Self-Stigma, Depressive Symptoms and Coping Strategies among Care Givers of Children with Mental Disorder in Uganda

By

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Declaration

This work is my original work and no part of this thesis has been presented for a degree in any other university / Institution of learning. No part of this thesis or all of it should be duplicated or used without permission of the author, supervisor or Makerere University.

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Declaration by the Supervisors

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Dedication

To all caregivers of children with Mental disorders.
Abstract

People with mental disorder suffer from stigma in addition to the illness itself; their caregivers also suffer from stigma of having a child with mental disorder. The study examined the levels and associations between self-stigma, depressive symptoms and nature of coping strategies adopted by caregivers of children with mental disorder who attend Children and adolescence mental health unit at Butabika Hospital. A correlational study design with quantitative data collection method was used. One hundred and forty-one (N=141) caregivers of children with mental disorder participated in the study. Self-stigma was measured using affiliated Stigma scale, while depressive symptoms was determined using Patient Health Questionnaire (PHQ-9) and brief cope for nature of coping strategies.

Using the statistical package for social sciences (SPSS version 20.0) descriptive statistic was used to determine the levels of self-stigma, depressive symptoms and nature of coping strategy. Spearman correlation was used to determine relationship between variables. A significant relationship was found between self-stigma and depressive symptoms (p< 0.05) and between depressive symptoms and nature of coping strategies (p< 0.05). However, there was no statistical significant relationship between self-stigma and coping strategies (p>0.05). Further analysis using chi-square was done to establish existing association, and this revealed that caregivers of children with mental disorder are more likely than the general population to suffer self-stigma and depression; and used dysfunctional coping strategies in dealing with the challenges. Professional, government support, and public awareness of mental illness are important in addressing the challenges facing these caregivers.
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Chapter One
Introduction

This chapter entails background information, statement problem, purpose of the study, objective, research questions, significance of the study, scope of the study and conceptual framework.

Background

Mental illness is highly stigmatizing not only to the individuals who suffer from it but also to those related to them and caregivers (Dehnavi, Malekpour, Housing, & Talebi, 2011). Matters get worse for the caregivers if the person is a child. Stigma is a social process, experienced or anticipated and is characterized by exclusion, rejection and blame or devaluation of a person or group (Bifftu, Dachew, & Tiruneh, 2015). Furthermore, self-stigma is the internalization of public stigma that applies to corresponding stereotypes and prejudices to self (Corrigan, 2005). Self-stigmatization exists among caregivers following association with their loved ones with mental disorder (Ssebunnya, Kigozi, Lund, Kizza & Okello, 2009). Apart from the stigma, families with members suffering from mental disorder face a number of stressors that they have to cope or deal with (Kate, Grover, Kulhara, & Nehra, 2013). These stressors include things like diagnosis of mental disorder, changes in economic and social status, the individual’s inability to meet his/her daily tasks and uncertainties that the disease will ever be cured (Caqueo-Urízar, Miranda-Castillo, Lemos-Giráldez, Maturana & Ramírez, 2014).

In Africa, mental illness is believed to be a curse by evil spirits, ancestor’s spirit or evil eye (Bifftu, Dachew & Tiruneh, 2015), or a family having committed crimes against forefathers therefore the family is being punished (Terre des Hommes, 2007). All these creates tension and keeps the family and the caregivers in particular, not only in a state of worry and sadness, but also
that of self-stigmatizing. Perceptions of stigmatizing attitudes by the public toward mental health care are known to hinder care seeking or treatment (Ngugi, Bottomley, Kleinschmidt, Sander & Newton, 2010). Individuals affected are kept at home and their diagnosis kept secret (Bifftu, Dachew&Tiruneh, 2015), due to discrimination and ostracism/excluded from the community or societies (Nyamongo, 2013). As a result, the caregivers often fail to seek help from health care facilities but instead go to religious and traditional healers (BifftuDachew&Tiruneh, 2015). Care giving can often have great health impacts to caregiver.

Apart from Self-stigma, caring for a child suffering from mental disorder places emotional demand on the caregiver. And this may lead to development of health consequences to a caregiver, thus leaving the caregivers feeling very low in their spirits and confused. This has been observed to affect caregivers in several domains of their life especially mental health status which may lead to depression (Cappe, Wolff, Bobet, & Adrien, 2011). Depression is a psychological disorder characterized by at least two weeks or more of depressed mood or loss of interest which cause significant distress to individual and impairment in social or occupational functioning (DSM -V 2013). Depression has been found to be one of the ten leading worldwide causes of disability in high, middle and low-income countries, (Saxena, Paraje, Sharan, Karam&Sadan, 2006). And it has been estimated that the burden from depression alone is likely to increase to the single biggest burden of all health conditions by 2030 (Lopez, Mathers, Ezzati, Jamison & Murray 2006). A study on prevalence of depression in 2015 was estimated to be 4.4% (WHO, 2015). Depression is characterized by the following symptoms like loss of appetite, sadness most of the time, loss of sleep, weight and loss of pleasure. Such depressive symptoms are common among people who take care of children with mental disorder. Depressive symptoms is a disorder that involves the physical, emotional, and thoughts. It interferes with the way an individual feed, rest (sleeps), feels
about oneself, and the way one processes things mentally (Anyango, 2015). Studies have shown that depression is one of the most common illness among caregivers with a prevalence of 30 –59 % experiencing depressive symptoms (Family caregivers, Fact sheet, 2016). From my own observation caregivers of children with mental disorder at Butabika Hospital in Uganda present with depressive symptoms and go undiscovered, if noticed little or it’s never attended to professionally. When children are taken to the hospital by caregivers much of the concentration is to the children and little or nothing is done to the caregiver. However, caregiving of a child with mental illness does not always give rise to depression or not all caregivers go through negative feelings in caregiving, simply because, caregivers tend to look for coping mechanism or ways of dealing with the situation, which may be adaptive or maladaptive (Ong, Norhayati, & Wahab, 2016).

According to Smirth et al, (2008), coping is trying to overcome something that is causing stress and may refocus the significance associated with the difficulties, guide individual’s life and keep him or her physically, psychologically and socially healthy. Caregivers cope using either adaptive or maladaptive. The maladaptive coping strategies have been proved to be a major barrier to the care and treatment for a relative with a mental health problem (Zafar, 2015). Zafar found that, parents/caregivers are badly affected by the stressful events in their lives which leads to delay in diagnosing/ identification and treatment of their children’s condition. In other situations, caregivers give restrictive measures like over medication and/or application of brakes to their wheel chairs (Terre des Hommes, 2007).

Globally it is estimated that 10-20% of the world’s children and adolescence suffer mental illness at any developmental stage in their life posing a significant concern (Kieling et al., 2011). Children are always in company of caregivers. And Studies have shown that 14% of children in
sub-Saharan Africa suffer from some type of mental illness or psychopathology (Cortina, Sodha, Fazel, & Ramchandani, 2012). In Uganda’s National Referral and Teaching Mental Hospital Butabika (Butabika Hospital), the children and adolescent who attend mental unit were approximately 120 with psychopathologies in the out-patient (Hospital records) during clinic days. These children are always in company of their caregivers (personal observation), but what is not clear is whether these caregivers experience self-stigma and depressive symptoms as established elsewhere. As already indicated, caregivers’ strain has implications for children’s entry into mental health services, engagement with medical professionals, adhering to recommended interventions, and service use patterns while in treatment programs (Meltzer, Ford, Goodman, & Vostanis, 2011).

In Uganda and East Africa as a whole, there scanty literature regarding the care-givers of children and adolescents with mental illness.

**Statement Problem**

Having a member of the family with mental illness is highly stigmatizing more especially if the person is a child or adolescent. This is often associated with Self-stigma among caregivers. These in turn affect the care given to the children, which often may not only affect the quality of care given to the children but may further create a vicious circle of strain to the caregiver and the family as whole leading to clinical significant distress or impairment in social, psychological or other important areas of care giver. Perlick, and colleagues (2007), found that self-stigma may have negative implication to careers mental health and in turn may lead to depressive symptoms, hence affecting their way of coping or dealing with the challenges. Hence, there is need to understand what the caregivers of children with mental illness attending Butabika hospital go through and how they cope or deal with such experiences. A lot has been done in Uganda on self – stigma (Ssebunnya et al, 2009) and depressive symptoms (Hartley’s, 2005) among caregivers of
children with mental illness. But there is scanty literature on studies of coping strategies and relationship between the variables under study among caregivers in the clinical set up in Uganda.

**Purpose of the Study**

To establish relationship among self-stigma, depressive symptoms and nature of coping strategies adopted by the caregivers of children with mental disorder at Butabika Hospital.

**Specific objectives**

1. To establish the levels of self-stigma, depressive symptoms and nature of coping strategies among caregivers of children with mental illness attending Butabika Hospital.
2. To examine whether there is a significant relationship between self-stigma and the depressive symptoms among caregivers of children with mental disorder attending Butabika Hospital.
3. To establish relationship between self-stigma and coping strategies among caregivers of children with mental disorder attending Butabika Hospital.
4. To establish relationship between depressive symptoms and nature of coping strategies among caregivers of children with mental disorder attending Butabika hospital.

