Effectiveness of Advocacy Skills in Combating Self Stigma among Family Caregivers to Persons with Psychological Disorders in Tharaka Nithi County in Kenya

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Abstract
Stigma against psychological disorders is a global concern due to its devastating effects not only to persons with psychological disorders but also to the family members. This has led to global campaign initiatives to combat stigma against psychological disorders by the World Health Organization. As a result, the Government of Kenya through the Ministry of Health has adapted a variety of campaign strategies against stigma associated with psychological disorders in the country. However, the effectiveness of advocacy skills in combating self stigma among family caregivers to persons with psychological disorders is not well understood. Therefore, this study investigated the effectiveness of advocacy skills in combating self stigma among family caregivers to persons with psychological disorders in Tharaka Nithi County in Kenya. A Pretest/Posttest Quasi Experimental research design was adapted for the study. The target population was 1,966 respondents comprising of family caregivers to persons with psychological disorders and counsellors in Tharaka Nithi County. Snowball and purposive sampling techniques were employed in selecting a sample size of 322 respondents. Instruments for data collection included a family caregivers’ self stigma scale, the family caregivers’ questionnaire and the counsellors’ interview guide. Descriptive and inferential statistics were used to analyze the data with the aid of Scientific Package for Social Sciences version 21.0. Research hypotheses were tested using t-test statistic at a significance level of $\alpha = 0.05$. The findings of the study indicated that advocacy skills were effective in combating self stigma among family caregivers to persons with psychological disorders. It was recommended that policy makers avail advocacy skills to family caregivers of persons with psychological disorders in an attempt to combat self stigma.

Key words: Advocacy, Caregivers, Self stigma, Psychological disorders.

1. Introduction
Psychological disorders have received limited attention from governments, communities and nongovernmental organizations for many years (Marangu, Sands, Rolley, Ndebei & Mansouri, 2014). One reason for this is the inability by persons with psychological disorders to intellectually and emotionally express distressing experiences emanating from the disorders. This lack of insight together with abnormal behavior such as incoherent speech, diminished hygiene, hallucinations and delusions cause the general public to stereotype, prejudice and discriminate persons with psychological disorders (Worku & Shiferaw, 2014).
This explains why persons with psychological disorders were withdrawn from society and locked up in asylums by virtue of being labeled dangerous, cursed or possessed by an evil spirit (Lefley, 2009). By association, family members to persons with psychological disorders suffer feelings of shame, guilt and bitterness which are key aspects of self stigma against psychological disorders.

Concerns for human rights have led advocacy movements around the globe towards attempts to change peoples’ attitudes against and perceptions of psychological disorders (Marangu et al., 2014). Psychological health advocacy initiatives are conducted by family caregivers, the MOH, religious organizations and nongovernmental organizations. These groups require skills necessary in impacting and influencing policies, programs and legislation in favour of persons with psychological disorders and their families. Participation in family caregivers’ social support groups may facilitate acquisition of self advocacy skills as group members share experiences regarding self stigma against psychological disorders. This may help family caregivers to develop the capacity to cope, adjust and thrive amidst stigmatizing attitudes and behavior by recognizing that the emanating distress is part of the care giving role (NSW Mental Health Commission, 2014).

Social networking platforms that are widely available through mobile phones are possible avenues for psychological health advocacy. Using technology to create awareness and educate people about effects of self stigma against psychological disorders may serve to change negative attitudes and behavior (Marangu et al., 2014). Skills of using such technologies as advocacy tools build positive relationships and a safe space to live since communities develop a common understanding and mutual resolutions of the issues (NSW Mental Health Commission, 2014). For example, sensitizing mental health service providers about how stigma affects family caregivers and the care giving role may facilitate provision of holistic care based on experiences and individual needs of service consumers. This may be a valuable outlet for voicing pertinent issues and concerns to various stakeholders for appropriate action through representation, lobbying, educating and creating awareness about group members’ needs and perspectives.

