Assessment of Perceived Family Psychological Support among Depressed Patients in two Psychiatric Hospitals Kaduna State,

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Abstract

A family member experiencing mental illness or any other challenge usually finds the family as the first point of support. Family members supply the required psychological support and care for the affected family member. This study assessed the perceived family psychological support among depressed patients in Psychiatric Hospitals, Kaduna State Nigeria. The study adopted a descriptive cross sectional research design. One hundred and forty-four (144) depressed patients were randomly selected from Ahmadu Bello University Teaching Hospital and Federal Neuro-Psychiatric Hospital (FNPH) both in Kaduna State. Statistical package social sciences (SPSS) version 22, was used to analyse the data. The results showed that 40% of the 144 participants claimed to be psychologically supported by their families. This means that less than half of the depressed patients under review, had high level of perceived psychological support from their family members. Females received more family psychological support than their male counterparts. Recovery rate, using the Hospital Anxiety Depression Scale (HADS), was significantly correlated with the level of family members' psychological support. It is therefore, recommended that more focus should be placed on enhancing more family psychological supports for depressed patients most especially in the areas of encouragement towards health education, religious and / or spiritual activities, brightening the moods of their patients, and more moral support. Also, family focused psycho education should be provided to family members of depressed patients by the professional care givers.

Keywords: Psychological Support, Family, Care, Depression, Tertiary Hospital.

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Introduction

Humans by nature revolve within various states of mind: from being happy, sad, moody, irritable, indifferent, elated and being over excited. Some of these moods spectra, including grieving, are considered normal human emotions. Some feelings may persist beyond few days and often result into mental illness that warrants mental health intervention.[1]

Mental health as defined by WHO World Health Organisation, is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[2] It is believed that mental and social wellness is disrupted in at-least one-third of all persons during their lifetimes.[3,4]The disruption in mental and social wellness is basically the presence of emotional and social distress and often characterized by features of depression.[5]

Depression is something more than the ordinary feeling of sadness. It's a period of overwhelming downside sadness which involves loss of interest in things that used to bring pleasure. Those feelings are usually accompanied by other emotional and physical symptoms. Once present, it implies the absence of health and wellbeing.[6] Depression is not only a common illness worldwide, but is also the leading cause of disability globally.[6] Furthermore, depression is one of the forms of mental illnesses that affects mood and is characterised by a persistent feeling of sadness, empty feeling, loss of interest in pleasurable activities and/or irritable mood, with/without somatic and cognitive changes that do hinder the person's capacity to function.[6,7]

The prevalence of depression was found to be higher in developed countries (14.6%) compared to developing ones (11.1%).[8]Such difference in rate of occurrence has been ascribed to affluence[9] irrespective of the typical higher rates in women compared to men. In Nigeria, the national prevalence of depression (3.1%)[10] was much lower than pooled average for developing countries in the study of Bromet *et al.*[8] Such a low prevalence in Nigeria compared to other developing countries rate had been attributed to lower age group of the Nigerian sample and probably denial.

Hence, the recent argument by Kessler and Bromet[9] that substantive interpretation of prevalence should be adopted over methodological inferences.

Despite this high burden from depression, the non-clinical community approach like family psychological support which is effective in the management of mild depression and has also been identified to hasten recovery as adjuvant intervention in moderate to severe cases of depression are often lacking.[6] Interestingly, such non-clinical interventions are not expensive and are cost effective. However, the researcher did not come across any study on family support in the management of depression in this part of Nigeria. Hence, the focus of this study is to find out the level of family psychological support from the perspective of patients and how its availability will be of assistance in the care and management of depressed patients. The results of this study, would be used to advocate for how the depressed patients could benefit from family support activities when available.

Methods and Materials

This study was aimed at determining the level of family psychological support available in the care and management of depressed patient. It was descriptive cross sectional research carried out in Kaduna State, Nigeria. The study was carried out in two major hospitals in Kaduna State that care for the mentally challenged individuals and are located in the two most populous cities in the state. These hospitals are Ahmadu Bello University Teaching Hospital (ABUTH) and Federal Neuropsychiatric Hospital (FNPH). The targeted population were depressed patients attending the psychiatric out-patient clinics of Ahmadu Bello University Teaching Hospital, (ABUTH) Shika-Zaria and Federal Neuro-Psychiatric Hospital (FNPH), Barnawa-Kaduna.

Descriptive cross sectional research design was employed for the study. The study utilized the sample from the entire hospital attending population of patients receiving treatment for depression. The estimated number of depressed patients attending Federal Neuropsychiatric hospital is about 2000 per year, while that of Shika ABUTH is estimated to be more than 1500 per year. Therefore, the total annual depressed patients' attendance of the two hospitals is about 4000 per annum. .The sample size was determined using the formula for single proportion developed by Cochran utilizing one hundred and forty four (144) respondents from the two hospitals which were purposively selected for this study because both have psychiatric clinics.

