Socio-Economic Status, Perceived Stigma and Coping Strategies among the Caregivers of

People with Mental Illness

Brian Moses Katende

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Declaration

I, Brian Moses Katende hereby declare that unless otherwise indicated the content of this dissertation is entirely my own and has not been submitted or republished to any institution as an academic or any other requirement in pursuit for award of any honor.

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Brian Moses Katende

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Approval

This is to certify that this dissertation entitled *Socio-Economic Status, Perceived Stigma and Coping among the Caregivers of People with Mental Illness* has been carried out under mu supervision and has been approved for submission to the School of Psychology.

Supervisor Signature; .... Date; ....11/1/2023............

Dr Paul Nyende

Supervisor

Department of Mental Health and Community Psychology

School of Psychology

Dedication

I dedicate this book to my parents Mr David Kitunzi and Ms Robinah Nakibuule as well as my wife Abigail for their sacrificial love and inspiration that moved me through this journey. I pray that God blesses you to abundance.

Acknowledgement

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Abstract

The study sought to examine the relationship between socioeconomic status, perceived stigma and coping strategies among caregivers of people with mental illness. In Uganda, coping has been is a great challenge among caregivers of people with mental illness. This was a cross-sectional and comparative study approach which involved quantitative methods of data collection and analysis. Research variables were measured and the data was analyzed using the Statistical Package for Social Science (SPSS version 23). The results indicated that there was no significant relationship between socio-economic status and coping strategies. They further revealed that there was no significant relationship between the caregivers' socio-economic status and perceived stigma. Additionally, study results indicated that perceived stigma is not significantly related to the caregivers' coping strategies, while both socio-economic status and coping strategies of caregivers are not significantly moderated by perceived stigma (P= .081; F = 1.553). However, the results showed that the caregivers' gender has no significant difference in the adaptation of coping strategies (F=.487, P=.381). Over all, there is no association that was found between SES, perceived stigma and coping strategies of care takers. Whereas the verdicts find no substantial relationship between the study variables, more approaches and strategies need to be developed to break the bias so that caregivers of people with mental illness are free to come out and help those that are critically ill.

Chapter One

Introduction

Background

Mental illness has become a significant issue in the public health sector (Tayler, 2017). Globally, more than 70% of people with mental illness receive no treatment from health care staff (Pawar, Peters & Rathod, 2014;), but rather from other caretakers such as their family members or those hired to do the job, yet in 2014, a study report from Center for Behavioral Health Statistics and Quality (2015) revealed that almost 10 million Americans demonstrating 4.2% of the population, were struggling with serious mental illness (SMI) with about 65 million people who are offering financial and emotional support as well as treatment supervision while taking care of the people with MI in the United States (Tamar et al., 2018; Family Caregiver Alliance, 2017). In Uganda, an estimation of 35% of the general population is believed to struggle with mental illness such as schizophrenia, bipolar, depression, anxiety among many others (Ndikuno, Namutebi, Kuteesa, Mukunya & Olwit, 2016).

Perceived stigma is best described as an individual's extraordinary features and characteristics that ground them to be discriminated from full social and community acceptance (Tayler, 2017). Thus, stigma is simply defined as a mark of disgrace and/or shame in the community by other people (Tamar, Haleigh & Matthew, 2018). The establishment of taking care of people with mental illness has impacted majority of the people's coping styles and strategies regardless of their ethnicities, where they stay, their languages and their socioeconomic classes (Gitlin, 2018). In this matter, coping with the fact that a relative is mentally ill is a profound challenge affecting caretakers of people with MI where majority 57.3% of them report no satisfaction with their current predicament (Ndikuno et al., 2016). The fact that most of these

patients live at their respective homes together with their family members (Ghosh, Greenberg, & Seltzer, 2012) who have taken them on as their responsibilities, many have decided to put their patients into mental health institutions like Butabika national referral hospital which currently houses over 780 beds for patients (Hassan, 2015).

There is a lot of burden coiled around the socioeconomic status in relation to the stigma of the people that are involved in the act of providing care for a person with mental illness which usually constraints there coping strategies about the current predicament (Aschbrenner, Greenberg, Allen, & Seltzer, 2010). The fact that there has been a lot of economic crisis in Uganda's health sector with insufficient medication in the mental health insititutions, this has suppresed the soioeconomic status of some caretakers hence giving rise to perceived stigma amongst the caretakers themselves to the prevalence of mental illnesses (Roberts, Ocaka, Browne, Oyok, & Sondorp, 2008).

For that matter, it is assumed that almost 80% of mental illness sufferers are living in low- and middle-income countries, Uganda inclusive, distorting the caregivers coping strategies (McBain, Norton, Morris, Yasamy & Betancourt, 2012). This has left many caretakers with a big burden of taking good care of people with MI in Uganda since mental health services have not been given policy priority considering it to be a national minimum healthcare package (MoH, 2010) where "only1% of health care expenditures is specifically directed towards mental health care" (Olwit, 2015, p. 15; Kigozi, Kizza, Cooper, & Ndyanabangi., 2010). There is a variety of different serious mental illnesses that include some of the following; neurodevelopmental disorders, schizophrenia, obsessive conduct disorders, as well as bipolar disorder along-side other various mental and/or psychotic disorders (Development Services Group, 2016; Diagnostic and Statistical Manual for Mental Disorders-V, 2013).

Statement of the Problem

In Uganda, coping with the fact that one is taking care of a mentally ill person continues to be one of the biggest challenges irrespective of the socioeconomic status, families and communities (Verity, Turiho, Mutamba & Cappo., 2021). Caretakers' socioeconomic status has a very big contribution on the way they deal with this reality because in most cases, people with low SES are more likely to exhibit perceived stigma thus leading them to adopt poor coping strategies since they do not have enough money to look after their patients compared to those with high SES with low levels of perceived stigma and high coping strategies (Molodynski & Cusack, 2017). There are poor coping strategies exhibited by caretakers that are as a repercussion of perceived stigma as well as low socioeconomic status such as caretakers dissociating from the patients because the caregivers have not been supported financially, socially and also psychologically yet the treatment of mental illness is very expensive itself. Socioeconomic status is also linked directly to the perceived stigma for giving care to a mentally ill person. That is, the stigma and discrimination in relation to low financial support to people from low socioeconomic status may impact negatively to the caretaker of a sufferer of mental illness (Mugisha et al., 2019) since these people are not so much considerately helped look after the patients the way they would provide for persons with other biologically related illnesses. Many studies have been conducted about caregivers in Uganda but majority living out a gap in the way these people apply coping strategies with challenges of perceived stigma and socioeconomic status which is an area that this research is going to configure itself in.

Purpose of the Study

The study sought to examine the relationship between socioeconomic status, perceived stigma and coping strategies among caretakers of people with mental illness.

Objectives of the Study

The following objectives were put forward

1. To examine the relationship between socio-economic status and coping strategies among caretakers of people with mental illness.

2. To investigate the relationship between socio-economic status and perceived stigma among caretakers of people with mental illness.

3. To establish the relationship between perceived stigma and coping styles among caretakers of people with mental illness.

4. To scrutinize the moderating effects of perceived stigma on socio-economic status and coping strategies among caretakers of people with mental illness

5. To compare the levels of coping strategies between male and female caretakers of people with mental illness.

Scope of the Study

Geographical Scope

The study was carried out in Mulago referral hospital as well as Butabika national referral hospital in Kampala District. This is because they are the most accredited national health facilities in regards to MH treatment. Mental illness is defined as a condition that affects a person's thinking, feeling, behavior or mood (.

Content Scope

Socio-economic status (SES) is defined as an economic and sociological combination of total measure of a person's work experience and of an individual's or family's economic and social position in relation to others, based on income, education and occupation (Michelle, 2010).

Perceived stigma is best described as an individual's past experience of discriminating, prejudice, and stereotypes instigated by other people that ground them to be discriminate themselves from full social and community acceptance (Folkman &Lazarus, 1964; Tayler, 2017). Thus, stigma is simply defined as a mark of disgrace and/or shame in the community by other people whereas perceived stigma (PS) is the fear of being discriminated against or the fear of enacted stigma, which arises from society's belief.

Nikos and colleagues believed that coping strategies are an individual's ability to coordinate cognitive and behavioral determinations to positively workout life's demands that are believed to be brought about by the person's environment and how he or she deals with it (Nikos, 2009)

Significance of the Study

The finding of the study will help the government, MOH and other humanitarian organizations involved in reducing the stigma associated with mental illness as well as being a caregiver to someone with mental illness. Thus this study will educate them on how to deal with their challenges so as to do away with the stigma and cope positively.

This study will support various organizations and entities involved in fighting stigma as they may benefit from the research findings, there by establishing proper policies against stigma as a whole as well as come up with better ideas on how caretakers can cope with perceived stigma.

The study will be a revelation of the role of socioeconomic status in the management of mental illness in various families. This is because it will have to compare caretakers of people with mental illness with a high socioeconomic status as well as those with low socioeconomic status and how they deal with the stigma associated with it and also how they cope with the current predicament that they are in charge of.

On a larger extent, the findings of the study may add onto the existing body of literature on research and knowledge about the effect of socioeconomic status, stigma and coping among caretakers of people with mental illness in various communities and hospitals of Uganda with a good overview of the problem. This is because failure to cope is also believed to be inclined by the socioeconomic predicament of the caretakers where at times they fail to buy medication that is not available in hospitals. Thus, the study will help show a gap that is brought by socioeconomic status in coping of caretakers for people with mental illness.

Conceptual Framework
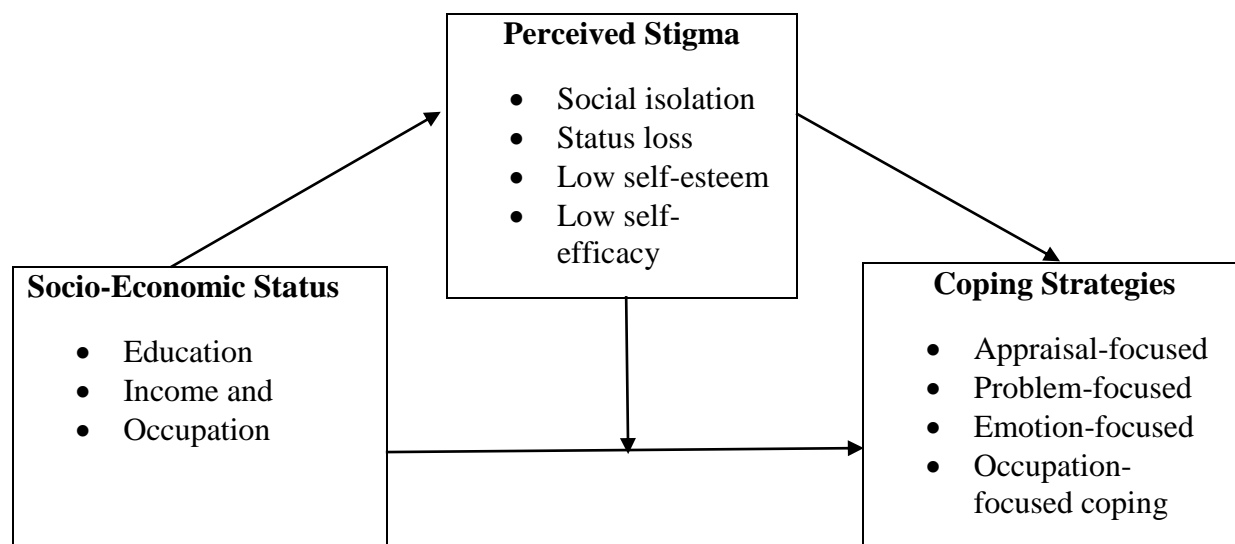
Figure 1: A conceptual frame work showing the relationship between socio-economic-status, perceived stigma and coping strategies

   The conceptual framework above shows that if a caretakers' socioeconomic status is poor, they are most likely not able to cope with whatever predicament they might go through because they cannot manage to sort out most issues with money around. However, as socioeconomic status is directly related to the coping strategies mechanisms of most caretakers, perceived stigma moderates the effect of SES to coping strategies of the caretakers (Link & Phelan, 2001; 2013). That is, people with good SES are rarely affected by stigma upon their coping mechanisms because they are in most cases inspired to take good care of patients compared to those people with poor SES who have nothing to motivate them into taking good care of patients. Furthermore, just as well as a SES significantly influences stigma, stigma is also influential and directly impacts the caretakers' coping while attending to people with mental illness. However, coping strategies also significantly have an impact on the stigma associated with caretakers of people with mental illness because a person with proper coping mechanisms is not so much negatively affected the stigma (Ali, Hassiotis, Strydom, & King, 2012).