**Significance of the Study**

The findings of this study shall be used by social workers, counsellors and psychologists in the care and follow up of children with mental disorder. The children with mental illness and their relatives will also benefit from new psychological intervention that will be developed and financial implication shall be reduced and careers will have improved coping strategies. Furthermore, the findings shall inform other stake holders like the government in establishing appropriate rules that will govern the treatment and prevention of mental health problems among children and adolescents. Lastly, this study will contribute to the body of scientific knowledge in
the field of mental health as a basis of other studies in the field. It will also be used by students at Butabika Hospital and Makerere University.

**Scope of the Study**

The study was confined to care givers of children with mental illness who attend Children and Adolescent Mental Health Unit (CAMHU) at Butabika Hospital. In this study a caregiver is defined as an individual who may be a friend or family member who stays closely with a child with mental disorder in his or her social interaction, activities of daily living and health care. The caregivers should be one with 18 years and above and understands English. While a child is defined as any female or male person who is below 18 years as defined by the Ugandan constitution. The hospital was chosen specifically because it is a National Referral Hospital with a high number of patients referred from different hospitals in the country. This research has specifically focused on the nature of self-stigma like rejection, self-blame and devaluation. Depressive symptoms like loss of appetite, sadness most of the time, loss or gain weight, loss of interest of things that previously gave pleasure, loss of sleep among the caregivers and nature of coping strategies like use of dysfunctional coping, problem focus and emotional focus used by the caregivers in coping with the challenges.
Conceptual Framework

Figure 1

Self-stigma, Depressive Symptoms and Coping Strategies

Having or taking care of a child/adolescent with mental illness, may give rise to depressive symptoms like lack of motivation, feelings of hopelessness or helplessness, sadness and others (Bababola, et al. 2014). Apart from the depressive symptoms, being a care giver to mentally sick child/adolescent may also give raise to self-stigma (Dehnavi, et al, 2011) which is characterized by feelings of self-devaluation, exclusion/isolation, rejection and self-blame. The felt stigma may in turn trigger off depressive symptoms as well. The care giver in order to deal or cope with such stressors may employ some coping strategies, which may include: Problem focused coping strategies.
strategies (like active coping, instrument support and planning), dysfunctional coping strategies (namely substance use, self-distraction, denial, self-blame, behavioral disengagement, and venting) and/or emotional focused coping strategies (like emotional support, positive reframing, acceptance, religion and humor). Collectively self–stigma and depressive symptoms may affect individual coping strategies resources by eroding (Perlick 2007). It is important to understand that the level to which caregiver may cope is defined by other extraneous factors for example financial levels or social status. And these determines the quality of care that will be given to the children.
Chapter Two

Literature Review

Introduction

This chapter is concerned with reviews of different literature pertaining the study from different sources which includes books, journals, conference proceeding that have been researched by different researchers. It is organized according to the various objectives of the study; levels of Self-stigma, depressive symptoms and nature of coping strategies, relationship between Self-stigma and depressive symptoms, Self-stigma and coping strategies, and depressive symptoms and coping strategies.

Overview

Care giving is understood as a changing process that caregivers go through across the course of care (Oyebode, 2005). A caregiver in this study is defined as an individual who may be a friend or a family member who has been always staying with a child with mental illness in his or her social interaction, health care and activities of daily living, (Ranjan & Kiran, 2016). While a child is defined as any female or male person who is below 18 years as defined by the Ugandan constitution (Chapter 59, part II, 1997). Care giving has undefined responsibilities that needs more effort in performing the tasks. Caregivers go through a number of difficulties in the course of care giving for example physical strain, emotional difficulties and self – stigma caused by loss of functionality of the child causing some impact on the caregiver’s mental health (Kudlicka, Clare &Hindle, 2014).

Care giving is a stressful responsibility that may adversely affect caregiver’s psychological/mental state (Brodaty, Woodward, Boundy, Ames, &Balshaw, 2014). Moreover, the strain experienced in caring for a child with mental disorder may result in psychiatric problems,
for example depression, as observed by Capistrant, Berkman, and Glymour (2014). Persons with mental illness experience stigmatization following their impairments or affected areas for example disruptive behavior, incontinence or poor self-care. Stigma affects not only individuals with mental illness but also extends or spills over to their relatives who are caregivers (Simon & Schuster, 2009) which may give rise to self-stigma. Self-stigma is the internalization negative feeling about self and perceived prejudices, (Bos, Pryor, Reeder and Sutterheim 2013).

However, in Uganda it is encouraged to have children with mental illness managed by their caregivers at home unless they are critically ill, Nakigudde et al, 2016). And such stressful demanding responsibilities contribute to caregivers’ distress rendering such caregivers too busy to have time for others and self. This in the long run generates self-stigma. There is little documented literature about association between self-stigma, depressive symptoms and coping strategies among caregivers.

**Self-Stigma and caring for the mentally sick**

Stigma may affect an individual’s general way of presentation in her or his daily way of performance. Mental illness is highly stigmatizing and not only to the patient but to relatives and caregiver, (Dehnavi, 2011). Mental illness is always associated with self-stigma among careers who relate with stigmatized group. The existence of self-stigma among caregivers results into caregivers feeling rejected, isolated and devalued (Barke, Nyarkos & Klecha, 2011). Existing studies have shown the degree to which stigma is experienced or perceived by caregivers. In United States a study on caregivers of adults with mental illness showed that caregivers experienced self-stigma that leads to relatives/caregivers concealing the condition of their patients and hiding their relation (National alliance of caregivers NAC, 2016). Another quantitative study in USA on 170 caregivers of people with mental illness showed that caregivers experienced low levels self-stigma,
(Girma, et al, 2014). In China a quantitative study on 427 caregivers of persons with schizophrenia indicated that caregivers experienced general stigma, because discrimination was rare and presents of social support, (Yin ,Zhang, et al, 2014).

Self-stigma among care givers of children with intellectual disability, autism spectrum disorder and physical disabilities showed that care givers of autistic children experienced more stigma than care givers of children with intellectual disabilities and physical disabilities (Werner & Shulman, 2015). Conversely, Polaha, Williams, Heiflinger and Studits (2015) in their study using 347 care givers of White, Hispanic, Blacks and Asians, established that care givers of family members with mental illness experience self-stigma and this prevented them from seeking health support from professionals. While a comparative study among 30 caregivers of patients with Bipolar disorder and 30 caregivers of patients with schizophrenia showed that stigma among caregivers varied from low to medium levels (Yannawar, Gajendragad, Gotewal, & Singh, 2015).

In West Africa, stigma has been found to be one of the challenging psychosocial difficulties faced by care givers. Biftu, Dachew, and Tiruneh, (2015) in their studies on Self-stigma among care givers of people with epilepsy showed that 71.6% of them experienced self-stigma. While a comparative study between patients with schizophrenia and their care givers showed that they both had high levels of internalized stigma on mental illness (Magaña, Ramírez, García & Cortez, 2007). In Tanzania a qualitative study where four focused group discussions and two in depth interview was done on stigma among caregivers. It was established that self-stigma is one of the biggest social challenge affecting caregivers (Iseseo, Kajula & Khadija, 2016). Self-stigma affects caregiver’s mental health, which may lead to psychological disturbance causing depressive symptoms among them.
Depressive Symptoms and Care for the mentally sick

Mental health is a state of well-being. It includes spiritual, physical, social and psychological aspect of an individual. When an individual is healthy he/she is able to estimate his weakness/strength, face every day challenges of life and becomes fruitful and productive in the society (Herrman & Swartz, 2007), on other hand tasks and emotional demands of caring of a child with mental disorders may lead to development of depressive disorder (ibid). Depression can vary in severity from mild to severe depression. Depressive symptoms are some of the risk…. factors that come as a result of care giver-patient effect. Researchers generally agree that caregivers for mentally sick do experience depression. A quantitative study among the Latino on 85 families showed that 40% of caregivers in the study met the criterion for being at a risk of suffering depression (had scores of 16 and above). In another study Caregivers of patients with mental illness like schizophrenia have significantly high levels of depression even in situations where mood disorder has never existed (Vitalianno & Katon, 2006). These come as a result of care giving roles that are varied, constant and long periods of care leading to stress and psychological disturbance. Other studies on depression among care givers in Canada and U.S.A, established that the care givers experience depression due to children’s severe behavioral disturbance combined with care givers restriction of personal life; and mothers experienced more depression than fathers (Lopez, Clifford, Minnes & Ouellette-Kuntz, 2008). In India a quantitative study on 200 caregivers of patient with schizophrenia and mood disorder, posited that almost half (42.5%) of caregivers experienced depression (Vijayalakshmi, 2016).

In Africa, two prevalence studies carried out in Nigeria and Kenya among caregivers of children with seizures and mental illness reported that 50.5% and 56.2% of the respondents respectively, having experienced depressive symptoms (Babalola, Adebowale,
Onifade & Adelufosi, 2014), Otieno, Obondo, & Kang’ethe, 2015), that could have been contributed by the stressful nature of taking care of this children amidst other family responsibilities. These studies suggest the relevance of establishing presence of depressive symptoms among caregivers.

Coping Strategies and Caring for the Mentally Sick

Caregivers adopt different coping strategies that may be culturally acceptable or not. Caregivers/family members of individuals with mental illness cope with the situation or the challenges of caring of a child/adolescents by concealing the diagnosis of their patients and hiding their relation (Chang & Horrocks, 2006). Another view of a quantitative research on coping strategies among caregivers of children with intellectual disability, Autism spectrum disorder and physical disabilities with a sample size of 171 caregivers showed that caregivers coped with caregiving role by hiding their loved ones, acting as a barrier to health seeking behavior among caregivers (Werner & Shulman, 2015). There is also a growing evidence that caregivers of White, Hispanic, Blacks and Asians caregivers cope by hiding the children with mental illness (Polaha, Williams, Heiflinger & Studits, 2015).

