89 (44.5%) males and 111 (55.5%) females) who are caregivers at the Federal Neuro-Psychiatric Hospital Aro-Abeokuta. An 89 item questionnaire was used to tap information on the care givers' demographic and psychological variables. Multistage sampling technique was used. The study adopted multiple regression, 2x2x2x2 analysis of variance and Manova to test the significance of the demographic and psychosocial variables on attitude to mental illness and care givers burden of psychiatric patients.

Keywords: General Health, Self Efficacy, Social Support, Demographic, Attitude, Mental Illness and Care Givers

1. Introduction

Attitude influences both professional and personal behaviour. In particular, stigma and discrimination associated with mental illness and expressed by mental health professionals as well as the general public, result in the under-use of mental health services [1]. Contact with individuals who have mental illnesses, and education that replaces myth with fact, can decrease stigmatization and positively affect attitudes [2]. For the past fifty years, programs aiming to de-stigmatise mental illness have advocated for medical rather than psychological explanations of mental illness. Biological and genetic factors have been promoted as underlying causes and people with mental disorders were considered 'ill' in the same sense as those with medical conditions.

Mental health problems remain a huge stigma or mark of shame in Nigeria and most other societies. A resulting factor in this trend is that most people even relatives choosing to ignore people with mental illness. This attitude has been shown to exacerbate the mental health condition of the mentally challenged resulting in many of them suffering-unnecessarily and in most cases are subjected to being chained, beaten and terrible abuse; sometimes at the hands of those who they have turned to for care. [3]. The mentally ill are often blamed for bringing on their own illness; others may see them as victims of bad fate, religious and moral transgression or witch craft [4]. Mental illness is a disorder characterized by disturbances in person's thoughts emotions or behavior.

Attitude to mental illness among care givers may in fact determine the nature of care given to the mentally ill [1]. This attitude might also affect the type of treatment the mentally ill receive from both care givers and other health care professionals. For example, some care givers might hold an attitude that those who suffer mental illness may not recover fully despite treatment and this attitude may influence the type of treatment they give to this category of people as well as the type of care given attitude to mental illness has been shown to be influenced by psychological variables such as self-efficacy and perceived social support.

Social support refers to the function and quality of social relationships such as perceived availability of help or support actually received. It occurs through an interactive process and the perception of reciprocity. It may be regarded as resources provided by others as coping assistance or as an exchange of resource. Several types of social support have been investigated such as instrumental (assist with a problem) tangible (donate goods) information (give advice) and emotional (give reassurance) among others. Social support can have a main effect on various outcomes or it can interact with the experience of stress. It has been postulated that social support might reveal its beneficial effect on health and emotions in time of distress, overtime, due to social stigma associated with mental illness [5, 6].

Self efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective and selection processes. A strong sense of efficacy enhances human accomplishment and personal well being in many ways. People with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. They approach threatening situations with assurance that they can exercise control over them. Such an efficacious outlook produces accomplishments, reduces stress and lowers vulnerability to depression (in care giving) People's beliefs about their efficacy can be developed through four main sources of influence. The most effective way is through mastery of experiences. The second way is through the vicarious experiences provided by social models, seeing people similar to oneself succeed by sustained effort raises observers belief. Social persuasion is a third way of strengthening people's belief that they have what it takes to succeed. The fourth way is to reduce people's stress reactions and alter their negative emotional proclivities (caregivers) [7, 8].

General health depicts the total health condition of a person in all aspects. It is also a level of function and metabolic efficacy of an organism often implicitly human. Overall health is achieved through a combination of physical, mental and social well-being which is commonly referred to as health triangle. [9, 10]. The Lalonde report (1974) suggests that there are four determinants of general health which include human biology, environment, lifestyle, and health care services. It includes the following elements, observation of daily living, social activity, Hygiene, stress management Health care, work place well programs, and public Health.

2. Statement of Problem

Negative attitude to mental illness is alarming in Nigeria with most cultures holding negative perceptions about the mentally ill. This negative attitude has resulted to abandoning people with mental illness by care givers and significant others. In addition, negative attitude to mentally challenged individuals has resulted in poor prognosis and increase in number of people who suffer mild and severe mental illnesses [11, 12]. Moreover, care givers experiences are usually not desirable during mental illnesses of relatives and this might account for the negative attitudes held by care givers, especially with those holding the belief that people with mental illness are not likely to fully recover from their impair psychological condition [13, 14].