Theoretical Framework

According to Lazarus' coping theory, he believed that coping is the capability of being able to cognitively and behaviorally manage the external and internal demands of the environment that are believed to exceed the resources of the individual (Sanden et al., 2016) and these being mediated by the emotions that come out of stigma, which is responsible for the changes in the emotional state of a caretaker way from the beginning of the role up to the end of the role taken on (Folkman & Lazarus, 1984). Major and O'Brien (2005) enlightened on Folk and Lazarus' theory revealing their investigation on coping as related to stigma that stigmatization is very responsible for increasing a person's direct vulnerability to possibly stressful circumstances. They believe that stigmatization can threaten one's social status and identity hence triggering coping responses in effort to control their behavior, emotions and their own perceptions as well as the environment around them. Due to the demands of social stigma and its negative impact on their wellbeing as well as their resources to facilitate coping, people succumb to finding a better coping strategy for the stressful situation such as stigma (Major & O'Brien, 2005; Folkman & Lazarus, 1984).

Chapter Two

Literature Review

Introduction

This chapter discusses the relevant literature about socioeconomic status, parenting styles and delinquency among adolescents. It is organized under the sub tittles, socioeconomic status and parenting styles, socioeconomic status and delinquency as well as parenting styles and delinquency among adolescents.

Coping Strategies among Caretakers of People with Mental Illness

A coping strategy is best defined as a "constantly changing cognitive and behavior efforts to manage specific external and internal demands that are appraised as taxing the resources of the person" (Lazarus & Folkman, 1984, p. 141). Coping is not measured to be of a usual strategy in relation to personality traits nor styles that are stable across many predicaments, instead it is considered to be a set of strategies that are available to be implemented to match specific situations (Dana, 2004).

Coping is believed to comprise two broad forms and the first being the *emotional-focused* coping strategies which is presumed to focus on the internal emotional states such as perceived stigma instead of the external factors like their socioeconomic status in this case that are responsible of precipitating emotional responses. This type of coping is mostly achieved when a perceived appraisal has been made with modification of the harm, threat as well as environmental challenges not being in position to be changed. Emotion-focused coping is mostly directed towards changing the emotional response of the individual when they are faced with a problem, and this is achieved through giving them strategies like aspiration thoughts, minimization of the problem and avoiding the emotional strains that come with the problem (Zakowski et.al., 2001).

The *problem-focused* as the second form of coping is presumed to focus more on the alternation of an individual's stressor through directly acting about it. This coping style is also believed to work on the assumption that if conditions are evaluated to be agreeable to change, they are most likely to be reason for positive coping strategies towards individuals. This is more achieved thorough the different problem-focused coping strategies like learning new skills on how to cope with challenging situations, behavior change as well as creating new sights of delight in life where some of the strategies may include seeking of social and economic support during hard times which is also an incorporation of both the problem and emotional focused strategy functionalities (Vitaliano, Dewolfe, Maiuro, Russo & Becker, 1990).

Socioeconomic Status and Coping Strategies among People with Mental Illness

Many of the mental illnesses today have been linked with a major loss of proper quality of life among sufferers and caretakers and the type or level of socioeconomic status is a big precipitating factor (Delespaul, 2012). In most cases, it is believed that mental illness is accompanied with increased physical sicknesses as well as death rates which becomes a challenging situation due to the economic costs that comes with taking care of people with mental illness (Hert et al., 2011; Whitefors et al., 2013; Ebrahimi, Seyedfatemi, Namdar, Ranjbar, Thornicroft, Rahmani, & Whitehead, 2018).

Truly majority of the patients' caretakers do go through some negative experiences and effects of the mental conditions, however, (Pedersen, & Kolstad, 2009) families that have taken on the responsibility of being the primary source of care for their family members suffering from mental illnesses are facing a number challenges that are correlated with their socioeconomic status (Awad & Voruganti, 2008).

Research findings of Oyebode (2005) have revealed that family members taking care of their own people suffering with MI are assumed to provide physical, emotional and financial support to their relative with this kind of illness. However, mental illness is devoted to act as a stressor that strategic ways of coping are initiated, though at some point the stress that comes with financial constraints is assumed to hinder the coping mechanisms of the caretakers (Robinson, 2017).

A number of studies have come to reveal that taking care for a someone who is mentally ill has significantly affected the caratakers in very many ways of life, including their coping strategies in relation to their socio-economic status (Addo, 2018) [8]. Family caregivers, for instance, are usually required to provide financial support, and endure the burden of economic difficulties.

When a clinical diagnosis of a psychological or mental illness has been made to a family member, family caretakers are assumed to face challenges in their roles that include perception of the psychosocial support, financial predicament as well as the affiliated challenges that come with taking care of a MI personnel which negatively affect the common coping approaches (Ebrahimi et al., 2018). Thus, caretakers invest all of their financial and emotional as well as physical capacities to do away with this stressful situation alongside managing difficulties associated with taking care of the mentally ill person (Ebrahimi et al., 2018).

According to Chadda (2014) in relation with Salles and Barros (2009), the provision of constant care to the patients with severe mental illness without supportive resources could lead to frustration and burden in family caregivers thus negatively influencing their coping skills strategies. Raj (2013) goes on to reveal that there are a lot of challenges associated with severe

mental illness that may significantly affect the coping skills of caretakers for mentally ill people that usually leads to loss of energy and guts to provide care due to the patients' failure to adhere to treatment given (Ebrahimi et al., 2018). Financial constraints are thought to bring about feelings of helplessness, stress and depression upon caretakers mostly manifesting among parents and spouses of the mentally ill thus leading to resignation form the role of giving care to the sufferers (Steele, Maruyama, & Galynker, 2010; Ebrahimi et al., 2018).

Studies have revealed that the failure of health professionals to incorporate advanced psychological treatments is assumed to bring about recurrence of the problems as well as lower adherence levels hence treatment failure which is also believed to come with a high financial strain for the caretaker of the mentally ill (Kallivayalil, 2008). This kind of predicament has made it quite hard for caretakers of the mentally ill to find it hard to cope with the whole situation thus neglecting their patients with mental illness (Shamsaei, Cheraghi, & Bashirian, 2015a).

Studies that have been conducted about mental illness in the low and middle-income countries has come out to reveal that less than 10% of the people with mental illness have been hospitalized because of the assumed high levels patient care provided by the family members (Ebrahimi, 2018; World Health Organization, 2013; Ganev, Onchev, & Ivanov, 1998). It is believed that the strength of the family bonding as well as their socioeconomic network plays a big role in the social support needed to reduce the burden of taking care of the mentally ill among majority of the developing countries (Naheed, Akter, Tabassum, Mawla, & Rahman, 2012; Ebrahimi, 2018).

The fact that developing countries lack enough resources to facilitate mentally ill patients as well as their own caretakers (Flisher, et al., 2007; Ae-Ngibise, et al., 2015), more focus is has been put on to the adoption of less emotion-focused coping skills to reduce the caetakers' feelings of burdens (Eaton, Davis, Hammond, Condon, & McGee, 2011; Hassan, Mohamed, Elnaser, & Sayed, 2011) towards their roles hence preventing relapse and readmission (Rosland, Heisler, & Piette, 2012).

In conclusion, socio-economic status is assumed to have an impact on the coping strategies of caretakers of the mentally ill. For this reason, the link between difficulties in coping is clear and therefore, the society as well as allied health professionals need to be educated about the significant implications of social support both financially and socially rendered to the caretakers of the mentally ill.

Socio-Economic Status and Perceived Stigma among Caretakers of People with MI

Stigma is best described to be a form of negative deviance from the society to the carrier with the intention that stains the identity and status of the person who has the mark (Sanden et al., 2016). Most of the carriers are branded with a mark of being avoided and socially excluded from the other social members (Bos, Pryor, Reeder & Sutterheim, 2013). Corrigan and Miler (2004) revealed that majority of people suffering with mental illness are more severely stigmatized compared to people suffering with other health illnesses such as cancer and cardiovascular diseases. Furthermore, people who are related and/or associated with the mentally ill people are also prone to stigmatization because of the simple connection they might be sharing in common and this occurrence is known as stigma by association (Bos et al., 2013; Pryor et al., 2012)

There are very many undesirable consequences faced by the caretakers of the mentally ill that they have to deal with in their daily life. Stigma is believed to be the potent source of stress and its challenges for the caretakers and family members of the mentally ill person (Ebrahimi, 2018; Girma et al., 2014; Shamsaei, Kermanshahi, Vanaki, & Holtforth, 2013; Thornicroft, 2008) which has led to an increase in the need of professional health support such as hospitalization (Taghva, Farsi, Javanmard, Atashi, Hajebi, & Noorbala, 2017).

In this context, research by Sanden and Pryor (2016) reveals that many of the family members and caretakers are prone to experience a wide range of struggles that involve family burdens, such as financial problems time spent on the patient as well as missing out on career opportunities while taking care of the patient which in most cases results into family feuds and quarrels.

Differences in the socioeconomic status create are alleged to create differences in the strategies of coping with stressful and negative emotional climates in the homes of those taking care of people with mental illness (Crowe & Lyness, 2014). A study conducted by Link and Phelan (2001; 2013) outlined a process through which people with mental illness are treated differently than other members of society. Stigma is also assumed to negatively impact on the caretakers' ability to cope with the fact that they have a mentally ill person they are entitles to look after for the betterment of their life (Karnieli-Miller et al., 2013).

Socioeconomic status in relation to the discrimination acts of devaluation, rejection, and social exclusion of the mentally ill is reported to lead to unsatisfactory outcomes for people with taking care of these patients (Link & Phelan, 2001). The incidences that overwhelm the lives of caretakers of people with mental illness are usually within their friends, family, and service

providers, through a phenomenon known as courtesy stigma which may result in families being blamed, socially isolated, and discriminated against (Larson & Corrigan, 2008). As a result, family members may become depressed or reclusive, negatively affecting their socioeconomic status (Ali, Hassiotis, Strydom, & King, 2012).

