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Original Research Article

EXPERIENCE OF PSYCHOLOGICAL PROBLEMS AND COPING STRATEGIES OF FAMILY CAREGIVERS OF PSYCHIATRIC PATIENTS IN NEUROPSYCHIATRIC HOSPITAL RUMUIGBO, RIVERS STATE

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ABSTRACT

Caregiving for a psychiatric patient is a demanding task involving family caregivers in a 24-hours' job with no rewards, sick leave or pay checks, and this has a negative impact on them. This study explored the experience of psychological problems and coping strategies of family caregivers of psychiatric patients in Neuropsychiatric Hospital Rumuigbo, Rivers State. A Hermeneutic phenomenological qualitative design was adopted for this study. This study involved 22 caregivers. An in-depth open-ended face-to-face interview was conducted on the caregivers who were selected purposively using a structured interview guide. Six steps thematic method of data was assumed which was supported by Nvivo Software version 12. The results were presented in themes, quotes and word cloud. The study consisted of two research questions that were answered with 25 sub-themes in all. It's revealed that most family caregivers are faced with psychological problems like embarrassment, emotional disturbance, loss of personal time, depression, sleep disturbance, sadness, and lack of productivity, rejection and fatigue. Coping strategies adopted by the caregivers were: support from family, support from church members, support from friends, relying on God, passive appraisal, acceptance and avoidance. It reveals that family caregivers had difficulty coping with psychological problems; however, they all use one form of coping strategy. Future intervention toward alleviating family caregiver's psychological problems may be connected to improving caregivers coping strategies. There is a need for family support groups to be created for assisting caregivers and advocating for the promotion of their cause in society.

Keywords: Experience, Psychological Problems, Coping Strategies, Family caregivers, Psychiatric Patients

1. 0 INTRODUCTION

Psychiatric disorders are common in human existence (Sharifi, *et al.,* 2015). They are of wide variations and affect all persons. According to Polanczyk *et al* (2015), psychiatric disorders are the third most leading cause of hospitalization with an estimation of 13.4% significant global burden. And 1 in 7 adults experienced a serious psychiatric disorder as estimated in the United State and more than 44 million persons are affected by the psychiatric disorders annually (Polanczyk*et al* (2015). Furthermore, Okyere (2015) reported that in developing and developed countries, more than 25% of individuals develop one or more psychiatric or behavioral disorder during their entire lifetime. Psychiatric disorder is managed not only in hospitals but in the community. Wan and Michael (2019) noted that modern management of psychiatric patients has shifted from institutionalization to community base care which involves family caregivers to participate in patient's care. According to Chorwe-Sunganiet al. (2015), family caregivers include parents, uncles, aunts, siblings, children, spouses, friends and significant others. Family care giving has been reported to be beneficial to patients and caregivers. For instance, family caregiver's involvement in treatment of a psychiatric patient is related to vital enhancements on symptoms and the quality of life, fewer in-patient admissions for the patients and reduced risk of relapse (Stuart *et al.,* 2019). Family caregivers support also accelerates patient's recovery, lowers the risk of death, and lessens dependency on medical.

India, Ethiopia, Malawi & Ghana (Raj *et al.,* Woldearegai& Das;Gonani, 2019; Ae-Ngibise *et al.,* 2015), in Nigeria however, there are few studies in this area of interest (Experience of psychological problems and coping strategies among family caregivers of Psychiatric patients in Psychiatric Hospital Rumuigbo, Rivers State). In the western part of Nigeria, a study of the stress on caregivers of patients with mental disorders was carried out (Ajibade*et al.,* 2016). This indicates that there is a dearth of literatures on the investigation of the psychological problems and coping strategies of the family caregivers especially in the Southern part of Nigeria where this present study was conducted. To this end, there is need to focus on the psychological problems of family caregivers and identifying the coping strategies using neuropsychiatric Hospital Rumuigbo Port-Harcourt, Rivers State as focal point.

Services, promotes medication adherence, and improve patient's interpersonal and family ties (Mohammed *et al.,* 2018). On the other hand, caregiving is a rigorous and challenging endeavor for a psychiatric sufferer that has negative impact on family caregivers (Aarti *et al.,* 2019).Woldearegai and Das, (2019) posited that the psychological problems experienced by caregivers includes blame, feeling of shame, frustrations, fear, anger, bad feelings, self-insult, losing respect, embarrassment, worry, loneliness, despairing, isolation, stigma and discrimination. It also includes problems such as stress, anxiety, depression, insomnia, poor social interaction and reduced life expectancy which give rise to denial and possibly early sickness and death (Remko *et al.,* 2016). In Nigeria, 68% of family caregivers experienced mild-moderate forms of psychological problems (Ajibade*et al.,* 2016). Thus, results from previous studies show that family caregivers need coping strategies to effectively provide care to their psychiatric relatives needing care. To deal with the psychological problems they experience, family carers use a variety of coping mechanisms (Pompeo *et al.,* 2016). Although, different approach may be involved in coping, the most prevalent coping mechanisms can be separated into two different categories;Emotion Focused Group, that seeks to reduce the psychological problems, negative emotional impact through fatalism, denial, event religion, avoidance and the second group is the Problem focused group which include coping with direct actions, that individuals undertake to change the problem. These include solving the problems or finding social assistance to reduce the psychological problems of caregiving (Rahmani*et al.,* 2019). Thus, it is practical to note that understanding the coping mechanisms used by family cares can be quite useful in assisting family caregivers in adapting to the psychological problems caused by caring for relatives living with psychiatric disorders. On the other hand, family caregiver's psychological problems have increasingly been documented; concept of psychological problems and the coping strategies among family caregivers is still vague.