In Asia, a study on 50 caregivers on coping strategies used by caregivers indicated that 68% of caregivers use problem focused and emotional coping strategies and 32% used dysfunctional coping strategies. In another study, a qualitative study using four focused groups and two in depth interview indicated that caregivers used acceptance and prayers as a coping strategy, (Iselelo, Kajula & Khadija, 2016). A similar study using descriptive explorative study on 100 caregivers showed that majority of caregivers used seeking spiritual support as a coping strategy and mobilizing family to accept (Batra, Ghildiyal, a & Mathews, 2015).

In Africa, a study in Zimbabwe among thirty-one caregivers of mentally ill patients indicated that caregivers used emotional focus and problem focused coping strategies where
seeking spiritual assistance emerged as the most commonly used way of coping (Marimbe- dube, 2013). In general, reviewed literature shows that the demands of being a caregiver and the need for constant care is stigmatizing and stressful resulting to psychological disturbances like depression and to cope with the challenges caregivers adopt different ways of coping. This could as well be or not be the situation in Uganda yet no evidence is available. Hence the need for this study.

**Self- Stigma and Depressive Symptoms**

Several models of stigma describe internalization of stereotype as a key mechanism of how stigma may affect caregiver of children with mental illness. According to Mukolo, Anne, Hefflinger and Wallston, (2010), Label theory states that stigmatization is mainly a process that starts with labelling and stereotyping by others. Resulting to loss of status and followed by discrimination. Labelling may negatively affect ones mental state and for one to decrease threats individual then makes responds to the direct discrimination through cognitive response.

In USA a study linked to relationship between self-stigma and depressive symptom on 47 persons with dementia and 51 caregivers showed that care givers of people with dementia felt more depressed when they perceived more stigma, (Liu, Buckwalter, &Burgener, 2014). Another study on 85 caregivers of patients with schizophrenia and schizoaffective disorder showed a significant relationship between self-stigma and depressive symptoms (Magaña, García, Hernández &Cortez, 2007). In Indian research was done using 500 care givers of bipolar patients which showed relationship between self- stigma and depression among caregivers of people with bipolar disorder (Perlick, et al., 2007). The two studies were done on care givers of adults with mental disorder

In a comparative study in Egypt between caregivers of patients with schizophrenia and healthy non-caregivers as control group posited that depressive disorder was higher (18.33%) among care givers of patient with schizophrenia than the control group who had 3.3% (El-
Tantawy, Raya & Zaki, 2016). And further established that there was a relationship between depressive disorder and stigma (ibid). A study in Uganda by Hartley et al. (2005) reported that caregivers of children’s with disabilities were found to be in isolated and felt loneliness. They further explained that by taking care of a child with disabilities may affect caregivers’ personal health, by affecting ones emotions, increase time spend on care, and affect sleep pattern where all this may indicate presents of depressive symptoms or self-stigma among the caregiver. In all, this explains that caregivers of individual with children with mental illness may experience self-stigma or depressive symptoms when they are isolated or discriminated. It is important to understand what caregivers of children with mental illness in Uganda go through on their caregiving roles.

**Self-Stigma and Coping Strategies**

Coping strategy is define as something that one acts or thinks in responds to stressors, in order to reduce discomfort or increase the feeling of well –being in ones lives and to prevent being affected by stressful demands (Smith et al, 2008). In this study self-stigma is hypothesized to be associated with coping strategies. Coping strategies used by care givers is related to self-stigma. Self-stigma may negatively affect caregivers mental health by reducing their coping effectively (Perlick et al., 2007), for a care giver to be able to cope effectively one must have a good mental health.

According to Tawiah, Adongo, and Aikins (2015), in their study in Africa using focus group discussions with caregivers and patients with mental illness, they established that caregivers suffer from self-stigma. And that this makes them to avoid rehabilitation services and treatment, hence adopting maladaptive coping strategies for example (not- to –be- seen syndrome) prayers, avoidance of marriage, prayers, reaction and aggression (ibid). While in Zambia Elafros et al (2013), on 100 caregivers of children with epilepsy, established that 20% of the caregivers found
to be feeling stigmatized because of their children suffering from epilepsy and higher stigma was related with lack of social support as well as higher anxiety and depressive symptoms. This study suggests the relevance of establishing the link between self-stigma and coping strategies among caregivers of children and adolescents with mental illness.

**Depressive Symptoms and Coping Strategies**

Caregiving responsibilities among caregivers of children with mental illness affects their physical health and mental wellbeing causing psychological disturbance. In USA a study linked to relationship between depressive symptom and coping strategies (Macdonald, 2011) using 221 caregivers of children with Autism who completed anonymous online survey. The researcher posited that use of emotional – based coping was related to caregivers feeling depressed and anxiety. Another parallel longitudinal study on 246 caregivers of adults with mental illness and 74 caregivers of children with intellectual disabilities. In the two groups the researcher established that increase in use of emotional coping led to increase in psychological distress among caregivers (Magaña, García, Hernández & Cortez, 2007). However, another study in America using 40 relatives of people with mental illness used social support and problem solving and showed mild or no distress in the roles of caregiving, (Pompeo, Carvalho, Olive, Souza, & Galera, 2016). While in Malaysia, Ong et al (2016), in their research on self-stigma and coping strategies among 200 caregivers of patients with schizophrenia, it was found that 31.5% care givers experienced psychological distress and community rejection that was related to depression, and these had positive correlation with behavioral disengagement, venting and self–blame, which are dysfunctional coping. Another view in India by Venkatesh, (2008) using 62 parents of children with mental retardation, both fathers and mothers showed that the relationship between psychological distress and coping strategies was negative and highly significant. And Grover,
Pradyumna and Chakrabarti (2015), in their study among caregivers of patients with schizophrenia found that caregivers use mixed type of coping mechanisms like problem focused and avoidance in dealing with stress of care giving. In another study on 50 caregivers, it was established that 86% of caregivers experience moderate stress and 32% experienced severe stress in caregiving roles. It was established that there was a significant relationship between moderate stress with problem focused and emotional coping strategies, (Darlami, Ponnose & Jose, 2015). Zafar (2015), study on the relationship between Psychological well-being (depression) and coping strategies among caregivers of children with down syndrome using 120 caregivers (60 mothers and 60 fathers), using exploratory study. He established that there was a significant correlation between psychological well-being and coping strategies. Where parents who relied on avoidance-coping reported lower levels of psychological well-being (depression, anxiety and stress) which was found to be common among mothers compared to fathers. In Africa a study done in Ethiopia using 284 caregivers of children with severe mental illness was established that 19% of caregivers experienced depression (Derajew, Yolessa, Feyissa, Addisu & Soboka, 2017).

In Uganda, Ndikumo et al (2016) caring for a child with mental illness is related to increase responsibilities and as a result increases caregivers levels of stress which may affect caregivers coping strategies. The study seeks to established whether this is associated with interplay between self – stigma, depressive symptoms and coping strategies as such documented literature is scanty in Uganda.

**Hypotheses**

1. There is a relationship between Self stigma and depressive symptoms experienced by caregivers of children with mental illness who attend CAMHU at Butabika hospital.
2. There is significant relationship between Self stigma and coping strategies among caregiver of children with mental disorder attending CAMHU at Butabika Hospital.

3. There is a significant relationship between depressive symptoms and coping strategies among caregivers of children with mental disorder attending CAMHU, at Butabika Hospital.
Chapter Three

Methodology

Introduction

This chapter deals with detailed information regarding procedures used in the study. The procedures include research design, population, sample size, and sampling technique, measuring instruments, and their respective data management and analysis.

Research Design

The study was a quantitative, correlational and cross sectional in nature. It was descriptive as it aimed at explaining the characteristic of the study population. It was also correlational because it examined the degree of relationship among the variables under study population. It was regarded as a cross sectional study because the study was conducted at single point in time.

Study Site

The research was carried out at Butabika hospital, which is located approximately 13 kilometers East of Kampala city center, in Nakawa division. Butabika hospital is a mental hospital with specialized units including that of Children and Adolescent Mental Health Unit (CAMHU) is one of such units. The hospital had approximately 3591 children and adolescents cumulatively, who attended CAMHU in the fiscal year 2015/2016. The unit has two specialized days set aside every week for children and adolescence to be seen by health providers at out-patients that is Tuesday and Wednesday. On these days children come in company of their parents/care givers.
**Study population.** The study population was on the caregivers of patients suffering from mental illness. The study sample was drawn from caregivers of children and adolescents who attend CAMHU-outpatient clinic at Butabika Hospital. The respondent of this study are caregivers of children with mental illness for example children with epilepsy, attention deficit hyperactivity disorder, conduct disorder, bipolar affective disorder and HIV induced psychosis.

**Inclusion and exclusion criteria**

Children considered for this study were aged below 18 years.

**Inclusion criteria.**

The respondent must have been;

1. A care giver who accompanies the child to CAMHU.
2. Aged 18 years and above and taking care of the child or adolescent diagnosed with mental illness.
3. One that has been living with the child for at least the past six months and has been involved directly in giving care to the child.
4. One who agreed to consent for the study.