According to Chronister, Chou, and Liao (2013), the stigmatization of mental illness initially involves the labeling of differences that are deemed to be socially relevant. Stereotyping then links the mentally ill person's differences to undesirable characteristics (Link & Phelan, 2001). This has left a gap in the research concerning caregivers' behavioral responses to the stress of stigma, including the factors related with their socioeconomic status (Taghva et al., 2017).

In a study conducted by Barry and colleagues (2013) in examination of people's perception about mental illness after the Newton massacre of schoolchildren in the United States, 46% of people revealed that people suffering from serious mental illness were thought to be more dangerous compared to the general population. This report revealed that stigma towards the mentally ill was its peak as he reveals that 67% of the population were not ready to have a mentally ill person as their immediate neighbor (Barry et al., 2013).

In conclusion, stigma among caretakers of the mentally ill is still prominent regardless of their socio-economic status of caretaker. More so, stigma becomes more alarming if the caretaker is from a relatively lower socioeconomic status compared to those with a higher SES since majority of the kind can afford to buy medication or even hospitalize their patients. However, the society needs to be urged not to be socially isolate, discriminate or even label the caretakers of the mentally ill because this is not a simple task because it comes with costing people of their freedom,

happiness and at times losing career opportunities so that they can take good care of the mentally ill.

Perceived Stigma and Coping Strategies among Caretakers of People with Mental Illness

Pescosolido et al., (2010), assessment on stigma against mentally ill people with their caretakers revealed that there has been a gross increament in stigma amongest the caretakers of the mentally ill denoting that majority of the people do not want to have or associate with someone having mental illness as well as having little to know associaition with their caretakers. This kind of stigma makes caretakers more prone to very many stressors that mya find it hard to cope with the situation

Research done by Koschorke and Thornicroft, (2014; 2006) has identified undisputable negative outcomes of stigma upon coping amongst majorities of the caretakers of people with mental illness. They point out that majority of persons stigmatized have testified that the effects of stigma are more of a burden and a distress than the major problem leading to a number of challenges like keeping personal relationships and engagement in work (Koschorke et al., 2014). This kind of treatment is seen to bring about self-stigma amongst the caretakers which may result into abandoning or even hiding of the patients without providing any necessary care in order to cope with the current predicament (Koschorke & Thornicroft, 2014; 2006).

According to Livingston and Boyd, (2010) as well as Mestdagh and Hansen, (2014) by shows that stigma is a very immense factor in the lives of caretakers, that is, regardless of the socioeconomic status, caretakers of the mentally ill are stigmatized and they are finding it hard to negatively affecting their coping mechanisms and resorting to self-blame. Thus, coping strategies in this case are usually more based on what the sufferers of stigma consider what matters the most in their lives while giving care to the mentally ill (Koschorke et al., 2014; Yang, 2014). The study

here reveals that men cope more-less differently from women with issues related to stigma of taking care of a mentally ill though they face evasive effects in their marriages, work and social lives (Yang, Thornicroft, Alvarado, Vega, & Link, 2014).

In addition, Pryor and Colleagues (2012) revealed that people's affect, cognitions as well as their behaviours significantly relate with the reactions other people, more so family members avail that seem to be perceived as stigmatizing conditions. This kind of perception from the caretakers is assumed to bring about psychological distress amongst them hence defecting their coping levels and strategies (Pryor et al., 2012). Furthermore, people caretakers of the mentally ill tend to distance themselves from their family members or friends whom they believe they stigmatize them and seek comfort while alone as part of their coping style (Pryor, Reeder, & Monroe, 2012).

Hoop, (2008) came out to reveal that family members as well as caretakers' knowledge of mental illness being at some point a hereditary cause through the explanation of mental illness being a biological determination has not done any good because. This is thought to worsen stigma by caretakers making a label of mental illness being in their bloodline hence self-stigma which is believed to be the strongest hindrance in any form or strategy of coping (Pryor, et al., 2013). Corrigan, Watson, and Miller (2006) also believed that the family of people with mental illness has a role it plays in inducing stigma among caretakers. They revealed that parents were commonly blamed for causing mental illness in their children, at the same time blaming siblings for not controlling their mentally ill persons and making sure that they adhered to treatment (Corrigan et al., 2006). This kind of infested stigma makes it hard for the caretakers to come up with positive coping strategies resulting to self-blame upon the situation hence being distressed the more

In conclusion, caretakers' perception of stigma in relation to their coping styles is very vital in giving good care to the mentally ill. Therefore, the society but most particularly the family members being the immediate source of help to the caretakers are urged to talk and behave appropriately towards the caretakers and the mentally ill without any association of stigma towards them so that both parties could learn to live a happy and satisfied life, fostering adherence to treatment minimizing its diverse effects.

Moderating Factor between Socioeconomic Status, Perceived Stigma and Coping Strategies among Caretakers of People with Mental Illness

A lot of stigma is assumed to come from close relatives and friends towards the caregivers in relation to the care they give to the mentally ill people which is believed to also prevail in their respective societies (Mak & Cheung, 2008). This kind of public stigma may make caretakers to also develop some form of self-stigma that may result them feeling unhappy, helpless and dissatisfied with life hence making coping a more complicated case.

Most of the times caretakers decide to further conceal their socioeconomic status from others and also withdraw form most of the social relations that they were previously engaged in as well as dissociating form the patients as a form of coping which tends to also inconvenience adherence hence making them more distressed (Singh et al., 2016; Mak & Cheung, 2008)

According to Gerlinger, Hauser, De Hert, Lacluyse, Wampers, and Correll, (2013) that there is no direct moderation between the caretakers' perceived stigma and marital status, education, age, gender, ethnicity, place of residence, income, and employment in relation to coping. Another study by Singh, Mattoo, and Grover (2016) has reported that caretakers of the Islam faith as well as those that are in their youthful age with a higher socioeconomic status are believed to perceive a perceive stigma differently, that is, moslems perceive lower stigma due to

their faith whereas the young people in their high socioeconomic status perceive higher stigma.

A research conducted by Evans (2016) revealed that the caretakers' perception of stigmas responsible for illumination an association of socioeconomic status and coping towards mental health. She believes that majority of the people in the United States are experiencing stigma in relation to their origin, sex as well as their socioeconomic status. For this matter, feelings of being stigmatized by other members of the society through discrimination (Shariff-Marco et al., 2011) has had a long time negative impact on their coping strategies as they deal with the reality of taking care of their mentally ill personals (Evans, 2016).

Pascoe & Smart Richman, (2009) revealed that the experience of stigma among the caretakers of people with mental illness is worth a consideration because it is assumed to lead to lower and poorer levels of coping among the caretakers who are of a low socioeconomic status, hindering any positive change towards mental health outcomes.

According to study conducted by Ssebunnya, Kigozi, Lund, Kizza and Okello (2009), While there is considerable descriptive evidence regarding the role of stigma in mental illness, there is also a large body of evidence from high, middle and low-income countries, demonstrating an association between poverty and mental illness (Saraceno, Levav & Kohn, 2005). Furthermore, the stigma attached to mental illness is reported to affect the caretakers at all economic levels ending up in poverty, making coping a very difficult resolution to consider leaving the caretakers helpless (Ssebunnya et al, 2009)

In conclusion, it is fascinating how stigma can be a very strong factor in moderating the causal relationship of socioeconomic status and coping among caretakers. The fact that the greater the stigma, the lower the coping strategies, this obviously negatively impacts on the socioeconomic status of the caretakers hence not being helped to get a better mental health as they perform their

roles and duties towards the mentally ill people.

Coping Strategy Levels between Male and Female Caretakers of People with Mental Illness

It is greatly assumed that there is a clear difference between male and female in the way they cope while in stressful situations, more so with issues that would require finances and social acceptance. According to the research findings of Gerlinger, Hauser, De Hert, Lacluyse, Wampers, and Correll, (2013), male caretakers are more prone to being negatively impact with the stigma associated with taking care of the mentally ill person, purely compromising their coping in the society.

Brown et al (2017) revealed that truly gender is a very strong factor in coping stressing that given the association of the public stigma about having a family member with mental illness, men are more subjected to mental illness-related stigma. He believes that this comes as a fact that women open up more and seek assistance in relation to a mental illness predicament than men would, thus recommending that gender has underlying factors that determine one's coping during stressful times associated with stigma and mental illness that need to be clarified (Brown, 2017).

The fact that keeping secrets about the perceived stressful burdens as well as failure to disclosure about mental illness related issues varies profoundly, it is assumed that women do not often conceal issues about self and are less secretive compared to men (Turner & Brown, 2010) thus seeking assistance on how to cope with the fact that they are taking care of a mentally ill person thus bringing variations in coping styles and strategies between men and women (Brown et al., 2017)

Hypotheses

The following hypotheses are put forward;

1. Socio-economic status significantly predicts coping strategies among caretakers of people with mental illness.

2. Socio-economic status significantly predicts perceived stigma among caretakers of people with mental illness.

3. Perceived stigma significantly affects the coping strategies among caretakers of people with mental illness.

4. Perceived stigma significantly moderates the relationship between socioeconomic status and coping strategies among care takers of people with mental health.

5. There is a significant difference in the levels of coping strategies between male and female caretakers of people with mental illness.

Chapter Three

Methodology

Introduction

This section presents a blueprint of the methodological measures that were employed to conduct the study. These included the study design, sample size and selection, research instruments, procedure, data management, quality control and data analysis as well as ethical considerations to the study.

Study Design

The study engaged both a cross-sectional and comparative study approach which is quantitative in nature. Specifically, descriptive, correlational and comparative methods are to be used in the study to examine the relationship between socioeconomic status, stigma and coping among caretakers of people with mental illness as well as the difference in levels of coping strategies. A cross-sectional design applied to all respondents that were in the researchers reach while collecting data, Pearson correlation was to measure the relationships between variables, regression to measure the moderation while t-test to capture the difference in coping strategies on a gender basis. Thus, they were all important to capture. Correlation method refers to an illustrative scheme guided by researchers who wish to discover the extent to which two or more research variables covariate, (Creswell, 2008).

Inclusion Criteria and Exclusion Criteria

The study focused on caregivers who brought their patients to Mulago and/or Butabika hospitals. This study was limited to Mulago and Butabika because these are the biggest mental health hospitals publicly known in the country that act as the main referral mental health hospitals and have a higher probability of receiving almost all mental health cases. The study was also

limited to caregivers of people already diagnosed or receiving treatment for mental illness, while those that never had direct link to the patient were excluded. These caregivers are those nonprofessional people who take care of mental health patients outside the hospital settings. Those who were in the area of scope for consultation as well as newly diagnosed were not included in the study.

Population

This study was grounded on caretakers of people with mental illness in and out of hospitals in the age bracket of 20 to 50 years and above in both male and female respondents but majorly focusing on those that bring their patients to Butabika hospital, Kampala district for treatment and/or review of the current and/or ongoing mental illness.

 Sample Size

The target population that were included in the sample were adult caretakers and the target sample was 217 caretakers of people with mental illness. The sample was attained through the use of Epi Info -7 STATCALC, assuming a confidence level of 95% with a prevalence rate of 10% and confidence limit of 5%.

Sampling Technique

These were selected using stratified random sampling where simple random sampling technique was applied to each stratum which allows the researcher to give equal chances to all members in the population to participate in the study. Stratified random sampling technique is a process of sampling that encompasses the splitting up of a general population into smaller groups well-known as strata yet in the use of stratification, the strata are designed centered on participants' common characteristics (Meng, 2013).