Furthermore, to date, much of the research into attitudes has focused on a broad range of health professionals including medical practitioners and psychologists [15, 16], and comparisons of their attitudes to those of the general public [11, 17].

It is also surprising that very few literatures in Nigeria has given attention to the self-efficacy level of care givers thereby limiting the role of self-efficacy in care giving. Though self-efficacy has been noted in previous studies to affect outcome variables which mentioned its influence on perceived stress and coping, performance etc [18, 19]. But its influence on care giving outcomes has not been given adequate attention.

The researcher is therefore interested in investigating the psycho demographic variables that predicts attitude to mental illness of psychiatric patients. In this study, the researcher attempts to find answers to the following questions;

1. Can psychological variables such as general health, self efficacy, and social support significantly predict attitude towards mental illness of psychiatric patients?
2. Can psychosocial variables and demographic factors jointly predict the attitude towards mental illness among psychiatric patients care givers?
3. Psychological factors will significantly independently and jointly predict attitude to mental illness.

3. Methodology

3.1. Design

This study which examined the influence of general health, self efficacy, social support and demographic factors on attitude to mental illness adopted a cross sectional research design. The justification for using this research design is because the researcher intended to obtain the respondents report of their internal state at the same time as their report of their past behaviour related to those internal state [15]. The independent variables are self-efficacy, social support and general health and each independent variable was dichotomized using the mean scores of each level. Age and sex were the demographic variables of interest, while the dependent variable is attitude towards mental illness. This design was adopted because none of the variables was

manipulated, also it allow for the representation of the population.

3.2. *Setting*

The participants in this study were drawn from Federal Neuro Psychiatric Hospital, Aro-Abeokuta, Ogun state. The Neuropsychiatric hospital, Aro, Abeokuta, designated by the World Health Organization in 1979 as the WHO Collaborating Centre in Research and Training in Mental Health and Neuroscience, selected by the Federal Government of Nigeria as one of the 7 specialty hospitals in Nigeria to be rehabilitated and equipped to a 5-star status, categorized as a 3-star service provider in 2008 by SERVICOM for acceptable quality service delivery, awarded a National Honour as the best Specialty Hospital in 2007 by the National Council on Health, one of the twenty resource centres in the world for the UNODC/TREATNET project, a complex institution situated in two locations, Aro and Lantoro. The hospital at ARO occupies a landmass of 274.75 acres and has 226 beds distributed over 5 Wards; while Lantoro annex sits on 69 acres and has 300 beds distributed over 9 Wards. The hospital has a tripartite functions of mental health clinical service delivery, research, and training in mental health and neurosciences.

3.3. *Participants*

The participants were two hundred caregivers of psychiatric patients in Federal Neuro-psychiatric Hospital, Aro-Abeokuta. The participants cut across varying sex, ages, job status, levels of education, marital status, and income. Their ages ranged from 20 to 60 years with a mean of 29.70 years and standard deviation of 8.11. There were eighty-nine (44.5%) males and one hundred and eleven (55.5%). The levels of education of the participants ranged from primary school to BSC. Two (1.0%) had primary school certificate; eight (4.0%) had junior secondary school certificate; NCE holders were eighteen (9.0%); OND, ninety-one (45.5%); HND, twenty (10.0%), while four (2.0%) were holders of BSC degree certificate. On marital status, one hundred and eight (54.0%) were single; married, fifty-eight (29.0%); divorced, fifteen (7.5%); single parents, sixteen (8.0%), while three (1.5%) were widowed. Income per annum ranged from 1000 Naira to 51000 Naira and above.

3.4. *Sampling Technique*

A Multistage sampling technique was adopted and the participants were accidentally selected. The researcher cannot carry out the study in all the psychiatric hospitals in Nigeria, hence Aro was chosen. It is ideal for this study.

3.5. *Ethical Considerations*

In obtaining ethical approval, a proposal for the study accompanied with a letter was sent to the management of Neuro-psychiatric Hospital, Aro, Abeokuta management. The researcher also went through an ethical training through the internet and obtained a certificate indicating that the

researcher had been well certified on the different ethical concerns of research involving human beings. The reply to the letter sent to the management took a while, though interim approval was granted, while the researcher nonetheless awaited the response of the management of the psychiatric hospital. However, while the researcher had begun the study, ethical approval was received and this allowed the researcher to obtain better cooperation from the staff of the organization.