**Exclusion criteria.**

1. Any person who accompanies the child to the clinic because caregiver was not able.
2. Any caregiver who was below 18 years.
3. Caregiver who has not been involved directly in giving care to the child for at least a period of six months.
4. Those who declined to sign informed consent.
**Sample Size and Sampling Technique**

**Sample size.** The study targeted all care givers at Butabika hospital who brought their children or adolescents to CAMHU in the month of August to October 2017. The researcher identified the caregivers (respondent) using the children’s files numbers. Since the total number of the population could not be established, the number of respondents were approximated using Global prevalence rate of children and adolescence with mental disorder which is 20% according to (Kieling, et. al. (2011). The projected number of children expected to be seen within the period of data collection was 800. Among the 800 children seen some were new client without established diagnosis and others were still undergoing investigation. Hence respondent number was calculated using an average of 80 children per week (80*8=640*20/100=128 +10/100) who have received diagnosis giving the number of respondents to be 138. The other additional number of respondents were those who were available and willing to participate. Therefore 141 respondents were considered for data collection for a period of eight weeks.

**Sampling technique.** Purposive sampling technique was used where by respondents were selected as they become available to the researcher, and those who had the characteristic of sample population

**Procedure**

Acquired an introductory letter from Makerere University, approval of Research and Ethical Committee of Mulago Hospital and permission from Butabika Hospital. Caregivers of children with mental disorder who visited Butabika Hospital in the month of August to October were considered. The nurse in charge of outpatient department of children and adolescence mental health unit who availed the files. On the day of data collection, the researcher checked the child’s file for confirmation of mental illness according to classification of mental illness in DSMI-IV and
DSM-V. Then the researcher identified and confirmed the caregiver using the child’s file. And approached the caregivers of the children and adolescence at the waiting bay by explaining the study and its importance and request for their participation. Only caregivers who assented for the study were included. She then purposively subjected them to the tools.

**Research Instruments**

The instruments that the researcher used in data collection were: Socio demographic questionnaire, PHQ - 9 for depression, affiliated stigma questionnaire and brief cope questionnaire.

**Socio-demographic questionnaire.** This questionnaire was used to collect the socio-demographic data of the respondents. This included things like: age, gender, education level, and relationship to the child under care, age of the child, diagnosis and duration of care giving.

**Affiliated stigma scale questionnaire:** Affiliated stigma scale was developed by Mak and Cheungs (2008) to measure self-stigma among caregivers. And the tool was validated using caregivers of people with intellectual disabilities and caregivers of people with mental illness in general, no specific diagnosis was considered. It has 22 items with 3 components which include; cognitive, behavioral and affective. The three components were analyzed together, according to Panchankis (2007), they are interlocked. Each item is rated on a 4-point Likert scale, scored 1- 4. Where 1= strongly disagree, 2=Disagree, 3= Agree and 4 = strongly agree. To determine the scoring in this study, Mak and Cheungs (2008) categorized Affiliated stigma into two categories those who score below mean that is 1- 2.50(low self-stigma) and those with 2.51 – 4 (high self-stigma).
Validity and reliability

The tool was validity and tested for reliability among caregivers’ self-stigma, (Mak & Cheung, 2008), the validation was done using a total of two hundred and ten Caregivers of People with Intellectual Disabilities (CPID) and one hundred and eight Caregivers of People with Mental Illness (CPMI). It was tested in China and it indicated internal reliability for both CPID (Cronbach’s alpha = 0.95 and CPMI (Cronbach’s alpha =0.94). Pretest using Split half reliability was done and in this study the affiliated stigma tool demonstrated a high reliability with Cronbach’s alpha of 0.781

**PHQ-9 questionnaire.** The PHQ-9 is a questionnaire that assesses presence of depressive symptoms by Kroenkek, (2001). The PHQ-9 has 9 questions to be responded on a Likert scale of 0 – 4, where 0 = not at all, 1 = several days, 2 = more than half a day, and 3 = nearly every day. A score of 0-4 signifies minimal depressive symptoms, 5 – 9, mild depression, 10 – 14 moderate depression, 15 -19 moderately severe depression and 20 – 27 signifies severe depression.

Validity and reliability

The PHQ 9 scale was developed by Kroenkek, Spitzer& William, 2001), and tested for reliability and established 88% sensitivity and 88% specificity of the tool in adults. In Uganda PHQ 9 reported to have been tested and registered sensitivity of 0.74 when used among Ugandan subjects and Validity using content validity and found to be valid using the 9 item version (Nakku et al, 2016). The tool demonstrated reliable and valid for measuring depression.

**Brief cope questionnaire.** Brief cope is a self-reporting scale developed by Hastings, Kovshoff, Brown, Ward, Espinosa, & Remington, 2005b). It assesses coping strategies that caregivers use when trying to face problems. The tool was used to measure nature of coping strategies among
caregivers of children with mental illness. The scale has 28 items that are grouped into 14 subscales that were responded on a Likert scale of 1-4, where 1 = I haven’t been doing at all, 2 = I’ve been doing a little bit, 3 = I’ve been doing this a medium amount, 4 = I’ve been doing this a lot. The scale was regrouped after getting the results. These assesses three broad categories of the fourteen subscales. The broader categories was adapted as categorized by Pozzi et al (2015) include; Emotional focus strategy: with five sub-scales and this are Accepting, Religion, positive reframing, emotional support and humor. Problem focused has three sub-scale; Active coping, planning and Instrument support and Dysfunctional coping: has six subscales self –distraction, Denial, Substance use, Behavioral disengagement, Venting and Self – blame.

**Validity and reliability**

In the study to determine validity and reliability of brief cope tool for assessing coping strategies (Brasileiro et al 2016) used a total of 237 subjects. The findings indicated that internal consistency of brief cope measured by Cronbach’s alpha was 0.60; the pretest-split half reliability was 0.6. In this study brief cope demonstrated reliability with cronbach’s alpha of 0.677.

**Data Management and Analysis**

The researcher cleaned the data by checking for completeness. Data was then entered and analyzed using Statistical package of social scientist (SPSS) Version 20.0(IBM SPSS Armonk NY; IBM Corp, 2013). Descriptive statistics were done to summarize data. While Spearman correlation coefficients were used to determine the strength and direction of relationship between Variables. And further analysis using Chi square was done to establish association between categorical variables. In this study a p-value of <0.05 was considered significant.
**Ethical Consideration**

Acquired an introductory letter from Makerere University. Research clearance was obtained from both Research and Ethics Committee Mulago Hospital and permission from Butabika National Teaching and Referral Hospital. The caregivers received an explanation on voluntary participation and right to withdraw from the study at any point with no consequences. The care giver was informed that there was no direct personal gain or benefit to the participant.

The research was conducted in an honest manner. Confidentiality was observed and caregivers did not use their names, children’s names or outpatient registration number. Informed consent was signed by the respondent for confirmation of acceptance to participate in the study.
Chapter Four

Results

Introduction

In this study the researcher was out to establish whether the care givers of children with mental disorder who attend Butabika Hospital experience self-stigma and depressive symptoms and also to ascertain how they cope/ or deal with these challenges. To achieve this, three hypotheses were tested namely: (1) there is a relationship between self-stigma and severity levels of depressive symptoms among caregivers of children with mental disorder who attend Butabika Hospital. (2) There is a relationship between levels of perceived self-stigma and nature of coping strategies among caregivers of children with mental disorder who attend Butabika hospital. (3) There is a relationship between severity levels of depressive symptoms and the nature of coping strategies among caregivers of children with mental disorder. The results are presented below beginning with the socio-demographic characteristics and the distribution of levels of self-stigma, depression and nature of coping strategies.

Socio-Demographic Characteristics

In this study the researcher analyzed the characteristics of 141 respondents, which included age, gender, education levels, relationship, and duration of care and the children’s characteristics which included age and diagnosis.
Table 1: *Socio-Demographic Characteristics of Caregivers and the Children*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency N=141</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>56</td>
<td>39.7</td>
</tr>
<tr>
<td>Female</td>
<td>85</td>
<td>60.3</td>
</tr>
<tr>
<td><strong>Ages</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18- 35year</td>
<td>61</td>
<td>43.3</td>
</tr>
<tr>
<td>36- 50years</td>
<td>80</td>
<td>56.7</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>28</td>
<td>19.9</td>
</tr>
<tr>
<td>Secondary</td>
<td>66</td>
<td>46.8</td>
</tr>
<tr>
<td>College</td>
<td>47</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Relationship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>81</td>
<td>57.4</td>
</tr>
<tr>
<td>Guardian</td>
<td>60</td>
<td>42.6</td>
</tr>
<tr>
<td><strong>Child’s age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 -3</td>
<td>0</td>
<td>0.7</td>
</tr>
<tr>
<td>4 -94</td>
<td>23</td>
<td>29.8</td>
</tr>
<tr>
<td>10-18</td>
<td>98</td>
<td>69.5</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>88</td>
<td>60.3</td>
</tr>
<tr>
<td>BAD</td>
<td>25</td>
<td>17.7</td>
</tr>
<tr>
<td>ADHD</td>
<td>7</td>
<td>7.0</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>6</td>
<td>4.3</td>
</tr>
<tr>
<td>Others</td>
<td>11</td>
<td>7.7</td>
</tr>
</tbody>
</table>

NB: BAD=Bipolar affective disorder; ADHD=Attention deficit hyperactivity disorder. Others=intellectual disabilities.** Frequencies using mode

As indicated in table 1 above, majority (60.3%) of the respondents were female and the male were only 39.7%. Majority (56.7%) of the respondents were aged between 36 – 50 years and a significant number (43.3%) were aged between 18-35 years. Most (46.8%) of the respondent had secondary level of education, followed by those that went up to college level (33.3%) and 19.9% had only primary level of education. All respondents had taken care of the children for a period of not less than six months. The highest number (60.3 %) of the respondents had children diagnosed with Epilepsy, followed by BAD 17.7%, ADHD 7.0%, conduct disorder 4.3%, and others diagnoses
were 7.7%. The relationship with the caregivers was categorized into two, majority (57.4) being parents and Guardians were 42.6%.