Instruments

The researcher used purpose built self-administered questionnaires to obtain information from the respondents about the study variables. The questionnaire was made up of closed ended questions that required each respondent to circle or tick the best alternative of choice. More so, the questionnaire consisted sections that included; bio-data (section A), Socio-Economic Status (section B), Perceived Stigma (section C) and Coping Strategies (section D).

Bio-data

The biodata sought to measure the respondents' gender, age bracket, marital status, level of education as well as their time spent giving care to patients with mental illness.

Socioeconomic Status

The researcher adopted a Socioeconomic Status Questionnaire tool that was developed by Aggarwal and colleagues (2005) to measure the families' socioeconomic status of the respondents. It focused more on the individuals' economic status through asking about their employment status, income generating assets, and also their gross annual income. The tool is revised from the prominent Kuppuswami's modified socioeconomic status scale (Aggarwal, 2005). The tool also looked out on the house hold characteristics like source of water, electrical appliances, type of dwelling, food security module, type of cooking fuel and as well as transportation. Its validity and reliability in Africa is not well stated, thus its validity will be gotten from a pilot study, though it is advised to always run a reliability analysis to get its reliability (Aggarwal, 2005). This tool consisted of 14 items measuring the SES of caretakers of people with mental illness

Perceived Stigma

Stigma was measured using the Devaluation of Consumer Families Scale that was developed by Chang and colleagues (2018) which commonly used to measure perceived stigma

among caretakers as well as family members that have people anguishing with mental illness. It has been reported to also possess a good validity as well as an outstanding reliability of .86 in parents who had children with mental illness. This tool consists of 9 items of measurement identifying perceived stigma in the caretakers of people with mental illness.

Coping Strategies

Coping strategies were measured using the Coping Strategies Questionnaire that as developed by Aloha Hand (2016) looking at the quality of life that enhances the caretakers' awareness on the availability of coping strategies. This tool is a revision of the Coping strategies questionnaire initially designed by Riddle and Jensen (2013) to measure brief coping scales in persons with chronic pain. This tool focused on how caretakers respond and adjust to the challenges revolved around the stigma and societal negative perceptions on mental illness. This tool is believed to be with a strong justification in validity as well as caring a reliability score of 0.71 in recognizing respondents who display deficits in functionality (Hand, 2016; Riddle & Jensen, 2013). The coping strategies questionnaire carries 14 items measuring the coping mechanisms for caretakers of people with mental illness. More importantly, this item measurers two main aspects of coping, that is, questions 1, 2, 4, 6, 9, 10, and 13 measure the emotional-focused strategies whereas questions 3, 5, 7, 8, 11, 12 and 14 measure the problem-focused. During data analysis, there was a comparison between the two strategies on manifesting one that is mostly used by caretakers while coping with their stressors.

Procedure

The researcher obtained an introductory letter from the Department of Mental Health and Community Psychology-School of Psychology, Makerere University. The letter served the purpose of introducing the researcher to the authorities where the study is going to be conducted.

After the Human Resource manager or the director of the institution verifies the researcher as a student of Makerere University, permission was sought and provision of the acceptance letter will be of importance. Thereafter, the researcher shared the topic, purpose and objectives of the study with his target respondents. Self-administered questionnaires were then distributed among respondents in explanation on how to answer the questionnaires.

Data Management

Biodata items was measured and coded as follows; Gender a = male, b = female; age brackets a = 20-30years, b = 30-40years, c = 41-50yeas, d = 51years and above; marital status a = married, b = Single, c = Divorced, d = Widowed; level of education a = None, b = Certificate, c = Diploma and d = Degree; time spent giving care to the patient(s), a = Less than 5years, b = 5-10years and c = above 10years.

Socioeconomic status, items were included and scores were coded respectively as shown in the questionnaire. Items in this instrument were scored differently, that is, some items a respondent can fill in a number of responses while in other items they were required to fill in one response describing their predicament. Thus, as the scores go high, it implied that an individual is from a high social class and as well as manifesting an individual to be of low SES as the scores also drop lower were whereas some questions were giving an over view of their caretakers' general source of income.

Perceived Stigma scale that was developed by Chang et al (2018) was adopted to measure the perceived stigma and it is to be coded on a 4-point Likert scale as follows: Strongly Agree=3, Agree=2, Disagree=1, Strongly Disagree=0. This scale has three items that are to be reverse coded which include item 2, 5 and 6.

The 14 coping strategies items derived from Hand (2016) and Riddle and Jensen (2013) was adopted to measure the way caretakers cope with their predicaments and it was coded on a 5-point Likert scale as follows: Never=1, Rarely=2, Sometimes=3, Most of the time=4, Always do=5.

Validity

For validity, a copy of a questionnaire was given to two (2) subject matter experts in the school of Psychology who commented on the comprehensiveness and construction of items in the questionnaire. Their recommendations helped on the construction of the study questionnaire. However, the Critical Validity Index (CVI) also calculated for each of the scales from the formula below. CVI=$\frac{No\ of\ relevant\ items}{Total\ no.of\ items}$ in addition of a pilot study to be carried out by the researcher to ascertain that the instruments are valid. Reliability of the instrument is assumed to be already determined since the instruments in use are already standardized with a determined Cronbach's alpha

Data Analysis

Statistical Package for Social Science (SPSS version 21) was used for data analysis. Both descriptive and inferential statistical methods were used. In descriptive statistics, frequency tables were constructed to summarize data and then for inferential statistics, Pearson's correlation coefficient (r) were used to determine the relationship respectively between the study variables. However, Andrew P Hayes's regression analysis was used to assess the moderation between the study variables (Hayes, 2014). The *t*-test (*t*) was used to analyze the difference in the levels of coping strategies among male and female respondents.

Ethical Consideration

The study purpose was explained to all respondents. Participants were guaranteed of confidentiality and that their identities are to be protected as they are required neither to pen their names nor contacts on the questionnaire form. A written and signed consent form was acquired from the respondents and making it clearer that their participation in the study is to be voluntary.

Chapter Four

Results

Introduction

This chapter demonstrations results that have been obtained from the study. It includes tables of frequencies and percentages showing results. The chapter also includes correlations of hypothesis one to three, a regression analysis for hypothesis four and an independent sample *t* test for hypothesis five.

Descriptive Statistics

Table 1: *Background Information*

Characteristics	N=148(%)
Gender	
Male	59(39.9)
Female	89(60.1)
Age	
20-30 years	80(54.1)
31-40 years	40(27.0)
41-50 years	18(12.2)
51 years and above	10(6.8)
Marital Status	
Married	52(35.1)
Single	76(51.4)
Divorced	12(8.1)
Widowed	8(5.4)
Education	
Certificate	60(40.5)
Diploma	30(20.3)
Bachelors	50(33.8)
Other Qualifications	8(5.4)
Time spent giving care to patients	
Less than 5 years	91(61.5)
5-10 years	45(30.4)
Above 10 years	12(8.1)

The results (see Table 1) indicates that majority of respondents (60.1%) were female, while (39.9%) were male, majority of the respondents were in the age brackets of 20-30 years (54.1%) followed by those aged between (27.0%) while the least of the respondents were those aged 51 years and above (6.8%). The results also indicate that most of the respondents were (52.0%) had never gotten married before while those that were married came second with (34.5%) whereas the widowed were represented with the least participation, 40.5% of respondents had attained certificate as their level of education, 33.8 had achieved a bachelors' degree of a kind while 20.3% had a acquired a at least a diploma. The results also indicate that majority of the respondents (61.5%) had been taking care pf the patients for five or less years compared to those (8.1%) who had given care for over 10 years to the patients.

Relationship between Socio-economic Status, Perceived Stigma and Coping Strategies among Caregivers of People with Mental Illness

Table 2: Correlational Results

	1	2	3
1. Socio-economic status	-		
2. Coping strategies	.134	-	
3. Perceived stigma	-.097	-.147	-

Relationship between Socio-economic Status and Coping Strategies

The first hypothesis stated that there is a significant relationship between socio-economic status and coping strategies among caregivers of people with mental illness. Results in the table above reveal that there is no significant relationship between socio-economic status and coping strategies ($r = .134$; $p = .104$). Therefore, the alternative hypothesis is rejected and it is concluded that caregivers' socio-economic status is not significantly related to their coping strategies. The results indicate that the caregivers' socio-economic status has no implications upon one's coping strategies and how they are supposed take care of the patients, rather everyone adopts a coping strategy that fits in their capability in their own stature. However, to some extent, a caregiver's socio-economic status is crucial when it comes to providing the basic needs and medications of the mental patients because SES is a type of coping used as a strategy by the caregivers.

Relationship between Socio-economic Status and Perceived Stigma

The second hypothesis stated that there is a significant relationship between socio-economic status and perceived stigma among caregivers of people with mental illness. However, results in the table above reveal that there is no significant relationship between socio-economic status and perceived stigma (r = -.097; p = .248). Therefore, the alternative hypothesis is rejected and it is concluded that there is no significant relationship between the caregivers' socio-economic status and perceived stigma. This gives an insinuation that caregivers do not hold any sort of perceived stigma with the fact that they are having someone with mental illness in their homes nor hospitals regardless of their socio-economic status. This could be affiliated to the current frequent metal health campaigns and awareness sessions carried out by different people and organizations promoting early identification of mental illnesses within the communities, as well as creating a referral pathway to provide psychosocial support to both caregiver and patients.

Relationship between Perceived Stigma and Coping Strategies

The third hypothesis stated that there is a significant relationship between perceived stigma and coping strategies among caregivers of people with mental illness. However, results in the table above reveal that perceived stigma is not significantly related to the caregivers' coping strategies (r = -.147; p = .076). Therefore, the alternative hypothesis is rejected and it is concluded that there is no significant relationship between perceived stigma and coping strategies among caregivers of people with mental illness. Results give an impression that perceived stigma has no impact on one's adaptation of a coping strategy while giving care to the mentally ill. However, to some extent perceived stigma could play a role in one's ability to cope with the social predicaments that are attached to taking care for a mentally ill person.

Table 3: Moderation of Perceived Stigma between SES and Coping Strategies

Model		Unstandardized Coefficients		Standardized Coefficients	t	P	R^2
		B	Std. Error	Beta			
1	(Constant)	26.741	2.467		10.84	.000	.007
	SES	.170	.097	.146	1.757	.081	
	P-Stigma	.045	.115	-.032	.388	.698	

a. Dependent Variable: Coping Strategies

The fourth hypothesis stated that perceived stigma significantly moderates the relationship between socio-economic status and coping strategies among caregivers of people with mental illness. However, study findings in the table above reveal that both socio-economic status and coping strategies of caregivers are not significantly moderated by perceived stigma (P= .081; .698 > .05, R^2 = .007). Therefore, the alternative hypothesis is rejected and it is concluded that perceived stigma does not significantly moderate the relationship between socio-economic status and coping strategies among caregivers of people with mental illness. Results reveal that a caregiver's SES is neither preconditioned to their own perceived stigma, however, to a lesser extent, perceived stigma can manipulate the kind of coping strategies adapted by the caregiver. For instance, a caregiver might forego problem-focused coping strategy and focus more on emotion-focused coping strategy due to perceived stigma.