The method of sampling used in this study was convenience sampling. On the clinic day in ABUTH /FNPH depressed patients at the clinic who met the inclusion criteria were recruited for the study until the required sample size was obtained. These were patients, 18 years and above, who were stable and had been diagnosed with depression by the Psychiatrists (based on ICD-10 Research Diagnostic Criteria) and attended the psychiatric outpatient clinic of the two hospitals. Patients with other psychiatric illnesses (e.g. psychosis, suicide, dementia, anxiety, substance abuse etc.), those that were too sick to participate in the study i.e. those who were in the acute stage of depression with/without cognitive impairment and those with severe depression were excluded from the study. The study lasted for four months in which the rate of recovery was determined.

The instrument for data collection comprised three parts: the first part assessed the socio-demographics of the participants; the second part was a researcher developed scale that assessed the patients' perception of the level of family members' psychological support; while the last part was standardized measuring scale of depression subscale of the Hospital Anxiety Depression Scale. Ethical clearance was obtained from the ethical committees of the respective health institutions (i.e. ABUTH and FNPH). In obtaining written informed consent from the participants, the following were also observed: respecting the provision of the Helsinki's declaration, communicating in a language easily understood by the participants, anonymising the obtained data, and all the collected data were kept confidential.

Family psychological (12-item) supports was scored on 3 points Likert scale ranging from none/none at all (= 0), to some/some of the time (= 1) and all/all of the time (= 2). The scores were summed and the mean score of all the participants according to each measuring scale was determined and used to categorized respondents into either low (i.e. those that scores below the mean) or high (i.e. those whose scores are from mean and above). The mean score for psychological family supports was 15.22.

The Hospital anxiety and depression scale (HADS) was used to screens for the presence of anxiety or depressive state in the respondents after three months of follow-up. It consists of seven depression items and seven anxiety items. A score of 8 and above on either of the two components is regarded as an active case. This was used to ascertain the rate and level of recovery of the participants in the study.

Data generated from the computed questionnaires was subjected to analysis using the Statistical Package for Social Sciences (IBM-SPSS version 22). The data was presented in form of tables, frequencies and percentages. Student's t-test was used to determine the difference between means of perceived level of family members' psychological support and socio-demographic characteristics of the respondents. Pearson's Product Moment Correlation (PPMC) was used to test for the relationships between perceived level of family members' psychological

support and recovery rates of the respondents.

Results

The mean age of the participants was 42.3years and majority were within the age group of 30-39 years (40.3%) and 40-49years (24.3%). There was higher representation of female gender among the participants (96 i.e. 66.7%). Also noted is the higher representation of married couple among the respondent (59.7%). More than half of the respondents had at least one form of western education (56.9%). (Table 1)

Table 2 showed the type of psychological support received by the respondents. The respondents maintained that they received a lot of the psychological support in the following aspects: Participation in worship activities e.g. Reading Religious Books, listening to religious tapes (Mean = 1.55); Spiritual support towards overcoming distress (Mean = 1.51); Love and compassion received during illness (Mean = 1.42), Support towards raising respondents' confidence and how much encouragement gotten from family ranked the same (1.31);while maintaining happiness of the respondent (1.27). The respondents posited that they received some of the social supports that include: Support received during feeling of hopelessness (Mean = 1.19); Support rendered to give basic moral support and remind respondents about health issues (Mean = 1.17). Also, assistance provided to brighten the mood of the respondents had a mean rank of 1.13.Assistance provided regarding reassurance about patient's condition (Mean = 1.12). Least psychological support was encouraging patients on their health education (Mean = 1.08). The weighted mean was 1.27 (from a maximum of 2.00) which indicated that the level of psychological support available to the patient with depression was on the average (Table 2). However, further classification of the responses revealed that 57 (39.6%) out of the 144 ranked above 1.00.

Table 3 reported the levels of patients' depressive symptomatology as at the time of data collection and their perception of recovery based on the role of family support. The table showed that more than two-third of the participants (77.1) had sub-threshold level of depressive symptoms. The same table also shows that more than half of the patients had felt the experience of recovery from the role of family support in their depressive illness career.

Considering the relationship of the participants' sociodemographic variables with their mean family supports characteristics (Table 4); the females received more family psychological support compared to their respective counterparts ($p<0.001$). Also, patients with high family psychological support (57, 39.6) reported higher recovery from depression (Table 5) ($p<0.001$).