Levels of self-stigma, depressive symptoms and coping strategies

Levels of self-stigma and severity levels of depression

In the study, the first objective was to establish the levels of self-stigma, depressive symptoms and nature of coping strategies used in dealing with the challenges by caregivers who attend Butabika Hospital CAMHU. Using descriptive statistics, the researcher established levels of self-stigma and depressive symptoms among the caregivers of children with mental illness. The results are presented in Table 2 below.

Table 2: Self-stigma and Depressive Symptoms

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>levels of self-stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>high self-stigma</td>
<td>76</td>
<td>53.9</td>
</tr>
<tr>
<td>Low self-stigma</td>
<td>65</td>
<td>46.1</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild depression</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Minimal depression</td>
<td>90</td>
<td>63.8</td>
</tr>
<tr>
<td>Moderate depression</td>
<td>7</td>
<td>5.0</td>
</tr>
<tr>
<td>Moderately severe depression</td>
<td>22</td>
<td>15.6</td>
</tr>
<tr>
<td>Severe depression</td>
<td>20</td>
<td>14.2</td>
</tr>
</tbody>
</table>

*Frequencies using percentage*
Table 2 above indicates a total of 141 caregivers responded to affiliated stigma scale that was measuring high and low levels of perceived self-stigma. The results from table two shows that those who experienced high self-stigma were majority (53.9%) and those who experienced low levels of perceived self-stigma were minority (46.1%). Most of the caregivers who attend Butabika hospital with children with mental disorder experienced high perceived self-stigma. Majority (63.8%) of caregivers experienced minimal depression, while those who had moderately severe depression were 15.6%, those with severe depression were 14.2%, moderate depression constituted only 5.0%, and least (1.4%) were those with mild depression. Indicating that all caregivers of children with mental disorder at Butabika Hospital attending CAMHU had depressive symptoms at a varied levels.

Nature of coping strategies

Furthermore, the researcher established nature of coping strategies that were being utilized by the care givers using descriptive statistics as shown in table 3 below.
Table 3: *Nature of coping strategies*

<table>
<thead>
<tr>
<th>Broader categories of coping strategies</th>
<th>Subscales of coping strategies</th>
<th>Less Utilized N (%)</th>
<th>Most Utilized N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion focused strategies</td>
<td>Emotional support</td>
<td>47(33.3)</td>
<td>94(66.7)</td>
</tr>
<tr>
<td></td>
<td>Positive reframing</td>
<td>97(68.8)</td>
<td>44(31.2)</td>
</tr>
<tr>
<td></td>
<td>Acceptance</td>
<td>71(50.4)</td>
<td>70(49.6)</td>
</tr>
<tr>
<td></td>
<td>Religion</td>
<td>47(33.3)</td>
<td>94(66.7)</td>
</tr>
<tr>
<td></td>
<td>Humor</td>
<td>124(87.9)</td>
<td>17(12.1)</td>
</tr>
<tr>
<td>Problem focused strategies</td>
<td>Active coping</td>
<td>43(30.5)</td>
<td>98(69.5)</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>85(60.3)</td>
<td>56(39.7)</td>
</tr>
<tr>
<td></td>
<td>Instrumental support</td>
<td>57(40.4)</td>
<td>84(59.6)</td>
</tr>
<tr>
<td>Dysfunctional coping strategies</td>
<td>Self-distraction</td>
<td>45(31.9)</td>
<td>96(68.1)</td>
</tr>
<tr>
<td></td>
<td>Denial</td>
<td>138(97.9)</td>
<td>3(2.1)</td>
</tr>
<tr>
<td></td>
<td>Substance Use</td>
<td>134(95.0)</td>
<td>7(5.0)</td>
</tr>
<tr>
<td></td>
<td>Behavioral disengagement</td>
<td>83(58.9)</td>
<td>58(41.1)</td>
</tr>
<tr>
<td></td>
<td>Venting</td>
<td>89(63.1)</td>
<td>52(36.9)</td>
</tr>
<tr>
<td></td>
<td>Self-blame</td>
<td>107(75.9)</td>
<td>34(24.1)</td>
</tr>
</tbody>
</table>

*Frequencies using percentage*

Coping strategy questionnaire is a multiple response questionnaire. According to table 3 above emotional focused coping was used and the results showed the subscale that were most utilized by the caregivers, and these are emotional support and religion both with 66.7% respectively. These were followed by acceptance (49.6%), positive reframing (31.2%) and the least utilized was humor with 12.1% of the respondent. Pertaining to the problem focused coping strategy, active coping subscales was being utilized by the majority (69.5%) of the respondents, followed by instrument support with 59.9% and planning was the least (39.7%) used. In terms of dysfunctional coping strategies, the most (68.1%) utilized was self-distraction, second highest
(41.1%) was behavior disengagement, followed by venting (36.9%) and self-blame (24.2%). Substance use and denial were the least (5.0% and 2.1%) utilized respectively.

**Self-Stigma and the Depressive Symptoms**

In the study the second objective intended to establish whether there is a relationship between levels of perceived self-stigma and the depressive symptoms among the caregivers of children with mental illness. It was therefore, hypothesized that; there is a significant relationship between levels of perceived self-stigma and levels of severity of the depressive symptoms experienced by caregivers of children with mental illness at CAMHU, Butabika hospital. A bivariate correlation was run using Spearman correlation coefficient which intended to determine the relationship between 2 variables at a 95% confidence level. The results are as shown below in table 4.

**Table 4: Relationship between levels of perceived self-stigma and the severity levels of the depressive symptoms**

<table>
<thead>
<tr>
<th></th>
<th>Depressive symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-stigma</strong></td>
<td>Spearman correlation</td>
</tr>
<tr>
<td></td>
<td>p-value</td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
</tbody>
</table>

From table 4 above, the results show a positive relationship between levels of self-stigma and the severity levels of depressive symptom with a Spearman correlation of \( r_s = .450, \ p < 0.000 \) where p-value is less than 0.05 showing that there is a statistical significant positive relationship between self-stigma and depressive symptoms, the higher the Self-stigma, the higher the
depressive symptoms. We therefore agree with the hypothesis that there is a significant relationship between Self-stigma and depressive symptoms among caregivers of children with mental disorder attending Butabika Hospital. Further analysis was done using chi-square and results showed that depressive symptoms significantly depended on self-stigma with \( \chi^2 (1) = 18.668, \ p < 0.001 \).

**Self-stigma and Coping Strategies**

The third objective was to establish whether there was significant relationship between levels of self-stigma and the nature coping strategies utilized to deal with the stigma. The researcher therefore hypothesized that “there is a significant relationship between levels of perceived self-stigma and nature of coping strategies”. It was tested using the Spearman correlation coefficient which intended to determine the relationship between 2 variables at a 95% confidence level. The results are as shown in table below;

<table>
<thead>
<tr>
<th>Table 5: Relationship between Self stigma and coping strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coping strategies</strong></td>
</tr>
<tr>
<td><strong>Self-stigma</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Significant level 0.05

The results above show that there is no statistically significant relationship between levels Self stigma and the nature of coping strategies utilized by the caregivers \( r_s = 0.103, \ p > 0.223 \) where p-value is more than 0.05 with Spearman correlation coefficient. The hypothesis was, therefore, rejected. There is no relationship between level of self–stigma and the nature of coping among caregivers attending Butabika Hospital. Further analysis using chi-square and results also revealed that coping strategies do not depend on self-stigma.
Depressive symptoms and Coping Strategies

The fourth objective of the study was to establish whether there was a relationship between the severity levels of depression and the nature coping strategies adopted by caregivers. It was thus hypothesized that “There is a relationship between severity levels of the depressive symptoms and nature coping strategies utilized by the caregivers of children with mental illness. It was tested using the Spearman correlation coefficient which intended to determine the relationship between 2 variables at a 95% confidence level. The results are as shown in table below;

Table 6: Relationship between the Severity Levels of Depression and the Nature of Coping Strategies

<table>
<thead>
<tr>
<th>Depress symptoms</th>
<th>Spearman correlation</th>
<th>p-value</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.17</td>
<td>0.034</td>
<td>141</td>
</tr>
</tbody>
</table>

From table 6 above the results showed that there is a statistical significant positive relationship between depressive symptoms and coping strategies with Spearman correlation coefficient of 0.178 and the p <0.034 which is less than 0.05, meaning that when there is increase in depressive symptoms, there is increase in nature of coping strategies. We therefore agree with the hypothesis that there is a significant relationship between depressive symptoms and coping strategies among caregivers of children with mental disorder attending Butabika Hospital. Further analysis was done using chi-square and the results (p<0.05) showed that coping strategies significantly depended on the levels depressive symptoms.
Chapter Five

Discussion, Conclusion and Recommendations

Introduction

The purpose of this study was to ascertain whether there was a relationship among self-stigma, depressive symptoms and nature of coping strategies adopted by the caregivers of children with mental disorder at Butabika Hospital. Thus, the chapter presents findings as an integration of the related literature. The researcher presents the discussion of the results, conclusion and recommendations made, beginning with the socio-demographic characteristics.