Family caregivers play a significant role in the lives of psychiatric patients; studies confirm that involvement of family caregivers is also associated with significant improvements in symptoms and quality of life, a lower risk of relapse, and fewer inpatient admissions (Stuart *et al.,* 2019). However, prolonged period of Psychological problems has resulted in chronic stress that affect the caregivers' daily live and health (Vainganka r *et al.,* 2016). For instance, family caregivers were reported to have complained of psychological problems that affect their well-being as members of the society (Settiner i*et al.,* 2014). It is even more distressing in societies like Nigeria where family caregivers are discriminated because of notions that psychiatric problems are spiritual matters and the chances of spread of the illness to other member of the family is high.

2.0 METHODS

Research Design: A Hermeneutic phenomenological qualitative design was adopted for this study.

Study Setting

The research was conducted in Neuropsychiatric Hospital Rumuigbo Rivers State. It is located along the East West Road, Port-Harcourt. It was established in 1977 and was commissioned by the federal government. As the time of commencement of operation, accommodations were free, but in 1996 when the regime realized that patients from the neighboring States were withal benefiting more from the program, patients were required to pay from their pocket at a subsidized cost. The hospital is managed by the board of management, hospital management committee and the departments. The hospital building comprised of a male and female ward, emergency unit with bed capacity of forty-two (42); respectively. Also, it consists of consulting rooms, treatment room, (Strong room) and outpatient clinic. The clinic runs days are Tuesdays and Thursdays and offers the following services; general medical checkup, treatment adherence monitoring, home visit and follow up, health education, counseling activities and drug compliance. It comprises of a team of psychiatric doctors, dieticians, psychiatric nurses, general medical practitioners and nurse practitioners, medical social workers, pharmacist, medical laboratory scientist and supporting staff. Neuropsychiatric hospital Rumuigbo was selected for this study because it serves as a referral center for neighboring states Hospitals within and outside the state.

Population of the Study

The study population consisted of 326 family caregivers obtained from the hospital record both inpatient and outpatient in Neuropsychiatric Hospital Rumuigbo, Rivers state.

Sample Size

This study involves twenty-two (22) family caregivers. This was attained at data saturation at a point when no new information was obtained to replace the study and extra coding was not possible (Creswell, 2014).

Inclusion Criteria

These are characteristics that prospective participants must have if they are to be included in the study. Below are the inclusion criteria:

- Individuals who are 18 years of age and above and willing to participate in the study by signing the consent form
- Who understand and communicate in English language
- Who visited their psychiatric patients at least three to four times during the period of the studies

Sampling Technique

Purposive sampling was adopted for this study to recruit the twenty-two (22) participants for the research. Purposive sampling technique is a process of selecting a population on the grounds that they are able to give the required information in tackling the research problem (Burns & Groves, 2020).

Instruments for Data Collection

The researcher developed a semi-structured interview guide as the instrument for data accumulation in this study. The instrument was developed by the researcher in English being the official language of the state.

Methods of Data Collection

The objective of the study was explained to each participant by the researcher, and assisted by trained research assistant to each participant before the interview commenced and participants gave their consent with a written and signed consent form. The researcher interviewed the participant with the aid of an android voice recorder that lasted for about 30-45minutes with English language being the official language. A private room was used to conduct an in-depth open-ended face-to-face exploratory interview. Each participant was interviewed individually to ensure minimal disturbance and confidentiality of participant was highly maintained.

Method of Data Analysis

All interviews were fully transcribed, and thematic analysis process was adopted, following the six steps of thematic analysis for qualitative study (Creswell (2014),

Ethical Consideration

Permission: Ethical clearance letter was obtained from the research committee in Neuropsychiatric hospital Rumuigbo, Rivers state. Written and signed informed consent form clearly addressing and informing them, the purpose and benefit of the study.

3.0 RESULTS

The analyses of the results were represented in themes, subthemes, quotes and word cloud. The analyses of the results were represented in themes, subthemes, quotes and word cloud.