Based on the relationship between measures of

Table 1: Distribution of Respondents based on their Sociodemographic Variables (N=144)

Variables	Frequency	Percentage (%)
Age (years)		
<30	15	10.4
30-39	58	40.3
40-49	35	24.3
50-59	14	9.7
60-69	20	13.9
>69	2	1.4
Mean age= 42.3 years	**Age range**= 21-72years	
Gender		
Male	48	33.3
Female	96	66.7
Marital Status		
Currently married	86	59.7
Currently unmarried	58	40.3
Ethnicity		
Hausa	73	50.7
Igbo	10	6.9
Yoruba	19	13.2
Others	42	29.2
Educational Status		
Non-western Education	62	43.1
Western Education	82	56.9
Employment Status		
No	73	50.7
Yes	71	49.3

Table 2: Level of psychological support available to the patient with depression

S/N	Psychological support	None n(%)	Sometimes n(%)	A lot n(%)	Mean
1	When you express hopelessness, how much support is provided to get you out of this?	28(19.4)	60(41.7)	56(38.9)	1.19
2	How much assistance is provided to you regarding reassurance about your problem?	26(18.1)	75(52.1)	43(29.9)	1.12
3	How much assistanceis provided to you to brighten your mood?	26(18.1)	73(50.7)	45(31.3)	1.13
4	How Much support did you receive regarding participation in worship activities e.g. Reading Religious Books, listening to religious tapes?	6(4.2)	53(36.8)	85(59.0)	1.55
5	How much spiritual support is provided to overcome your distress?	2(1.4)	66(45.8)	76(52.8)	1.51
6	How much love and compassion did you receive during your illness?	2(1.4)	80(55.6)	62(43.1)	1.42
7	How much support is provided to keep you happy?	9(6.3)	87(60.4)	48(33.3)	1.27
8	How much support is provided to raise your confidence about yourself?	8(5.6)	84(58.3)	52(36.1)	1.31
9	How much support is provided to give you encouragement?	6(4.2)	88(61.1)	50(34.7)	1.31
10	How much support is provided to giveyou basic moral support?	22(15.3)	75(52.1)	47(32.6)	1.17
11	How much support is provided in reminders of health issues?	24(16.7)	72(50.0)	48(33.3)	1.17
12	How much support is provided to encourage you for health education?	35(24.3)	63(43.8)	46(31.9)	1.08
	Aggregate MeanScore				**1.27**
	Aggregate Means %				**0.88**
	Aggregate Mean= 1.00 = 57 (39.6%); Aggregate Mean < 1.00= 87 (60.4%)				

Table 3: The level of patients' depression and perceived recovery from depression (N=144)

Hospital Anxiety Depression Scale (HADS)	Level of Depression*
Cases [n (%)]	33 (22.9)
Non-Cases [n (%)]	111 (77.1)
Recovery Based on Family Support	Level ofRecovery**
< Mean scores [n (%)]	67 (46.5)
=/> Mean scores[n (%)]	77 (53.5)

Note: * = Based on the participants scores on depression subscale of Hospital Anxiety Depression Scale, the non-cases were patients who did not meet the HADS threshold for depression (i.e. a score of 7 and below) and those that meet criteria for depression are cases (i.e. a score of 8 and above); ** = the mean score for recovery based on perceived family support and Standard Deviation are respectively 43.80 and 5.05.

family psychological supports and patients' recovery from depression, family psychological support significantly correlated with generic social support scales and patients' recovery from depression (Cronbach's alpha of 0.958) (Table 6).

Discussion

This study set out to determine the role of family psychological support in patients with depression attending outpatient clinics in two tertiary health centres in Kaduna. The results showed that two-third of the study participants were females (66.7) and about half were of the Hausa ethnicity (50.7%). The participants expressed low family psychological support, about than 40%. This study also found significant relationship between participants with high family psychological support and good level of recovery in patients with depression. The magnitude of

Table 4: Relationship between Socio demographic Variables and Participants' Mean Family Support Characteristics

Variables	Psychological support scores	
Age (years/n)	**Mean**	**SD**
Below mean age (86)	15.62	6.616
Mean age and above (58)	14.64	5.803
t-test (p-value)	**0.914 (0.36)**	
Gender (n)		
Male (48)	12.52	6.540
Female (96)	16.57	5.747
t-test (p-value)	**3.807 (<0.001)***	
Marital status (n)		
Currently married (86)	14.97	5.906
Currently unmarried (58)	15.60	6.875
t-test (p-value)	**0.595 (0.56)**	
Educational Status		
Non-Western	14.87	6.331
Western	15.49	6.300
t-test (p-value)	**0.581 (0.56)**	
Employment Status		
No	16.04	6.365
Yes	14.38	6.161
t-test (p-value)	**1.590 (0.11)**	

*=p<0.05

this relationship from the correlational analysis was direct and moderate in the study population.