Socio-demographic characteristic

Regarding the socio-demographic characteristics of the respondents, female respondents were the majority (see table 1) this was simply because there is a strong cultural expectation in Uganda that females tend to play the care giving role (Carroll, 2008). These results are consistent with several other studies (Cabrara, Duarte, Ferreiraa, & dos Santos, 2014; Mak & Chueng, 2008) but contrary to the study in Saudi Arabia where the men constituted the majority (El-Tantawy, Raya & Zaki, 2010). Still this was due to the Saudi Arabian culture where men who are married are believed to be the ones responsible for others. Furthermore, majority of caregivers were adults aged between 36-50 years, and most of them had secondary level of education and above (see table 1). This was simply because caregivers with higher education level can easily seek professional help because they are aware of or exposed to available facilities that will improve their child’s condition. The results are in consistent with a study in India (Kumar, 2008). But contrary to the findings in Ethiopia where majority were aged between age 18 – 38 years and most (48 %) of them had primary level of education and below, (Babalola et al., 2015). The variation is due to area of
study, in Ethiopia the study was carried out in a rural town while the current study was done in Kampala city where majority of the people are educated.

In this study majority of the caregivers were caregivers of children with epilepsy (see table 1). This is because epilepsy is the most common neurological disorder among children and has a unique unhidden signs that pushes one to seek professional help. It is also estimated that 10.5 million children under 15 years have active epilepsy and 80% of these children live in developing countries where Uganda is among them. A study in Uganda by Doggan (2010) established that 2.4 % of children suffer from Epilepsy. And approximately 156 per 100000 people are diagnosed with Epilepsy yearly in Uganda, (Hansen, 2011). And this could probably explain why there were more children with epilepsy, which is reflected by the number of caregivers/respondents, who accompanied children to the hospital. The study is in agreement with the findings of Okewole and colleagues, (2016).

Therefore, the socio–demographic data in table 1 is similar to other studies (Kate, Grover, Kulhara & Nehra, 2014), that suggests that the socio-demographic data of caregivers in the study is a representative one.

**Levels of Self-Stigma, Depressive Symptoms and Coping Strategies among Care-givers**

The first objective of the study was to establish the levels of self-stigma, level of depressive symptoms and nature of coping strategies among the care givers of children with mental illness attending Butabika Hospital. According to the results majority of caregivers (53.9%) experience high levels of perceived self- stigma, and minimal to moderate levels of depressive symptoms (see table 2). In terms of stigma it was highly expected given the fact that mental illness is highly stigmatizing particularly for epilepsy, not only to the sufferer but also to those that look after them
For example, Most of the caregivers were taking care of children with epilepsy. Epilepsy carries a lot of stigma for both the sufferer and to those related to that individual (Spangenberg & Lalkhen, 2006). This may imply that Self-stigma may occur as a result of caregiver associating with individuals with mental disorder, who have been labelled and have come to accept the label. A high level of self-stigma is related to high public stigma. The caregivers feel embarrassed because of the children’s behavior, leading to reduction in going out with the child or contact with others like friends because of feelings a shame. And with difficulties together with association of seizures with socially unacceptable signs for example tongue biting, loss stool, foaming, and urine. All this probably explains the high levels of self-stigma among the respondents in this study. These results are in agreement with Hailermariam, (2015), who observed that among the caregivers in Ethiopia, Majority (52%) of them were found to experience very high perceived self-stigma and high self-stigma (47.43%) respectively.

In a different study in Ethiopia, (Bifftu et al, 2015), they found that 71.6% of caregivers of epileptic patients experienced high self-stigma where the results of this study are lower as compared to the study. But to the contrary to this study Yannawar et al, (2015), caregivers in India experience minimal self–stigma, this still could be because of their rich values and high tolerance levels that enable the caregivers to cope and support from family members to caregivers and patients. Girma et al, (2014), established lower levels of perceived stigma among caregivers. This may be due to lower levels of social stigma to caregivers in the community or care giving is more equally distributed among several family members so that burden of care is reduced. Mak and Kwok (2010), reported relatively low levels of self-stigma among caregivers, this may be because caregivers wanted to avoid the family pain by hiding or concealing mental illness in the family
hence they reported low levels. It would be interesting also if a study can be considered on stigma among children with mental illness.

In the side of depression according to table 2 majorities of caregivers experienced minimal to moderate depression. Furthermore, when caregiving is not equally distributed among relatives, in most cases one individual is burdened with the tasks, responsibility, living the person over strained, leading him/her to experience some level of depression. This may imply that caregivers feel stressed and low since the illness tend to be chronic and demanding in the long run; caregivers feel isolated from the community due to restriction of social life and leisure activities in addition to discrimination and stigma attached to mental illness. Collectively factors like diagnosis of mental disorder in a family, economic strain, and lack of support from other family members, frequency of problem behavior and level of functional impairment in the child can contribute. The results are in agreement with Azeem et al (2013), established that 30–40 % caregivers experienced depressive symptoms. Similar results were found in Ethiopia where majority of caregivers who take care of patients with severe mental illness, found that 11.3% experienced moderate depression, 3.5% moderately severe and 4.2% had severe depression. Okewole et al (2016) in Nigeria 23% of mothers with children with seizure disorder experienced major depressive disorder. But in contrary Eisenhower et al (2005), who found that over one-third of the mothers of both toddlers and adolescence of children with autism experienced high levels of depressive symptoms with a score of 36% having scored above clinical risk depression.

Perlick and colleagues, (2014) argues that depression could be associated with caregiver’s depression existence prior to caregiving role. The fact that caregivers could have suffered depression earlier and was not diagnosed, hence with increase in responsibilities and roles may increase or precipitate mental illness among caregivers. The results in this study are lower as
compared to a study in Nigeria 50.5% and 42.5% caregivers experienced major and moderate depression respectively, (Babalola and colleagues, 2014). Another study in India showed that 42.5% caregivers experienced major depression Vijayalakshmi, (2016). However, the inconsistent with the results could have been as a result of varied different cultural background of understanding depression or tools of screening with different scoring points.

In terms of coping strategies, the results revealed that most of the respondents utilized mainly the emotional focused and problem focused coping strategies, although a significant number of them also were employing some dysfunctional coping strategies, particularly self-distraction, venting and self-blame (see table 3). This is because emotional focus and problem focused are coping strategies that are culturally acceptable while dysfunctional coping strategies could have been employed in times of distress. Similar observation of utilizing both the active coping and dysfunctional coping strategies by the care givers was also observed by other researchers elsewhere (Smirthet al 2008; Darlami, Ponnose& Jose, 2016). Contrary to the findings in Zimbabwe caregivers used problem focused and emotional focused coping strategies where seeking spiritual assistance was utilized most ( Marimbe,2013). And Iselelo et al (2016) in Tanzania caregivers used only emotional focus coping strategy, prayers and acceptance were used mostly. A similar observation was seen in India by Batra and colleagues (2015), where majority of caregivers’ utilized spiritual support and mobilizing the family to accept. This can be through values and beliefs or through attending church and performing rituals. It may also include seeking counselling services from a church minister, praying alone in private or with others, attending church service and belief in miracles. Still this could be due to what is culturally acceptable and how much they value spiritual powers interventions among caregivers in Tanzania, Indian and people from Zimbabwe.
Therefore, with the above findings on perceived self-stigma, depressive symptoms and coping strategies among caregivers, it can be concluded that majority of the caregivers of children with mental disorder who attend Butabika Hospital experience self-stigma, suffer depressive symptoms and use problem focus with emotional more than dysfunctional coping strategy. These findings could probably explain why they have managed to continue to take care of their children and adolescence with mental disorder and persistently attend Butabika Hospital.

**Self- stigma and depressive symptoms**

The second objective of the study was to establish a relationship between self- stigma and depressive symptoms experienced by care givers of children with mental illness who attend CAMHU at Butabika hospital. The results in this study, were in agreement with the hypothesis and there was a statistical significant relationship (see table 4). This is because mental illness tends to be chronic and demanding to the caregiver, and in the long run caregivers feel isolated from society due to restriction of social, leisure activities in addition to stigma attached to. These social avoidance behavior affect caregiver’s mental health making them feel stressed and low.

According to these results the caregivers with high self-stigma experienced depressive symptoms more than those with low self-stigma. Probably, this could be attributed to caregivers being close to their loved ones who are stigmatized by public in the society. It may also be due to caregiver’s concealing or not disclosing patient’s condition to avoid being exposed to risk of discrimination by others. The results are consistent with the findings by Magaña and colleagues, (2007), and Liu et al, (2014) that affirmed a significant relationship between perceived self-stigma and depressive symptoms. This was because patient bizarre and embarrassing behaviors may lead to caregivers feeling ashamed in the presents of relatives,friends or in public places which causes a significant level of distress and eventually may lead to impairment in social or occupational
functioning. The behavior of the individual with mental health disorder may further lead to feelings of rejected or isolation among caregivers, jeopardize their relationship with others and diminish their reputation, and further complicating distress (González-Torres and colleagues, 2007).