THEMES	SUB-THEMES
THEME-1: Psychological Problem	1. Feeling of being embarrassed 2. 2 Emotional Disturbance 3. Loss of Personal Time 4. Depression 5. Sleep Disturbance 6. Sadness 7. Lack of Productivity 8. Fatigue 9. Rejection 10. Burden 11. Sick 12. Restricting Oneself 13.Feeling of Pity 14. Feeling of Loss
THEME-2: Coping strategies	SUB-THEMES
	1: Support system from families 2. Support from church members 3. Support from friends 4. Relying on God 5. Passive Appraisal 6. Acceptance 7. Avoidance 8. Managing the Situation 9. Monitoring the patient 10.Going for therapy 11. Engaging in Discussion

Figure 1: Showing the themes and subthemes

Theme 1: Psychological Problem

What are the psychological problems experienced by family caregivers of psychiatric patients in Neuropsychiatric Hospital Rumuigbo, Rivers State?

Sub-Theme 1: Feeling of being embarrassed

More than half of the family caregivers are of the view that they face embarrassment as a result of having a family member who is a psychiatric patient in the hospital. One of the caregivers submitted that, she suffers social stigmatization". Another caregiver posited that I feel shame, where I am living, where I stay, people were looking as I was battling with the whole situation".

Figure 2: Word Cloud showing frequency of 'talking', 'stigmatize', 'ashamed', 'public' were terms mentioned by participant (n=22)

Sub-Theme Two: Emotional Disturbance

Findings from the interview were assigned the sub-theme 'emotional disturbance'. Majority of the family care giver maintained that they faced or are currently facing emotional disturbances as a result of having a family member who is a psychiatric patient in the hospital. One of the caregivers submitted that "you won't be comfortable and be moved to find a solution on how you can help to resolve the issue" having the feeling that a family member is having psychiatric disorder results to worrying and anxiety. Another family caregiver revealed that "It has affected us emotionally because I knew him right from time. I know how he was before this sudden change. So, any time I think about how he was before he manifested all these things it has affected the family. His sudden misbehavior".

Figure 3: Word Cloud showing frequency of the words 'think', 'comfortable', 'worried', 'pressure' were terms mentioned by participant (n=22)

Sub-Theme 3: Loss of Personal Time

Findings from the interview were assigned the subtheme 'loss of personal time'.

Almost half of the caregivers submitted that they have lost some personal time as a result of taking care of psychiatric patients. A caregiver maintained that "...like today now I have somewhere I was about to go, but when they told me that I need to suspend it". "I won't be able to meet up to where I suppose to be today. So as a person, to my family, If I have in mind a little gathering, I would not be able to do that again because I've taken today to bring them to this new thing. So as a person, it won't be that easy because if she was normal, I won't be here". Other caregivers submitted that she did not actually enjoyed her teenage experience because of her sick parents, Ididn't go for prayers, church activities, I will have to stay back and watch her "I was not able to read, always looking after her". Another family caregiver expressed her view that "have no time to pursue my personal things especially my business"

Figure 4: Word Cloud showing frequency of the words 'time', 'personal', 'suspend' were terms mentioned by participant (n=22)

Sub-Theme 4: Depression

Almost half of the participants interviewed are reportedly facing depression as a result of having a family member who is a psychiatric patient in the hospital. A family caregiver posited that: "…even when we are going to work, we are not happy, as we are coming back, we are thinking, what would have happened again". as regards the behavior of the psychiatric patient and the depression the family members faced, a caregiver asserted that "Sometimes he would just come and be displaying in front of your friends and you now as a man, sometimes bring women to your house, all those things make me feel depressed.

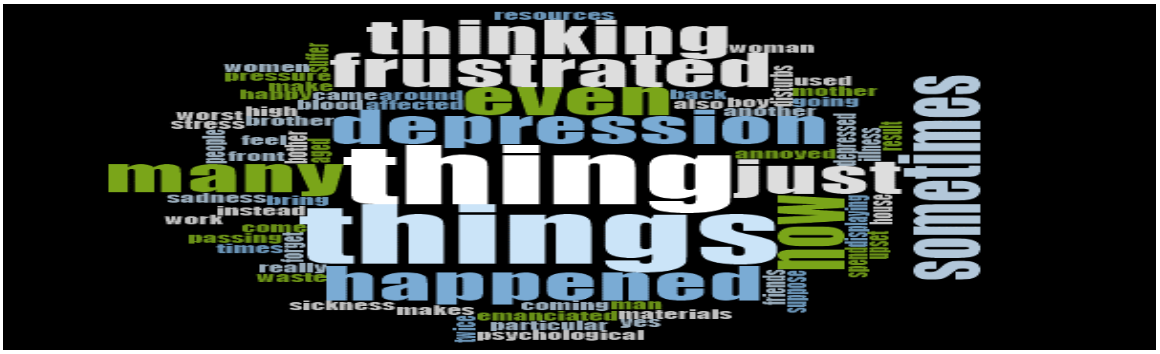

Figure 5: Word Cloud showing frequency of The words 'frustrated', 'depression', 'feeling', 'were terms mentioned by participant(n=22)

Sub-Theme 5: Sleep Disturbance

Findings from the interview were assigned the subtheme 'sleep disturbance'. Eight caregivers submitted that they had sleep disturbance as a result of caring for the psychiatric patients. One of the caregivers submitted that they have sleep disturbance because of caring for the psychiatric patients. "that problem is that sometimes you might not be able to sleep well, having sleepless nights, any time you remember".