Table 4: Gender and Coping Strategies among Caregivers

	N	Mean	Std. Deviation	t	Sig.
Male	59	30.1864	4.79754	-.878	.486
Female	89	30.9438	5.35206	-.898	

Results in the above table show that female caregivers (M=30.1, 30.9, SD= 6.84) report slightly higher levels of coping strategies. However, results show that there is no significant difference in the coping strategies adapted by the male and female caregivers of the mentally ill patients (t = -.878, -.898; P= .486). Thus, the alternative hypothesis is rejected and it is concluded that there is no significant difference in the coping strategies adapted by the male and female caregivers of people with mental illness. This suggests that even when female tend to cope higher than male caregivers, there is no significant difference because the margin is really small to make a huge impact.

Chapter Five

Discussion, Conclusion and Recommendations

Introduction

This chapter entails the discussion in relation to research findings and in accordance with the hypotheses. It also presents a conclusion and recommendations in line with the purpose and objectives of the study.

Discussion

Socioeconomic Status and Coping Strategies among People with Mental Illness

Objective one sought to examine the relationship between socio-economic status and perceived coping strategies. Results of this study revealed that there is no significant relationship between socio-economic status and coping. However, the results are not in agreement with Delespaul (2012) who stated that many of the mental illnesses today have been linked with a major loss of proper quality of life among sufferers and caretakers and the type or level of socioeconomic status is a big precipitating factor. Likewise, the results are not in line with Hert et al. (2011), Whitefors et al. (2013) and Ebrahimi et al. (2018) who stated that in most cases, it is believed that mental illness is accompanied with increased physical sicknesses as well as death rates which becomes a challenging situation due to the economic costs that comes with taking care of people with mental illness.

The results of this study are also not in agreement with Pedersen et.al (2009) and Awad et.al (2008), who stated that majority of the patients' caregivers do go through some negative experiences and effects of the mental conditions as well as families that have taken on the responsibility of being the primary source of care for their family members, face a number of challenges that are correlated with their socioeconomic status. However, the study shows that one can take care of a mental health patient and still be doing fine with SES because the latter has no cause-effect relationship with the former.

The results are not in line with the research findings from Oyebode (2005) who revealed that family members taking care of their own people suffering with MI are assumed to provide physical, emotional and financial support to their relative with this kind of illness. And the results are also not in agreement with Robinson (2017) who stated that mental illness is devoted to act as a stressor, that strategic ways of coping are initiated to address the stress that comes with financial constraints of the caregivers of the mentally ill person.

The results are also not in agreement with Addo (2018) who revealed that taking care for a someone who is mentally ill has significantly affected the caratakers in very many ways of life, including their coping strategies in relation to their socio-economic status, where family caregivers, for instance, are usually required to provide financial support, and endure the burden of economic difficulties. The results aline with the fact that there are institutions that are meant to rehabilitate critically ill mental health patients for free most of the time, such as Butabika hospital.

The results are not in agreement with Ebrahimi (2018) who concluded that when a clinical diagnosis of a psychological or mental illness has been made to a family member, family caretakers are assumed to face challenges in their roles that include perception of the psychosocial support,

financial predicament as well as the affiliated challenges that come with taking care of a MI personnel, which negatively affect the common coping approaches. Study findings further refute Ebrahimi's findings where he further stated that caretakers invest all of their financial and emotional as well as physical capacities to do away with this stressful situation alongside managing difficulties associated with taking care of the mentally ill person (Ebrahimi, 2018).

The results of this study are not in line with Chadda (2014) and Salles and Barros (2009) who stated that the provision of constant care to the patients with severe mental illness without supportive resources could lead to frustration and burden in family caregivers thus negatively influencing their coping skills strategies. Additionally, study findings are in disagreement with Raj (2013) and Ebrahimi et al. (2018) who go on to reveal that there are a lot of challenges associated with severe mental illness that may significantly affect the coping skills of caretakers for mentally ill people that usually leads to loss of energy and guts to provide care due to the patients' failure to adhere to treatment given. Also, Steele et al. (2010) stated that financial constraints are thought to bring about feelings of helplessness, stress and depression upon caretakers mostly manifesting among parents and spouses of the mentally ill thus leading to resignation form the role of giving care to the sufferers, but the study results rather find no relationship with the variables in study.

The results are also not in agreement with Kallivayalil (2008) and Shamsaei et al. (2015) who stated that studies have revealed that the failure of health professionals to incorporate advanced psychological treatments is assumed to bring about recurrence of the problems as well as lower adherence levels hence treatment failure which is also believed to come with a high financial strain for the caretaker of the mentally ill. This kind of predicament has made it quite hard for caretakers of the mentally ill to find it hard to cope with the whole situation thus neglecting their patients with mental illness.

The results of the study are not in line with Ebrahimi (2018), WHO (2013), Ganev et al. (1998) and Nasheed et al. (2012) who stated that the studies conducted about mental illness in the low and middle-income countries revealed that less than 10% of the people with mental illness have been hospitalized because of the assumed high levels patient care provided by the family members and it was believed that the strength of the family bonding as well as their socioeconomic network plays a big role in the social support needed to reduce the burden of taking care of the mentally ill among majority of the developing countries.

The results are also in disagreement with Singh et al. (2016), and Mak and Cheung (2008) who stated that most of the times caretakers decide to further conceal their socioeconomic status from others and also withdraw from most of the social relations that they were previously engaged in as well as dissociating from the patients as a form of coping which tends to also inconvenience adherence hence making them more distressed.

In conclusion, all of the previous studies above are not in line with the results of the current study. This could be attributed to the fact that mental health awareness has been wide spread by different stake holders to ensure that suffers as well as their caregivers are all given the essential psychosocial support on how to handle such situations. Thus, there is no significant relationship between socio-economic status and coping strategies among caregiver of people with mental illness.

Socio-Economic Status and Perceived Stigma among Caretakers of People with MI

Objective two sought to investigate the relationship between socio-economic status and perceived stigma. Results of this study revealed that there is no significant relationship between socio-economic status and perceived stigma. The results of this study are not in agreement with Bos et al. (2013) who stated that most of the mental illness carriers are branded with a mark of being avoided and socially excluded from the other social members. In addition, the results are also not in line with Corrigan and Miler (2004) who revealed that majority of people suffering with mental illness are more severely stigmatized compared to people suffering with other health illnesses such as cancer and cardiovascular diseases. Also, the results are not in agreement with Bos et al. (2013) and Pryor et al. (2012) who further stated that people who are related and/or associated with the mentally ill people are also prone to stigmatization because of the simple connection they might be sharing in common and this occurrence is known as stigma by association.

The results of this study are also not in line with research by Sanden and Pryor (2016) who revealed that many of the family members and caretakers of mentally ill people are prone to experience a wide range of struggles that involve family burdens, such as financial problems, time spent on the patient as well as missing out on career opportunities while taking care of the patient which in most cases results into family feuds and quarrels.

The results are also not in line with Crowe and Lyness (2014) who stated that the differences in the socioeconomic status create are alleged to create differences in the strategies of coping with stressful and negative emotional climates in the homes of those taking care of people with mental illness. In addition, the results are also not in agreement with a study conducted by Link and Phelan (2001; 2013) that outlined a process through which people with mental illness are

treated differently than other members of society. Also, the results are not in line with Karnieli-Miller et al. (2013) who stated that stigma is also assumed to negatively impact on the caretakers' ability to cope with the fact that they have a mentally ill person they are entitles to look after for the betterment of their life.

The results are also not in line with Link and Phelan (2001), Larson and Corrigan, (2008) and Ali et al. (2012) who stated that socioeconomic status in relation to the discrimination acts of devaluation, rejection, and social exclusion of the mentally ill is reported to lead to unsatisfactory outcomes for people taking care of these patients. The incidences that overwhelm the lives of caretakers of people with mental illness are usually within their friends, family, and service providers, through a phenomenon known as courtesy stigma which may result in families being blamed, socially isolated, and discriminated against and that these family members may become depressed or reclusive, negatively affecting their socioeconomic status.

The results are not in line with a study conducted by Barry et al. (2013) who examined people's perception about mental illness revealed that stigma towards the mentally ill was at its peak as they revealed that 67% of the population were not ready to have a mentally ill person as their immediate neighbor. All these are not in line with results of this study which has found that there is no significant relationship between socio-economic status and perceived stigma.

In conclusion, people's SES can not be threatened by their own perceived stigma, rather, people are obliging to cause of breaking the bias against mental illness. Thus, this could be the reason to why the study findings found no relationship between SES and perceived stigma among the caregivers of people with mental illness.

Perceived Stigma and Coping Strategies among Caretakers of People with Mental Illness

Objective three sought to establish the relationship between perceived stigma and coping styles. The results of the study revealed that perceived stigma is not significantly related to the caregivers' coping strategies. These results are not in agreement with Pescosolido et al. (2010) whose assessment on stigma against mentally ill people with their caretakers revealed that there has been a gross increament in stigma amongst the caretakers of the mentally ill denoting that majority of the people do not want to have or associate with someone having mental illness as well as having little to know associaition with their caretakers. And that this kind of stigma makes caretakers more prone to very many stressors that may find it hard to cope with the situation

The results are also not in agreement with the research by Koschorke and Thornicroft (2014; 2006) that identified undisputable negative outcomes of stigma upon coping amongst majorities of the caretakers of people with mental illness. They point out that majority of persons stigmatized have testified that the effects of stigma are more of a burden and a distress than the major problem leading to a number of challenges like keeping personal relationships and engagement in work. Thus, this kind of treatment is seen to bring about self-stigma amongst the caretakers which may result into abandoning or even hiding of the patients without providing any necessary care in order to cope with the current predicament.

The results of this study are also not in agreement with Livingston and Boyd (2010), and Mestdagh and Hansen (2014) who showed that stigma is a very immense factor in the lives of caretakers, that is, regardless of the socioeconomic status, caretakers of the mentally ill are stigmatized and they are finding it hard and this negatively affects their coping mechanisms and thus resorting to self-blame. In addition, Koschorke et al. (2014) and Yang (2014) state that these coping strategies in this case are usually more based on what the sufferers of stigma consider

matters the most in their lives while giving care to the mentally ill something that is not in line with the results of the study.

The results of this study are also not in agreement with Pryor et al. (2012) who revealed that people's affect, cognitions as well as their behaviors significantly relate with the reactions of other people, more so family members avail that seem to be perceived as stigmatizing conditions. This kind of perception from the caretakers is assumed to bring about psychological distress amongst them hence defecting their coping levels and strategies. Furthermore, people caretakers of the mentally ill tend to distance themselves from their family members or friends whom they believe they stigmatize them and seek comfort while alone as part of their coping style.

The results are dissimilar to research conducted by Hoop (2008) and Pryor, et al. (2013) who revealed that family members as well as caretakers' knowledge of mental illness being at some point a hereditary cause through the explanation of mental illness being a biological determination has not done any good because. This is thought to worsen stigma by caretakers making a label of mental illness being in their bloodline hence self-stigma which is believed to be the strongest hindrance in any form or strategy of coping.

In conclusion, infested perceived stigma does not make it hard for the caretakers to come up with positive coping strategies, because they are most assured that their mental health matters in their subconscious, hence playing their part by giving care to the mentally ill, rather than being distraught upon their role. Thus, the previous study findings are all not in line with the results of the study that revealed that perceived stigma is not significantly related to the caregivers' coping strategies.