In Zambia by Elafros & colleagues, (2013), relationship between self-stigma and depressive symptoms among caregivers, was consistent with this study. But contrary to the study Chang and Horrock (2006), established that there was no relationship between perceived self-stigma and depressive symptoms. This is because caregivers avoided talking about their relatives with mental illness to relatives or extended family members or friends in order to protect the family face and caregivers adopted positive attitude and behavior that helped them cope with the stigma.

From other studies with the above findings on self-stigma and depression we therefore conclude that there is a statistical significant relationship between self-stigma and depressive symptoms among caregivers of children with mental disorder in Uganda.

**Self-stigma and coping strategies**

The third objective of the study was to establish relationship between self-stigma and coping strategies among caregivers of children with mental illness. According to this study the researcher had hypothesized that there is a significant relationship between self-stigma and coping strategies. Results in table 5 reject the hypothesis. This was because most of the children who attend Butabika hospital were not admitted and received out patient care, hence the caregivers don’t leave in Isolation from the family members and community thus giving room for social support from other members of the family and community (there is shared responsibility) (Ndikumo,2016).In Malaysia, Ong and colleagues (2016), findings were consistent with the study.
But contrary to the study Tawiah et al (2015) found that there was a relationship between self-stigma and coping strategies. This implies that caregivers are stigmatized by individuals, family members or workplace because of their children’s behaviors, which leads to them shying away from public and look for means to cope with stigma, for example concealing their diagnosis or hiding children. The fact that caregivers spend most of their time in caregiving roles, the more they feel or experience isolation from others. Therefore that promotes feeling of discrimination. This contributes to the negative ways that caregivers perceive about themselves and adopt dysfunctional coping strategies due to negative thoughts/attitudes, lack of shared experience or social support from the family. Kanter et al (2008), found a relationship between perceived self-stigma and coping strategies. This could be attributed to caregivers internalizing public stigma which may lead to caregivers isolating themselves, not seeking support from other. Thus this contributes to lack or limited resources of coping strategies. This therefore increases avoidance behavior as a coping strategy. Perlick and colleagues (2014) found that there was a relationship between caregivers’ self-stigma and coping strategies. This implies that stigma influences the coping strategies adopted by caregivers that is stigma erodes caregivers’ psychological health hence decreasing their coping strategies. Therefore, from the above findings we conclude that there is no relationship between self-stigma and coping strategies among caregivers of children with mental disorder who attend Butabika hospital.

**Depressive symptoms and coping strategies**

The fourth objective of the study was to establish relationship between depressive symptoms and coping strategies. According to the researcher the hypothesis was “There is a relationship between depressive symptoms and coping strategies among caregivers of children with mental illness”. The result in this study was in agreement and there was a statistically
significant relationship (see table6), therefore the stated hypothesis in the study is retained. This implies that caregiver’s role may cause psychological disturbance following caregiving challenges thus causing significant distress and impairment in social or occupational functioning which in turn impact on the coping strategies that are adopted in caregiving. Depression among caregivers erodes their morale of caregiving hence affecting the coping resources. This is consistent with Zafar (2015) findings, caregivers with low psychological well-being use dysfunctional coping strategies while those with greater psychological well-being used problem focused coping. Darlami et al (2015) was in agreement with the study where moderately (68%) stressed caregivers used problem focus and emotional focus coping, and 32% were depressed and used dysfunctional coping strategy.

Smith and colleagues (2008) found that majority of the caregivers were female, were depressed and they utilized avoidance coping strategies. This might be because in Pakistani society female are no much independent and male are head of the family hence held responsible for decision making and handling major issues in the family. Machdolad, (2011) came up with the same findings which showed that greater use of self-distraction, denial, substance use, behavior disengagement, venting coping was associated with depressive symptoms, but contrary to the findings. Venkatesh, 2008), findings are inconsistent with the study; there was inverse relationship between depressive symptoms and coping strategies. This implies that caregivers of children with mental illness undergo more than average amount of psychological distress. The effects affect them psychologically and physically, where coping strategies are combination of physical and psychological factors. When there is increase in depressive symptoms there is a decrease in coping strategies and vice versa. Following the findings above on depressive symptom and coping
strategies, it can be concluded that there is statistical significant relationship between depressive symptoms and coping strategies.

**Conclusion**

The study confirms that having a child with mental disorder is a highly stigmatizing situation which in most cases has impact on the caregiver. The results from this study can be generalized since the sample size is a representative to the study population. The findings provide insight on understanding relationship that exists between self-stigma, depressive symptoms and nature of coping strategies used by caregivers. The finding suggests that there was a statistical significant relationship between self-stigma and depressive symptoms. Second, the data suggested that there was no significant relationship between self-stigma and coping strategies. Finally, the researcher suggests that there is a relationship between depressive symptoms and coping strategies. Therefore, the clinicians managing children/adolescence with mental disorder must focus on caregivers’ levels of self-stigma, depressive symptoms and nature of coping strategies adopted by caregivers and plan for intervention. Since caregivers’ self-stigma can negatively affect patients’ seeking professional help, treatment adherence, availing counselling programs to caregivers by health care providers, rehabilitation services and establishing family support groups may be helpful in dealing with self-stigma which in turn decreases levels of depressive symptoms leading to better coping strategies among caregivers of children with mental illness.

**Limitation**

The researcher used non-probabilistic sample leading to a possible bias and being less representatives to the population. The researcher did not look at other variables that could intervene with coping strategies for example personality, stress.
Recommendation

The study finding confirms that caring for a mentally ill child or adolescent can affect caregiver in different ways and as a result they look for ways of coping. A longitudinal study can be done using same variable in order to establish the pattern of self-stigma, depressive symptoms and nature of coping strategies in different stages of life. The finding will identify the stage at which caregivers are most affected for intervention purposes. There is also need to establishing whether caregivers have any mental illness or psychological disturbance prior to care giving role or at the first contact with the caregiver. Thus need for caregivers to receive routine assessment to identify the extent to which care giving tasks has affected them. There is need to do a similar study on a particular diagnosis since the rate of stigma, depression and coping varies from one diagnosis to another.
Reference


http://hdl.handle.net/2027/spo.10381607.0007.102


Kroenke, s. ,. (2001). The PHQ-9; Validity of a brief depression Severity measure. JGIM, 16, 606 - 616.


http://ghdx.healthdata.org/gbd-results-tool, p

### Appendix 1: Time Frame

<table>
<thead>
<tr>
<th>Activity</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>S</td>
<td>O</td>
</tr>
<tr>
<td>1 Proposal Writing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Preparation Of questionnaire</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Submission of proposal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Defense of proposal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 IREC approval and collecting data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Data Analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Report Writing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Report defense and presentation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table represents the timeline for various activities, with months and years specified for each activity.
Appendix 2: Budget

<table>
<thead>
<tr>
<th>Items</th>
<th>Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printing papers 3 reams @</td>
<td>360000</td>
</tr>
<tr>
<td>Printing</td>
<td>850000</td>
</tr>
<tr>
<td>Transport</td>
<td>700000</td>
</tr>
<tr>
<td>Binding</td>
<td>60000</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>900000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,287,000</strong></td>
</tr>
</tbody>
</table>

Appendix - Approvals

Appendix 5; Letter of introduction from school of psychology department of mental health and community psychology.

Appendix 6: Approval letter from Mulago National Hospital Research and Ethics Committee.

Appendix 7: Permission from Butabika National Hospital
Appendix 3: Consent Form

PREAMBLE

Title of the study; Self-Stigma, Depressive Symptoms and Coping Strategies among Care Givers of Children with Mental Disorder in Uganda

I am Rael J. Kiprotich, a postgraduate student in Makerere University conducting a research on Perceived Stigma, depressive symptoms and coping strategies among care givers of children with mental illness who attend follow up at Butabika Hospital. The rationale of the study is to establish if caregivers of children with mental illness experienced Perceived Stigma and depressive symptoms and how they Cope/deal with the challenges.

You are among the chosen respondents and your responds is highly appreciated, and will contribute to the success of the study.

Objectives of the study are: to find out if caregivers of children with mental illness attending Butabika Hospital experience perceived stigma, whether caregivers experience depressive symptoms, to examine whether there is a relationship between perceived stigma and depressive symptoms, and to establish the nature of coping strategies used by caregivers in dealing with perceived stigma and the associated depressive symptoms.
The study requires you to sign two consent forms on your participation in the study where you will retain one copy and the researcher will remain with another. The researcher will read instructions and you will respond to 68 questions, which describes your experience in the care of your child with mental illness. Your responds will be treated with confidentiality.

The research will benefit the children with mental illness and the family members /caregivers where they will learn new psychological intervention that will be established, and they will have better coping strategies.

During the study you are free to withdraw from the study at any point. And withdrawal from the study will not affect the services you receive from the hospital or any consequences attached to. There is no personal gain or benefit to the participant following time spend during the interview.

In case of any question or concern you are free to contact the following, researcher Rael J. Kiprotich +254722942432, Supervisor Dr. Kizza+256774997364, and Chairman Mulago Hospital IREC + 256772325869.