In response to self stigma, family caregivers may acquire a distorted sense of self by defining themselves solely in regard to the care giving role. The newly acquired self stigmatizing label may dent the family caregiver’s self concept, self esteem and self efficacy among other personal attitudes (Angermeyer & Dietrich, 2006). The dented self conception serves to elicit self defeating beliefs, attitudes and behavior that generate emotional pain, social alienation and low quality of life. This scenario has drawn attention of mental health personnel to the cognitive processes involved in the invention and advancement of self stigmatizing complexities (Stuart, 2008). Research endorses that dissemination of psychoeducational programs on mental health for service consumers tends to enhance user friendly communication channels (Tanis, 2008). This means that psychoeducation is meaningful in counteracting myths and combating self stigma against psychological disorders among cultures that endorse secrecy for fear of stigmatization.

Family members to persons with psychological disorders may feel guilty about the condition of the ailing member by internalizing the blaming stereotypes that consider psychological disorders as originating from lack of care and family dysfunction (Hailemariam, 2015). The natural way of counteracting this guilt is by family caregivers is getting emotionally over involved with the patient in the care giving relationship. This manner of coping tends to exacerbate the ill member’s psychological disorder which in turn compounds the initial guilt.
(Corrigan, Druss & Perlick, 2014). As a result, feelings of frustration and helplessness occur especially when family and personal resources get wasted to the unremitting and escalating symptoms of the psychological disorder (Worku & Shiferaw, 2014). This distressing situation produces self defeating beliefs and attitudes characteristic of self stigma among family caregivers. Thus, psychoeducational interventions may provide an informed stance in coping with guilt related to caring for a relative with a psychological disorder.

The fear of contracting a psychological disorder due to genetic loading is apparent among family caregivers (Lefley, 2009). This is facilitated by self stigmatizing beliefs such as “our family is under a curse, we are bewitched, I am genetically predisposed to psychosis and if I do not take care of the ailing member my children may become sick”. These fears may be alleviated by learning the environmental risk factors that trigger psychotic symptoms. These risk factors include: sleep deprivation, solitary confinement, drug abuse, recent bereavement, post traumatic stress disorder, sexual abuse and sensory deprivation (Sickel, Seacat & Nabors, 2014). The environmental risk factors interact with genetic inclination towards psychosis for the expression of psychological disorders in vulnerable individuals (Quinn & Chaudoir, 2009). This explains why many children and siblings to persons with psychological disorders do not experience the onset of the disorders despite genetic susceptibility. This knowledge may help family caregivers to overcome self stigmatizing fears originating from genetic vulnerability by reinforcing an environment that fosters psychological wellbeing.

2. Objectives
The main objective of this was to determine the effectiveness of advocacy skills in combating self stigma between family caregivers of persons with psychological disorders exposed to the skills and those who are not in Tharaka Nithi County in Kenya

3. Methodology
This study employed the Pretest/Posttest Quasi Experimental research design to investigate the effectiveness of advocacy skills in combating self stigma among family caregivers to persons with psychological disorders in Tharaka Nithi County in Kenya. The population of the study was 1,966 comprising of 8 counsellors and 1,958 family caregivers to persons with psychological disorders in the county. Purposive and snowball sampling techniques were used in selecting the study participants. A sample of 157 family caregivers was selected for the experimental group and another sample of 157 family caregivers constituted the control group. The criteria for inclusion of family caregivers was attainment of the age of majority, an encounter with a psychiatric doctor, living with and caring for a family member ailing from a diagnosed psychological disorder as well as a written consent to participate in the study. Purposive sampling was used to select two counsellors from each of the four study regions. This sampling matrix generated the required sample size of 322 respondents. A self stigma scale was used to determine the levels of self stigma against psychological disorders among family caregivers. Data from the self stigma scale facilitated computation of paired t-test statistic. Questionnaires were administered to the family caregivers who were the key informants while the interview guide was used to obtain in depth information from the counsellors. Data collected was cleaned then coded and entered into the computer for analysis using SPSS version 21.0. The paired t-test statistic was used to analyze the quantitative data obtained from the self stigma scale. The qualitative data from interviews were analyzed thematically. Data from questionnaire’s likert scale items were analyzed by use of means and standard deviation. The analyzed data were represented on statistical figures and tables.
4. Ethical and Logistical Considerations
To guard against ethical malpractice in this research, legal requirements were fulfilled by acquiring a research permit from the National Commission of Science Technology and Innovation after ethical clearance from Chuka University Research and Ethics Committee. A written voluntary and informed consent to participate in the study was obtained from the respondents prior to administration of the research instruments. The respondents were also accorded the freedom to withdraw participation at any point of the study without penalty. Confidentiality was promised and maintained at all stages of this research including data collection, data analysis, report writing and dissemination of the information. In addition, the language used throughout the process of the study was sensitive to the feelings of the respondents as well as free from prejudice and discrimination. To avoid intrusion into the respondents’ personal and social space, the respondents were allowed to choose an appropriate time and venue from where instruments would be completed and advocacy skills provided. The beneficence and true purpose of the study were disclosed to the respondents in order to dispel any fears or doubts. This also facilitated free and informed consent to participate.

