Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

The prevalence of Psychological Distress and associated factors among Caregivers of Schizophrenia Outpatients:

The Case of Amanuel Mental Specialized Hospital

By: Emebet Girma

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Addis Ababa, Ethiopia

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Approval of Board of Examiner

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Abstract

The main purpose of this study was to assess the prevalence of psychological distress and associated factors among caregivers of schizophrenia outpatients in Amanuel mental specialized hospital, Addis Ababa, Ethiopia. This study used a cross-sectional survey research design and selected 110 sample of caregivers by using purposive sampling technique. Standardized instruments were used to collect data, namely Self Report Questionnaire (SRQ 20), Experienced Stigma Scale the Family Version, and Oslo 3 items Social Support Scale (OSS-3). The results of the study showed that 53 (48%) of the participants were found psychologically distressed. Current symptomatology compared to a year ago shows a significant relationship with psychological distress of caregivers (p- value <0.01).employed and unemployed caregivers show a significant mean difference on the score of psychological distress. Spearman's correlation indicated that Experience of stigma has a positive and social support has a negative statistically significant relationship with psychological distress (p-value=.000). Logistic regression analysis indicates that caregivers who experience stigma and low social support have the likelihood of experiencing psychological distress. Mental health professionals and social workers have to give concern for the psychological wellbeing of caregivers of schizophrenia out patients.

Abbreviations

AMSH:	Amanuel Mental Specialized Hospital
DSM:	Diagnostic and Statistical Manual for Mental Disorder
MOH:	Ministry Of Health
OSS-3:	Oslo 3 Items Social Support Scale
SRQ 20:	The 20 Item Self Reporting Questionnaires
WHO:	World Health Organization

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CHAPTER ONE

1. INTRODUCTION

1.1.Background of The Study

Schizophrenia is one of the severe and disabling mental disorders which affect about 7 per 1000 of the adult population most of them between the age of 15 and 35 years (WHO, 2010). WHO (2010) estimated that globally about 29 million people have schizophrenia with a large number of untreated cases. 90% of the untreated cases of schizophrenia are in the developing world including Ethiopia (WHO, 2009). In developing countries, despite the apparent downfall of traditional family structure, over 60% of patients with Long-term schizophrenia live with at least one significant other, that are considered to be primary caregivers (Wiedemann, 1994). But many studies on the disorder have mainly focused on patients, with relatively less emphasis on the caregivers (Osman, Alipah, Tutiiryani, and Ainsah, 2010).

Caregivers are people who take care of other adults, often parents or spouses, or children with special medical needs or disability, they are usually unpaid family members or friend of the person with the disability or illness including severe mental illness (Given, Wyatt, Given, Gift, Sherwood, and Deross, 2005). Individuals with a severe mental illness have typically been mentally ill for many years and are unable to fulfill roles in society normally expected from individuals of their age and intellectual ability; thus, they are most likely to receive family care giving (Sanders, 2003). Caring for such patients may lead to psychological problems among the caregivers (Weisman, Rosales, Kymulainan and Armesto, 2005). In a sample of caregivers for family members with severe mental illness, Oldridge and Hughes, (1992) reported that psychological distress (anxiety, depression, and insomnia) was twice as high as in the general population.

Psychological Distress is conceptually defined as a unique, discomforting, emotional state experienced by an individual, in response to a specifics stressor or demand, that results in harm either temporary, or permanent to the person (Ridner, 2004). Clinically, psychological distress can be defined as a state of emotional suffering characterized by symptoms of depression which include sadness, hopelessness and symptoms of anxiety, such as restlessness, feeling tense (Mirkowsky and Ross, 2002). Losing interest in things and thoughts of suicide are also seen as symptoms of psychological distress (Weaver, 1995). These symptoms may be tied in with somatic symptoms (insomnia; headaches; lack of energy) that are likely to vary across cultures (Kermayer, 1987).

Psychological Distress among caregivers has been seen as mood disturbances like anxiety, depression, feeling of loneliness, isolation, fearfulness and being easily bothered arising from providing care for a sick relative (Fortinsky, Kerener, and Burant, 2002). Family caregivers have often been described as forgotten patients and it was suggested that caregiver's symptoms such as mood swing, fatigue, headaches, joint and muscle pains, marital and family conflicts, and financial problems may be a reflection of caregiver stress in looking after a sick relative (Medianos, Economoy, Dafnio, Koukia, Palli,and Rogakou, 2004).

Different scholars investigate different source of caregiver's psychological distress and this paper tries to investigate the role of socio demographic characteristics, experience of stigma and social support. Mitsonis, Voussoura, Dimopulos, Psarra, Karavizou, Latzouki, Zervas,and Katsanou, (2012), Suggests that when caregivers are in younger age, female in sex, higher educational level, and part time occupation result in to higher levels of psychological distress and when patient is in younger age and male sex are linked with higher caregiver's psychological distress. The study of Yosuf and Nuhu, (2009) which was conducted in Nigeria reported that caregivers without education were more likely to have significantly higher scores in the anxiety sub scale. on the patient caregiver relationship the study of Mitsonis, et al (2012), found that kinship relationship has been found to influence caregivers distress so parents and particularly mothers experience greater distress, additionally caregivers residing with the patient or spending a great amount of time with them report greater distress.

Tantawy, Raya, and Zaki (2010), found the experience of stigma as one factor for increased caregiver's psychological distress. In relation to mental illness stigma refers to the negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illnesses (Wong, et al, 2009). The stigma attached to mental illness is an issue of great concern to mentally ill patients this stigma is also conferred upon relatives, close friends and all those who come into close contact with the mentally ill individuals, including mental health professionals (Tantawy, et al, 2010). The process by which a person is stigmatized by virtue of association with another stigmatized individual has been referred to as 'courtesy' (Goffman, 1963) or 'associative' stigma (Mehta & Farina, 1988).

Some reports documented the negative impact of stigma on families that are primary caregivers of schizophrenia patients that it leads to sleep and relationship disturbances, poor psychological well-being and decrement in quality of life. It has been shown that as many as 70% of caregivers of individuals with mental illness believe that most people devalue patients and that this devaluation extends to their families (Wong, et al, 2009). Stigma is usually attached with a decrement in social support which can help caregivers to be psychologically healthy (Shankar and Muthuswamy, 2007).

Social support is a multidimensional concept and is generally conceptualized from a quantitative-structural perspective of social networks, such as numbers of persons and formal relationships with them, or from a qualitative–functional perspective of social support, such as the perceived content and availability of relationships with significant others (Helgeson, 2003). It has been suggested that social support helps people stay mentally healthy in stressful situations (Albert and Adelman, 1987). Findings suggest that a large measure of the stress experienced by caregivers may be associated with the lack of essential supports such as crisis information and support services, continuity of care, psychosocial rehabilitation programs for skill development and participation in work or education, caregiver counseling, and respite services (Shankar and Muthuswamy, 2007).

1.2.Statement of the problem

Care givers play a vital role in supporting relatives who are mentally ill, infirm, have disabilities, and there is concern that the families of those with mental disorders are affected by the condition of their near ones (Shan, Waddo, and Latoo, 2010). Numerous studies have demonstrated that family caregivers of persons with a severe mental illness suffer from significant stresses, experience moderately high levels of burden, and often receive inadequate assistance from mental health professionals. Effective family functioning and psychological wellbeing in families with schizophrenia (which are considered to be primary caregivers) may be influenced by a variety of psychosocial factor (Sanders, 2003).

research in to the impact of care giving shows that one third to one half of care givers suffer from significant psychological distress and experience higher rates of mental health problems than the general population (Shan, et al 2010). This may be due to different psychosocial care giving issues like the stigma attached to the mental illness which extends to their caregivers and the low social support from both the mental health professionals and the community.

World Health Organization (2001), declared stigma and discrimination associated with mental disorder to be one of the most important barriers to overcome in the community. Stigma affects not only people with mental illnesses, but their caregivers as well (Margareta and Lars, 2002). this is called stigma by association (Mehta and Farina, 1988) .In Ethiopia widespread beliefs that severe mental illnesses are due to demon possessions, bewitchment by evil spirits, ancestors' spirits or the evil eye have existed for many years, but the attitude of the public towards such illnesses has only recently been addressed(Alem, Jacobson, and Desta, 1996). This situation can further exacerbate the stigma of mental illness in Ethiopia both for the patient and caregivers.

The world Health Organization, (2006), report shows that in Ethiopia 75% of caregivers of schizophrenia patients have experienced stigma because of the presence of mental illness in the family and 37% hide the fact that the relative was ill. In other study of caregivers in Africa (Morocco) most of the caregivers in the study suffer from experience of stigma because of the patient's illness, a total of 86.7% of family members reported that they have hard lives because of the illness, and 72% reported psychological suffering, sleep and relationship disturbances, and poor quality of life (Nadia, Fatiha ,Soumia, and Driss 2004). The experience of stigma can limit the quality and availability of the needed social support for caregivers from the social system.

Social support for families with severe mental illness has been identified as one of the most important family resources to stay mentally healthy (Marsh, 1992). But only 10% of the caregivers even in developed countries receive psychological support when a relative is ill. This lack of services further adds to the sufferings of the caregivers (Maglino, Fiorillo, and

Malangone, 2006). Caregivers often feel isolated and alienated from their usual channels of social support because their role of care giving (Marsh, 1992).

According to World Health Organization, (2006) in Sub Saharan countries including Ethiopia mental illness is not well address in services, and there are limited trained professionals in comparison with the number of population. Thus, relatives are the sole caregivers to their severely mentally ill relatives. But very little is known about the extent of the relatives' care giving-related distress (Shibere et al, 2002). In order to make intervention on the psychological wellbeing of caregivers the researcher believes that it is right to assess the role of socio-demographic characteristics, experience of stigma, and social support. Therefore, the current study is designed to assess the prevalence of psychological distress and associated factors like socio-demographic characteristics stigma and social support among caregivers of schizophrenia outpatients. In line with this; the current study answered the following basic research questions:

1. What is the prevalence of psychological distress among caregivers of schizophrenia patients?
2. Is there any relationship between psychological distress and socio-demographic characteristics?
3. How does stigma explain or predict psychological distress?
4. How does social support explain or predict psychological distress?

1.3.Objective of the Study

1.3.1. General Objective

The general objective of this study was to assess the prevalence of psychological distress and associated factors among caregivers of schizophrenia out patients at Amanuel Mental Specialized Hospital

1.3.2. Specific Objective

- To assess the prevalence of psychological distress on caregivers of schizophrenia out patients.
- To examine the relationship between socio demographic characteristics and psychological distress.
- To assess if experience of stigma predicts psychological distress.
- To assess if social support predicts psychological distress.

1.4.Significance of the Study

The researcher hopes that the findings of this study can be significant for the caregivers of schizophrenia patients, caregivers with all kinds of disabilities and mental disorders, governmental, and non- governmental organizations which are working on mental health issues. By providing information on how being a caregiver for schizophrenia patient can cause psychological distress. It can also contribute relevant information and insights for designing possible intervention programs on minimizing the stigma attached to mental illness which extends to their caregivers and the quality of social support that caregivers receive both from the mental health professionals and the community.

Besides, this study can also give insight for mental health professionals and social workers to plan intervention programs at hospital level by providing psychosocial support, psycho education, and supportive therapy for the care givers and by designing possible coping mechanisms for them. They can also help the caregivers to establish peer self-help groups that can make caregivers to fight against stigma and psychological distress.

Moreover, this study can help the caregivers of schizophrenia patients and other mental disorders by providing relevant information on how care giving and its social consequences like associative stigma and social support can be associated with psychological distress. On the long term the caregivers can be benefited from the outcome of this research, for example if mental health professionals and social workers can design different caregivers support programs in hospital level based on the findings of the study.

Finally, this research can serve as a stepping stone for other research on the same area of interest.

1.5.Delimitation of the Study

The study has been delimited to Amanuel Mental Specialized Hospital, Addis Ababa Ethiopia; at the outpatient department. Aiming on assessing the prevalence of psychological distress and associated factors like stigma and social support among caregivers of schizophrenia out patients. This study also examined the relationship between socio-demographic characteristics and psychological distress. The participants were 110 caregivers of schizophrenia outpatients.

1.6.Limitations of the study

This study has its own limitations. The first limitation of the study is the number of variables which was used to assess psychological distress is limited there are many other socio demographic variables and associated factors which can be investigated here for example place of residence of the caregivers. The second limitation of this research was using a single data analysis method that is quantitative method but mixed approach of data analysis method was better.

1.7.Operational definition

Psychological distress:

Total score of SRQ 20 more than or equal to 7 is considered as distressed.

The total score of SRQ 20 less than or equal to 6 is considered as non-distressed.

Caregivers: in this study caregivers are peoples who take care of schizophrenia outpatients without any payment at Amanuel Mental Specialized Hospital. They may be parents, spouses, children's, siblings, aunt or uncles', grandmothers or fathers friends or they may have other kinds of relationship with the patient.

Stigma: in this study stigma refers to the total score obtained from stigma experience scale the family version.

Social support: Total score of OSS-3 which ranges from 3 – 8 is considered as low social support, 9–1 intermediate support, and 12 – 14 is considered as high social support.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

This part of the study is concerned with the related literatures, conceptual definitions and elaboration of the variables

2.1. The concept and Definition of Psychological Distress

Understanding the concept of psychological distress has been controversial for many years, but different scientific literature shows that the expression “psychological distress” is often applied to the undifferentiated combinations of symptoms ranging from depression and general anxiety symptoms to personality traits, functional disabilities and behavioral problems (Drapeau, Marchand, and Beaulieu, 2012). According to Ridner (2004), psychological distress is conceptually defined as a unique, discomforting, emotional state experienced by an individual, in response to a specifics stressor or demand, that results in harm, either temporary, or permanent, to the person.