Therefore, all ethical concerns raised by the management through the ethical approval committee were met as stipulated.

3.6. *Pilot Study*

In order to determine vital information about the study and to identify any methodological problem, a pilot study was carried out. The pilot study was undertaken to ensure that the language used in the questionnaire was appropriate and well understood by the participants of the study, to determine the strength and weakness of the instrument especially the reliability and validity of the instruments, to determine the time needed for administration of the questionnaires, assess difficulties and limitations associated with administering the questionnaire and to develop strategies to overcome difficulties before the project started. In order to ensure that the scales that formed the questionnaire were valid and reliable, it was pilot tested. This was done by administering the questionnaire intended to be used for the main study to twenty purposively selected caregivers at the New World Psychiatric Hospital, Molete, Ibadan.

3.7. *Reliability Estimation*

The researcher was interested in the reliability coefficients of each item in the scales that would be used for the main study. Therefore, item by total correlation was conducted for all the scales and involving all the items in the various scales adopted for the study. From the result, it was shown that the coefficient scores for the items in the scales ranged from .28 to .65. However, according to Nunnally (1978), an item is selected when its coefficient score is up to .30 and above. Therefore, in any scale, items with coefficient scores lower than .30 were expunged from the original scales. This procedure led to reduction in the number of items in some of the scales.

Furthermore, the composite coefficient scores for the scales were also found. That is, the reliability coefficient for the entire items in the scales was also investigated. The result showed that for the General Health Questionnaire (GHQ), the reliability alpha coefficient was .70 and there was no item expunged from the scale. Therefore, the 28 items were retained and were used in the main study. Using the Guttman-split half method, .61 was obtained as the reliability alpha coefficient for this scale. The scale yielded reliability alpha coefficients of .63 and .58 for part 1 and 2 of the scale, respectively.

Reliability tests were also conducted for the self-efficacy

scale by Mathias and Schwarzer (1979) which has 21 items. Total by item analysis conducted revealed that three items in the scale scored below .30 as suggested by Nunnally (1978). Therefore, these three items were deleted from the original scale, which culminated in the reduction of the items in the scale. However, the composite reliability alpha coefficient for the remaining 19 items in the scale was examined and they yielded reliability coefficient of .71, while the Guttman-split half method yielded alpha coefficient of .51. The reliability alpha coefficient for parts 1 and 2 of the 19 items in this scale were .75 and .69 for parts 1 and 2 of the scale respectively.

For the scale used in measuring social support which was developed by Zimet *et al.* (1988) with 14 items, the same procedure was applied in revalidating the instrument. The items were subjected to item total correlation. There were no items deleted in this scale. Therefore, the entire items were retained because they all had coefficient scores exceeding .30. The scale yielded composite reliability alpha coefficient of .65, while the Guttman-split half method was obtained as .61. The reliability alpha coefficients for parts 1 and 2 of the scale were .51 and .58, respectively.

The attitude to mental illness scale was also revalidated prior to its being used for the main study. The scale was developed by Luty *et al.*, (2006) and has 5 items. Upon revalidation, the scale yielded reliability alpha coefficient of .67, while alpha for the two parts of the scale were obtained as .56 and .61 for part 1 and 2 of the scale respectively.

3.8. Instruments

A structured questionnaire was used to tap relevant information from the participants of the study. The questionnaire consisted of different sections with each of the sections collecting information on the variables of interest. It comprised A, B, C, D, E and F. The structure of the questionnaire is outlined below:

SECTION A: Socio-demographic characteristics for the study

In this section of the questionnaire, demographic information of the participants were captured ranging from age to their highest level of education. This section consisted of variables such as age, sex, marital status, relationship to the patient, caregivers' income and educational status. Age was dichotomized with those from 20-30 years categorized as young, while 31 years and above was classified as old. Sex was divided into two with male scored 1 and female scored 2. Marital status was at four levels with single scored 1, married 2, divorced 3, while widowed was 4.

SECTION B: General Health Questionnaire (GHQ-28)

This instrument was used to measure participants' psychological well being. It was developed by Goldberg (1972) and was revalidated by Goldberg and Healey (1979). It is a 4-point Likert type scale with degree of responses ranging from not at all (1) to much more than usual (4). The scale has factors on anxiety/insomnia, social dysfunction, depression, and somatic symptoms with seven items

measuring each subscale. Items 1-7 assessed somatic symptoms; 8-14 measured anxiety/insomnia; 15-21 assessed social dysfunction, while 22-28 measured depression.