The most represented ethnic group in this study were Hausas. This is expected considering the place of study which is Kaduna State, a major north-western State in Nigeria. The presence of other tribes in this study pointed to the diverse nature of Kaduna State, a major metropolitan settlement in Nigeria. The mean age in this study is 42.3years and corresponded to one of the age group where prevalence of depression is highest second to elderly.[10]The proportion of female to male recruited in this study is 2:1. The observed ratio is similar to global experience where more females were affected by depression than males.[6]The majority of the respondents were married as at the time of data collection. This might not be surprising considering that marriage takes place earlier in northern Nigeria compared to other regions.[21]

The psychological support from family is perceive as being low. This is because just above one-third of the participants (39.6%) were enjoying good psychological support. Psychological support entails how family members instil and raise in the patient hope, reassurance, joy, self-worthiness, morale and self-learning. The difficulty in providing this type of support can be akin to how challenging it can be for nurse to do similar for medical patient in need of psychological intervention where cheering up is the most used mechanism to achieve this.[22] This highlighted the need to

Table 5: Participants' Family Supports and mean patients' recovery

Types of Family Support	Family Support-Based Recovery	
Psychological	**Mean**	**SD**
Below mean (87)	42.03	4.581
Mean and above (57)	46.49	4.536
t-test (p-value)	**5.731 (<0.001)***	

*=p<0.05

Table 6: Correlation between Measures of Family Support and Patients Recovery

	Variables	1	2	3	α
1	Psychological Support	1	0.186*	0.474**	0.958
2	Hospital Anxiety Depression Scale		1	0.064	0.471
3	Family Support-Based Recovery			1	0.738

Note: * = p<0.05; ** = p<0.01; α = Chronbach's alpha

proactively increase not only the mental health literacy on depression, but to also help both patient and their family members with more psychological skills to effectively meet patient's cognitive and emotional needs. Here, interventions that emphasising and deepening empathy is paramount.[22]

The findings in this study showed that participants with high in family psychological support exhibited good recovery compared to those who received low family psychological support. The recovery were ranked to be a direct and moderate one. This agreed with previous studies[11,23,24,25,26] that demonstrated that family social support influence mental wellbeing through two mechanisms, biological and behavioural. Biologically by modulating the release of interleukin-6, a pro-inflammatory that limits stress hormone in the body, promote neurogenic activities and increase growth of hippocampal volume. Behaviourally, family supports will promote health seeking activities and buffers against the burden of depression on the patients.

Family support has been shown to significantly promote faster and sustained recovery from depression and had moderated the impact of stress on recovery[15,16] this assertion is in agreement with the outcome of this study which got a very significant data on psychosocial support . This shows that, support especially from family members is a critical component of recovery from depression and in the sustenance of wellbeing. In other words, family support is crucial in the care and management of depression and do offer some non-pharmacological benefits for depression. Hence, understanding this and rightly applying it will go a long way in reducing the high burden of depression among people suffering from depression. Thus, family supports when available work in tandem with other variables to bring about recovery. Hopefully, future studies will look at how increase in family support . Furthermore it is recommended that family focused psycho education should be provided to members of depressed patients**.**

Conclusion and Recommendations

The finding on the level of perceived psychological support revealed that less than half of the depressed patients under review, had high level of perceived psychological support from their family members. Some of the areas in which families should intensify their efforts include: encouragement towards health education, religious and / or spiritual activities, brightening the moods of their patients, and more moral support.

The study has implication for policy makers as most patients with depression do not receive high support from family members. Hence, the researcher's position thus is that, there should be policies that inculcate routine assessment of family psychological support during consultation encounters with depressive patients to unravel family variables that can positively or negatively influence depressive mental illness. The same routine assessments should be included for health professionals, also, in the nursing processes to influence nursing care plan and psycho educational processes. This also goes for other members of the mental health managing team like the clinical psychologists, social workers and occupational therapists.

Recommendations

Based on the outcomes of the study, it is essential emphasize on training family members to be literate and become aware of the common elements of family psychological support is essential. This should facilitate the family members to report challenging elements that could not be provided to the patient during the next clinical encounter. Also, family member should be guided on the right amount of family psychological support activities to provide to depressed patients e.g. type of recreational activities to allow patient to engage in and for how long. Family focused psycho education should be provided to members of depressed patients. Home visitation should be regular to assess the provision of psychological support to depressed patient by family members and facilitate any missing skills when noted during such visits. Observations made should be reported to the managing team to help them in further management of the patient.

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