Another submitted that "I've not been sleeping well like that because there are times, he himself will not sleep and if he is not sleeping nobody will have to sleep. Making noise throughout, sometimes throughout the night, sometimes throughout the night we should not sleep because we will be making noise singing and because of that we won't be able to sleep".

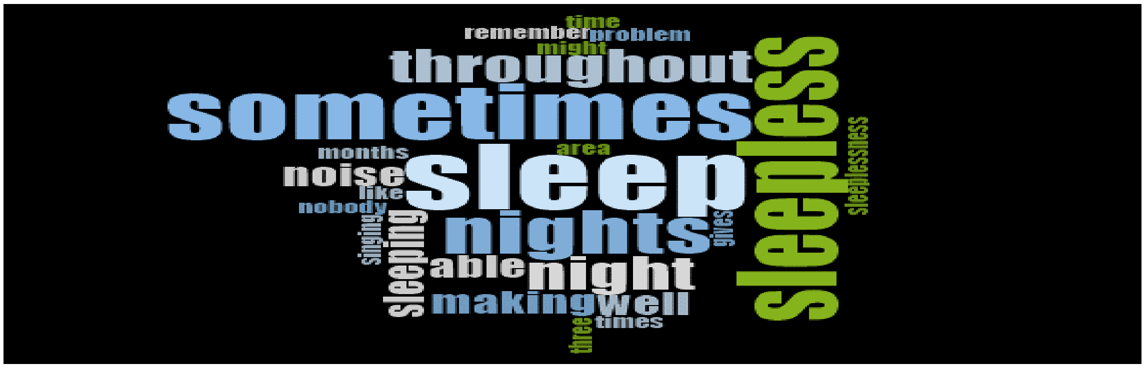

Figure 6: Word Cloud showing frequency of The words 'nights', 'sleeping', 'throughout', 'sleepless' were terms mentioned by participant(n=22)

Sub-Theme 6: Sadness

Findings from the interview were assigned the subtheme 'sadness. Five caregivers submitted that they became sad as a result of caring for their psychiatric patients. One of the caregivers reported that:"l was so sad". This showed the condition of the family caregivers. Also, a caregiver submitted that: I can never be happy seeing her like this

Sub-Theme 7: Lack of Productivity

Six caregivers maintained that they were not productive during the period of taking care of the psychiatric patient. One of the caregivers asserted that "It reduces productivity of my work"other caregivers maintained that "It makes me not to go for my routine, day to day activities. I stopped doing it for some time. I'm not going to leave her because I'm the only person close to her though my people are not able to stay with her, I'm the only one staying with her for some months now".

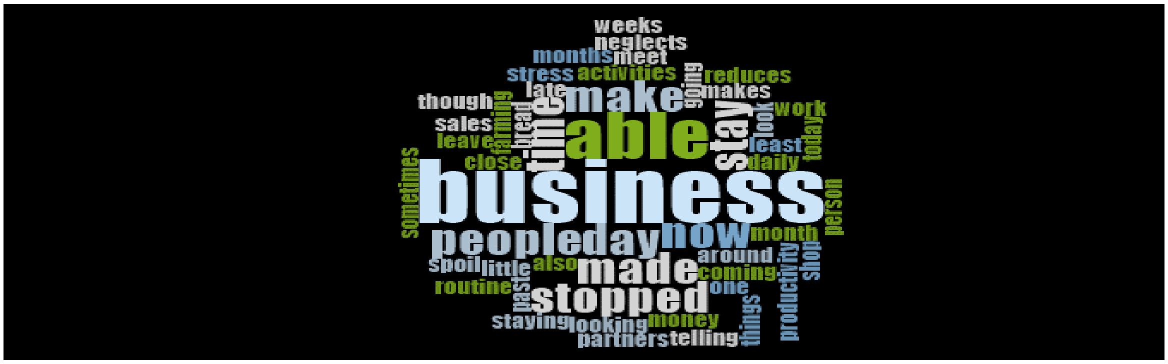

Figure 7: Word Cloud showing frequency of 'business', 'stopped', 'neglects', 'reduces' were terms mentioned by participant(n=22)

Sub-Theme 8: Fatigue

Findings from the interview were assigned the subtheme 'fatigue' Three family caregivers interviewed submitted that they had fatigue that came as a result of taking care of a family member who is a psychiatric patient in the hospital. One of the care givers complaints of "Serious headache ". A female caregiver asserted that she is always tired because of the time she spends taking care of the patient. She explained that: "I have not been able to do anything because I am always tired".