The scoring procedure for the scale indicates that participants who scored above 56.90 were high scorers on any of the subscales and this implies low positive general health, while low scorers were those who scored below 56.90 and which reflect high positive general health. That is, the scores on the items are reversed in order to determine the general health of the participants. The scale enjoys wide usage among clinicians (Harley, 1979; Goldberg, 1990) and the author reports reliability alpha coefficient of 0.79 for the entire items in the scale. The Cronbach alpha co-efficient was 0.82 and internal consistency was 0.92 as reported by Goldberg (1990). Adejuwon (2004) used the scale and reported the reliability co-efficient of the scale to be 0.79, split half reliability 0.69 and Spearman Brown of 0.70. In the current study, the reliability alpha coefficient for the scale was .85, while reliability alpha co-efficients for the two halves of the scale were obtained as .78 and .67 for part 1 and 2 of the scale, respectively. The researcher reported a Cronbach alpha co-efficient of .72 from the pilot study he conducted.

SECTION C: Generalized Self-efficacy Scale

Self efficacy in this study was measured by general self efficacy scale developed by Mathias and Schwarzer (1979). The scale has 21 items. It is a 4 point Likert scale with the following anchors: 1= not at all true, 2= hardly true, 3=moderately true, 4=exactly true. The scoring procedure for this scale indicates that participants who scored above 52.02 had high self-efficacy, while those who scored below 52.02 had low self-efficacy. Reliability co-efficient alpha of 0.81 and Cronbach of 0.83 were reported by the authors, while in the current study, .92 was obtained as the reliability alpha coefficient. The Guttman split half was .88, while alpha for the two halves of the scale were obtained as .83 and .85 for part 1 and 2 of the scale, respectively. The researcher conducted a pilot study and reported a Cronbach alpha coefficient of .57.

SECTION D: Social Support Scale

Social support in this study was measured by a multi dimensional scale of perceived social and emotional supports from family members, friends and significant others constructed and validated by Zimet, Dahlem and Faley (1988). The scale consisted of 14 items. The response format ranged from very strongly agree (7) to very strongly disagree (1). The scoring modality for the instrument is such that participants who score above 52.43 had high perceived social support, while those who scored below 52.43 had low perceived social support.

The authors reported internal consistency co-efficient alpha of 0.91. In the current study, .93 was obtained as the reliability alpha coefficient. The Guttman split half was .95, while reliability alpha coefficients for the two halves of the scale were .85 and .87 for part 1 and 2 of the scale respectively. The researcher conducted a pilot study and reported a Cronbach alpha coefficient of .79 respectively.

SECTION E: Attitude to Mental Illness Questionnaire

Attitude to mental illness was measured using Attitude to mental illness questionnaire developed by Luty et al. (2006). It consisted of 5 items and anchored on 5 point Likert type scale with response format ranging from strongly disagree (1) to strongly agree (5). The procedure for scoring this scale indicates that scores above 12.20 implies positive attitude to mental illness, while scores below 12.20 reflects negative attitude to mental illness. The authors reported alpha reliability co-efficient of 0.70 and Spearman-Brown reliability .70, using the equal length method. In the current study, reliability alpha coefficient of .55 was found for the four items, while reliability coefficients for the two halves of the scale were obtained as .45 and .75 for part 1 and 2 of the scale, respectively. Using the Guttman split half method, .44 was obtained as the reliability alpha coefficient. The researcher conducted a pilot study and reported a Cronbach alpha coefficient of .50.

3.9. Procedure for Data Collection

The researcher randomly selected three hundred caregivers from the Federal Neuro-psychiatry Hospital, Aro, Abeokuta, Ogun State, Nigeria using the simple random selection. The respondents cut across different ages, sex, marital status, income per annum and level of education. The criteria for inclusion were: must be caregivers, must have close relationship with psychiatric patients and understands English language.

The respondents were approached upon having acquainted them the intention of the researcher. The respondents' consent was duly sought by asking them whether they would participate in the study and signing the consent form. Those who responded in the affirmative participated in the study, while also at the time requesting them to pick one ballot paper from the basket presented to them. However, this was done individually in the wards of the respondents. Those who picked 'No' were excluded from the main study, while their counterparts who picked ballot papers with 'Yes' written on them were drawn into the study. This procedure ensured that every participant was given equal opportunity of participating in the study. The researcher was assisted by two corps member serving in the psychology department of the psychiatric hospital.