Other study define the concept of psychological distress as a state of emotional suffering characterized by symptoms of depression which includes worthlessness ; sadness; hopelessness and anxiety like restlessness; feeling tense (Mirkowsky and Ross, 2002) losing interest in things and thoughts of suicide(Weaver, 1995). In another study of, Challfant et al (1990) psychological distress is defined as a continuous experience of unhappiness, nervousness, irritability and problematic interpersonal relationships and physical symptoms such as stomach upset and headache.

Decker (1997), defined psychological distress as lack of enthusiasm, problems with sleep (difficulty falling asleep or staying asleep), feeling downhearted or blue, feeling hopeless about the future, feeling emotionally bored (for example, crying easily or feeling like crying) these symptoms may be tied in with somatic symptoms like headaches and lack of energy that are likely to vary across cultures, (Kermayer, 1987).

2.2. **Psychological Distress on Caregivers of Schizophrenia Patients**

2.2.1. Schizophrenia

Schizophrenia is a severe form of mental illness that affects about 7 per 1,000 of the adult population, most of them between the ages of 15 and 35 years (WHO, 2001). It has been estimated that globally about 29 million people have schizophrenia. Although its incidence is low (3 per 10,000), its prevalence is high due to the chronic nature of this illness (WHO, 2010).

Schizophrenia is a clinical syndrome of variable, but profoundly disruptive, psychopathology that involves cognition, emotion, perception, and other aspects of behavior. The expression of these manifestations varies across patients and over time, but the effect of the illness is always severe and is usually long lasting (kaplan and sadok’s, 2007). DSM IV (1994) describes schizophrenia as a disturbance that lasts for at list six months and includes at list one month of active phase symptoms, that is two or more of the following: Delusion, Hallucination, Disorganized Speech, Grossly catatonic or Disorganized behavior and Negative symptoms (Affective flatting, Alogia, or Avolation) this signs and symptoms are associated with marked social occupational dysfunction. Studies suggested that about 20% of people with schizophrenia show unremitting symptoms, and increasing disability, and around 35% of them show a mixed pattern with varying degrees of remission and exacerbations of different lengths (Chien, Chan, &Morrissey, 2007).

According to DSM-IV (1994), there are five subtypes of schizophrenia namely paranoid, disorganized, catatonic, undifferentiated, and residual and this is defined by the predominant symptomtology at the time of evaluation. Although the prognostic and treatment implications of the subtypes are variable, the paranoid and disorganized Types tend to be the least and most severe, respectively .The diagnosis of a particular subtype is based on the clinical picture that occasioned them during evaluation or admission to clinical care and may therefore change overtime.

The choice among subtypes depends on the following algorithm: Catatonic type is assigned when ever prominent catatonic symptoms are present (regardless of the presence of other symptoms);disorganized type is Assigned whenever disorganized speech and behavior and flat or in appropriate affect are prominent (unless Catatonic Type is also present);Paranoid Type is assigned whenever there is a preoccupation with delusions or frequent hallucinations are Prominent (unless the Catatonic or Disorganized Type is present). Undifferentiated type is a residual category describing presentations that include prominent active –phase (DSM_IV, 1994).

2.2.2. The Prevalence of Psychological Distress among Caregivers of Different Kinds of Mental Disorders.

Caregivers are people who take care of other adults, often parents or spouses, or children with special medical needs or disability; they are usually unpaid family members or friend of the person with the disability or illness including severe mental illness (Given, et al 2005). Individuals with a severe mental illness have typically been mentally ill for many years and are unable to fulfill roles in society normally expected of individuals of their age and intellectual Ability; thus, they are most likely to receive family care giving (Sanders, 2003). Caring for such patients may lead to psychological distress among the caregivers (Weisman, et al 2005). In a sample of caregivers for family members with severe mental illness, Oldridge and Hughes (1992) reported that psychological distress (anxiety, depression, and insomnia) was twice as high as in the general population. other researches in to the impact of care giving shows that one third to one half of care givers suffer significant psychological distress and experience higher rates of mental health problems than the general population (Shan, Waddo,and Latoo, 2010).

Caregivers play a significant role in the rehabilitation of their relatives with psychiatric disabilities. They provide financial, instrumental and emotional support to their ill relative and offer assistance in the management of symptoms and functional deficits (Dixon et al. 2001, Marsh 2001, Mueser & Glynn 1999). Due to this overloads they become vulnerable to psychological distress. The manifestation of psychological distress among caregivers has been seen as mood disturbances like anxiety, depression, feeling of loneliness, isolation, fearfulness, sleep disturbance, behavioral problems and being easily bothered arising from providing care for a sick relative (Fortinsky, Kerener,& Burant, 2002). caregivers have often been described as forgotten patients and it was suggested that caregiver's symptoms such as mood swing, fatigue, headaches, joint and muscle pains, marital and family conflicts, and financial problems may be a reflection of caregiver stress in looking after a sick relative (Medianos, et al, 2004).

On the study of Lee et al (2011), on the Predictors of Patient and Caregiver Distress in an Adult Sample with Bipolar Disorder, from the total samples of care givers 30% of them had scores exceeding the cutoff point for clinically significant depression and nearly50% of the caregivers had scores exceeding the cutoff for clinically significant anxiety. On the study Schulz, et al, (1995) the prevalence rates for depressive symptoms among caregivers of persons with dementia are reported to range from 28% to 55%. On another study of Steele, Maruyama,and Galynker, (2010) they found that the many of the studies examining symptoms in bipolar caregivers reported the presence of caregiver psychiatric symptoms, with approximately 46% of caregivers reporting depression and approximately 32.4% reporting mental health service use.

2.2.3. Prevalence of Psychological Distress Among Caregivers of Schizophrenia Patients

Schizophrenia is a severe mental disorder which has a considerable impact on families and caregivers, but many studies on the disorder have mainly focused on patients, with relatively less emphasis on the family and caregivers (Osman, et al, 2010). The shifts towards community and outpatient care for chronic mental illness have increased the role of relatives in the caring of patients with schizophrenia. In developing countries, despite the apparent downfall of traditional family structure, over 60% of patients with long-term schizophrenia live with at least one significant other, that is primary caregiver (Wiedemann, 1994).

Caregivers of the patients with schizophrenia have significant high level of depression (Wittmund, Wilms, Mary, and Angermeyer, 2002). According to Ashraf, et al (2010), a comparative study on the prevalence of depression among caregivers of schizophrenia patients confirmed that caregiver’s depressive disorders where significantly higher than control group. About 18.33% of the primary caregivers verses 3.33% of the control group with ($p< 0.05$) were confirmed to have depressive disorders according to DSM-IV-TR criteria. Another comparative study on the same issue shows that Scores on the Symptom Check List Revised, it is a 90-item self report symptom inventory broadly used as a screening Instrument for psychological distress and psychopathology (SCL-90-R) were significantly higher among caregivers of patients with schizophrenia than healthy controls, showing that caregivers experienced greater overall psychological distress (Mitsonis et al, 2012). In a sample of caregivers of schizophrenic patients at Nigeria from the total participants of the study Emotional distress was found in 79.84% of the caregivers (Yesuf and Nuhu, 2011).

Another study of Magana, Ramirez, Hernandez, and Cortez, (2007) on the mental health of Latino caregivers confirmed that from the total participants of the study 34 of them (40%) of the caregivers were presented to met the criterion for being at risk of depression (that is, a score of 16 or higher on the Center for Epidemiologic Studies–Depression CES-D scale). On other hospital based study carried out in Psychiatry Department of Khyber Teaching Hospital, Peshawar on psychological distress among caregivers of schizophrenic patients, out of the total participants (50) Majority of the caregivers 36 (72%) were found to have a score of 9 or more on SRQ-20 and were found to be distressed this indicates higher levels of psychological distress among the caregivers (Shah, et al, 2013).

2.3. The Relationship between Socio Demographic Characteristics and Psychological Distress on Caregivers of Schizophrenia Patients

Some studies suggest that womens have higher rates of depression than men in the care giving role (Mitsonis et al, 2012). On the study of Shah et al (2011), from the total participants of the study all female participants that is 8(100%) of them scored more than 9 on SRQ-20 though this does not represent the population but it shows that female caregivers show being at risk of developing psychological distress when compared to male caregivers. On the study of Schulz & Wiliamson, (1991) 39%of female caregivers compared to 16% of men caregivers qualified as at being risk of psychological distress. The study of Mitsonis, et al (2012) also found that female caregivers experienced significantly greater psychological distress than males. Mcdonell, et al, (2003), found that when caregivers are in younger age when the patient is Young in age and male sex is linked to higher psychological distress on caregivers.

Kinship relation has been found to influence caregivers' distress, so parents, and particularly mothers, experience greater distress (Gutierrez, Caqueo, & Karanagh, 2005). On the other hand in the review of research on dementia caregivers, being the patient's spouse was associated with increased depression (Schultz et al, 1995). Additionally, caregivers residing with the patient or spending a great amount of time with them report greater distress (schene, wijngaurden, karanagh 1998). Similarly, Baronet, (1999) and, Stengard & Salokangas, (1997) found that residing with a relative with a mental illness increased the experience of distress.

Regarding Educational and employment status, studies suggest that employed caregivers are less likely to experience psychological distress than unemployed once (Greenberg et al. 1997). Lower educational level is found to be more related to psychological distress in many studies, in the context of caring for an adult with schizophrenia, low levels of education are related to lower socioeconomic status and it results in fewer resources available to caregivers (Magna, et al, 2007).

Some studies suggest that frequent psychiatric hospitalizations, short illness duration and young patients age have been associated with increased level of distress in caregivers' of persons with schizophrenia (Mcdonell, Short, Berry, and Dyck, 2003). On the study of Martins and Addington, (2000), duration of illness was significantly associated with psychiatric well being this indicates that a higher risk of distress in caregivers of individuals who are experiencing there first on set of schizophrenia in the contrary caregivers with relatives with long duration of illness shows low level of distress.

2.4. Experience of Stigma and Its Role on Psychological Distress

According to Gofman, (1963), Stigma is defined as a sign of disgrace or discredit that sets a person apart from others. In relation to mental illness stigma refers to the negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate against people with mental illnesses (Wong, et al, 2009). The stigma attached to mental illness is an issue of great concern to patients and their families (Tantawe, et al, 2010). Obviously, stigma can be a major obstacle to recovery and can limit opportunities of work, education, relationships and social functioning of patients across the world (Struening, Perlick, Link, Hellman, Herman,and Sirey, 2001) . Therefore, World Health Organization, (2001), declared stigma and discrimination associated with mental Disorder to be one of the most important barriers to overcome in the community.

However, individuals with mental illness are not the only ones to be stigmatized. The stigma is also conferred upon relatives, close friends and all those who come into close contact with the mentally ill, including mental health professionals (Perlick, Miklauitz, Link, Struening, Kaczynski, and Gonzalez, 2007). It has been shown that as many as 70% of caregivers of individuals with mental illness believe that most people devalue patients and that this devaluation extends to their families (Stutuning, et al 2001). The process by which a person is stigmatized by virtue of association with another stigmatized individual has been referred to as ‘courtesy’ Goffman,(1963) or ‘associative’ stigma (Mehta and Farina, 1988). This courtesy stigma has a negative consequence on caregivers of mentally ill including schizophrenia patients that it leads to sleep and relationship disturbances and poor psychological well-being (Martins and Addingtons, 2001).

The focused group study of Angermeyer, Schilze, and Dietrich, (2003) proposed four courtesy stigma domains of caregivers of schizophrenia patients: the first one is interpersonal interaction (stigma experienced in the context of social interaction like, with health professionals, social exclusion and with drawl), the second is structural discrimination (imbalances and injustices inherent in social structures, political decisions, and legal regulations, like poor facility of mental health care), the third one is public image of mental illness (stereotypes about mental illness held by the public and disseminated by the media), and access to social roles (stigma makes an obstacle in making access to major social roles for patients, such as, creating and staying with friends and getting a job).

The first two domains, interpersonal interaction and structural discrimination, include direct and indirect experiences, relatives' statements for the latter two domains almost exclusively refer to indirect stigma experiences. Direct experiences allude to stigma encountered by the relatives themselves. Indirect experiences are stigma experiences of the persons with schizophrenia observed and identified by their caregivers (Angermeyer, et al, 2003).

In Ethiopia widespread beliefs that severe mental illnesses are due to demon possessions, bewitchment by evil spirits, ancestors' spirits or the evil eye have existed for many years, but the attitude of the public towards such illnesses has only recently been addressed (Alem, Jacobson, and Desta, 1996). This situation can further exacerbate the stigma of mental illness in Ethiopia both for the patient and caregivers. A study on the interest of stigma of caregivers which was conducted in the Butajira region (Ethiopia) showed that 75 % of the relatives of cases of schizophrenia and affective disorders perceived stigma related to mental illnesses to be a major problem they encounter (Shibre et al. 2001).

In the sample of caregivers in Morocco Most of the participants suffer from stigma because of the patient's illness. A total of 86.7% of family members who give care for the patients reported that they have hard lives because of the illness, and 72% reported psychological suffering, sleep and relationship disturbances, and poor quality of life (Nadia , et al, 2004). Similarly, the study of Ostman and Kjellin, (2002), on the psychological impact of stigma by association they found that a relatively high proportion of caregivers considered that the patient's mental illness had affected the possibilities of having company of their own or had influenced relations with others, and had also led to mental health problems in the care givers themselves.