Sub-Theme 9: Rejection

Findings from the interview were assigned the subtheme 'rejection'. Five caregivers admitted that they received rejection from friends and family throughout the period of them caring for the psychiatric patients. One of the caregivers when interviewed asserted that "It's just that the apartment where we stay, our landlord recently said that we should take him out of compound, we should take him to the village so he won't spoil something. So, it has affected us". Some of the caregivers maintained as the extended family became aware of the psychiatric patient, they that, they were disserted because it was a taboo for the family. Another caregiver asserted that "Some other members of the family are running away from him thinking that it is a family problem”.

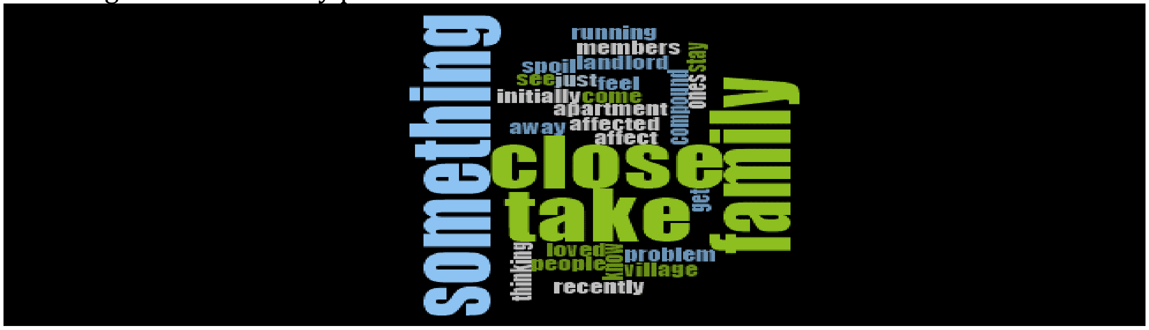

Figure 8: Word Cloud showing frequency of the word ‘running’, ‘away’, ‘take’ were terms mentioned by participant (n=22)

Sub-Theme 10: Burden

Five of the caregivers narrated their ordeal on the burden they face taking care of the psychiatrist patient, a caregiver explained that the family could not cope during the period. She narrated that: “We don’t; there’s no how we would cope well, even if ordinary sickness or normal headache, we don’t, we would be looking for help from the pharmacist, doctor or whoever that would help”. Another caregiver posited that the situation is a sacrifice the family needs to make for the sake of the patient. “It doesn’t disturb me. I take it as a cross like something you can do for somebody”.

Sub-Theme 11: SICK

Two of the caregivers did not know what to do as soon the psychiatric patient starts manifesting mala-adaptive or emotional behaviors. One of them asserted that: “Because I always feel since he is sick, I don’t know what will happen the next morning” Another caregiver expresses uncertainty about the behavior displayed by the psychiatric patient: “The children that were attending school can no longer go to school again”.

Sub-Theme 12: Restricting Oneself

Some of the caregivers believed that the situation requires restricting oneself from other activities in order to cater for the patient. The female caregiver submitted that: “The only issue I am having is restricting myself from my job ”another put forward that” “It made me not to go anywhere”

Sub-Theme 13: Feeling of Pity

Findings from the interview were assigned the theme ‘feeling of pity’. A caregiver maintained that they felt pity when one of their family members started showing signs of psychiatric behavior. she maintained that “Though I might pity them, I might feel sorry but the effects, I'm sorry there's nothing I can do about that for him”.

Sub-Theme 14: Feeling of Loss

The subtheme from the interviews of caregivers on the psychological problems the family caregivers undergo as a result of caring for the psychiatric patients. Findings from the interview were assigned the theme ‘feeling of losses’. One of the caregivers submitted that they felt a deep absence of patient when she started showing some signs of psychiatric behavior.

Theme 2: coping strategies

What are the different coping strategies employed by family caregivers of psychiatric patients in Neuropsychiatric Hospital Rumuigbo, Rivers State?

The twenty-two participants interviewed showed emergence of eleven sub-themes under theme two explaining the coping strategies utilized by family caregivers of psychiatric patients in neuropsychiatric hospital Rumuigbo were: Support from family, friends, church members; relying on God; passive appraisal; acceptance; avoidance; managing the situation; monitoring the patient; going for therapy; and engaging in discussion (Communication)

Sub-Theme 1: Support system from families

Majority of the caregiver interviewed pointed out that they receive social support from their families. One of the participants submitted that “Only his siblings and his mum have been helpful” another participant admitted that “Yes, families are there, everybody is helping out, and all hands are on deck. They try to see who can at any time feel good to watch over her, then we send her to school, she works with therapist, when she’s out of school, at home, we try to ensure that someone is always at home to stay with her so that she doesn’t leave the house, or she doesn’t get bored, because if she gets bored, she might start crying or she gets too excited she might start hitting anyone. She has this younger sister who can take care of her”.