3.10. Statistical Analysis

Data generated in this study was analyzed using multiple regression analyses, analyses of variance (ANOVA) to test for their joint and independent relationships.

4. Results

For all the hypotheses tested the minimum level of significance is 0.05. As stated in the methodology section, the independent variables are General Health, Self Efficacy and Social Support and the dependent variables are Attitude to Mental Illness.

Table 1. A summary of 2x2x2x2 ANOVA Showing the Main and Interaction Influence of Psychological and Demographic Factors on Attitude to Mental Illness among Caregivers.

Source	SS	Df	MS	F	P
General health (A)	30.39	1	30.39	5.27	0.02
Self-efficacy (B)s	5.90	1	5.90	0.79	0.38
Social support (C)	54.45	1	54.45	7.28	0.01
Age (D)	12.08	1	12.08	1.62	0.21
Sex (E)	0.31	1	0.31	0.04	0.84
A x B	0.34	1	0.34	0.05	0.83
A x C	95.58	1	95.58	12.79	0.00
A x D	1.99	1	1.99	0.27	0.61
A x E	23.14	1	23.14	3.09	0.08
B x C	4.42	1	4.42	0.59	0.48
B x D	190.18	1	190.18	25.43	0.00
B x E	56.56	1	56.56	7.56	0.01
C x D	11.45	1	11.45	1.53	0.22
C x E	0.39	1	0.39	0.05	0.82
D x E	104.89	1	104.89	14.02	0.00
A x B x C	0.00	0	0.00	-	-
A x B x D	2.95	1	2.95	0.39	0.53
A x B x E	0.00	0	0.00	-	-
B x C x D	4.42	1	4.42	0.59	0.44
B x D x E	3.57	1	3.57	0.48	0.49
A x B x C x D	0.00	0	0.00	-	-
A x B x C x E	0.00	0	0.00	-	-
A x B x C x D x E	0.00	0	0.00	-	-
Error	1293.10	173	7.48		
Total	2844.00	199			

The result in Table 1 shows that the main influence of general health on attitude to mental illness was significant $F(1, 199) = 5.27; p = 0.02$. This result implies therefore that caregivers with good general health ($\bar{X} = 13.10$) significantly reported more favourable attitude to mental illness than those with poor general health ($\bar{X} = 11.18$). The main influence of self-efficacy on attitude to mental illness was not significant $F(1, 199) = 0.79; p = 0.38$. The main influence of perceived social support on attitude to mental illness was significant $F(1, 199) = 7.28; p = 0.01$. This result indicates that caregivers who were high in perceived social support ($\bar{X} = 13.22$) significantly reported more favourable attitude to mental illness than those who were low perceived social support ($\bar{X} = 11.20$). The main influence of age on attitude to mental illness was not significant $F(1, 199) = 1.62; p = 0.21$. The main influence of sex on attitude to mental illness among caregivers was not significant $F(1, 199) = 0.04; p = 0.84$.

The interaction influence of general health and perceived social support $F(1, 199) = 12.78; p = 0.00$; self-efficacy and age $F(1, 199) = 25.43; p = 0.00$; age and sex $F(1, 199) = 14.02; p = 0.00$; self-efficacy and sex $F(1, 199) = 5.56; p = 0.01$; self-efficacy, support and sex $F(1, 199) = 7.37; p = 0.01$; and perceived social support, age and sex $F(1, 199) = 4.90; p = 0.03$ on attitude to mental illness were significant. However, the interaction influence of general health and self-efficacy $F(1, 199) = 0.05; p = 0.83$; self-efficacy and perceived social support $F(1, 199) = 9.51; p = 0.48$; general health and age $F(1, 199) = 0.27; p = 0.61$; perceived social support and age $F(1, 199) = 1.53; p = 0.22$; general health, self-efficacy and perceived social support $F(1, 199) = 0.00; p = 0.99$.

=-); general health, perceived social support and age $F(1, 199) = 1.00; p = 0.32$); self-efficacy, perceived social support and age $F(1, 199) = 0.59; p = 0.44$); general health, perceived social support, age and sex $F(1, 199) = 0.00; p = -$) were not significant.

Table 2. Inter-correlation Analysis Showing the Relationship between Psychological Factors and Attitude to Mental Illness.