5. Results and Discussion
The following were the results and discussion of the study:

5.1 Demographic Characteristics of the Respondents
Section A of the research instruments generated information about the demographic characteristics of the respondents. Demographic attributes such as gender, age, academic qualifications and work experience of the respondents were required. This information was necessary for describing the nature of the study participants.

5.1.1 Demographic Characteristics of the Experimental Group
The family caregivers were required to state their gender. The total number of family caregivers in the experimental group was 157 of whom 79% were female and 21% were male. This shows that there were more female than male family caregivers to persons with psychological disorders in Tharaka Nithi County in Kenya.

The respondents were required to indicate their age category as 18 – 35 Years, 36 – 55 Years, 56 – 65 Years, 66 – 75 Years or 76 Years and above. Most of the family caregivers in the experimental group were aged between 56 Years and 65 Years. This comprised 47.77% of the respondents in the experimental group. The age groups 18 - 35 Years and those above 75 Years had the least number of family caregivers. These age groups made up 1.911% and 1.274% of the experimental group respectively. The majority of the family caregivers to persons with psychological disorders ranged between 56 Years and 75 Years who made up 87.26% of the experimental group members.

The findings about highest level of formal education of family caregivers in the experimental group indicated that most family caregivers in the experimental group had acquired secondary school level of education as their highest level of formal education. Those with Bachelors degree comprised 24.84%. The category of “others” who mainly indicated Certificate level of education and Diploma level of education made up 25.48%. The findings on highest level of formal education may be an indication that most respondents had the cognitive capacity to respond to question items in the research instruments.
The respondents specified their relationship with the ailing relative under the categories of being a parent, sibling, grandparent, child or others. The findings revealed that majority of the respondents comprising of 67.52% were a parent to the ailing relative. The least burdened with the care giving obligation were the grandparents who comprised of 1.274%. This information identified parents and siblings as most likely to take up the responsibility of caring for persons with psychological disorders.

5.1.2 Demographic Characteristics of the Control Group
There were 157 family caregivers in the control group of whom 77.71% were female and 22.29% were male. This implies that there were more female than male family caregivers to persons with psychological disorders in Tharaka Nithi County in Kenya.

The respondents in the control group indicated their age category as 18 – 35 Years, 36 – 55 Years, 56 – 65 Years, 66 – 75 Years or 76 Years and above. Most of the family caregivers in the control group were in the age category 56 - 65 Years constituting 44.59% of the respondents. The age groups 18 - 35 Years as well as 75 Years and above had the least number of family caregivers with 3.822% and 1.911% respectively. The information indicated that majority of the family caregivers to persons with psychological disorders ranged between 56 Years and 75 Years comprising 82.17% of the control group members.

The respondents were required to denote their highest level of formal education. Most family caregivers in the control group had studied up to secondary school level of education. This made up 42.68% of the control group members. The Masters level of education had the least number of family caregivers comprising of 4.459%. These findings suggested that most respondents had the ability to understand and respond to question items in the research instruments.

The respondents indicated whether they were a parent, sibling, grandparent, child or had any other kind of relationship with the ailing relative. Data analysis results revealed that most respondents (63.69%) were parents to the ailing relative. Grandparents comprised the smallest number of caregivers in the control group indicated by 3.185%. The findings indicate that persons with psychological disorders were most likely to be under the care of a parents and siblings.

5.1.3 Demographic Characteristics of the Counsellors
The total number of counsellors interviewed for this study was eight. The gender of the respondents was noted by the interviewers and data analysis results were indicated that 75% of the interviewed counsellors were female and 25% were male. This shows that there were more female than male counsellors recruited for the study.