Additionally, a study with an interest of assessing stigma among relatives of mentally ill patients found that from the total respondents (77%), of them said that their ill relative had been much or very much affected by stigma, difficulties to make and keep friends (65 %), and to find a job (64 %). Respondents further indicated that stigma was a problem for themselves, 56% of the respondents stated that stigma much or very much affected families of a mentally ill person, respondents also identified specific personal stigma experiences (Wahl & Harmann, 1989).

The study of Lee, et al, (2004), also suggest that caregivers of patients with schizophrenia who are shame prone as a result of stigma may be disposed to view incidents, such as having a relative with a mental illness, as something that reflects negatively upon them. This implies that it is of great importance to evaluate caregivers' shame proneness as this could help identify family members who may be at high risk for experiencing depression, anxiety and stress. Even in the absence of a prior mood disorder (Taj, Hameed, Mufti, Khan, and Rehman, 2005).

2.5.Experience of Social Support and Its Role on Psychological Distress

Social support is defined as the physical and psychological comfort provided by other people (Sarason, Sarason ,and Pierce, 1994), and understood to be an integral part of our psychological make -up of always wanting to affiliate with others (Baumeister, Smart,and Boden, 1995). It is further recognized as the implicit aspect of affiliation and conceptualized into friendliness, socialization, close interaction, cooperativeness, positive communication and lovingness (Hill, 1987). According to National child Traumatic Stress Network and National Center for PTSD, (2006) social support can come in many forms as emotional support, social connectedness, feeling needed, reassurance of self-worth, reliable support, advice and information, and physical and material assistance.

On the other hand according to Albert and Adelman (1987), social support is a verbal and non verbal communication between recipients' and providers that reduces uncertainty about the situation, the self, the other or the relationship and functions to enhance a perception of personal control in one's life experience. It is a multidimensional concept and is generally conceptualized from a quantitative-structural perspective of social networks, such as numbers of persons and formal relationships with them, or from a qualitative–functional perspective of social support, such as the perceived content and availability of relationships with significant others (Helgeson, 2003).

The study of Cohen, (1992), proposed three classes of support concepts this are social networks, perceived social support and supportive behaviors. Social networks refer to structure of social relationship that is the existence, quantity and type of relationship. the perceived social support refers to the function of social relationships, that is the perception of social relationships will (if necessary) provide resources such as emotional and informational support at last, supportive behaviors refers to the mobilization and receipt of behaviors intended to aid persons in to face of stress full events.

It has been suggested that social support helps people stay mentally healthy in stressful situations and it has been repeatedly connected with low levels of psychological distress (Albert and Adelman, 1987, Magliano, et al, 2000). Findings suggest that a large measure of the stress experienced by caregivers of peoples with different kinds of mental and physical impairment may be associated with the lack of essential supports such as crisis information and support services, continuity of care, psychosocial rehabilitation programs for skill development and participation in work or education, caregiver counseling, and respite services (Shankar and Muthuswamy, 2007).

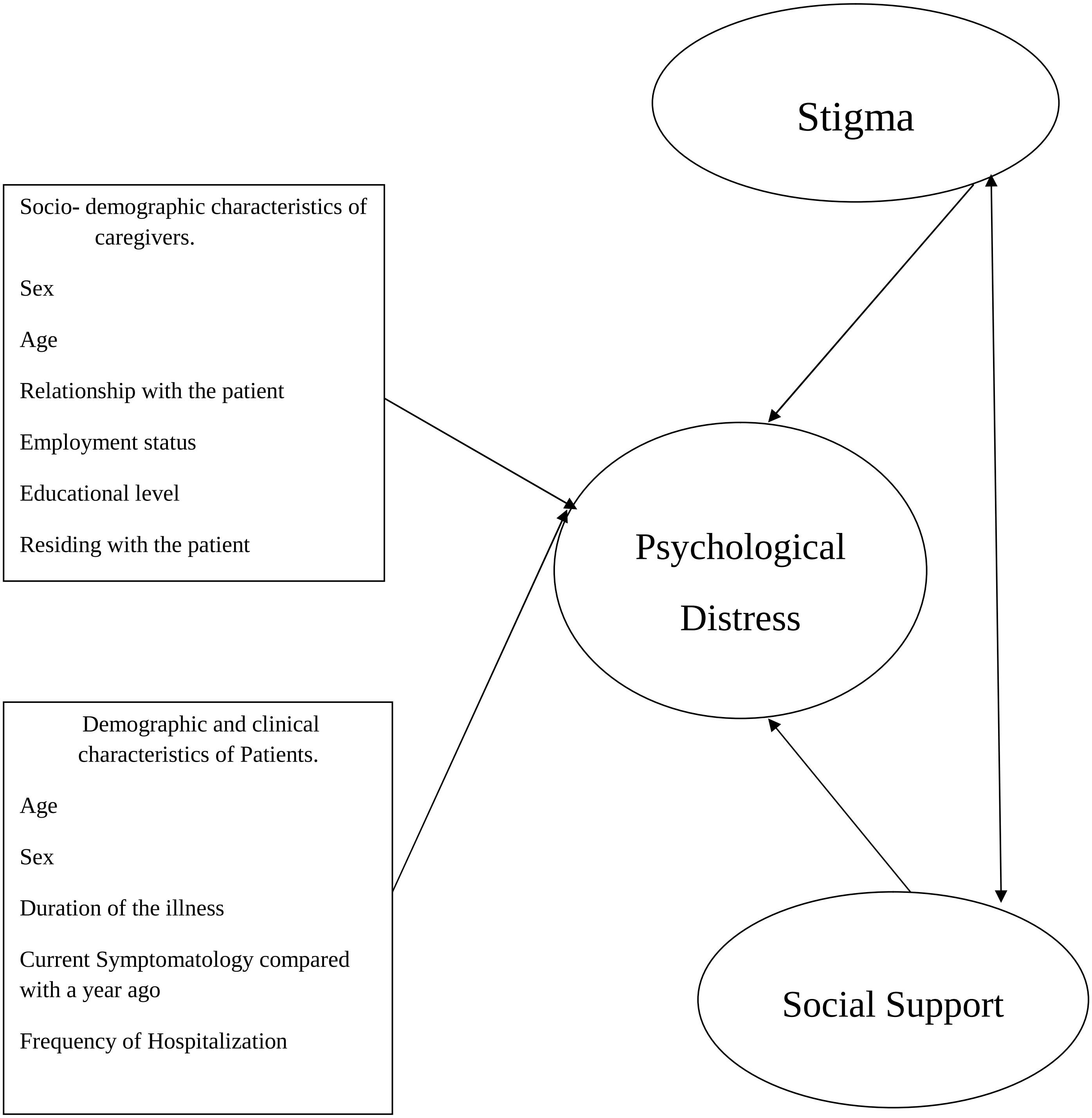
Schizophrenia is one of the devastating kinds of mental disorder worldwide; it is severe mental disorder which has a considerable impact on caregivers (Osman, et al, 2010). when a family member find outs that their relatives developed schizophrenia they experience helplessness, anger, despair and anxiety (Spaniol, Zipple,and Lockwood, 1992) .They are confronted with uncertainty and emotions of shame, guilt, and anger. Like the patient, they feel stigmatized and socially isolated (Lee, et al, 2004).

Their lives may be disrupted by providing more care than would normally be appropriate for someone of the patient's age. In those cases where reciprocity between family members is out of balance, normal care changes into care giving. Addition of the care giving role to already existing family roles may become stressful, both psychologically and economically (Schen,Wijngaurden, and Koeter ,1998).

Social support for families with severe mental illness like schizophrenia has been identified as one of the most important family resources (Marsh, 1992), But only 10% of the caregivers even in developed countries receive psychological and social support when a relative is ill. This lack of services further adds to the sufferings of the caregivers (Maglino, Fiorillo, and Malangone, 2006). Caregivers often feel isolated and alienated from their usual channels of social support because their role of care giving (Marsh, 1992).

Support groups have been shown to provide an effective means of reducing social isolation and enhancing social support by meeting behavioral, cognitive, emotional, and social needs of families providing care to a family member with severe mental illness. It has been indicated that participation in a family support group is an important coping strategy and a source of social support for caregivers of individuals with severe mental illness (McFarlane, 1994).

Figure 1: Conceptual Frame Work



CHAPTER THREE

3. METHODS

3.1.**Study Design**

The study employed cross sectional survey study design to obtain relevant data concerning psychological distress among caregivers of schizophrenia outpatients and the role of stigma and social support on psychological distress at Amanuel Mental Specialized Hospital, from caregivers of schizophrenia outpatients.

3.2.Study Setting

The study was conducted in Amanuel Mental Specialized Hospital, Addis Ababa, Ethiopia at the outpatient department. Amanuel Mental Specialized Hospital is the only specialized mental health Federal hospital in Ethiopia under Ministry of Health (MoH), which is offering both outpatient and inpatient services for individuals who are suffering from mental illness. The hospital has 12 rooms and 350 psychiatric beds. There is also a large out-patient service, with around 115,000 visiting outpatient department each year. Even if the hospital offers treatment for all psychiatric disorders except child psychiatry, the most common mental illness identified and addressed are schizophrenia, mood disorder, anxiety and substance related disorders respectively (Alemayehu, 2004).

3.3.Population, Sample Size and Sampling Technique

The target population of this study was all caregivers of schizophrenia out patients at AMSH. From all caregivers of schizophrenia outpatients who underwent their monthly follow up at AMSH from May 1, 2014 to May 30, 2014, 110 caregivers were selected as a study sample based on the inclusion criteria. The inclusion criterias were a) Taking care of a patient with the diagnosis of Schizophrenia as per the DSM-IV criteria without any payment. b) Taking care of a patient who is on regular follow up in outpatient department. c) Immediate family relative (Parent, spouse, sibling, brother or sister), non immediate family relative (Other relative) or non-relative. The patients are formally diagnosed with schizophrenia as per the criteria of DSM IV by the psychiatrists at the hospital. In order to select the participants of the study the researcher used purposive sampling technique. Purposive sampling technique was used because the researcher was interested in finding caregivers who fulfill the inclusion criteria.

The caregivers excluded if:

1. If the patient has a diagnosis other than schizophrenia.
2. If the patient was admitted to the inpatient departments during the past 2 months.
3. If the caregiver is not involving directly in giving care.
4. If the caregiver has a history of psychiatric disorder before being a caregiver.

3.4.Variables

Socio demographic variables

Predictor variables- experienced stigma and Social Support

Criterion variable- Psychological Distress

3.5.Data Collection Instrument

The study used structured questionnaires to collect data about background information and standardized scales to measure psychological distress, experienced stigma, and social support, namely the self report questionnaire (SRQ 20), the stigma experience scale the family version and Oslo 3 items social support scale (OSS-3)

3.5.1. The Socio-Demographic Data

The socio demographic data was collected using a semi structured questionnaires which includes sex, age, relationship with the patient, educational level, employment status, and residing with the patient. Demographic and Clinical features of patients which was reported by the caregivers includes sex, age, duration of illness, frequency of treatment and current symptomatology compared to a year ago.

3.5.2. The Self Reporting Questionnaire (SRQ 20)

The self reporting questionnaire (SRQ20) has been developed by WHO as an instrument designed to screen for psychiatric disturbances and as a brief screen to measure levels of distress in developing countries. SRQ 20 has been adopted, validated and translated to the local language (Amharic) and extensively used in previous studies (Tafari, Aboud,and Larson, 1991, Alem et al 1990, Ermiyas and Samueal, 2003, Abateneh, Tesfaye, Bekele, and Gelaw, 2013). SRQ20 consist 20 questions which includes the symptoms of depression, anxiety, cognitive disturbance, somatic symptoms, and behavioral disturbances like, decreased energy. Which are answered by yes or no. it can be used either as a self administered or as an interview administered questionnaire, interview is allowed because of the high literacy rate in developing countries (WHO, 1994).

Each of the 20 items of SRQ is scored as 0 or 1. A score of 1 indicates that the symptom was present during the past 30 days. A score of 0 indicates that the symptom was absent. The maximum score is therefore 20. No global generally applicable cutoff score can be recommended for the SRQ 20 and each study should determine its own. The score used will be depend up on the language used the method of administration, the population answering it as well as the needs of the research designs (high sensitivity, high specificity, or optimum predicted value). As investigated by many different countries including Ethiopia the coefficient of reliability for this scale was highly acceptable most of them found (KR-20=0.81) and around this (WHO, 1994).

On this study SRQ 20 has been administered as an interview form. Respondents who score 7 and above was considered as having psychological distress, and respondents who report 6 or less symptoms were considered as not having psychological distress. The cut off score 6/7 is based on other researches that used SRQ20 in assessing mental distress both in Ethiopia and as a whole in Africa (Alem et al, 1999, Tefari et al, 1991, and Abbo, Ekblad, Waako, Okello, Muhwezi,and Musisi, 2008). According to WHO, (1994), if SRQ 20 has been used in previous studies on similar populations using the same method of administration then the cutoff score obtained from the study can be used in another study.

3.5.3. Stigma Experience Scale the Family Version

As proposed by Stuart, Koller, and Miler (2008), the Stigma Experience Scale is a frequency scale based on seven items which was developed to be applied to people who have serious mental health problems and are living in the community, and for the family members who are caring for the patients to assess their experience of stigma.