By signing this document, it indicates that you have read and understood the form, and you have made a free decision to participate in the study.

I (respondent).............................................. agree to participate in the above study.

Signature/ Thumbprint.............................. Date................................................

If thumbprint witness name........................ Signature............................................

Researchers Name ................................. Signature.............................................
Appendix 4: Research Instruments

Instructions: Please read the following set of questions and carefully respond to each item as they apply to you. Respond to all the items in the questionnaire.

Section A: Socialdemographic characteristics.

Put a tick mark (√) against the response that applies to you.

Care giver details

1. Gender
   - Male (1)
   - Female (2)

2. What is your age?
   - 18 – 35 years (1)
   - 36 - 50 years (2)
   - Over 50 (3)

3. Marital status
   - Married (1)
   - Single (2)
   - Divorced/Separated (3)
   - Widowed (4)

4. What is your highest level of education?
   - Never been to school (1)
   - Primary level (2)
   - Secondary (3)
   - College (4)
5. Relationship to the child

   Parent (1)
   Guardian (2)

6. Duration of caring

   0-6months (1)
   7 months -1year (2)
   Over one year

Child details

1. Age of the child?
   0 - 3 (1)
   4 - 9 (2)
   10 - 18 (3)

2. What is the diagnosis of the child? .................................................................

Section B: perceived stigma questionnaire.

Instructions; Please read each of the statement carefully, and pick one. Respond to all the items by putting a mark (\(\sqrt{\)} in this questionnaire by selecting one response in each statement that best describes or applies to you in relation to your child with mental disorder.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Others will discriminate against me if I am with my child with mental disorder</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2 My reputation is damaged because I have a child with mental disorder at home</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>People’s attitude toward me turns sour when I am with my family member with mental disorder.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td>Having a family member with mental disorder negatively affects me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Having a family member with mental disorder makes me think that I am incompetent compared with others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Having a family member with mental disorder makes me think that I am lesser than others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Having a family member with mental disorder makes me lose face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Affective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>I feel inferior because one of my family member has mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I feel emotionally disturbed because of my family member with mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The behavior of my family member with mental disorder embarrasses me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I feel helpless because I have a family member with mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>The behavior of my family member with mental disorder embarrasses me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I worry whether others know my family member has mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I am under great stress because of my family member with mental disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>I avoid communicating with my family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Statement</td>
<td>Not at all</td>
<td>Several days</td>
<td>More than half the day</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>2</td>
<td>I dare not tell others that my family member has mental disorder</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>I have cut down on going out with my family member with mental disorder</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Because of my family member with mental disorder, I have reduced my contacts with friends and relatives</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>When I am with my family member with mental disorder, I keep an especially low profile</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>I have reduced my contacts with my family member with mental disorder</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>I dare not participate in activities related to mental disorder lest others suspect that my family member has mental disorder.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Because of my family member with mental disorder, I have reduced my contacts with my neighbors</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Section C: Patient Health Questionnaire (PHQ9).**

The following are a number of common symptoms of depression. Over the last 2 weeks, how often have you been bothered by any of the following?

(Use “√” to indicate your answer)
<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Trouble falling/staying asleep, sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself, or that you are a failure, or have to let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>Trouble concentrating on things, such as reading newspaper or watching TV</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Section D: Brief Cope Questionnaire.

I’m interested in how you respond when you confront difficult or stressful events in your life. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Respond to all the items by putting a mark (√) in this questionnaire by selecting one responds in each item that best describes or applies to you.

<table>
<thead>
<tr>
<th>Statements</th>
<th>I haven't been doing this at all</th>
<th>I've been doing this a little bit</th>
<th>I've been doing this a medium amount</th>
<th>I've been doing this a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I've been turning to work or other activities to take my mind off things</td>
<td>1</td>
<td>2</td>
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<tr>
<td>2. I've been concentrating my efforts on doing something about the situation I'm in.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>3. I've been saying to myself &quot;this isn't real&quot;.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4. I've been using alcohol or other drugs to make myself feel better.</td>
<td>1</td>
<td>2</td>
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<tr>
<td>5. I've been getting emotional support from others.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
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<tr>
<td>6. I've been giving up trying to deal with it</td>
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<td>4</td>
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<tr>
<td></td>
<td>Description</td>
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<td>----------------------------------------------------------------------------</td>
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<tr>
<td>7.</td>
<td>I've been taking action to try to make the situation better.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>8.</td>
<td>I've been refusing to believe that it has happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>9.</td>
<td>I've been saying things to let my unpleasant feelings escape.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>10.</td>
<td>I’ve been getting help and advice from other people.</td>
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<tr>
<td>11.</td>
<td>I've been using alcohol or other drugs to help me get through it.</td>
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<td>12.</td>
<td>I've been trying to see it in a different light, to make it seem more positive.</td>
<td></td>
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<tr>
<td>13.</td>
<td>I’ve been criticizing myself.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14.</td>
<td>I've been trying to come up with a strategy about what to do.</td>
<td></td>
<td></td>
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<tr>
<td>15.</td>
<td>I've been getting comfort and understanding from someone</td>
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<td>16.</td>
<td>I've been giving up the attempt to cope.</td>
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<td>17.</td>
<td>I've been looking for something good in what is happening</td>
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<td>18.</td>
<td>I've been making jokes about it.</td>
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<td>19.</td>
<td>I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping</td>
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<td>20.</td>
<td>I've been accepting the reality of the fact that it has happened</td>
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<td>21. I've been expressing my negative feeling</td>
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<td>2</td>
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<tr>
<td>22. I've been trying to find comfort in my religion or spiritual beliefs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23. I’ve been trying to get advice or help from other people about what to do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24. <em>I've been learning to live with it.</em></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>25. I've been thinking hard about what steps to take</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>26. I’ve been blaming myself for things that happened.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>27. I've been praying or meditating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28. I've been making fun of the situation.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>
Appendix 5: Letter of Introduction

The Director,
Butabita National Teaching and Referral Mental Hospital
P.O. Box 7017,
Kampala

Dear Sir/Madam,


Ms. Rael J. Kiprotich is a Master of Science in Clinical Psychology student at Makerere University. She is in the process of writing her final dissertation and collecting data for that purpose. She is interested in exploring the link between “Perceived Stigma, Depressive Symptoms, and Coping Strategies among Caregivers of Children with Mental Disorder”. The purpose of this letter is to request for your assistance in regard to this matter.

The results are to be used for academic purposes only, participation is voluntary, and there is no compensation for involvement in this study. The participants will be provided with, and consider information about the study, and are free to withdraw from participation at any time. The information collected from them is to remain confidential, and their names are not required.

Any assistance rendered to her is highly appreciated.

Best regards,

[Signature]

Kajumba M. Mayanja, PhD
Head of Department
Email: kajumba@chuss.mak.ac.ug

In future correspondence please quote the reference number above
Appendix 6: Approval of Protocol MRED

14th July, 2017.

Ms. Rael J Kiprotich
Principal Investigator
School of Psychology
Makerere University.

Dear Kiprotich,

Re: Approval of Protocol MREC: 1219: “Perceived Stigma, Depressive Symptoms and Coping Strategies among Care Givers of Children with Mental Disorder in Uganda”.

The Mulago Hospital Research and Ethics Committee reviewed your proposal referenced above and hereby grant approval for the conduct of this study for a period of (1) year from 14th July, 2017 to 13th July, 2018.

This approval covers the protocol and the accompanying documents listed below:
- Consent form
- Questionnaire

This approval is subjected to the following conditions:

1. That the study site may be monitored by the Mulago research and ethics committee at any time.
2. That you will be abide by the regulations governing research in the country as set by the Ugandan National Council for Science and Technology including abiding to all reporting requirements for serious adverse events, unanticipated events and protocol violations.
3. That no changes to the protocol and study documents will be implemented until they are reviewed and approved by the Mulago Research and Ethics Committee.
4. That you provide annual progressive reports and request for renewal of approval at least 60 days before expiry of the current approval.
5. That you provide an end of study report upon completion of the study including a summary of the results and any publications.
6. That you will include Mulago hospital in your acknowledgements in all your publications.

I wish you the best in this Endeavour.

[Signature]

DR. NAKWAGALA FREDERICK NELSON
CHAIRMAN- MULAGO RESEARCH & ETHICS COMMITTEE

Vision: “To be the leading centre of Health Care Services”
Appendix 7: Request to Carry out Research

August 10, 2017

Ms. Rael J. Kiprotich
Principal Investigator
School of Psychology
Makerere University
KAMPALA.

RE: REQUEST TO CARRY OUT RESEARCH ON PERCEIVED STIGMA, DEPRESSIVE SYMPTOMS AND COPING STRATEGIES AMONG CARE GIVERS OF CHILDREN WITH MENTAL DISORDER IN UGANDA, A CASE STUDY BUTABIKA HOSPITAL

We have noted the approval of your research Protocol by Mulago Hospital Research and Ethics Committee (Protocol MREC: 1219): Your request to undertake research at Butabika hospital has been granted. You have been given permission to carryout data collection for a period of five months (August – December 2017). You are bound by ethical standards that govern undertaking research.

You are requested to provide an end of study report upon completion of the study, including any publication.

Yours sincerely,

Dr. H. Birabwa-Oketcho
HEAD TRAINING/ BUTABIKA HOSPITAL