Figure 9: Word Cloud showing frequency of the word ‘family’, ‘members’, ‘brother’ and ‘help’ take’ were terms mentioned by participant (n=22)

Sub-Theme 2: Support from church members

Findings from the interviews revealed the sub-theme ‘support from church members. Majority of the caregivers interviewed pointed out that they received one form of social support in form of donation, gift and prayers from church members. One participant submitted that “Yes our church organization, Jehovah Witness, they altered prayers and sympathized and they helped in their little way”. Similarly, another participant admitted that: “Social support was from church. One Lady, use to come and carry him and take him to church, try to make him go to church”. Another admitted that “The church group, that supports so the family don’t really care because they don’t have much. It’s only the church that cares. The charity organization. It’s the charity organization of the church, the catholic church that takes care of her, that takes care of everything all their bills, the feeding, everything about them. Yea. This is why they are here. It is them that brought them here”.

Figure 10: Word Cloud showing frequency of the words ‘church’, ‘prayers’ were terms mentioned by participant(n=22)

Sub-Theme 3: Support from friends

Five of the caregivers pointed out that they received one form of social support from friends and well-wishers. One of the participants submitted that “There was help from outsiders, like the day we carried him here, somebody gave us her car, and fill it with fuel, and another person volunteered to give us N30000". Also "I see that the friends they were learning work together contributed money and gave the family". "The oga of the work contributed some money and gave to us".

Figure 11: Word Cloud showing frequency of the words 'church', 'friends', 'people' were terms mentioned by participant(n=22)

Sub-Theme 4: Relying on God

Findings from the interviews revealed the Sub-theme 'relyi.ng on God' one of the family caregivers pointed out that as a way of coping strategy; they backed their faith in God with the traditional medicine. Other participants submitted that: "if you think is spiritual too, Africans believes things are spiritual, go to church, and back it up with your faith, with the Orthodox medicine". Another participant explained her ordeal that the situation of her ill relative has increased her faith: "Faith in God; we have attended up to 30 churches, this has increased my mother's faith". Another participant submitted that "We use God to encourage ourselves, we pray and read Bible. I am a Jehovah witness. That Jehovah God will solve it and he has solved it for us".

Sub-Theme 5: Passive Appraisal

More than half of the caregivers maintained that they use passive appraisal as a coping mechanism. One of the participants asserted that: We are managing it, if we go to were people don't know us, we feel free. we tell ourselves that it's not his portion, we encourage ourselves, if you're like this that would end up too in life others who have seen him would have to sit up and learn. So, we try to learn from what have happened to him". Another submitted that: "I have learnt the fact that where there is life, there is hope and since from experience, I have seen people who suffered this and still lived their lives normal till their old age. We ignore some things. I wouldn't allow her nasty behaviour".

Figure 12: Word Cloud showing frequency of words 'time', 'believing', 'encouraging', 'hope' were terms mentioned by participant (n=22)

Sub-Theme 6: Acceptance

Findings from the interview revealed the sub-theme 'acceptance'. Nine of the caregivers maintained that accepting the psychiatric patient is one of the means they cope with the situation. One of the participants asserted that: "She's accepted totally, we involve her in everything we do, even when we have session to conduct in the house, she has her own session to conduct no matter how she manages with it, she's just integrated into the system. They go for the child and do the best they can do for the child because basically what they need is love and care, if they know that they're loved, it helps them to cope better too". Similar submission was made by another family caregiver which states that "Those who are his friends before he became sick still come close to him, the family members and villagers still come close to him"

Figure 13: Word Cloud showing frequency of words 'love', 'close', 'relate', 'accepted' were terms mentioned by participant(n=22)

Sub-Theme 7: Avoidance

Family caregiver used avoidance as a way of coping with the psychiatric patient. Explaining how avoidance is used as a coping strategy, one of the family caregivers maintained that "Isolation, people tried to avoid the people, they tend to generalize it to the whole family, they avoid us, and we tend to stay in our home so there won't be issues of victimization". Other participants admitted that: "My father now has the feeling that these children are already useless because of the mistake one person made".

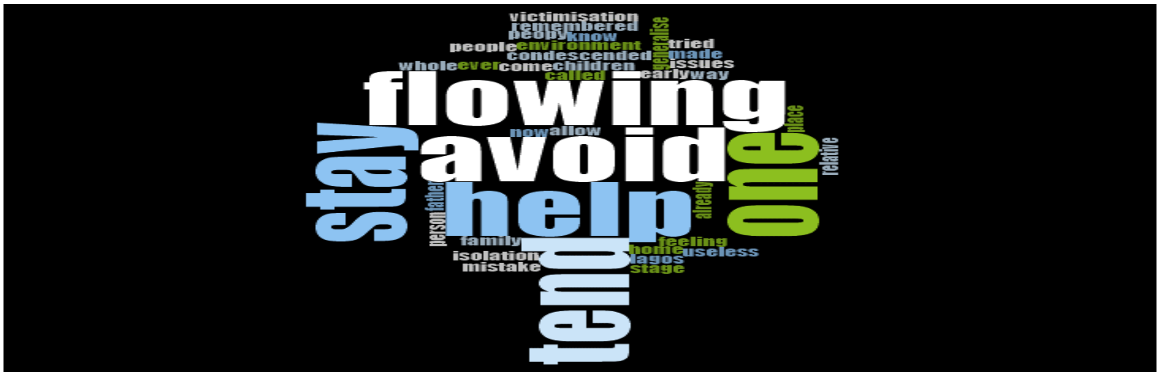

Figure 14: Word Cloud showing frequency of words 'avoid', 'flowing', 'isolation', were terms mentioned by participant (n=22)