The respondents were required to state their age category as 18 – 35 Years, 36 – 55 Years or 56 – 65 Years. Majority of the interviewed counsellors were aged between 36 Years and 55 Years. This comprised 62.5% of the respondents. The age groups 56 - 65 Years (12.2%) had the least number of counsellors.

The counsellors were asked about their highest level of formal education. The results showed that 50% of the counsellors had other academic qualification such as Diploma and Certificate while those with Bachelors and Masters comprised 12.5% and 37.5% respectively.

The respondents were required to mention the length of work experience and analysis of their
responses are represented in Figure 13. The work experience was categorized as 1-10 Years, 11-20 Years, 21-30 Years and 31-40 Years. The data analysis results indicated that 50% of the counsellors had worked for 1-10 years while 12.5% had work experience of 21-30 years.

5.2 Advocacy Skills and Self Stigma against Psychological Disorders
To determine the effectiveness of advocacy skills in combating self stigma among family caregivers to persons with psychological disorders, a paired sample t test statistic was carried out. To enable data analysis, an assessment scale was used to measure the self stigma of family caregivers to persons with psychological disorders before and after providing advocacy skills sessions.

5.2.1 Experimental/Control Groups Pre-test Paired Samples Statistics
The advocacy skills pre-test paired samples statistics between the experimental and control groups were generated. Information in Table 1 represents the data analysis results. This was necessary for determining the pre-test means of the respective groups.

Table 1: Advocacy Skills Experimental/Control Groups Pre-test Paired Samples Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group Advocacy Skills</td>
<td>4.4936</td>
<td>157</td>
<td>.25468</td>
<td>.02033</td>
</tr>
<tr>
<td>Control Group Advocacy Skills</td>
<td>4.5573</td>
<td>157</td>
<td>.29126</td>
<td>.02325</td>
</tr>
</tbody>
</table>

Information in Table 1 reveals a disparity between the advocacy skills pre-test means with 4.4936 as the mean for the experimental group and 4.5573 for the control group. Family caregivers to persons with psychological disorders suffered self stigma as indicated by high advocacy skills pre-test scores on the self stigma scale. The high self stigma scores were attributed to deficits in advocacy skills among the family caregivers. This finding relate to the outcome of a research by Worku and Shiferaw 2014 who documented that lack of insight caused the general public to stereotype, prejudice and discriminate persons with psychological disorders. When family caregivers to persons with psychological disorders internalize the stereotyping, prejudices and discrimination, experiences of negative emotions and social alienation ensue leading to self stigma.

To determine whether the pre-test mean discrepancies were significant, a paired samples t test statistic was conducted.

5.2.2 Experimental/Control Groups Pre-test Paired Samples t test Statistic
Information in Table 2 represents the advocacy skills pre-test paired samples t test data analysis results between the experimental and the control groups. The information was used to determine the equivalence in self stigma between the experimental and control groups before treatment.

Table 2: Advocacy Skills Experimental/Control Groups Pre-test Paired Samples t test

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Std. Deviation</th>
<th>Mean</th>
<th>Std. Error</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean n Mean Difference t df</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The study sought to determine whether psychoeducational intervention by provision of advocacy skills was effective in combating self stigma among family caregivers to persons with psychological disorders. This was done by examining whether there were differences in the means of the pre-test and post-test scores for the experimental group and the control group.

### 5.2.3 Experimental Group Pre-test/Post-test Paired Samples Statistics

Paired samples t test was run for the experimental group’s advocacy skills pre-test and post-test scores to indicate whether there were differences in the means of the two tests. Information in Table 3 represents the paired samples statistics data analysis results.