From the seven items of stigma experience scale the family version, the first four items are scored on a 5-point likert-type scale, that is ‘never’ ‘rarely’, ‘sometimes’, ’often’, and ‘always’. Items are then recoded into binary variables to reflect the presence or absence of each specific stigma experience in the way that ‘never’, ‘rarely’ and ‘sometimes’ are recoded as zero to reflect the absence of stigma and ‘often’ and ‘always’ are recoded as one to reflect the presence of stigma. The Rest three items are scored using the response categories (yes, no, unsure) and recoded by 0 and 1 to reflect the presence (yes) is coded as 1 or absence (no and unsure) is coded as 0. Values are then summed across the seven items for a scale score ranging from 0 to 7 so the increase in the score of scale shows that respondents are experiencing more stigma and low scores show that respondents are experiencing lower levels of stigma. The coefficient of reliability for this scale was good (KR-20=0.76) this proves that the scale achieved an acceptable level of internal consistency.

3.5.4. Oslo 3 Items Social Support Scale (OSS-3)

Oslo three items social support scale (OSS-3) provides a brief measure of social support and functioning and it is considered to be one of the best predictors of mental health. It covers different fields of social support by measuring the number of people the respondent feels close to, the interest and concern shown by others, and the ease of obtaining practical help from others.

In order to score OSS-3, total scores are calculated by adding up the raw scores for each item. The sum of the raw scores has a range from 3-14. A score ranging between 3 and 8 is classified as poor support, a score between 9 and 11 as intermediate support, and a score between 12 and 14 as strong support. The Cronbach’s alpha level of OSS-3 is relatively low (.60). In this case, however, the low Cronbachs’s alpha does not necessarily reflect a low reliability, but rather the multidimensional structure of the index (Dalgard, 2008).

3.6.Instrument Translation

This study used two structured questionnaires to collect socio demographic data and 3 standardized scales to measure psychological distress (SRQ 20), experienced stigma and social support (OSS-3). SRQ 20 has an Amharic version which is validated in Ethiopia by previous studies, but the researcher cannot find the Amharic version of the rest two scales namely the experienced stigma and social support scale (OSS-3). The items of stigma experienced and social support scales were translated in to Amharic with an appropriate words and phrases which are considered to be appropriate for caregivers in Ethiopia, with the help of English and Amharic language teachers at Addis Ababa university, and with different psychology professionals at Amanueal Mental Specialized Hospital to confirm the appropriateness of the words used.

For ward and back ward instrument translation was done by six psychology professionals independently. Finally the translation were reviewed all of the items readability, clarity and comprehensiveness, appropriateness and agreed on to which items should be included in the final instrument.

3.7.Data Collection Procedure

After obtaining and adjusting the appropriate scales of measurement for this study. The following data collection procedures were taking place. The first procedure was that the researcher requested a letter of introduction from Clinical Health and counseling Program Unit of the School of Psychology, Addis Ababa University to Amanuel Specialize Mental Hospital administration to allow the researcher work at the hospital. After obtaining the ethical approval of the proposal, the researcher has continuously visited the outpatient department of the hospital to meet with the staff members and to plan how to choose participants and collect the data successfully.

110 participants were selected by using purposive sampling technique based on the inclusion criteria, from all caregivers of schizophrenia outpatients who attend their follow-up from May 1, 2014 to May 30, 2014. The participants were informed about the research objectives, process and confidentiality of the information. The data were collected by the researcher and with the help of 3 assistant data collectors (2 psychiatric nurses and 1 clinical psychologist at the hospital). The assistant data collectors were trained by the researcher on how they collect the data by using the scales, on interview techniques like encouraging respondents to give honest answers, and to be free from any judgment during the interview.

3.8.Pilot Testing

Before applying the instrument on the actual sample of the study pilot test was done on 20 caregivers of schizophrenia out patients at St. Paul General Referral Hospital, at the psychiatry department. This site was chosen because it is the second most appropriate option next to Amanuel Mental Specialized Hospital in Addis Ababa to find schizophrenia out patients with their caregivers. Though there is no inpatient service for psychiatric patients except, substance related disorders, there are a number of schizophrenia patients who are using the outpatient services at St. Paul Hospital.

Pilot test was done to prove that the items in the scale works for the target population and to see the reliability of self report questionnaire (SRQ20), experienced stigma the family version scale, and Oslo 3 items social support scale (OSS-3). after administering the instrument for the pilot samples, based on the response of the participants the internal consistence (reliability) of the self reporting questionnaire SRQ 20, experienced stigma scale the family version, Oslo 3 items social support scale OSS-3 were seen by Calculated coefficient alpha and its results are presented in the following table.

Table1. Alpha Value of Scale Instruments

	Types of alpha value		
Scales	Psychological distress (SRQ 20)	Stigma experience	social support (OSS-3)
Cronbach's α level	(α =.86)	(α=.78)	(α=.90)

The above table indicates that, the cronbach's alpha coefficients for the given instruments look acceptable and reliable. On the socio demographic questions of the study some items with minor confusion was corrected based on the obtained pilot data.

3.9.Data Analysis

This study was used quantitative data analysis method. Statistical package for the social science SPSS version 20 was used to clean and analyze the collected data from 110 participants. Descriptive statistics that is frequency count was done for socio demographic characteristics of the care givers and demographic and clinical characteristics of the patients as reported by the caregivers. A particular response to individual questions and percentage was done.

Independent sample t-test used to test the significant mean difference between male and female, employed and unemployed, caregivers and respondents who residing with the patients or not with psychological distress.

Spearman's rank order correlation was done to test the relationship between socio demographic characteristics of caregivers, demographic and clinical characteristics of patients as reported by the caregivers with psychological distress. The relationship between stigma, social support and psychological distress was also investigated by using spearman's rank order correlation.

Logistic regression was employed to investigate the likelihood of stigma, social support, and socio demographic characteristics which show a significant relationship, to report psychological distress among the respondents of the study.

3.10. **Ethical Consideration**

In order to protect the right and welfare of participants the following ethical considerations were applied: - Ethical clearance was obtained from Amanuel Specialized Mental Hospital research ethical review board. The board confirms that the study was in line with research ethics and it has no harm on the respondents. A written Informed consent was obtained from caregivers (respondents) who were participated in the study. The purpose, objective and confidentiality of the study were explained to the participants by the data collectors. Confidentiality was maintained by omitting the participant's name.

CHAPTER FOUR

4. RESULTS

The main purpose of this study was to assess the prevalence of psychological distress and to examine the role of socio demographic characteristics, stigma and social support on the level of psychological distress. The respondents of this study were 110 caregivers of schizophrenia out patients. So, this part presents the major findings of the study in line with the stated purpose.

4.1.Background information

4.1.1. Socio Demographic Characteristics Of Participants

Table 2: Frequency of Socio Demographic Characteristics of Caregivers n=110

Variables		Frequency	Percent
Sex	Male	54	50.9
	Female	56	49.1
Age	20-39	36	32.7
	40-59	41	37.3
	60+	33	30.0
Relationship	Mother	20	18.2
	Father	8	7.3
	Sister/brother	45	40.9
	Husband/wife	14	12.7
	Child	15	13.6
	Friend	2	1.8

	Others*	6	5.5
Educational Level	Can’t read and write	20	18.2
	Elementary school	24	21.8
	High school	15	13.6
	Preparatory school	25	22.7
	College and above	26	23.6
Employment Status	Employed	77	70.0
	Unemployed	33	30.0
Does your relative lives with you?	Yes	76	69.1
	No	34	30.9

*= 6 neighbors

Table 1 presents about the socio demographic characteristics of the caregivers. As shown in table 1 the majority of participants 56(50.9%) were females followed by 54(49.1%) males. Most of the respondents age were ranged from 20-29, 41(37.3%) followed by 30-49, 36(32.7%) and the rest 33(30.0%) were 60 and above. Regarding their relationship with the patient the majority 45(40.9%) of the respondents were siblings followed by 20(18.2%) mothers,15(13.6%) offspring’s, 14(12.7%) spouses, 8(7.3%) fathers, 2(1.8%)friends, 6(5.5%) others (non relative neighbors) respectively. On their educational level 26(23.6%) 0f them were college and above, 25(22.7%) preparatory school, 24(21.8%) elementary school, 20(18.2%) cannot read and write, and the rest 15(13.6%) were high school. Regarding their employment status 47(70.0%) of them were employed and the rest 33(30.0%) were unemployed. 76(69.1%) were living with their ill relative and the rest 34(30.9%) of them were not live with their ill relative.

4.1.2. Demographic and Clinical Characteristics of Patients as Reported By Caregivers

Table 3: Frequency of Demographic and Clinical Characteristics of the Cared Patients as reported by the caregivers n=110

Variables		frequency	Percent
Sex	Male	44	40.0
	Female	66	60.0
Age	20-39	39	35.5
	40-59	50	45.5
	60+	21	19.1
Duration Of Illness	Under 5 years	63	57.3
	5-10 years	25	22.7
	11-19 years	12	10.9
	20-29 years	9	8.2
	30-39 years	1	0.9
symptomatology compared to a year ago	Better	76	69.1
	About the same	17	15.5
	Worse	17	15.5
Frequency Of Treatment	Weekly	4	3.6
	2 or 3 times per month	39	35.5
	Monthly	38	34.5
	Every 2 or 3 months	23	20.9
	1 to 2 times per year	6	5.5

Table 3 presents the demographic and clinical characteristics of cared patients as reported by the caregivers. As the table indicates the majority of patients were females 66(60.0%) and the rest 44(40.0%) were males. Regarding age the majority50 (45.5%) of them have an age range from 40-59 followed by 39(35.5%) from 20-39 and the rest 21(19.1%) above 60. regarding duration of illness the majority of patients 63(57.3%) were being ill for under 5 years, followed by 25(22.7%) from five to ten years,12(10.9%) from eleven to nineteen years,9(8.2%) from twenty to twenty nine years, 1(0.9%) from thirty to thirty-nine years respectively.

Concerning mental illness compared to a year ago the majority 76(69.1%) of caregivers reported that the patients are better than a year ago and 17(15.9%) reported that the patients symptoms are about the same, and the rest 17(15.9%) reported that the patients symptoms are getting worse when compared to a year ago. regarding frequency of treatment the majority 39(35.5%) of caregivers report that the patients see their doctors two or three times per month and 38(34.5%) see their doctors monthly, 23(20.9) every two or three months, 6(5.5%) see their doctors one to two times per year and the rest 4(3.6%) of the caregivers report that the patients see their doctors weekly.

4.2.Prevalence of psychological distress

Table 4: Prevalence of Psychological Distress among Caregivers n=110

Level of distress		Frequency	Percent
Non-Distressed	Female	25	44.6
	Male	32	59.3
	Total	57	51.8
Distressed	Female	31	55.4
	Male	22	40.7
	Total	53	48.2

Table 4 presents the prevalence of psychological distress among the respondents of the study. As table 3 indicates the majority of males 32(59.3%) were non-distressed and the rest 22(40.7%) of them were psychologically distressed. Regarding females the table shows that the majority 31(55.4%) of them were psychologically distressed and the rest 25(44.6%) of them were non-distressed. Regarding the total prevalence of psychological distress among caregivers 53(48.2%) of them were distressed and the rest 57(51.8%) were non-distressed.

Table 5: mean difference of sex of participants

	Test values						
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Psychological distress	**1.124**	**108**	**.264**	**1.05754**	**.94121**	**-.80810**	**2.92318**

An independent-samples t-test was conducted to compare the psychological distress scores for males and females. There was no significant difference in scores for males (*M* = 6.88, *SD* = 4.4) and females (*M* = 7.94, *SD* = 5.38; *t* (108) = 1.12, *p* = .26, two-tailed). The magnitude of the differences in the means (mean difference = 1.05, 95% *CI*: –.80 to 2.9) was very small (eta squared = .01). This indicates that both male and females experience psychological distress regardless of their sex difference

Table 6: mean difference of employment status of participants

	Test values						
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Psychological distress	**-2.091**	**108**	**.039**	**-2.11688**	**1.01247**	**-4.12377**	**-.10999**

An independent-samples t-test was conducted to compare the psychological distress scores for employed and unemployed respondents. There was a significant difference in scores for employed (*M* = 6.79, *SD* = 4.4) and unemployed (*M* = 8.90, *SD* = 5.81; *t* (108) = -2.09, *p* = .03, two-tailed). The magnitude of the differences in the means (mean difference = -2.11, 95% *CI*: –-

4.1 to -.10) was very small (eta squared = .04). This indicates that unemployed respondents experience psychological distress than that of the employed ones

Table 7: mean difference of residing with the patient of the participants

	Test values						
	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Psychological distress	**-.228**	**108**	**.820**	**-.23297**	**1.02388**	**-2.26248**	**1.79654**

An independent-samples t-test was conducted to compare the psychological distress scores for caregivers who live together with their relative patients and for those who do not live with the cared patients. There was no significant difference in scores for caregivers who live with the patient (*M* = 7.35, *SD* = 5.07) and caregivers who live apart from the cared patient (*M* = 7.58, *SD* = 4.69; *t* (108) = -2.2, *p* = .82, two-tailed). The magnitude of the differences in the means (mean difference = -.23, 95% *CI*: –-2.26 to 1.79) was very small (eta squared = .04).

Table 8: mean difference of patients sex of the participants

	Test value						
	T	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Psychological distress	**2.071**	**108**	**.041**	**1.96212**	**.94743**	**.08416**	**3.84008**

An independent-samples t-test was conducted to compare the psychological distress scores for patients' sex, males and females of participants. There was no significant difference in scores for males (*M* = 6.88, *SD* = 4.4) and females (*M* = 7.94, *SD* = 5.38; *t* (108) = 1.12, *p* = .26, two-tailed). The magnitude of the differences in the means (mean difference = 1.05, 95% *CI*: –.80 to 2.9) was very small.