S/N	Variables	N	\bar{X}	SD	1	2	3	4	5
1	Mental illness	200	12.200	3.78	-				
2	General health				0.18*	-			
3	Self-efficacy	200	58.92	11.56	0.43**	0.18*	-		
4	Social Support	200	52.09	13.61	0.43**	0.37**	0.04	-	
			52.43	18.71		0.53**	0.01	0.75**	-

Key: ** $P < .001$ * $P < .05$

The result in Table 2 shows that the relationship between general health and attitude to mental illness was positive and significant ($r = 0.18; df = 198; p < .05$). This result implies that the more positive the general health, the more favourable the attitude to mental illness. The relationship between self-efficacy and attitude to mental illness was positive and significant ($r = 0.43; df = 198; p < .001$). This result indicates that higher level of self-efficacy led to more favourable attitude to mental illness. The correlation between perceived

social support and attitude to mental illness was positive and significant ($r = 0.43; df = 198; p < .001$). This result implies that the higher the perceived social support, the more favourable the attitude to mental illness.

Hypothesis one stated that general health, self efficacy and social support would jointly and independently predict Attitude to Mental Illness. A multiple regression statistical tool was used to evaluate this and the result is presented in Table. 3.

Table 3. Multiple Regression Analysis Showing Psychological Factors Independent and Joint Prediction of Attitude to Mental Illness.

Variables	R	R ²	F	P	β	t	P
General Health					0.17	2.77	0.00
Self Efficacy	0.49	0.24	20.62	0.00	0.23	2.50	0.01
Social Support					0.25	2.63	0.00

The result from table 3 shows that general health, self-efficacy and social support showed significantly joint prediction of attitude to mental illness among caregivers ($R^2 = 0.24; F(3, 196) = 20.62; P < 0.00$) The exogenous variables jointly accounted for 24 % variation in Attitude to Mental Illness.

Furthermore, general health ($\beta = .17; t = 2.77; p = 0.00$); self-efficacy ($\beta = 0.23; t = 2.50; p = 0.01$); and Social Support ($\beta = .25; t = 2.63; p = 0.00$) showed significantly independent prediction of Attitude to Mental Illness. This result implies that caregivers who are high in general health,

self-efficacy and perceived social support tend to have more favourable attitude to mental illness than those low in general health, self-efficacy and perceived social support. Moreover, perceived social support contributed most to the explained variation of attitude to mental illness than other exogenous variables. This result fully supported hypothesis one.

Hypothesis two which stated that general health, self efficacy, social support and demographic factors would jointly and independently predict attitude to mental illness among caregivers was tested using multiple regression analysis. The result is presented in Table 4.

Table 4. Multiple Regression Analysis Showing general health, self efficacy, social support and Demographic Factors Independent and Joint Prediction of Attitude to Mental Illness among Caregivers.

Variables	R	R ²	F	P	β	t	Sig.
Age					-0.04	-0.59	0.55
Sex					-0.03	-0.47	0.63
General health	0.49	0.24	12.37	0.00	0.18	2.79	0.00
Self-efficacy					0.24	2.49	0.01
Social support					0.26	2.67	0.00

The result from Table 4 shows that psychological and demographic factors (i.e., age, sex, general health, self-efficacy and social support) showed significantly joint prediction of attitude to mental illness among caregivers ($R^2 = .36; F(5, 194) = 12.37; p < 0.00$). The predictor variables jointly account for 24 % variation in attitude to mental illness.

Furthermore, general health ($\beta = .18; t = 2.79; p = < 0.00$); self-efficacy ($\beta = .24; t = 2.49; p = < 0.01$) and social support ($\beta = .26; t = 2.67; p = < 0.00$) showed significantly

independent prediction of attitude to mental illness. This result implies that caregivers who were high in general health, self-efficacy and perceived social support tend to have more favourable attitude to mental illness than those low in general health, self-efficacy and perceived social support. Moreover, perceived social support contributed most to the explained variation of attitude to mental illness than other predictor variables.

However, age ($\beta = -.04; t = -.59; p = 0.55$) and sex ($\beta = -.03; t = -.47; p = 0.63$) did not show significantly

independent prediction of attitude to mental illness. This result partially supported hypothesis two.

Hypothesis three states that psychological factors will significantly independently and jointly predict attitude to mental illness and ANOVAs. The result is presented in table 5. below.

Table 5. ANOVA Table Showing the influence of general health, self efficacy and social support on Attitude to Mental Illness.