Moderating Factor between Socioeconomic Status, Perceived Stigma and Coping Strategies among Caretakers of People with Mental Illness

Objective four sought to examine the moderating effects of perceived stigma between socio-economic status and coping strategies. The results of this study revealed that perceived stigma does not significantly moderate the relationship between socio-economic status and coping strategies. The results of this study are not in line with Mak and Cheung (2008) who stated that a lot of stigma is assumed to come from close relatives and friends towards the caregivers in relation to the care they give to the mentally ill people which is believed to also prevail in their respective societies, in which this kind of public stigma is believed to make caretakers to also develop some form of self-stigma that may lead them into feeling unhappy, helpless and dissatisfied with life hence making coping a more complicated case.

Evans (2016) revealed that the caretakers' perception of stigma is responsible for illumination of an association of socioeconomic status and coping towards mental health. She believes that majority of the people are experiencing stigma in relation to their origin, sex as well as their socioeconomic status. For this matter, feelings of being stigmatized by other members of the society through discrimination (Shariff-Marco et al., 2011) has had a long-time negative impact on their coping strategies as they deal with the reality of taking care of their mentally ill personals. All these researches are not in line with the results of the study that showed that perceived stigma does not significantly moderate the relationship between socio-economic status and coping strategies.

The study results do no concur with Pascoe and Smart Richman (2009) who revealed that the experience of stigma among the caretakers of people with mental illness is worth a consideration because it is assumed to lead to lower and poorer levels of coping among the

caretakers who are of a low socioeconomic status, hindering any positive change towards mental health outcomes.

The results of this study are incongruent with Ssebunnya et al. (2009) and Saraceno et al. (2005) who stated that, while there is considerable descriptive evidence regarding the role of stigma in mental illness, there is also a large body of evidence from high, middle and low-income countries, demonstrating an association between poverty and mental illness. In addition, they also stated that the stigma attached to mental illness is reported to affect the caretakers at all economic levels ending up in poverty, making coping a very difficult resolution to consider leaving the caretakers helpless.

However, results of the study concur with Gerlinger et al. (2013) who stated that there is no direct moderation between the caretakers' perceived stigma and marital status, education, age, gender, ethnicity, place of residence, income, and employment in relation to coping. Likewise, the results are also in line with a study by Singh et al. (2016) who reported that caretakers of the Islam faith as well as those that are in their youthful age with a higher socioeconomic status are believed to perceive stigma differently, that is, people perceive stigma differently due to their faith.

Coping Strategy Levels between Male and Female Caretakers of People with Mental Illness

Objective five sought to compare the levels of coping strategies between male and female caretakers. The results of this study indicated that there is no significant difference in the coping strategies adopted between male and female caregivers. The results are dissimilar with research findings by Gerlinger et al. (2013) who revealed that male caretakers were more prone to being negatively impacted with the stigma associated with taking care of the mentally ill person, purely compromising their coping strategy in the society. Rather, the results show that there is no gender difference in coping strategies adopted by the caregivers, no matter the circumstance.

The results of this study incongruent with Brown et al (2017) who revealed that gender is a very strong factor in coping, stressing that given the association of the public stigma about having a family member with mental illness, men are more subjected to mental illness-related stigma. The study does not coincide with the results that believed women open up more and seek assistance in relation to a mental illness predicament than men would, thus recommending that gender has underlying factors that determine one's coping during stressful times associated with stigma and mental illness that need to be clarified.

Furthermore, study findings are dissimilar with Turner and Brown (2010), and Brown et al. (2017) who stated that the fact that keeping secrets about the perceived stressful burdens as well as failure to disclosure about mental illness related issues varies profoundly, it is assumed that women do not often conceal issues about self and are less secretive compared to men thus seeking assistance on how to cope with the fact that they are taking care of a mentally ill person thus bringing variations in coping styles and strategies between men and women.

Conclusion

Despite the numerous literature that clearly shows the linkage between socio-economic status, perceived stigma and coping strategies among the caregivers of people with mental illnesses, this study has indicated that there is no linkage between these variables. This could be attributed to the fact that the nature of the scope of mental health and its treatment is attributed to both the culture of the people of Uganda where some attribute mental illness to culturally related sicknesses, as well as the government institution where most of the services such as medication, care taking, feeding among others are entirely for the government and thus the care takers under this institution are known to be government employees.

These attributions make caregivers at all levels not to be so much concerned about their SES while providing a service to the mentally ill, thus a minimized level of perceived stigma. The fact that distress is a common factor that people have to put up with in their daily lives, coping strategies adapted would be much more directed to the daily stressors rather than focusing it to the SES and perceived stigma, due to the fact that one is taking care of a mentally ill patient.

Recommendations

Whereas the findings find no significant cause effect relationship upon the study variables, stigma still stands in relation to mental illness. Thus, more approaches and strategies need to be developed to break the bias so that caregivers of people with mental illness are free to come out and help those that are critically ill without any fear of being stigmatized in their respective societies.

The study recommends that attention needs to be conveyed to creating more mental health campaigns and awareness sessions through community leaders on ground to capture the attention of donors and sponsors to help in bridging the gap of socioeconomic imbalances in the societies

of the people that are giving care to the mentally ill, to feel supported, rather than feeling left out and discriminated when it comes to service delivery with financial constraints.

Furthermore, attention needs to be given to both male and female caregivers of people with mental illness because the study findings have revealed that they have no difference in coping strategies. This implies that all people need to be supported to go through the situation they are in to fully support the mentally sick and/or disabled

The study also recommends another investigation into the factors that are generally influencing the results of this study that showed that there was no relationship between these variables and yet most of the literature of this study indicates that there is a relationship between these study variables.

References

Abbo, C., (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action*; 4. DOI: 10.3402/gha.v4i0.7117

Addo, R., Agyemang, S,A., Tozanm, Y., & Nonvignon, J. (2018). Economic burden of caregiving for persons with severe mental illness in sub-Saharan Africa: A systematic review; PloS ONE 13(8): e0199830.

Ae-Ngibise, K. A., Doku, V. C. K., Asante, K. P., & Owusu-Agyei, S. (2015). The experience of caregivers of people living with serious mental disorders: a study from rural Ghana. *Global Health Section, 8*(1), 26957. doi: 10.3402/gha.v8.26957.eCollection 2015.

Aggarwal, O.P., Bhasin, S.K., Sharma, A.K., Chhabra, P., Aggarwal, K., & Rajoura, O.P. (2005). A New Instrument (Scale) for Measuring the Socioeconomic Status of a Family: Preliminary Study. *Indian Journal of Community Medicine* Vol. 30, No. 4

Ali, A., Hassiotis, A., Strydom, A., & King, M. (2012). Self-stigma in people with intellectual disabilities and courtesy stigma in family carers: A systematic review. *Research in Developmental Disabilities, 33*(6), 2122-2140. doi:10.1016/j.ridd.2012.06.013

Amy Morin A., & Gans., S (2021). Mental Illness Types, Symptoms, and Diagnosis. https://www.verywellmind.com/definition-of-mental-illness-4587855

Aschbrenner, K. A., Greenberg, J. S., Allen, S. M., & Seltzer, M. M. (2010). Subjective burden and personal gains among older parents of adults with serious mental illness. *Psychiatric Services, 61*(6), 605-611. doi:10.1176/appi.ps.61.6.605

Awad, A. G., & Voruganti, L. N. (2008). The burden of schizophrenia on caregivers. *Pharmacoeconomics, 26*(2), 149-162.

Barry, C. L. (2013). After Newtown Public opinion on gun policy and mental illness. *The New England Journal of Medicine*: 368 (12): 1077-1081.

Bos, A. E. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: advances in theory and research. Basic Appl Soc Psychol 35(1):1–9. doi:10.1080/01973533.2012.746147

Brohan, E., Slade, M., & Clement, S, G., (2010). Thornicroft Experiences of mental illness stigma, prejudice and discrimination: a review of measures BMC Health Services Research, p.80, 10.1186/1472-6963-10-80

Brown, R. L., Monoley, M. E., & Brown, J., (2018). Gender differences in the processes linking public stigma and self-disclosure among college students with mental illness. *Journal of Community Psychology*: DOI: 10.1002/jcop.21933

Chadda, R. K. (2014). Caring for the family caregivers of persons with mental illness. *Indian Journal of Psychiatry*, *56*(3), 221. doi: 10.4103/0019-5545.140616.

Chang, C., Su, J., Chang, K., Lin, C., Koschorke, M., & Thornicroft, G. (2018). Perceived stigma of caregivers: Psychometric evaluation for Devaluation of Consumer Families Scale. *International Journal of Clinical and Health Psychology*, 22, pp. 170-178

Chang, C.-C., Su, J.-A., & Lin C.-Y., (2016). Using the Affiliate Stigma Scale on caregivers of people with dementia: *Psychometric evaluation Alzheimer's Research & Therapy*, 8 (2016), p.45, 10.1186/s13195-016-0213-y

Chronister, J., Chou, C. C., & Liao, H., (2013). The role of stigma coping and social stigma in mediating the effect of societal stigma on internalized stigma, mental health recovery, and quality of life among people with serious mental illness. *J Commun Psychol* 41(5):582–600. doi:10.1002/jcop.21558

Corrigan, P. W., & Miler, F. E., (2004). Shame, blame, and contamination: a review of the impact of mental illness stigma on family members. *J Ment Health* 13(6):537–548. doi:10.1080/09638230400017004

Corrigan, P. W., Watson, A. C., & Miller, F. E. (2006). Blame, shame, andcontamination: The impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology, 20,* 239–246.doi:10.1037/0893-3200.20.2.239

Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Upper Saddle River, NJ: Pearson.

Crowe, A., & Lyness, K. P., (2014). Family functioning, coping, and distress in families with serious mental illness. *Fam J* 22(2):186–197. doi:10.1177/1066480713513552

Delespaul, P. (2012). Consensus regarding the definition of persons with severe mental illness and the number of such persons in the Netherlands. *Tijdschrift Voor Psychiatrie, 55*(6), 427-438.

Development Services Group. (2016). *Behind the term: Serious mental illness.* No. 283-12-3702). Rockville, MD: SAMSHA's National Registry of Evidence-based Programs and Practices.

Eaton, P. M., Davis, B. L., Hammond, P. V., Condon, E. H., & McGee, Z. T. (2011). Coping strategies of family members of hospitalized psychiatric patients. *Nursing Research and Practice,2011(2011)*doi:10.1155/2011/392705

Ebrahimi, H., Seyedfatemi, N., Namdar, A, H., Ranjbar, F., Thornicroft, G., Rahmani, F., & Whitehead, B. (2018). Barriers to Family Caregivers' Coping With Patients With Severe Mental Illness in Iran. *Qualitative Health Research*, DOI:10.1177/1049732318758644

Evans, M. S. S., (2016). "Examining the relationship between socioeconomic status and mental Health quality of life in a rural neighborhood context." MS (Master of Science) thesis, University of Iowa, 2016. https://ir.uiowa.edu/etd/3081.

Family Caregiver Alliance. Caregiver Statistics: Demographics, 2017. Available at: https://www.caregiver.org/caregiver-statistics-demographics. Accessed May 5, 2017.

Flisher, A. J., Lund, C., Funk, M., Banda, M., Bhana, A., Doku, V., ... & Petersen, I. (2007). Mental health policy development and implementation in four African countries. *Journal of health psychology, 12(3), 505-516.* DOI:10.1177/1359105307076237

Ganev, K., Onchev, G., & Ivanov, P. (1998). A 16- year follow- up study of schizophrenia and related disorders in Sofia, Bulgaria. Acta Psychiatrica Scandinavica, 98(3), 200-208. doi: 10.1111/j.1600-0447.1998.tb10067.