4.3.Relationship Between Socio Demographic Characteristics And Psychological Distress

Table 9: Spearman's Rank Order Correlations between Socio Demographic Characteristics and Psychological distress

	1	2	3	4
1. age of caregivers	-	**.220**[*]	**-.165**	**.084**
2. relation with the patient	-	-	**-.124**	**.033**
3. educational level	-	-	-	**-.135**
4. psychological distress	-	-	-	**-**

*. Correlation is significant at the 0.05 level (2-tailed).

As table 9 indicates no variable was significantly correlated with psychological distress. However, educational level rho=-.131 n=110, p>.05, show a week relationship with psychological distress.

Table 10: Spearman’s Rank Order Correlations between Demographic and Clinical Characteristics of Patients as Reported by Caregivers and Psychological Distress

Variables	1	2	3	4	5
1. Age of The Mentally Ill Relative	_	**.296****	**-.153**	**.169**	**-.059**
2. Duration of Illness	_	_	**.119**	**.249****	**-.098**
3. Current Symptomatology Compared to a year ago	_	_	_	**.072**	**.322****
4. Frequency Of Treatment	_	_	_	_	**-.011**
5. Psychological Distress	_	_	_	_	_

***p< 0.01 level (2-tailed).*

As indicated on table 5 There was a significant positive relationship between psychological distress and mental illness compared to a year ago rho=.322 n=110 p<0.01.with the increase in symptoms of mental illness psychological distress increases. There was also low relationship between sex of the patient and psychological distress rho=-.174 n=110 p>0.05. Other variables did not show any relationship with psychological distress.

4.4.Relationship between Stigma and Social Support With Psychological Distress

Table 11: Spearman's Rank Order Correlations between Independents (Stigma, Social Support) With Psychological Distress

Scales	1	2	3
1. Stigma	_	**-.431****	**.760****
2. Social Support	_	_	**-.776****
3. Psychological Distress	_	_	_

***p< 0.01 level (2-tailed).*

The relationship between stigma (measured by stigma experience scale) and social support (measured by Oslo 3) with psychological distress (measured by SRQ 20) has been investigated by using spearman's rho. There was a strong positive relationship between stigma and psychological distress rho=.760 n=110 p<.001this indicates that, with high levels of stigma there is high levels of psychological distress. And there was a strong negative relationship between psychological distress and social support rho=-.776 n=110 p<.001 which confirms, with low levels of social support there was high levels of psychological distress. There was an intermediate negative relationship between stigma and social support rho=-431 n=110 p<.01 which indicates with high levels of stigma social support decreases.

Table 12: Logistic Regression Predicting the Likelihood of Reporting Psychological Distress

	B	S.E.	Wald	df	P	OR	95% C.I.for EXP(B)	
							Lower	Upper
Sex	**.442**	**.726**	**.371**	**1**	**.543**	**1.556**	**.375**	**6.464**
Age	**-1.013**	**.831**	**1.486**	**1**	**.223**	**.363**	**.071**	**1.851**
Relationship	**.891**	**1.628**	**.300**	**1**	**.584**	**2.438**	**.100**	**59.202**
Educational level	**-.162**	**.762**	**.045**	**1**	**.832**	**.850**	**.191**	**3.786**
Employment status	**1.133**	**.942**	**1.449**	**1**	**.229**	**3.106**	**.491**	**19.665**
Residing with the patient	**.696**	**.844**	**.680**	**1**	**.410**	**2.006**	**.384**	**10.491**
Sex of the patient	**-.703**	**.758**	**.860**	**1**	**.354**	**.495**	**.112**	**2.187**
Age of the patient	**.155**	**.754**	**.042**	**1**	**.837**	**1.167**	**.266**	**5.117**
Duration of illness	**.555**	**1.272**	**.191**	**1**	**.662**	**1.742**	**.144**	**21.078**
Symptomatology comparison	**1.540**	**1.153**	**1.787**	**1**	**.181**	**4.667**	**.488**	**44.672**
Social Support	**-6.726**	**1.716**	**15.366**	**1**	**.000**	**.010**	**.000**	**.035**
Stigma	**1.008**	**.202**	**24.975**	**1**	**.000**	**2.740**	**1.845**	**4.068**
Constant	**-4.325**	**1.322**	**10.710**	**1**	**.001**	**.013**		

Logistic regression was performed to assess the impact of a number of factors on the likely hood of that respondents would report that they had psychological distress. The model contains 12 independent variables (sex, age, relationship with the patient, educational status, employment status, patients sex and age, duration of illness, current symptomatollogy compared to a year ago, stigma and, social support). The full model containing all predictors was statistically significant, x^2 (11, n=110) = 91.6 p<.001indicating that the model was able to distinguish between respondents who report and did not report psychological distress. The model as a whole explained between 56.6% (Cos and Snell R square) and 75.4% (Nagelkerke R squared) of the variance in psychological distress, and correctly classified 90.0% of cases. As table 8 indicates only two independent variables made a significant contribution to the model. The strongest predictor of reporting psychological distress was stigma by recording an odds ratio of 2.7.which indicates that respondents with a high score of stigma were 2 times psychologically distressed than those who have low scores on stigma scale by controlling all other variables. The Odds and Ratios of .010 for social support was less than one indicating that respondents with intermediate and high social support were .010times less likely to report psychological distress than respondents with low social support by controlling the other factor in the model.

CHAPTER FIVE

5. DISCUSSION

This study was conducted to assess the prevalence of psychological distress and its relationship with socio demographic characteristics, experienced stigma and social support among caregivers of schizophrenia outpatients. In order to achieve the objectives of these study 110 caregivers of schizophrenia outpatients were selected by using purposive sampling method based on the inclusion criteria's. Standard instruments were used to assess psychological distress, experienced stigma and social support. In this part of the study the findings indicated at the result section will be discussed with the available literatures and presented as follows.

5.1.Prevalence of Psychological Distress among Caregivers of Schizophrenia out Patients?

What is the prevalence of psychological distress? The finding of the current study concerning the prevalence of psychological distress among caregivers of schizophrenia out patients was in agreement with various literatures which explain that caregivers of schizophrenia patients are at high risk of developing poor psychological wellbeing, with a high prevalence of psychological distress among the participants of the study. Out of the total samples 48.2% of them were found psychologically distressed with a score of 7 and above in the SRQ 20. This result indicates that the high prevalence of psychological distress among caregivers of schizophrenia out patients is true for Ethiopian caregivers too, and the distressing nature of care giving for schizophrenia patient is common all over the world regardless of cultural difference.

Various literatures suggest that being a caregiver for a schizophrenia patient is connected with poor psychological well being and at risk of developing psychological distress (Witmend etal, 2002). In a sample of caregivers of schizophrenic patients at Nigeria, from the total participants of the study Emotional distress was found in 79.84% of the caregivers (Yesuf and Nuhu, 2011). Similarly on another study of Magana et al (2007), on the mental health of Latino caregivers of schizophrenia patients confirmed that from the total participants of the study 34 of them (40%) of the caregivers were presented to met the criterion for being at risk of depression (that is, a score of 16 or higher on the Center for Epidemiologic Studies–Depression CES-D scale).

On other hospital based study carried out in Psychiatry Department of Khyber Teaching Hospital, Peshawar on psychological distress among caregivers of schizophrenia patients, out of the total participants (50) Majority of the caregivers 36 (72%) were found to have a score of 9 or more on SRQ-20 and were found to be distressed this indicates higher levels of psychological distress among the caregivers (Shah, et al, 2013). Similarly, other comparative studies which compare the prevalence of psychological distress between caregivers of schizophrenia patients and healthy controls suggest that psychological distress was significantly high among caregivers of schizophrenia patients than control groups, showing that caregivers of schizophrenia patients experienced greater overall psychological distress (Ashraf et al 2010, Mitsonis et al, 2012).

The prevalence of psychological distress in this study was even high when compared with some other studies in different countries (Magana et al, 2007). This may be due to the low economical and social status that most caregivers in Ethiopia have, and the negative and unaware attitude of the community towards individual with Sevier mental illness. The cultural and religion based biases of mentally ill individuals and there family members (who are considered to be primary caregivers) in many part of regions in Ethiopia can also exacerbate the high prevalence of psychological distress among caregivers.

5.2.The Relationship between Socio Demographic Characteristics and Psychological Distress?

Is there a significant relationship between socio demographic characteristics and psychological distress? The assessed socio demographic characteristics of the caregivers in this study where age, sex, relationship with the patient, educational level, employment status, and residing with the patient. The socio demographic and clinical characteristics of the patient as reported by the caregivers' includes sex, age, duration of illness, mental illness symptomatology compared to a year ago, and frequency of treatment.

Socio Demographic Characteristics of Caregivers

In this study sex, age and residing with the patient did not show significant relationship with psychological distress. This is inconsistent with some studies which explain that females are more vulnerable to psychological distress in the care giving role than male. Caregivers who are in younger age and who are residing with the patient were found being at risk of developing psychological distress in the role of care giving (Shah et al, 2011, Schulz and Wiliamson, 1991, Mcdonell et al, 2003, Gutierrez, Caqueo, Karanagh, 2005, Baronet, 1999, Stengard & Salokangas, 1997). The possible explanation for this can be the cultural difference among the study areas.

The possible factor why residing with the patient did not show a significant relationship with psychological distress may be the unbalanced proportion of respondents in answering the item that may caregivers are residing with the patient and only few are living apart from the patient. on the other hand living together with the patient can be a factor that can decrease the worry of caregivers for the patient.

Without the researchers' imagination, the current study fails to find a significant relationship between kind of relationship with the patient and psychological distress. Unlike the current study, Gutierrez, Caqueo, & Karanagh, (2005), has found Kinship relationship to influence caregivers' distress, so parents were the most dominant group of caregivers to experience greater distress. The possible explanation could be cultural difference between the study areas, unlike other individualistic countries, a strong attachment between extended family members and collectivism is the commonest life style in Ethiopia. Most persons who consider themselves close to the patient, whether they have kinship (mother, father, and sibling) or other kinds of relationship (aunt, uncle, friends, friends of parents) are likely to be distressed and have a sense of care for their relative patients. The unbalanced proportion of respondents can be another potential reason for this result that large number of respondents were have a kinship relationship with the patients and only few of the samples were has other kind of relationship with the patients this may be why significant relationships were not shown.

Lower educational level is found to be more related to psychological distress in many studies, in the context of caring for an adult with schizophrenia, (Magna, et al, 2007). But this study fails to get significant relationship between these two variables. This result seems to show that the level of education can't determine the level of psychological distress among Ethiopian caregivers. Other possible explanation for this can be the unbalanced proportion of the respondents who have high and low educational status. Those participants who have low educational status were take the lion share in this study, this can be why the variable can't show a significant relationship with psychological distress. Different studies show that unemployed caregivers are more likely to experience psychological distress than the employed once. And the current study is consistent with those findings that there were a significant mean difference on the score of psychological distress among the employed and unemployed caregivers that the unemployed caregivers were show greater mean score of psychological distress than the employed ones.

The Socio Demographic and Clinical Features of Patients As Reported By the Caregiver

In this study among the socio demographic and clinical features of patients as reported by the caregivers, only mental illness compared to a year ago was significantly related to caregivers psychological distress that caregivers who respond that the symptoms of the illness of their patient is worse than a year ago reported higher levels of psychological distress this is in agreement with the study of Schene et al (1998), showed that current increased symptomatology, showed a strongest relationship with caregivers' distress. The possible explanation for this can be, in Ethiopia in which caregivers have poor informational and professional support, they don't know how to deal with the aggressive, socially unacceptable, and dangerous behavioral symptoms of schizophrenia patients this can increase their care giving related distress.

The age and sex of the patients was not significantly related to caregiver's psychological distress this finding is consistent with Mitsonis etal (2012) and similarly on the study of Schene et al (1998) sex of caregivers was not related with care giving problems. On the contrary of the researchers expectation duration of illness was not significantly related to caregiver's psychological distress and this is in agreement with the study of Schene et al (1998) but it is inconsistent with the study of Martins and Addington (2000), which explains that short duration of illness, was significantly associated with poor psychiatric well being of caregivers. The possible explanation for this may be the cultural difference in those two samples of caregivers. Frequency of treatment was not significantly related to caregiver's psychological distress this is consistent with the findings of Mitsonis etal (2012)

5.3. Experience of Stigma and Social Support the Likelihood of Predicting Psychological Distress?

Does experience of stigma and social support predict psychological distress? In this study, the spearman correlation indicates that experience of stigma has a positive correlation with psychological distress on caregivers. This means that when the experience of stigma increases the experience of psychological distress also gets increased. Furthermore, The logistic regression confirmed that experience of stigma significantly predicts the likelihood of psychological distress in this study caregivers who experienced stigma were two times psychologically distressed than those who do not experience it. This result is in agreement with various literatures, Lefley (1989), suggest that the behaviors of persons with psychotic disorders may further isolate the caregivers, diminish its reputation and jeopardize relationships with friends and neighbors.

Similarly on the study of Ostman and Kjellin (2002), on the psychological impact of stigma by association they found that that a relatively high proportion of caregivers considered that the patient’s mental illness had affected the possibilities of having company of their own or had influenced relations with others, and had also led to mental health problems in the care givers themselves. The study of Magna, et al (2007) and Tantaway, et al (2010) found that stigma was significantly related to the increased caregivers’ depressive symptoms.