<table>
<thead>
<tr>
<th>Advocacy Skills</th>
<th>Experimental Group Pre-test/Post-test Paired Samples Statistics</th>
<th>Std. Error</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I fear revealing my relationship with the ailing family member to friends and colleagues</td>
<td>4.54</td>
<td>157</td>
<td>.500</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td>I fear revealing my relationship with the ailing family member to friends and colleagues</td>
<td>1.62</td>
<td>157</td>
<td>.487</td>
<td>.039</td>
<td></td>
</tr>
<tr>
<td>I cannot seek help for fear of other peoples' reaction</td>
<td>4.46</td>
<td>157</td>
<td>.513</td>
<td>.041</td>
<td></td>
</tr>
<tr>
<td>I cannot seek help for fear of other peoples' reaction</td>
<td>1.60</td>
<td>157</td>
<td>.505</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td>Pair 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not expect landlords to easily rent out a residential place to me and my ailing family member</td>
<td>4.46</td>
<td>157</td>
<td>.500</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td>I do not expect landlords to easily rent out a residential place to me and my ailing family member</td>
<td>1.56</td>
<td>157</td>
<td>.498</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td>Pair 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am not as competent as my colleagues at my place of work due to the care giving role</td>
<td>4.51</td>
<td>157</td>
<td>.502</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td>I am not as competent as my colleagues at my place of work due to the care giving role</td>
<td>1.55</td>
<td>157</td>
<td>.512</td>
<td>.041</td>
<td></td>
</tr>
</tbody>
</table>

Information in Table 3 indicated that the pre-test means were greater than the post-test means for the experimental group. Since greater mean scores were associated with high self stigma, then advocacy skills were effective in combating the self stigma.
5.2.4 Control Group Pre-test/Post-test Paired Samples Statistics
To determine whether there were differences in the means of control group’s advocacy skills pre-test and post-test scores, paired samples statistics were computed. Information in Table 4 represents data analysis results for the paired samples statistics.

Table 4
Advocacy Skills Control Group Pre-test/Post-test Paired Samples Statistics

<table>
<thead>
<tr>
<th>Pair</th>
<th>Description</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1</td>
<td>I fear revealing my relationship with the ailing family member to friends and colleagues</td>
<td>4.57</td>
<td>157</td>
<td>.496</td>
<td>.040</td>
</tr>
<tr>
<td></td>
<td>I fear revealing my relationship with the ailing family member to friends and colleagues</td>
<td>4.50</td>
<td>157</td>
<td>.514</td>
<td>.041</td>
</tr>
<tr>
<td></td>
<td>I cannot seek help for fear of other peoples' reaction</td>
<td>4.54</td>
<td>157</td>
<td>.525</td>
<td>.042</td>
</tr>
<tr>
<td></td>
<td>I cannot seek help for fear of other peoples' reaction</td>
<td>4.49</td>
<td>157</td>
<td>.502</td>
<td>.040</td>
</tr>
<tr>
<td>Pair 2</td>
<td>I do not expect landlords to easily rent out a residential place to me and my ailing family member</td>
<td>4.68</td>
<td>157</td>
<td>.470</td>
<td>.037</td>
</tr>
<tr>
<td></td>
<td>I do not expect landlords to easily rent out a residential place to me and my ailing family member</td>
<td>4.41</td>
<td>157</td>
<td>.507</td>
<td>.040</td>
</tr>
<tr>
<td></td>
<td>I am not as competent as my colleagues at my place of work due to the care giving role</td>
<td>4.45</td>
<td>157</td>
<td>.559</td>
<td>.045</td>
</tr>
<tr>
<td>Pair 3</td>
<td>I am not as competent as my colleagues at my place of work due to the care giving role</td>
<td>4.43</td>
<td>157</td>
<td>.497</td>
<td>.040</td>
</tr>
</tbody>
</table>

Information in Table 4 specified the pre-test means as 4.57, 4.54, 4.68 and 4.45 while the post-test means as 4.50, 4.49, 4.41 and 4.43 respectively. The findings revealed similarity between the pre-test and the post-test mean scores for the control group.

5.2.5 Experimental/Control Groups Post-test Paired Samples Statistics
The advocacy skills Post-test paired samples statistics findings between the experimental and control groups represented in Table 5 were meant to determine the post-test means of the experimental and control groups.

Table 5
Advocacy Skills Experimental/Control Groups Post-test Paired Sample Statistics

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental group advocacy skills</td>
<td>1.5812</td>
<td>157</td>
<td>.31422</td>
<td>.02508</td>
</tr>
<tr>
<td>Control group advocacy skills</td>
<td>4.4602</td>
<td>157</td>
<td>.26930</td>
<td>.02149</td>
</tr>
</tbody>
</table>

Information in Table 5 revealed the post-test mean scores for the experimental and control groups as 1.5812 and 4.4602 respectively. This means that the experimental group experienced less self stigma than the control group after the advocacy skills
psychoeducational intervention. To investigate whether the difference between the means was statistically significant, a post-test paired t test was carried out.