Gerlinger, G., Hauser, M., De Hert, M., Lacluyse, K., Wampers, M., Correll, C.U., (2013). Personal stigma in schizophrenia spectrum disorders: A systematic review of prevalence rates, correlates, impact and interventions. World Psychiatry 2013;12:155-64.

Ghosh, S., Greenberg, J. S., & Seltzer, M. M. (2012). Adaptation to a spouse's disability by parents of adult children with mental illness or developmental disability. *Psychiatric Services, 63*(11), 1118-1124. doi:10.1176/appi.ps.201200014

Girma, E., Möller-Leimkühler, A. M., Müller, N., Dehning, S., Froeschl, G., & Tesfaye, M. (2014). Public stigma against family members of people with mental illness: findings from the Gilgel Gibe Field Research Center (GGFRC), Southwest Ethiopia. *BMC International Health and Human Rights, 14*(1), 1. doi: 10.1186/1472-698X-14-2

Gitlin L, Maslow K. National Research Summit on Care, Services and Supports for PersonsWith Dementia and Their Caregivers, 2018. Available at: https://aspe.hhs.gov/basic-report/national-research-summitcare-services-and-supports-persons-dementia-and-their-caregivers-finalsummit- report. Accessed April 27, 2018.

Hand, A. D., (2016). "Quality Improvement Project to Enhance Provider Awareness and Use of the Coping Strategies Questionnaire (CSQ) to Assess Patients' Level of Coping with Chronic Pain". *Doctor of Nursing Practice (DNP) Projects*. 69. Retrieved from https://scholarworks.umass.edu/nursing_dnp_capstone/69

Hassan, W., Mohamed, I. I., Elnaser, A., & Sayed, N. E. (2011). Burden and coping strategies in caregivers of schizophrenic patients. *Journal of American Science, 7*(5), 802-811.

Henderson C, Evans-Locke S, Thornicroft G. Mental health stigma; public health and programmes. Am J Public Health. 2013;103(5):777e780.

Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakamas, M., Cohen, D., Asai, I., Ndetei, D. M. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry, 10*(1), 52-77.

Hoop, J. G. (2008). Ethical considerations in psychiatric genetics. *Harvard Review of Psychiatry, 16,* 322–338. doi:10.1080/10673220802576859

Iversen AC, van Staden L, Hughes JH, et al. The stigma of mental health problems and other barriers to care in the UK Armed Forces. BMC Health Serv Res. 2011;11:31.

Kallivayalil, R. A. (2008). Are we over-dependent on pharmacotherapy? *Indian Journal of Psychiatry, 50*(1), 7. doi: 10.4103/0019-5545.39750

Karnieli-Miller, O., Perlick, D. A., Nelson, A., Mattias, K., Corrigan, P., & Roe, D. (2013). Family members of persons living with a serious mental illness: Experiences and efforts to cope with stigma. *Journal of Mental Health, 2013, 22*(3), 254-262.

Karp, D. A., & Tanarugsachock, V. (2000). Mental Illness, Caregiving, and Emotion Management. *Qualitative Health Research, 10*(1), 6-25. doi:10.1177/10497.

Kigozi, F., Ssebunnya, J., Kizza, D., Cooper, S., & Ndyanabangi., (2010). An overview of Uganda's mental health care system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). International journal of mental health systems. 4. 1. 10.1186/1752-4458-4-1.

Kim PY, Thomas JL, Wilk JE, Castro CA, Hoge CW. Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. Psychiatr Serv. 2010;61(6):582e588.

Koschorke, M. et.al., (2014). Experiences of stigma and discrimination of people with schizophrenia in India. *Journal of Social Science & Medicine:*123149e159

Larson, J. E., & Corrigan, P. W. (2008). The stigma of families with mental illness. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 32*(2), 87-91. doi:10.1176/appi.ap.32.2.87

Lazarus RS, Folkman S (1984) Stress, appraisal, and coping. Springer, New York

Leow, M, Q, H., Chan, S, W, C., (2011). Factors affecting caregiver burden of terminally ill adults in the home setting- A systematic review. JBI *Database of Systematic Reviews and Implementation Reports*; 9(45):1883–916.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27,* 363-385.

Link, B. G., & Phelan, J. C. (2013). Labeling and stigma. In C. S. Aneshensel (Ed.), *Handbook of the sociology of mental health* (2nd ed., pp. 525-541). Dordrecht: Springer Science and Business Media. doi:10.1007/978-94-007-4276-5_25

Livingston, J.D., & Boyd, J.E., (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Soc. Sci. Med*. 71 (12), 2150e2161.

Major B, O'Brien LT (2005) The social psychology of stigma. *Annu Rev Psychol* 56:393–421. doi:10.1146/annurev.psych.56. 091103.070137

Mak W.W.S. & Kwok Y.T.Y, (2010). Internalization of stigma for parents of children with autism spectrum disorder in Hong Kong. *Social Science in Medicine*, 70 (2010), pp. 2045-2051, 10.1016/j.socscimed.2010.02.023

Mak, W,W., & Cheung, R,Y., (2008). Affiliate stigma among caregivers of people with intellectual disability or mental illness. *Journal of Applied Research in Intellectual Disabilities*, 21 (2008), pp. 532-545

McBain, R., Norton, D, J., Morris, J., Yasamy, M, T., Betancourt, T, S., (2012). The role of health systems factors in facilitating access to psychotropic medicines: a crosssectional analysis of the WHO-AIMS in 63 low- and middle-income countries.

Mestdagh, A., & Hansen, B., (2014). Stigma in patients with schizophrenia receiving community mental health care: a review of qualitative studies. *Soc. Psychiatry Epidemiol*. 49 (1), 79e87.

Ministry of Health, Uganda. Health Sector Strategic and Investment Plan III (2010/11 – 2014/15). Government of Uganda, 2010.

Molodynski, A., Cusack, C., and Nixon, J. (2017). Mental healthcare in Uganda: Desparate challenges but real opportunities. *BJPsych International, 14*(4).

Mugisha, J., Hanlon, C., Knizek, B. L., Ssebunnya, J., Vancampfort, D., Kinyanda, E., & Kigozi, F. (2019). The experience of mental health service users in health system strengthening: lessons from Uganda. *International journal of mental health systems, 13*, 60. https://doi.org/10.1186/s13033-019-0316-5

Naheed, M., Akter, K. A., Tabassum, F., Mawla, R., & Rahman, M. (2012). Factors contributing the outcome of Schizophrenia in developing and developed countries: A brief review. *International Current Pharmaceutical Journal*, *1*(4): 81-85. Retrived from: http://imsear.hellis.org/handle/123456789/152826

Ndikuno, C., Namutebi, M., Kuteesa, J., Mukunya, D., & Olwit, C., (2016). Quality of life of caregivers of patients diagnosed with severe mental illness at the national referral hospitals in Uganda. *BMC Psychiatry* 16:400 DOI 10.1186/s12888-016-1084-2

Ndyanabangi, S., Funk, M., Ssebunnya, J., Drew, N., Dhillon, S., Sugiura, K., & Skeen, S. (2012). WHO Profile on mental health in development (WHO proMIND). Republic of Uganda. Geneva, World Health Organization

Olwit, C., (2015). Stigma towards people with mental illness: *A cross-sectional study among nursing staff in health facilities in Amolatar district, Uganda*. p.15

Olwit, C., Musisi, S., Leshabari, S., & Sanyu, I. (2015). Chronic Sorrow: Lived Experiences of Caregivers of Patients Diagnosed with Schizophrenia in Butabika Mental Hospital, Kampala, Uganda. *Archives of psychiatric nursing, 29*(1), 43-48.

Oyebode, J. R. (2005). Carers as partners in mental health services for older people. *Advances in Psychiatric Treatment, 11*(4), 297-304. **doi:** 10.1192/apt.11.4.297

Pascoe, E. A., & Smart, R. L. (2009). Perceived discrimination and health: a meta-analytic review. *Psychological bulletin*, 135(4), 531.

Patten SB, Remillard A, Philips L, et al. Effectiveness of contact-based education for reducing mental illness-related stigma in pharmacy students. BMC Med Educ. 2012; 12:120.

Pawar, A, A., Peters, A., & Rathod, J., (2014). Stigma of mental illness: A study in the Indian Armed Forces. *Medical Journal of Armed Forces India* 70. 354-359

Pedersen, P. B., & Kolstad, A. (2009). De-institutionalisation and trans-institutionalisation changing trends of inpatient care in Norwegian mental health institutions 1950-2007. *International Journal of Mental Health Systems*, *3*(1), 28. doi: 10.1186/1752-4458-3-28

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J.C., & Link, B. G. (2010) "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American Journal of Psychiatry*167:1321–1330.

Pryor, J. B., Bos, A. E. R., Kok, G., Sanden, R. L. M & Stutterheim, S. E., (2013). The Experiences of Stigma by Association Among Family Members of People With Mental Illness. *Journal of Rehabilitation Psychology,* 0090-5550/13/$12.00 DOI: 10.1037/a0031752

Pryor, J. B., Bos, A. E. R., Reeder, G. D., Stutterheim, S. E., Willems, R. A., & McClelland, S. (2012). *Reactions to stigma-by-association: Relationships to reduced psychological well-being, closeness to stigmatized relatives, and public stigma*. Manuscript submitted for publication.

Pryor, J. B., Reeder, G. D., & Monroe, A. E. (2012). The infection of bad company: Stigma by association. *Journal of Personality and Social Psychology, 102,* 224–241. doi: 10.1037/a0026270

Purkis, M. E., & Ceci, C. (2015). Problematizing care burden research. *Aging and Society, 35*(7), 1410-1428. doi:10.1017/S0144686X14000269

Raj, S. (2013). Living with a disability: A perspective on disability in people living with schizophrenia (PLS). *International Journal of Psychosocial Rehabilitation. 18 (1)115, 123*, 2.

Riddle, D.L. & Jensen, M.P. (2013). Construct and criterion-based validity of brief pain coping scales in persons with chronic knee osteoarthritis pain. Pain Med 14(2):265-275. doi:10.1111/pmc.12007

Roberts, B., Ocaka, K, F., Browne, J., Oyok, T., & Sondorp, E., (2008). Factors associated with post-traumatic stress disorder and depression amongst internally displaced persons in Northern Uganda. *BMC Psychiatry* 8: 38.

Robinson, C. A. (2017). Families living well with chronic illness: The healing process of moving on. *Qualitative Health Research, 27*(4), 447-461.

Rosland, A.-M., Heisler, M., & Piette, J. D. (2012). The impact of family behaviors and communication patterns on chronic illness outcomes: a systematic review. *Journal of Behavioral Medicine, 35*(2), 221-239. doi: 10.1007/s10865-011-9354-4

Salles, M. M., & Barros, S. (2009). The effect of mental illness on the activity of daily living: a challenge for mental health care. *Acta Paulista de Enfermagem, 22*(1), 11-16. doi:10.1590/S0103-21002009000100002

Sanden, R. L. M., Pryor J. B., Stutterheim, S. E., Kok, G., &. Bos, A. E. R. (2016). Stigma by association and family burden among family members of people with mental illness: the mediating role of coping. *Soc Psychiatry Psychiatr Epidemiol*: DOI 10.1007/s00127-016-1256-x

Saraceno, B., Levav, I., Kohn, R., (2005). "The public mental health significance of research on socio-economic factors in schizophrenia and major depression". *World Psychiatry*: 4:181-185.