In Ethiopia were the awareness of Sevier mental illness is poor, usually people’s perceive sevier mental illness as a result of sin that the patent him/her self or family members (who are considered to be the primary caregivers) committed. So the stigma experienced both among the patients and the care givers can be high. The caregivers’, especially family members themselves may feel guilty and worthless of having a family member with schizophrenia, so they have the probability to stigmatize themselves or to withdraw from the social system. This can be one factor which is associated to their increased level of stigma and its consistency with the above studies on the interest of the relationship between stigma by association and psychological distress.

The spearman's correlation shows that there was a negative relationship between social support and psychological distress on caregivers this indicates that when the level of social support decreases the experience of psychological distress increases. Besides, the logistic regression confirmed that social support significantly predicts psychological distress which means in this study caregivers who have low levels of social support were .02 times distressed than those caregivers who have intermediate and high levels of social support this result is consistent with different studies like, Albert and Adelman, 1987, and Magliano, et al, 2000, which suggested that social support helps people stay mentally healthy in stressful situations and it has been repeatedly connected with low levels of psychological distress. Social support for caregivers with severe mental illness like schizophrenia has been identified as one of the most important family resources (Marsh, 1992), which can prevent them from developing the symptoms of psychological distress this is consistent with the current study.

Unlike some other parts of the world caregivers of schizophrenia patients in Ethiopia can have low professional resources regarding schizophrenia. Especially older caregivers can be more susceptible to low informational and professional support this can be, due to the inadequate internet services and if there is so there is lack of skill in dealing with computers, illiteracy rate can be also other factor for low information that they can't read books, magazines and journals regarding schizophrenia. There is also poor Psychiatrist or Psychologist-Caregiver relationship this can also limit informational resources for caregivers.

The other possible factor can be the societal negative attitude towards peoples with severe mental illness which is based on cultural and religious beliefs, due to this the community can be in a very low potential to help out caregivers. Some caregivers themselves sometimes tend to keep secret that they have a relative with schizophrenia patient due to the fear of stigma, this may diminish their behavior of seeking support from others and actually others can’t be able to help them if they don’t know the case. There is a problem of meeting with other caregivers of schizophrenia patients that limits the opportunity of releasing bad emotions which can help them to stay psychologically well and to control their level of distress. The above explanations can be why caregivers in this study got low social support score and why this is connected with high levels of psychological distress.

CHAPTER SIX

6. SUMMARY, CONCLUSION, AND RECOMMENDATION

6.1.Summary

The main purpose of this study was to assess the prevalence of psychological distress and to examine the role of socio demographic characteristics, experienced stigma and social support among caregivers of schizophrenia out patients, in the case of Amanueal Mental Specialized Hospital. In order to achieve the stated purpose of the study caregivers of schizophrenia out patients at Amanuel Mental Specialized Hospital were selected as the population of the study. From the total population of the study 110 samples of caregivers of schizophrenia out patients were selected by using purposive sampling technique. Data was collected from the samples by using structured questionnaire and standardized instruments. The structured questionnaire was used to gather socio demographic information. Regarding, the standardized instruments self report questionnaire SRQ 20 was used to assess psychological distress, experienced stigma scale the family version was used to assess experienced stigma and Oslo 3 items social support scale OSS-3 was used to assess social support.

The collected data from the samples was organized and analyzed by using SPSS version 20. Descriptive statistics, spearman’s correlations and logistic regression analysis was used to analyze the data. Current symptomatology compared to a year ago was the only socio demographic variable which shows a significant relationship with psychological distress of caregivers. Other socio demographic variables which are included in this study did not show a significant relationship with psychological distress. Spearman’s correlation indicates that Experience of stigma and social support have a statistically significant relationship with psychological distress. logistic regression analysis indicates that caregivers who reported the current symptomatology of the patient was worse than a year ago, who experienced stigma and low social support was having a high likelihood of developing psychological distress in the care giving role.

6.2.Conclusion

From the result of this study the researcher concludes that there is a prevalence of psychological distress among caregivers of schizophrenia out patients in Amanuel Mental Specialized Hospital. Among the socio demographic characteristics of caregivers and the clinical features of patients as reported by the caregivers, only current symptomatology of patients compared to a year ago shows a significant relationship with psychological distress on caregivers. But other socio demographic characteristics like age, sex, relationship with the patient, employment and educational status, residing with the patient, duration of illness, and frequency of hospitalization did not show a significant relationship with caregiver's psychological distress.

Experienced stigma shows a positive relationship with caregivers' psychological distress. the logistic regression result indicates that caregivers who experience stigma are two times psychologically distressed than those who do not experience stigma. Social support shows a negative relationship with caregivers psychological distress, also the logistic regression result confirmed that having low social support predicts the likely hood of caregivers' psychological distress.

This study shows that it is necessary to give an attention and concern for caregivers of schizophrenia out patients, so as they are vulnerable to psychological distress, experience of stigma and low social support as a result of caring for the patient. Moreover, further researches' are needed to examine caregivers' experience of psychological distress from different dimensions and perspectives of care giving issue

6.3.Recommendations

Based on the findings of this study the following recommendations are drown.

- ✓ The prevalence of Psychological distress has been found high among caregivers in this study. In line with these finding mental health professionals (clinical psychologists, psychiatrists, nurses, and social workers e.t.c.) are recommended to consider that patients are not the only one to be supported but also their caregivers. They have to give special concern for the caregivers of schizophrenia out patients by providing psycho educations, supportive therapies and psychological first aids, and teaching possible coping mechanisms with the unusual behaviors of the patients and societal attitudes.
- ✓ Caregivers who reported the patients current symptomatology of illness was worse than a year ago reported high level of psychological distress so, it will be good if mental health professionals mostly target to support caregivers who have a patient with increasing symptomatology, by helping the caregivers on training how to manage the aggressive and dangerous behavioral symptoms, and by teaching them the correct way of managing medications and follow up.
- ✓ In this study Experience of stigma was found as one of the determinant factor for caregivers psychological distress in line with this finding stigma coping strategies can be help full for the caregivers to reduce their level of stress, besides anti-stigma advocacy programs of mental illness could be done by concerned bodies like MOH and other NGOs who works on community mental health services.

- ✓ In this study having low social support has been connected with increased level of psychological distress of caregivers. So community based intervention programs are advised for enhancing the awareness of the society about schizophrenia, the challenges of care giving for schizophrenic patients and the benefits of supporting caregivers. Mental health professional and social workers in hospitals also have to keep in mind that caregivers needed to be supported.
- ✓ Caregivers of schizophrenia out patients are advised to establish self help associations. and to join to with already established self help associations in which they can communicate and share experiences each other regarding the challenges of care giving, so as they can get relief from stress and to get important tips from the experience of others. Furthermore, through these they safeguard to the rights of their relative patients and themselves by exerting their effort to put their influence on stake holders to include their issue in different developmental economical social policies and programs. Self help associations are also important to implement anti- stigma and awareness creation programs in the form of community based interventions, in this process at list the members of the association will be able getting the chance of educating his/her neighborhood.
- ✓ It will be good if other clinical psychology researchers investigate care giving issues from different dimensions of caregiver’s experience. Especially , from the point of view of coping strategies of care giving stress and developing intervention strategies for mental illness stigma which extends to the caregivers,

Reference

Abbo, C. Ekblad, S., Waako, P., Okello, E., Muhwezi, W., and Musisi, S. 2008. Psychological distress and associated factors among the attendees of traditional healing practices in Jinja and Iganga districts, Eastern Uganda: a cross-sectional study. *International Journal of Mental Health Systems 2008, 2:16 doi:10.1186/1752-4458-2-16*

Abateneh, A., Tesfaye, M., Bekele, S., Gelaw, Y. (2013). Vision Loss and Psychological distress among Ethiopians Adults: A Comparative Cross- Sectional Study. *journal.pone.0078335. doi:10.1371*

Alem, A., Kebede, D., Woldesemayat, G., Jakobson, L., and Kullgren, G. (1999). The prevalence and socio-demographic correlates of mental distress in Butajira , Ethiopia,. *Journal of Acta psychiatrica Scandinevica : 100(48-55l.397):5- 10*

Alem,A,, Jacobsson, L., and Desta, M. 1996. Perception of Mental disorders and their treatment in Central Ethiopia. Yearbook of Cross-cultural Medicine and Psychotherapy. VWB_verlag fir Wissenschaft und Bildung, 1996.

Alemayehu, G. 2004**.** Psychiatric Nursing for Students**:** Lecture Note Series**.** University: Bole Printing Enterprise.

Angermeyer, M., Schilze, B., and Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. *Journal of socpsychiatry psychiatr epidemol 38: 593-602*

Baronet, A. 1999. Factors associated with caregiver burden in mental illness: A critical review of the research literature', *journal of Clinical Psychology Review, vol 19, no 7, pp 819-41*

Baumeister, R., Smart, L. and, Boden, J.1995. The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bullettin, 1995; 117: 497-529.*

Osman,O., Alipah,B., Tutiryani,M.,and Ainsah,O. 2010. Depressive disorders and family functioning among the caregivers of patients with schizophrenia. *East asian arch psychiatry 2010:20:101-8*

Chalfant, P., Heller, P., Roberts, A., Briones, D., Hochbaum, S. and Farr, W. (1990). the Clergy as A Resource for Those Encountering Psychological Distress. *Review of Religious Research, 31, 305-313.*

Chan, S. (2011). Global perspective of burden of family caregivers for persons with schizophrenia. *Archive of psychiatric nursing 25, pp 339-349*

Chien, W., Chan, S., and Morrissey, J. (2007). The perceived burden among Chinese family caregivers of people with schizophrenia. *Journal of Clinical Nursing, 16, 1151–1161.*

Dalgard,OS.2008. Explanation of OSS-3. In: EUPHIX, EUphact. Bilthoven: RIVM, <http://www.euphix.org> EUphact\ Determinants of health\ Environment\ Social support, 26 May 2008.

Decker, F. (1997). Occupational and Non-occupational Factors in Job Satisfaction and Psychological Distress among Nurses. *Research in Nursing & Health, (20),453-464.*

Drapeau,A.,Marchand A., and Beaulieu,D.(2012).Epidemiology of Psychological Distress, Mental Illnesses - Understanding, Prediction and Control, Prof. Luciano LAbate (Ed.),ISBN:978-953-307-662-1,retrived from http//www.intecopen.com/books/mental-illness-understanding-prediction and control/epidemiology-of-psychological-distress on may 3, 2014.

Ermias, M., and Samuel, E.2003. Correlates of mental Distress in Jimma town, Ethiopia. *Journal of Health Sciences ; (14:1), 39-49.*

Fortinsky, R., Kercher, K., and, Burant, C. (2002). Measurement and correlates of family caregiver self- efficacy for managing dementia. *Aging Ment Health 6:153–160.*

Goffman, E. (19 6 3) Stigma: Notes on the Management of spoiled identity. Englewood Cliffs, N.J., Prentice Hall, 1963

Greenberg, J.S., Greenley, J.R., and Brown, R. (1997). Do mental health services reduce distress of families of people with serious mental illness?. *Psychiatric Rehabilitation Journal* ***21****, 40–50.*

Gutierrez, J., Caqueo, A., and Kavanagh, D. (2005). Burden of care and general health in families of patients with schizophrenia. *Soc Psychiatry Psychiatr Epidemiol 40:899–904*

Helgeson, V.S. 2003. Social support and quality of life. *Qualitative Life Research 12, 25-31*

Hill, C. A. 1987. Affiliation motivation. People who need people but in different ways. *Journal of Personality and Social Psychology, 1987; 52: 1008-18.*

Shankar, J., and Muthuswamy, S. 2007 . Support Needs of Family Caregivers of People Who Experience Mental Illnes. *The Journal of Contemporary Social Services families in society | Volume 88, No. 2 DOI: 10.1606/1044-3894.3628.*

Kirmayer, L.J. 1989. "Cultural variations in the response to psychiatric disorders and psychological distress." *Social Science and Medicineno. 29:327-339.*

Lee,A., Simeon, D., Cohen, L., Samuel,J., Steele,A., and Galynker, I. 2011.Predictors of Patient and Caregiver Distress in an Adult Sample with Bipolar Disorder Seeking Family Treatment. *J Nerv Ment Dis 2011;199: 18 –24.*

Leff, J., Vaughn, C. Expressed Emotion in Families: It's Significance for Mental Illness. Guilford, New York, 1985.

Lefley, H. 1989. Family burden and family stigma in major mental illness. *Journal of American psychological association. Vol 44, No 3,556-560.*

Madianos, M., Economou, M., Dafni, O., Koukia, E., Palli, A., and Rogakou, E. (2004). Family disruption, economic hardship and psychological distress in schizophrenia: can they be measured? *jornal Eur Psychiatry 19:408–414.*

Magana, SM., Ramirez ,JI., Hernandez, MG.,and Cortez, R.2007. Psychological distress among latino family caregivers of adults with schizophrenia: The roles of burden and stigma. *Journal of Psychiatr Serv 2007;58:378–84.*

Magliano, L., Fiorillo, A., Malangone, C., DeRosa, C., Maj, M.2006. Patient Functioning and Family Burden in a Controlled, RealWorld Trial of Family Psychoeducation for Schizophrenia. *Journal Psychiatr Serv 2006;57:1784–91.*

Magliano, L., Fadden, G., Economou, M., Held, T., Xavier, M., Guarneri, M., Malangone, C., Marasco, C., Maj, M. (2000) Family burden and coping strategies in schizophrenia: 1-

year follow up data from the BIOMED I study. Soc *Psychiatry Psychiatr Epidemiol 35:109–115.*

Marsh, D.T. 2001. A Family-Focused Approach to Serious Mental Illness: Empirically Supported Interventions. Professional Resource Press, Sarasota, Florida.