Sub-Theme 8: Managing the Situation

One of the family caregivers explained that they managed the psychiatric situation the way it is. Another admitted that "So, if you try the one you could and the one you could not, don't carry it on your head, because that causes a lot of stress. Try to manage that stress so it won't accumulate in your body".

Sub-Theme 9: Monitoring the patient

Findings from the interviews revealed the sub-theme 'monitoring the patient'. One of the family caregivers posited that as a way of coping strategy, they monitor the situation of the psychiatric patient. Another admitted that admitted that: "My mother confides herself to one place and be monitoring the boy's movement regularly, as soon as he goes out, she follows him to question his movements".

Sub-Theme 10: Going for Therapy

The emerging sub-theme from the interviews of caregivers on the coping strategy employed by family caregivers of psychiatric patients in Neuropsychiatric Hospital. Findings from the interviews revealed the theme 'going for a therapy session'. One of the family explained that the family cope by taking the patient to see a therapist. Another submitted that submitted that:

"At least she goes for her therapist session where she's being helped to cope with her day to day life".

Sub-Theme 11: Engaging in Discussion

Findings from the interviews revealed the subtheme 'engaging in discussion' (communication). One of the family explained how communication is used as a coping mechanism with the psychiatric patient, the family caregivers submitted that "My mum has a way of calming him down, when he wants to start talking anyhow, she will always engage him in discussion, I don't have his time, my mum tried to talk to him, make him feel the belonging".

4.0 DISCUSSION

The study revealed a wide spectrum of psychological difficulties faced by family caregivers, most prominently experiences of embarrassment and emotional disturbance, sleep disruption and depressive symptoms, loss of personal time and reduced productivity, fatigue accompanied by somatic complaints, social rejection and withdrawal, as well as feelings of burden, uncertainty, pity, and loss. These findings align with earlier reports from a variety of contexts and underscore the role of sociocultural dynamics in shaping caregiver experience in the Niger Delta.

The prominence of embarrassment, shame, and emotional distress in this cohort mirrors evidence from other low- and middle-income countries where stigma constitutes a central feature of caregiving (Woldearegai & Das, 2019; Ebrahimi et al., 2018). In settings where mental illness is interpreted through spiritual or moral frameworks, caregivers are often exposed to shaming or social devaluation. Our data reinforce the interpretation that stigma acts as a significant driver of psychological strain. Similarly, the prevalence of depressive symptoms and disturbed sleep recalls findings from India and Hong Kong, where caregivers reported moderate-to-severe depression and insomnia attributed to continuous vigilance and persistent worry (Aarti et al., 2019; Wan & Wong, 2019). The narratives of our participants—describing themselves as "overcrowded with thought of responsibility throughout the night"—are strikingly consistent with these earlier accounts, pointing to chronic hypervigilance and rumination as mechanisms underlying poor sleep and mood disturbance.

The themes of diminished productivity and loss of personal time were also pervasive, resonating with literature documenting the erosion of employment, farming, and small business activities under the weight of caregiving responsibilities (Klevan et al., 2016; Raj et al., 2016). Within Nigeria, previous studies have identified elevated rates of caregiver psychological distress (Ajibade et al., 2016), further supporting the view that disruptions to occupational and social roles contribute to caregiver burden nationally. Reports of fatigue, headaches, and persistent tiredness similarly corroborate global evidence that chronic caregiving is linked to heightened stress physiology and deteriorating physical health (Remko et al., 2016; Vaingankar et al., 2016).

Social rejection and isolation also emerged as salient concerns, with some caregivers describing avoidance by relatives or friends. Comparable findings have been documented in Iran and Namibia, where abandonment and social exclusion were common experiences among caregivers (Ebrahimi et al., 2018; Shifiona, 2014). Expressions of burden, uncertainty about the future, and curtailed personal activities echo studies from India and Ethiopia that distinguish both objective and subjective dimensions of caregiver strain (Raj et al., 2016; Woldearegai & Das, 2019). Taken together, these parallels suggest that although sociocultural frameworks shape the visibility and interpretation of distress, the underlying experiences—stigma, emotional exhaustion, disruption of roles, and social withdrawal—are widely shared across settings.