Source	SS	Df	MS	F	P
General Health Mental illness Source	34.73	1	34.73	3.08	0.08
Self-efficacy Mental illness Source	11.73	1	11.73	1.04	0.31
Social support Mental illness	32.23	1	32.23	2.86	0.09

The result in Table 5 shows that there was no significant influence of general health on attitude to mental illness ($F = 3.08$; $p = 0.08$). There was no significant influence of self-efficacy on attitude to mental illness ($F = 11.3$; $p = 0.31$). Social support influence on attitude to mental illness was not significant ($F = 2.86$; $p = 0.09$). The result partially supports hypothesis three.

5. Discussion of the Findings

The study investigated general health, self efficacy and social support as predictors of attitude to mental illness of care givers of psychiatric patients. The discussion, conclusion and implication of the findings were discussed while recommendation was for various institutions that will find the outcome of the study useful.

Five hypotheses were tested.

The first hypothesis states that general health, self efficacy and social support will significantly jointly and independently predict attitude to mental illness. The three psychological variables contributed significantly jointly and independently as predictors of attitude to mental illness. This finding supports the earlier works of Collins; Guichard; Ford and Feeney(2006) that a person has an opportunity for exploration, learning or mastery and either needs help in taking advantage of the opportunity or seems eager to talk about,celebrate or be evaluated for certain aspirations and accomplishments. The person becomes motivated to provide care and support.

Results from hypothesis three shows that three (general health, self efficacy and social support) out of the five psycho demographic variables significantly predicted attitude to mental illness while sex and age did not. This agrees with the work of Gafflib (1983); Salnier (1982) that social support is provided in the con text of social support systems or social network which an individual is linked to by emotional bonds and behavioural interactions. Bandura (1977) confirms this by positing that people approach threatening situations with assurance that they can exercise control over them and this efficacious out look produce accomplishment and personal

well being in many ways. Age and sex did not significantly predict attitude to mental illness. Susan and Reinard (2008) had a contrary view when they found out that care givers over the age of 18 years (approximately one in every five adult) are women. Robb et al. (2003) and Segal et al. (2005) confirmed it also saying that more similarities than differences have been observed between old, young, male and female.

Result from hypothesis five shows that there was no significant influence of general health on burden of care and attitude to mental illness. The influence of self efficacy was not significant in attitude to mental illness. The influence of social support was not significant in attitude to mental illness. This supports the work of Ajzen (1991) that if people evaluated their behaviour as positive and if they think their significant others want them to perform the same behaviour this results in higher intention to do so.

6. Conclusion

The study investigated general health, self efficacy and social support as predictors of attitude to mental illness among care givers of psychiatric patients.

Findings from the present study revealed that care givers with high general health, self efficacy and social support will have favorable attitude towards mental illness than those that have low general health, self efficacy and social support.

The study also revealed that age and sex are not good predictors of attitude to mental illness. This implies that whether the care giver is old or young, male or a female the attitude towards mental illness is indifference. This have implication for the government whose duty is to provide good medical care and to mitigate the suffering of the masses to make good policies that will increase the general health self efficacy and social support of informal care givers so that they will have a favourable attitude to mental illness. Families, friends and religious groups should rally round any of their member that engages in care giving so as to increase general health, self efficacy and social support, which will make the care giver to have a favourable attitude towards mental illness.

Limitations of the Study

The participants used in this study were drawn only from Aro, if participants from other mental institution in other states were included it may have yielded a different result. The scales used in this study were written in English, this narrowed the number of participants as many of the informal care givers cannot read and write.

The study consumed money and time as the researcher keep travelling from Ibadan to Abeokuta.

Suggestions for Further Studies

In view of the above stated limitations, the researcher therefore suggests that further studies should include

participants from other mental institutions in other states.

The scales should be adapted into the three Nigerian main languages to eradicate language problem and provide a large population size.

Recommendations

In view of the findings the following recommendations were made. There will be an interventional program where informal care givers will receive psycho educational tips that will aid them in their care giving roles.

It is recommended that there will be a meeting point for care givers in different localities to share their care giving experiences and learn from one another. Government should formulate policies that will make it mandatory for formal care givers to be assisting in formal any they that there is a need for that.

Government should increase the funding of mental health sector and make provision (financial) for informal care givers. Families, religious organizations and significant others should be encouraged on the need to rally round their members that is giving care because anybody can be a care giver.

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