Martins, L., and Addington, J.2000. The psychological wellbeing of family member of individuals with schizophrenia. *Journal of Soc psychiatry psychiatr epidimiol 2001 36:128-133.*

McDonell, MG. Short, RA., Berry, CM. Dyck, DG. (2003). Burden in schizophrenia caregivers: impact of family psycho education and awareness of patient suicidality. *Journal of Fam Process 42:91–103.*

Mehta, S., and Farina, A. 1988. Associative stigma: perceptions of the difficulties of college-aged children of stigmatized fathers. Journal of Social Clinical Psychology *JournalofSocialClinicalPsychology,7 192-202.*

Mirowsky, J., and Ross,C.E. 2002. "Selecting outcomes for the sociology of mental health: Issues of measurement and dimensionality." *Journal of Health and Social Behaviorno. 43:152-170.*

Mitsonis, C., Voussoura, E., Dimopaus ,N., Zervas, I., katsanou, M., (2012). Factors associated with the caregiver’s psychological distress in chronic schizophrenia. *Journal of psyciatity psychiatr.epidemol, 47:331-337.*

Nadia, K., Fatiha, M., Soumia, B., Driss, M.,.2004. Stigma Impact on Moroccan Families of Patients with Schizophrenia. *Can J Psychiatry, Vol 49, No 9, 2004;49:625–629*

Oldrige,M., and Huges, I.1992. Psychological wellbeing in families with a member suffering from schizophrenia. *british journal of schichatry ,1992 161, 249-251.*

Perlick, DA., Miklowitz, DJ., Link, BG., Struening, E., Kaczynski, R., and, Gonzalez,J.2007. Perceived stigma and depression among caregivers of patients with bipolar disorder. *Br.J.Psychiatry 2007 Jun;190:535-6.*

Psychological First Aid – Field Operations Guide, 2nd Edition. 2006. National child Traumatic Stress Network and National Center for PTSD, on, www.nctsn.org and www.ncptsd.va.gov retrieved on April 1, 2014.

Ridner, S.H. (2004). Psychological distress: concept analysis. J Adv Nurs 45:536–545

Sarason, I.G., Sarason, B. R., and Pierce, G. R. 1994. Social Support. Global and relationship-based levels of analysis. *Journal of Social and Personal Relationships, 11: 295-312.*

Sanders, J.C. 2003. Families living with Sevier mental illness: a literature review. *Issues in Mental Health Nursing, 24:175–198, 2003.*

Schene, A., Wijngaurden, B.,and Koeter, M. (1998). Family care giving in schizophrenia domains and distress. *Schizophrenia bulletin vol 24 no 4*.

Schultz, R .A., O’Brien, T. Bookwala ,J., and Fleissner, K.1995. Psychiatric and physical morbidity effects of dementia care giving: Prevalence, correlates, and causes. *The Gerontologist, vol 35, no 6, pp 771-791.*

Schulz,R,and Wiliamson,G.1992. A two years longitudinal study of depression among alzimers caregivers. *Psycho.aging.6:569-578.*

Shah,T., Sultan M., Faisal., M., and Irfan, M. 2013. Psychological Distress among Caregivers of Patients with Schizophrenia. *Journal of Ayub Med Coll Abbottabad; 25(3-4).*

Shan, A., Wadoo, O., and Latoo, J.,(2010). Psychological distress in careers of people with mental disorder. *British Journal of medical practitioner 3 no 3*.

Spaniel L., Zipple AM., and Lockwood, D. 1992. The role of family in psychiatric rehabilitation. *Schizophr bull 18:341-348.*

Steele, A., Maruyama, N., and Galynker, I. (2010). Psychiatric symptoms in caregivers of patients with bipolar disorder: A review. *Journal of Affect Disord. 121:10 – 21.*

Stengard, E. and Salokangas, R.K.R. (1997). Well-being of the caregivers of the mentally-ill.*Nordic Journal of Psychiatry* ***51****, 159–164.*

Struening, E.L., Perlick. , DA., Link, BG., Hellman, F., Herman, D., and Sirey, JA.2001. Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatr.Serv. 2001 Dec;52(12):1633-8.*

Stuart, H., Koller, M., Milev, R. 2008. Inventories to measure the scope and impact of stigma experiences from the perspective of those who are stigmatized – consumer and family versions. Understanding the Stigma of Mental Illness: Theory and Interventions. John Wiley & Sons, Ltd. ISBN: 978-0-470-72328-9.

Tafari, S., Aboud, F.E., Larson, CP.1991. Determinants of mental illness in a rural Ethiopian adult population. *Soc Sci Med 1991, 32:197-201.21.*

Taj, R., Hameed, S., Mufti, M., Khan, A., and Rehman, G.2005. Depression among primary caregivers of schizophrenic patients. *Ann.Pak.Inst.Med.Sci. Apr-Jun 2005;1(2):101-4.*

Tantawe, A., Raya, Y., and Zaki, A.(2010). Depressive disorders among caregivers of schizophrenic patients in relation to burden of care and perceived stigma. *Journal of current psychiatry, 17 (3), pp 15-25.*

Weaver, J.A. (1995). Has There Been a Failure to Prepare and Support Parish-Based Clergy in Their Role as Frontline Community Mental Health Workers: A Review. *The Journal of Pastoral Care, 49(2), 129-147.*

Wiedemann, G., Hahlweg K., Hank, G., Feinstein, E., Muller, U., and Dose, M. Deliverability of psycho educational family management. *Schizophr. Bull. 1994; 20(3):547-56.*

Wittmund, B. Wilms, H.U. Mory, C. and Angermeyer, M.C. 2002. Depressive disorders in spouses of mentally ill patients. *Soc.Psychiatry Psychiatr.Epidemiol. Apr;37(4):177-82.*

Wong, C., Davidson, L., Anglin, D., Link, B., Gerson, R., Malaspina, D., McGlashan, T.,and Corcoran, C. 2009. Stigma in families of individuals in early stage of psychotic illness: family stigma and early psychosis. *Journal of early intervention in psychiatry 3:108-115.*

World Health Organization .2009. schizophrenia. Retrieved from www.who.int/mental-health/management/schizophrenia/en/. On April 8, 2014.

World Health Organization, 2010. Schizophrenia. Retrived from www.who.int/mental-health/management/schizophrenia/en/. On April 5, 2014.

World Health Organization. 2001. World health report 2001. World health organization Geneva-world health organization, retrieved from http://www.who.int/media/en/sspdf-retrived on April, 3, 2014.

World Health Organization.1994. A user's guide to the Self-Reporting Questionnaire (SRQ). World Health Organization, Geneva, Switzerland; 1994.

Yusuf. A. J., and Nuhu, F. T., 2009. Factors associated with emotional distress among caregivers of patients with schizophrenia in Katsina, Nigeria. *Soc Psychiat Epidemiol (2011) 46:11– 16 DOI 10.1007/s00127-009-0166-6.*

APPENDIX

Appendix A

Informed Consent

My name is ____. I am asked to participate in a research titled as "psychological distress among caregivers of schizophrenia outpatients: the role of experience of stigma and social support".

Before participating in this study the necessary information concerning the study that is the purpose of the research, procedures, risk and/ or discomforts with their solutions, benefits, privacy and confidentiality and freedom to withdraw is provided for me. including who are the investigators of this study in a well organized way. So, based on the information and by taking this study as a means of solution to reduce care giving related psycho-social problems I have decided to participate in this study by my own and I put my signature to certify this.

Name______________________________ signature____________

Witness ____________________________ signature _____________

Appendix B

በጥናቱ ላይ ለሚሳተፉ ሰዎች የፍቃደኝነት መጠየቂያ ፅሁፍ

ስሜ______________________________ የተባልኩ ግለሰብ የስኪዞፍሬኒያ አእምሮ ሕመም ታማሚ የሆነ የቤተሰብ አባል የሚንከባከቡ ሰዎች ያለባቸውን የስነ-ልቦና መረበሽ ከ ግል መረጃቸው፣ ከሚደርስባቸው መድሎ፣ ና ካላቸው የማህበረሰብ ድጋፍ ጋር አዛምዶ ለማየት በተዘጋጀዉ ጥናት ላይ እድሳተፍ በመታሰቡ አስፈላጊዉን የጥናቱ መረጃ ማለትም ስለጥናቱ ዓላማ፣ ስለ ጥናቱ ሂደት፣ ከጥናቱ ጋር ሊያያዙ ስለሚችሉ ችግሮች ከነመፍትሄያቸዉ፣ በጥናቱ ስለሚገኝ ጥቅም፣ ሚስጥር ጠባቂነትና ጥናቱን እነማን እንደሚያጠኑት እዳዉቅ ተደርጊያለሁ፡፡ ይህን የተሰጠኝን መረጃ መሰረት በማድረግና አጠቃላይ ጥናቱ የስኪዞፍሬኒያ አአምሮ ታማሚዎቸን በመንከባከብ ምክንያት የሚመጡ ማህበራዊ ና ስነ- ልቦናዊ ችግሮችን ከ ነ መፍትሄያቸው የሚዳስስ መሆኑን በመገንዘብ በዚህ ጥናት ላይ ለመሳተፍ በራሴ ሙሉ ፍቃድ መወሰኔን ከዚህ በታች በፉርማዬ አረጋግጣለሁ፡፡

የተሳታፊ ስም --ፊርማ --------------------

የእማኝ ስም ---ፊርማ----------------------

Appendix C

ADDIS ABABA UNIVERSITY

COLLEGE OF EDUCATION AND BEHAVIORAL SCIENCE

SCHOOL OF PSYCHOLOGY

CLINICAL PSYCHOLOGY PROGRAM UNIT

QUESTIONNAIRE

Dear participants

First of all I would like to thank you for your participation in advance. This instrument is meat to collect data in order to make opinion survey to a thesis for an M.A degree.

This questionnaire is designed to obtain relevant information about psychological distress in caregivers of schizophrenia out patients and the role of experience of stigma and social support on it. This questionnaire is to be filled out by caregivers of schizophrenic out patients in Amanuel specialize mental hospital.

I would like to assure you that your responses will be used only for academic research purpose and that it will be kept confidential. No need to write your name.

This questionnaire have 4 parts and Since the quality and success of this study depends on the validity and reliability of the information you provide, you are kindly requested to complete each item of the scale genuinely and return the questionnaire.

Sincerely yours,

Part One. Background Information

Instruction: This Part Of The Study Is Concerned With Your Background Information. Please Put (√) Mark on Questions That Are Applicable To You

No	Item	Response	
1	Sex	Male	
		Female	
2	Age	20-39	
		40-59	
		60+	
3	Relationship with the patient	mother	
		Father	
		Sister/brother	
		Wife/husband	
		Child	
		Friend	
		Other	
4	Educational level	Can read and Write	
		Elementary school 1-8	
		High school 9-10	
		Preparatory school 11-12	
		College and above	
5	Employment status	employed	

		unemployed	
6	Does your relative live with you?	yes	
		no	

Part Two. Socio Demographic and Clinical Characteristics of the Patient

Instruction: This Part Of The Questionnaire Is About The Socio Demographic And Clinical Characteristics Of Your Relative Patient. Please Put A **(√)** Mark On The Correct Answer.

No	item	Response	
1	sex	male	
		female	
2	Age	20-39	
		40-59	
		60 +	
3	Duration of illnesss	Under 5 years	
		5-10 years	
		11-19 years	
		20-29 years	
		30-39 years	
		40+	
5	Current symptomatology compared to a year ago?	better	
		About the same	

		worse	
6	Frequency of treatment	weekly	
		2-3 times per month	
		monthly	
		Every 2 and 3 month	
		1-2 times per year	

Part Three- Oslo 3 Items Social Support Scale

Instruction: This Part Of The Questionnaire Contains 3 Questions Regarding Your Experience Of Social Support And Related Issues. Please Circle On The Alternative That Is Applicable To You.

1) How many people are so close to you that you can count on them if you have serious?

Personal problems (choose one option)?

1. None
2. 1 or 2
3. 3-5
4. More than 5

2) How much concern do people show in what you are doing (choose one option)?

5. a lot of concern and interest

4. Some concern and interest

3. Uncertain

2. Little concern and interest

1. No concern and interest

3) How easy is it to get practical help from neighbors if you should need it? (Choose one Option)

5. Very easy

4. Easy

3. Possible

2. Difficult

1. Very difficult

Part Four- Stigma Experience Scale Family Version

Instruction: Below are statements that assess your experience of stigma. For the first 4 questions Indicate how each question applies to you in general by using the 5 point likert scales. if your answer is **NEVER** circle on number 1, **RARELY** 2, **SOMETIMES** 3, **USUALLY** 4,and circle on number 5 if your answer is **ALWAYS**. And for the rest 3 questions if your answer is **NO** circle on number 1, **UNSURE** 2, and if **YES** circle on number 3.

No	Item	response				
		Never	rarely	Sometimes	usually	always
1	Do you think that people think less of those with a mental illness?	1	2	3	4	5
2	Do you think the average person is afraid of someone with a mental Illness?	1	2	3	4	5
3	Has your relative been stigmatized because of their mental illness?	1	2	3	4	5
4	Have you felt stigmatized because of your relative's mental illness?	1	2	3	4	5

5	Has stigma affected your family's ability to make or keep friends?	no	Not sure	yes
		1	2	3
6	Has stigma affected your ability to interact with your other relatives?	1	2	3
7	Have your experiences with stigma affected your family's quality of life?	1	2	3

Part5: Self Administered Questionnaire SRQ20

Instruction: The following questions are related to certain pains and problems that may have bothered you the last **30 days**. If you think the question applies to you and you had the described problem in the last **30 days** answerer **YES**.