Turning to coping strategies, participants reported a diverse set of responses that align with established typologies of emotion-focused and problem-focused coping. Social support—particularly from relatives, friends, and religious communities—was a central resource. Many caregivers described receiving prayers, donations, and practical assistance such as help with hospital visits or bills from church members. These accounts are consonant with studies from Tanzania and Ghana that emphasize the salience of familial and faith-based support in caregiver adaptation (Iseselo et al., 2016; Ae-Ngibise et al., 2015). Other reported strategies included passive appraisal, reliance on faith, acceptance, and avoidance—forms of emotion-focused coping consistently noted in prior work (Ong et al., 2016). At the same time, some caregivers actively sought therapy, initiated conversations with peers, or involved patients in meaningful activities. These problem-focused approaches have been associated with more adaptive outcomes in other cultural contexts (Ong et al., 2016; Aarti et al., 2019).

Importantly, our findings also underscore variation in the availability of formal supports. While many participants benefited from dense informal networks, this contrasts with evidence from other settings where caregivers lack both institutional and communal supports (Ebrahimi et al., 2018; Shifiona, 2014). The observed reliance on churches and faith-based organizations as surrogate social safety nets highlights both opportunity and inequity: collaboration with these institutions may strengthen caregiver interventions, but households without such ties remain disproportionately vulnerable.

Several limitations of this study warrant emphasis. The single-site, qualitative design restricts generalizability beyond the sampled neuropsychiatric hospital and may not capture the experiences of community-based caregivers. The purposive and relatively small sample, while appropriate for qualitative depth, introduces the risk of selection bias, as those who access hospital services or consent to interviews may systematically differ from those who do not. Data derived from interviews are also susceptible to recall and social desirability biases, and interviewer effects cannot be excluded. Moreover, the cross-sectional nature of the study provides only a snapshot of caregiver experience and cannot illuminate how burdens and coping strategies evolve over time. These constraints counsel caution in inferring prevalence rates or causal pathways. Despite these limitations, the findings carry significant implications for clinical practice, health policy, and future research. At the facility level, hospitals should institutionalize caregiver-inclusive policies. This may include routine screening for depression, anxiety, and sleep problems; integration of caregiver needs into patient care planning; establishment of support groups and psychoeducational sessions; provision of stress-management workshops and respite opportunities; and stronger referral to social work and financial counseling services. Training curricula for health professionals should incorporate modules on family engagement, stigma reduction, and effective communication with caregivers.

At the community and governmental levels, it is imperative that mental health policies explicitly recognize caregivers as a target group requiring support. Potential measures include subsidized care or transport for low-income households, social protection schemes or stipends for heavily burdened caregivers, investment in community-based mental health services, and public anti-stigma campaigns involving religious and traditional leaders. Partnerships with churches, mosques, and NGOs could be formalized to mobilize existing networks while addressing inequities in access to such supports. Further research is needed to extend and refine these findings. Larger, multisite, and longitudinal studies are required to capture variation across rural and urban contexts and to track how caregiver distress and coping evolve over time. Mixed-methods approaches incorporating validated quantitative measures of burden and mental health outcomes would provide stronger empirical foundations. Intervention trials—testing caregiver psychoeducation, peer-support groups, or brief culturally adapted psychosocial therapies—are particularly necessary to establish what works in the Niger Delta and comparable settings.

Finally, this study corroborates a substantial body of international evidence on caregiver burden while highlighting locally specific patterns, particularly the centrality of stigma and the reliance on religious networks. Addressing caregiver needs requires both structural policy responses and context-sensitive interventions that acknowledge these realities while ensuring equitable support for all families.

5.0 CONCLUSION

It is important to understand the influence and complexities that caregiving has on family caregivers. This study represents an attempt to better understand the family psychological problems and coping strategies of family caregivers of psychiatric patients in Rivers State. Psychological problems are recognized among caregivers in this present study. This study also noted that some families' caregivers have greater difficulty in coping with these problems; however, they all use one form of coping strategies. Future intervention toward alleviating family caregiver's psychological problems may be best served by improving caregivers coping strategies through established government support system and educational training programs.

Recommendations

The presence of psychological problems among family caregivers cannot be denied as majority of persons with psychiatric illness are cared for by these persons. Based on this, the following recommendations are made:

1. There is a need for family support groups to be created for assisting caregivers and advocating for the promotion of their cause in society.
2. Proper education for all nurses involved in the management of not just the patients but also the family caregiver is important.
3. Nurses should actively participate in improving the psychological wellbeing of the family caregivers particularly at a community level.
4. Dedicated effort is needed by psychiatric centers to increase awareness of coping strategies of psychological problems among family caregivers.
5. Multi-centered research is recommended to advance the exploration the experience of caregivers along with the possible benefits from training caregivers in the use of necessary coping skills.
6. Government guidelines and legislature and approval are needed for establishment of social support centers for family caregivers of psychiatric patients.

Future Direction: It is recommended that more elaborate studies should be explored among family care givers experience of psychiatric patients in Nigeria

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