Shamsaei, F., Cheraghi, F., & Esmaeilli, R. (2015b). The Family Challenge of Caring for the Chronically Mentally Ill: A Phenomenological Study. *Iranian Journal of Psychiatry and Behavioral Sciences, 9*(3), e1898. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4644616/pdf/ijpbs-09-1898.pdf

Shamsaei, F., Kermanshahi, S. M. K., Vanaki, Z., & Holtforth, M. G. (2013). Family care giving in bipolar disorder: experiences of stigma. *Iranian Journal of Psychiatry, 8*(4), 188. doi: 10.17795/ijpbs-1898

Shariff-Marco, S., Breen, N., Landrine, H., Reeve, B. B., Krieger, N., Gee, G. C., & Alegría, M. (2011). Measuring everyday racial/ethnic discrimination in health surveys. Du Bois Review: *Social Science Research on Race*, 8(01), 159-177

Shpigner, E., Possick, C., & Buchbinder, E. (2013). Parents' experience of their child's first psychiatric breakdown: "Welcome to hell". *Social Work in Health Care, 52*(6), 538-557. doi:10.1080/00981389.2013.780835

Sideli et al., (2016). Validation of the Italian version of the Devaluation Consumers' Scale and the Devaluation Consumers Families Scale. *Journal of Psychopathology*, 22, pp. 251-257

Sideli, L., Mulè, A., La Cascia, C., Barone, M,V., Seminerio, F., Satorio, C., Tarricone, I., Braca, M., Magliano, L., Francomano, A., Inguglia, M., D'Agostino, R., Vassallo, G., La Barbera, D., (2016) Validation of the Italian version of the Devaluation Consumers'

Scale and the Devaluation Consumers Families Scale. *Journal of Psychopathology*, 22, pp. 251-257

Singh, A., Mattoo, S.K., & Grover, S., (2016). Stigma associated with mental illness: Conceptual issues and focus on stigma perceived by the patients with schizophrenia and their caregivers. *Indian J Soc Psychiatry*; 32:134-42

Ssebunnya, J., Kigozi, F., Kizza, D., & Ndyanabangi, S. (2010). Integration of Mental Health into Primary Health Care in a rural district in Uganda. *African Journal of Psychiatry, 13*(2).

Ssebunnya, J., Kigozi, F., Lund, C., Kizza, D., & Okello, E. (2009). Stakeholder perceptions of mental health stigma and poverty in Uganda. *BMC International Health and Human Rights, 9*(1), 5.

Steele, A., Maruyama, N., & Galynker, I. (2010). Psychiatric symptoms in caregivers of patients with bipolar disorder: a review. *Journal of Affective Disorders, 121*(1), 10-21. doi: 10.1016/j.jad.2009.04.020

Taghva, A., Farsi, Z., Javanmard, Y., Atashi, A., Hajebi, A., & Noorbala, A. A. (2017). Strategies to reduce the stigma toward people with mental disorders in Iran: stakeholders' perspectives. *BMC Psychiatry*, *17*, 17. doi.org/10.1186/s12888-016-1169

Tamar, H., Haleigh, M.S., Matthew, P.J, & PWCI/DD (2018). Caregiving, intellectual disability, and dementia: Report of the Summit Workgroup on Caregiving and Intellectual and Developmental Disabilities. *Translational Research & Clinical Interventions* 272-282

Tesfaw, G., Kibru, B. & Ayano, G (2020). Prevalence and factors associated with higher levels of perceived stigma among people with schizophrenia Addis Ababa, Ethiopia. Int J Ment Health Syst 14, 19. https://doi.org/10.1186/s13033-020-00348-9

Turner, R. J., & Brown, R. L. (2010). Social support andmental health. In T. L. Scheid& T.N. Brown (Eds.), *A handbook for the study of mental health: Social contexts, theories and systems*, *second edition* (pp. 200–212). Cambridge: Cambridge University Press.

Tyler, R.C (2017). *The Impact of Perceived Mental Illness Stigma on Caregivers' Desire to Relinquish Care.* 16-p3-5

Uganda Bureau of statistics, & ICF international Inc. (2012). Uganda Demographic and Health Survey 2011. Kampala Uganda: UBOS and Calverton, Maryland: ICF Intenational Inc.

Verity. F., Turiho, B.A., Mutamba. B., & Cappo. D (2021). Family care for persons with severe mental illness: experiences and perspectives of caregivers in Uganda. Int J Ment Health Syst 15, 48. https://doi.org/10.1186/s13033-021-00470-2

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., & Burstein R. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the global burden of disease study 2010, *The Lancet*, *382*(9904), 1575-1586.

Yang, L.H., Thornicroft, G., Alvarado, R., Vega, E., & Link, B., (2014). Recent advances in cross-cultural measurement in psychiatric epidemiology: utilizing 'what matters most' sto identify culture-specific aspects of stigma. *Int. J. Epidemiol*. 43 (2), 494e510.

Zendjidjian, X., Richieri, R., & Adida, M., (2012). Quality of life among caregivers of individuals with affective disorders. *J Affect Disorders*;136(3):660e665

Appendix I: Consent Form

Dear participant,

My name is Brian Moses Katende; I am a Clinical Psychology student carrying out a study about Social Economic Status, Stigma and Coping among caretakers of people with mental illness. I am kindly requesting your participation in this study. You are chosen to take part in this study because I believe you have valuable information you can render to us for the purpose of this study. However, you are free to withdraw your participation at any point of research process without losing any of the benefits you used to enjoy. Please be assured that this study is for academic purpose only. Thus, you are kindly requested to answer some questions given on the questionnaire, and this is likely to last you about 20 minutes of your time. The information you are going to give will be strictly confidential and will only be disclosed to other researchers.

By signing below, you indicate that you have understood the purpose, procedures and information presented to you about this study and that you will voluntarily participate.

Signature of Respondent: …………………………………. Date: …………………………

Signature of Researcher: …………………………………. Date: …………………………

Appendix II: Questionnaires

Dear Respondent

I am Brian Moses Katende, a student at Makerere University. I am carrying out a research on Socio-Economic Status, Stigma and Coping among Caretakers of People with Mental Illness. You have been identified as a key person who has got very useful information for this study. Note that all the information you are going to provide will be treated confidentially. You do not have to write your name anywhere that can identify you. The research proposal has been thoroughly reviewed and approved by the University Supervisors (Dr Paul Nyende)

Section A: Personal data

Tick appropriately in the box or space provided

1. Gender of respondents

   a. Male ☐   b. Female ☐

2. Age bracket of the respondent

   a. 20-30years ☐   b. 31-40 years ☐   c. 41-50 years ☐   d. 51years and above ☐

3. Marital status

   a. Married ☐   b. Single ☐   c. Divorced ☐   d. Widowed ☐

4. Level of education

   a. None ☐   b. Certificate ☐   c. Diploma ☐   d. Degree ☐

5. Time spent giving care to the patient(s)

   a. Less than 5 years ☐   b. 5-10 years ☐   c. above 10 years ☐

Section B: Socio-Economic Status

1. Are you employed?

      1. Yes   ☐   2. No   ☐

2. Do you own a working motor vehicle (car, truck, van) or a motor cycle?

      1. Yes   ☐   2. No   ☐

3. What type(s) of energy do you mostly use in your home for cooking? (Tick whatever you use list below)

    1.☐   Electricity
    2.☐   Gas
    3.☐   Firewood
    4.☐   Charcoal

4. What appliances do you use at home? (Tick whatever you own on the list below)

1. ☐   Radio   2. ☐ Television   3. ☐   Mobile Phone

4. ☐   Electric kettle   5. ☐ Electric iron   6. ☐   Non-electric iron

7. ☐   Refrigerator   8. ☐ Decoder   9. ☐   Blender

10.☐   Electric cooker

5. What kind of house do you stay in?
    1. brick walls and iron sheet roof
    2. mud and reed walls grass thatched roof   ☐
    3. brick walls and clay tiled roof

6. Do you have enough food throughout the year?

      1. Yes   ☐   2. No   ☐

7. What things do you do that generate your main income? (Tick whatever you own on the list below)
    1. ☐   Business

    2. ☐   A job/ Formal employment

    3. ☐   Agriculture

4. ☐ Livestock (Cow(s) and Bull(s))

5. ☐ Goats and/or Sheep

6. ☐ Poultry

8. What is the main domestic water source in your home? (Tick whatever you use on the list below)

1. ☐ Piped (Tap) water

2. ☐ Well water

3. ☐ Borehole water

9. What type of sanitation do you use at your home stead?

1. Flushing toilet.

2. Pit latrine ☐

10. Type of the family you are living in

1. Nuclear family (Not more than 6 members)

2. Polygamous family (More than 8 members) ☐

3. Extended family (Comprises of other family members)

4. Joint family (Comprise of friends and/or refugee/displaced families)

11. Type of locality the family is residing

1. Living in urban locality

2. Living in rural locality ☐

3. Living in resettlement colony

4. Living in slums

5. No fixed living and mobile

12. How would you describe your general health?

1. Excellent

2. Very good ☐

3. Good

4. Fair

5. Poor

Section C: Perceived Stigma

Kindly tick or circle on the response that best describes you in the community you live in. there is no right or wrong answer

	Question	Strongly disagree	Disagree	Agree	Strongly Agree
1.	Most people in my community would rather not be friends with families that have a relative who is mentally ill living with them	3	2	1	0
2.c	Most people believe that parents of children with a mental illness are just as responsible and caring as other parents	3	2	1	0
3.	Most people look down on families that have a member who is mentally ill living with them	3	2	1	0
4.	Most people believe their friends would not visit them as often if a member of their family were hospitalized for a serious mental illness	3	2	1	0
5.c	Most people would treat families with a member who is mentally ill in the same way they treat other families	3	2	1	0
6.c	Most people do not blame parents for the mental illness of their children	3	2	1	0
7.	Most people would rather not visit families that have a member who is mentally ill	3	2	1	0
8.	Most people would not be friends with families who have relatives with mental illness	3	2	1	0
9.	Most people stigmatize families of relatives with mental illness	3	2	1	0

Section D: Coping Strategies

In the questionnaire below, I am interested in your opinion on certain issues regarding your coping strategies. Please circle the statement that best describes you

		Never	Rarely	Some Times	Most of the Times	Always Do
1	I think of things I enjoy doing	1	2	3	4	5
2	I just think of it as some other sensation, such as numbness	1	2	3	4	5
3	It is terrible and I think it is never going to get any better	1	2	3	4	5
4	I don't pay any attention to it	1	2	3	4	5
5	I pray for the pain to stop	1	2	3	4	5
6	I tell myself I can't let the pain stand in the way of what I have to do today	1	2	3	4	5
7	I do something active like household chores or projects	1	2	3	4	5
8	I replay in my mind pleasant experiences in the past	1	2	3	4	5
9	I pretend it is not a part of me	1	2	3	4	5
10	I feel I can't stand it anymore	1	2	3	4	5
11	I ignore it	1	2	3	4	5
12	I try to think years ahead, what everything will be like after I've gotten rid of the pain	1	2	3	4	5
13	I see it as a challenge and don't let it bother me	1	2	3	4	5
14	I do something I enjoy such as watching TV or listening to music	1	2	3	4	5

Thank You