On the other hand if the question does not apply to you and you did not have the problem in the last **30 days** answer **NO**.

Please do not discuss the questions with any one while answering the questions.

If you are unsure about how to answer a question, please give the best answer you can.

No	Health Problems for the past 30 days	Yes	No
1	Do you often have headache?		
2	Is your appetite poor?		
3	Do u sleep badly?		
4	Are you easily frightened?		
5	Do your hands shake?		
6	Do you feel nervous tense or worried?		
7	Is your digestion poor?		
8	Do you have trouble thinking clearly?		
9	Do u feel unhappy?		
10	Do you cry more than usual?		
11	Do you find it difficult enjoying your daily activities?		
12	Do you find it difficult to make decisions?		

13	Is your daily work suffering?		
14	Are you unable to play useful part in life?		
15	Have you lost interest in things?		
16	Do you feel that you are a worth less person?		
17	Has the thought of ending your life been on your mind?		
18	Do you feel tired all the time?		
19	Do you have uncomfortable feeling in your stomach?		
20	Are you easily tired?		

Appendix D

አዲስ አበባ ዩኒቨርሲቲ

የድህረ ምረቃ የትምህርት ክፍል

የሳይኮሎጂ ት/ቤት ክሊኒካል ሳይኮሎጂ ትምህርት ፕሮግራም

መጠይቅ

ውድ ተሣታፊዎች

በመጀመሪያ ሰለ መልካም ትብብሮዎ አስቀድሜ ላመሰግንዋ እወዳለው። ይህ መጠይቅ በአማኑኤል ስፔሻላይዝድ የአዕምሮ ሆስፒታል ውስጥ በተመላላሽ ለሚታከሙ የአዕምሮ ህመም ተጠቂ የቤተሰብ አባል ላላቸው ተንከባካቢዎች ታስቦ የተዘጋጀ ሲሆን አላማውም የአእምሮ ህመም ያለበት ቤተሰብ ያላቸው ሰዎች የሚደርስባቸውን የአእምሮ መታወክ ወይም የስነ ልቦና መረበሽ ከሚደርስባቸው መድሎ፣አለን ብለው ከሚያስቡት የማህብረሰብና የቤተሰብ ድጋፍ እና አጠቃላይ መረጃቸው ጋር ያለውን ግንኙነት ለማወቅ ታስቦ የተዘጋጀ መጠይቅ ነው። መጠይቁ የሚውለው በአዲስ አበባ ዩኒቨርስቲ በክሊኒካል ሳይኮሎጂ የትምህርት ክፍል ለድህረ ምረቃ ጥናት የመመረቂያ ጹሁፍ ማሚያ ነው።

ለዚህ መጠይቅ የተሰጠው መረጃ ሚስጥራዊነቱ የተጠበቀ እና ለትምህርት አላማ ብቻ የሚውል እንደሆነ ላረጋግጥለዎት እወዳለሁ፡

ስሞን መጻፍ አያስፈልግም።

መጠይቁ 4 ክፍሎች ያሉት ሲሆን፡ የዚህ ጥናት አላማ ግቡን የሚመታው በእናንተ በሚሰጠው መረጃ ተገቢነትና እውነተኘነት ላይ ተወስኖ መሆኑን ተረድታችሁ በመጠየቁ ላይ ያሉትን ጥያቄዎች በአግባቡ እና በእውነተኘነት እንድትሞሉ ና መጠይቁን እንድትመልሱ በትህትና እጠይቃለሁ።

አመሰግናለሁ!

ክፍል አንድ፡- የግል ሁኔታ የተመለከቱ ጥያቄዎች፡፡

መመሪያ፡- እባኮዎትን ለሚከተሉት ጥያቄዎች በሚመለከቶት መልስ ላይ የ(√) ምልክት ያድርጉ፡፡

ተ.ቁ	ጥያቄ	መልስ	
	ፆታ	ወንድ	
		ሴት	
2	እድሜ	20-39	
		40-59	
		60+	
3	ከህመምተኛው ጋር ያለዎት ዝምድና	እናት	
		አባት	
		ወንድም/እህት	
		ባል/ሚስት	
		ልጅ	
		ጎደኛ	
		ሌላ	
4	የትምህርት ደረጃ	ማንበብና መፃፍ የማይችል	
		አንደኛ ደረጃ ት/ቤት 1-8	
		ሁለተኛ ደረጃ ት/ቤት 9-10	
		መሠናዶ ት/ቤት 11-12	
		ኮሌጅና ከዛበላይ	
7	የስራ ሁኔታ	መተዳደሪያ ስራ ያለው	
		መተዳደሪያ ስራ የሌለው	
8	ታማሚ ዘመድዎ አብሮ ነው የሚኖረው?	አዎ	
		አይደለም	

ክፍል 2 ፡-የታካሚው የግል ሁኔታ

መመሪያ፡ ይህ የመጠይቁ ክፍል የታከሚ ዘመድዋን የግል እና የህመም ሁኔታ የተመለከተ ነው እባክዎት ትክክለኛ ነው በሚሉት መልስ ላይ የ (√) ምልክት ያድርጉ።

ተ.ቁ	ጥያቄ	መልስ	
1	ፆታ	ወንድ	
		ሴት	
2	እድሜ	20-39	
		40-59	
		60 +	
3	ለስንት አመት ያህል ታመሙ	ከ5 ዓመት በታች	
		5-10 ዓመት	
		11-19 ዓመት	
		20-29 ዓመት	
		30-39 ዓመት	
		40+	
5	አሁን ያላቸው የጤና ሁኔታ ከዛሬ አመት ከነበረው ጋር ሲነፃፀር እንዴት ነው?	የተሻለ	
		አንድ አይነት	
		የባሰ	
6	ስንት ጊዜ የህክምና ክትትል ያደርጋሉ	በሣምንት	
		በወር 2-3 ጊዜ	
		በየወሩ	
		በየ2 እና 3ወር	
		በዓመት ከ1-2 ጊዜ	

ክፍል 3፡- ኦስሎ-3 የማህበራዊ ድጋፍ መጠይቅ

መመሪያ፡ ይህ የመጠይቅ ክፍል 3 ጥያቄዎች ያሉት ሲሆን ከ ማህበረሰቡና ከ ቤተሰብዎ የሚያገኙትን ድጋፍና ተዛማጅ ጉዳዮች ይዳስሳል፡ እባክዎትን ከተሰጡት አማራጭዎች ውስጥ እርስዎን በሚገልጻት መልስ ላይ ያክብቡ።

1. በጣም የሚቀረቦት ና በከባድ የግል ችግር ጊዜ የሚደርሱሎት ስንት ሰዎች ይሆናሉ (አንድ አማራጭ ብቻ ይጠቀሙ)

    1. የሉም
    2. 1 ወይም 2
    3. ከ 3 — 5
    4. ከ 5 በላይ

2. በሚያደርጓቸው ነገሮች ሰዎች ምን ያህል ትኩረትና ፍላጎት ያሳያሉ (አንድ አማራጭ ብቻ ይጠቀሙ)

    5. በጣም ብዙ ፍላጎትና ትኩረት

    4. መጠነኛ ፍላጎትና ትኩረት

    3. አላውቅም

    2. ትንሽ ፍላጎትና ትኩረት

    1. ምንም ፍላጎትና ትኩረት

3. እርዳታ የግድ በሚያስፈልግዎ ጊዜ ከጎረቤቶቾት ያንን እርዳታ ማግኘት ምንያህል ቀላል ነው (አንድ አማራጭ ብቻ ይጠቀሙ)።

    5. በጣም ቀላል
    4. ቀላል
    3. የሚቻል
    2. አስቸጋሪ
    1. በጣም አስቸጋሪ

ክፍል 4፡- የደረሰ የመድሎ ስሜት አስመልክቶ የተዘጋጁ ጥያቄዎች ለ የዐዕምሮ ህመም ተጠቂ የሆነ የቤተሰብ አባል ለሚንከባከቡ ሰዎች፡፡

መመሪያ፡- ይህ የመጠይቅ ክፍል የአዕምሮ ታማሚ ቤተሠብ ስላሎ ያጋጠሞትን መድሎ የሚዳስስ ክፍል ነው፡ ከዚህ በታች ለተዘዘሩት ጥቄዎች የተዘጋጁትን የመልስ አማራጮች በመጠቀም እርሶን የሚገልፀውን እና የሚስማማዎትን መልስ ይስጡ:: ስለዚህ ለመጀመሪያዎቹ 4 ጥያቄዎች መልሶዎት **በጭራሽ** ከሆነ (1) **በጣም በትንሹ** ከሆነ (2) **አልፎ አልፎ** ከሆነ (3) **አብዛኛውን ጊዜ** ከሆነ (4) **ሁልጊዜ** ከሆነ (5) ቁጥር ላይ ያክብቡ፡፡ ለቀሪዎቹ 3 ጥያቄዎች ደግሞ መልሶት **አይ** ከሆነ (1) **እርግጠኛ አይደለሁም** ከሆነ (2) **አዎ** ከሆነ (3) ቁጥር ላይ ያክብቡ

ተ.ቁ	ጥያቄ	በጭራሽ	በጣም በትንሹ	አልፎ አለፎ	አብዛኛውን ጊዜ	ሁል ጊዜ
1	ሠዎች የአዕምሮ ህመም ተጠቂዎችን ዝቅ አርገው ያያሉ ብለው ያስባሉ?	1	2	3	4	5
2	አብዛኛው ሠው የአዕምሮ ህመም ተጠቂዎችን ይፈራል ብለው ያስባሉ?	1	2	3	4	5
3	ታማሚ ዘመድዋ የአዕምሮ ህመም ተጠቂ ስለሆኑ መድሎ ደረሰባቸው ያውቃል?	1	2	3	4	5
4	በታካሚ ዘመድዎ የአዕምሮ ህመም ተጠቂነት የተነሳ እርሶ የመገለል ስሜት ተሠምቶት ያውቃል?	1	2	3	4	5

		አይ	እረግጠኛ አይደለሁም	አዎ
5	መድሎ የቤተሠቦቹን ጎደኛ የማፍራትና አብሮ የመቆት ችሎታ ላይ ተፅዕኖ አሳድሯል?	1	2	3
6	መድሎ ከሌሎች ዘመዶቾት ጋር ባሎት ግንኙነት ላይ ተፅዕኖ አሳድሯል?	1	2	3
7	ያጋጠሞት መድሎ በቤተሠብዎ የህይወት ደስታና እርካታ ላይ አሉታዊ ተፅዕኖ አሳድሯል?	1	2	3

ክፍል 5፦ በራስ የሚሞላ መጠይቅ

መመሪያ- የሚከተሉት ጥያቄዎች በለፉት 30 ቀናት ውስጥ ምናልባት ሲረብሾት ከቆዩ አንዳድ ህመሞችና እና ችግሮች ጋራ ይያያዛሉ፡፡ ጥያቄው እርሶን እንደሚመለከት ካሰቡ እና ላለፉት 30 ቀናት የተጠቀሠው ችግር አጋጥሞት ከነበረ፡ አዎ ብለው ይመልሱ፡፡

በሌላ በኩል ጥያቄው እንደማይመለከትዎት ካሰቡ እና ለለፉት 30 ቀናት ውስጥ የተጠቀሰው ችግር ካልደረሰቦት፡- አይ ብለው ይመልሱ፡፡

እባክዋት መጠየቁን ሲሞሉ ከማንም ጋር አይመካከሩ፡፡

ጥያቄውን እንዴት መመለስ እንዳለቦት እርግጠኛ ካልሆኑ፡ እባክዎት መስጠት የሚችሉትን ጥሩ መልስ ይስጡ፡፡

ተ.ቁ	ባለፈት 4 ሣምንታት የደረሰ የጤና ችግር	አዎ	አይ
1	እራስ ምታት ብዙ ጊዜ ያሞታል?		
2	ምግብ የመውሠድ ፋላጎትዋ ቀንሶል?		
3	በደንብ አይተኙም ወይ?		
4	በቀላሉ ይደነግጣሉ?		
5	እጅዋ ይንቀጠቀጣል?		
6	የመንፈስ መጠበብ መጨነቅ ሁኔታ አለብዎት?		
7	ምግብ ከበሉ በኂላ ሆድዋ ይከብዶታል?		
8	በትክክል ማሰብ ይቸግሮታል?		
9	ደስታ የማጣት ሰሜት አሎት?		
10	ያለበቂ ምክንያት እንባ እንባ ይሎታል?		
11	በየቀኑ በሚሠሯቸው ስራዎች መደሰት ይቸግሮታል?		
12	የእለት ተእለት ተግባሮን መወሠን ይቸግሮታል?		
13	የእለት ተግባሮን ለመፈፀም ያስቸግሮታል?		
14	በአካባቢዋ ጠቃሚ ተሳትፎ ማድረግ ያስቸግሮታል?		
15	በአንዳንድ ነገሮች ላይ የነበሮ ፍላጎት ወይም ስሜት ጠፍቷል?		
16	የማልጠቅም ሰው ነኝ ብለው ያስባሉ?		
17	ህይወትዎ አስጠልቶት መቼ ባረፍኩ ያሉበት ጊዜ አለ?		

18	ሁል ጊዜ ድካም ይሠማዎታል?		
19	ሆድዎ ይረበሻል?		
20	በቀላሉ ይደክሞታል?		

Declaration

I, undersigned declare that this thesis is my work and that all sources used to the thesis have been duly acknowledged.

Name_______________

Signature ____________

Date_________________