5.2.6 Experimental/Control Groups Post-test Paired Samples t test Statistic

Information in Table 6 represents advocacy skills post-test paired samples t test statistic results between the experimental and the control group. This test was intended to determine whether the mean difference in the post-test scores between the experimental and the control groups was significant.

Table 6
Advocacy Skills Experimental/Control Groups Post-test Paired Samples t-test

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Std. Deviation Mean</th>
<th>Std. Error Mean</th>
<th>95% Confidence Interval of the Difference</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental group advocacy skills - Control group advocacy skills</td>
<td>2.8789</td>
<td>0.42799</td>
<td>0.0341</td>
<td>-2.94645 -2.81151</td>
<td>84.286</td>
<td>156</td>
</tr>
</tbody>
</table>

The data analysis results in Table 6 regarding advocacy skills post-test scores paired samples t test statistic between experimental and control groups pointed out a mean difference of -2.87898, t statistic value of -84.286 and a P-value of 0.000. The P-value (0.000) was less than the set Alpha value (0.05) showing that the mean difference was statistically significant.

The hypothesis test results revealed that there were statistically significant differences between the advocacy skills post-test means of the experimental and control groups. This meant that advocacy skills were effective in combating self stigma among family caregivers to persons with psychological disorders in Tharaka Nithi County in Kenya. These results support the findings of a study by Marangu et al., 2014 who suggested that advocacy groups were able to avert attitudes against psychological disorders by creating awareness about the effects of stigmatization. Therefore, development of advocacy skills helped family caregivers to enhance the capacity to cope and adjust amidst stigmatizing attitudes and behavior.

Based on the advocacy skills self stigma scale test items, the psychoeducational intervention enabled the family caregivers to overcome the fear of being associated with the ailing family member; to seek help despite the reaction of other people; to have the expectation that landlords could easily rent out residential housing in spite of the condition of the ailing family member; and to feel that they were as competent as their colleagues at the place of work. These results are in line with the findings of Corrigan, Druss and Perlick 2014 who explained that skills deficits tend to exacerbate the ill member’s psychological disorder which in turn compounds the initial negative emotions experienced in the family. Thus having acquired the advocacy skills, the family caregivers to persons with psychological disorders were able to enhance their emotional wellbeing.

Research has endorsed that dissemination of psychoeducational programs on mental health for service consumers enhances user friendly communication channels (Tanis, 2008). This
argument is augmented by the ability of the family caregivers to advocate for residential arrangements as well as to seek help regardless of the reaction of other people. This means that psychoeducational intervention counteracts misconceptions and combats self stigma against psychological disorders among cultures that endorse secrecy for fear of stigmatization.

The family caregivers’ questionnaire solicited for the respondent’s perceptions about the effectiveness of the advocacy skills provided during the study in combating negative emotions and social alienation among the family caregivers to persons with psychological disorders. Data analysis results are represented in Table 7.

**5.2.7 Effectiveness of Advocacy Skills in Combating Self Stigma**

Respondents indicated their views on effectiveness of advocacy skills in combating self stigma against psychological disorders on a five level likert scale: Ineffective (IE), Less Effective (LE), Not Sure (NS), Effective (E) and Very Effective (VE). Data analysis results were indicated in Table 7.

Table 7

<table>
<thead>
<tr>
<th>Effectiveness of Advocacy Skills in Combating Self Stigma</th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>How effective is ability to use social media to create awareness about stigma against psychological disorders in combating negative emotions</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.46</td>
<td>.500</td>
</tr>
<tr>
<td>How effective is the ability to lobby for the rights of families affected by psychological disorders in combating negative emotions</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.50</td>
<td>.502</td>
</tr>
<tr>
<td>How effective are skills in communicating the effects of stigmatizing behaviour to perpetrators of stigma in combating negative emotions</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.55</td>
<td>.499</td>
</tr>
<tr>
<td>How effective is being able to join social support groups in their campaign against stigma of psychological disorders in combating negative emotions</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.57</td>
<td>.497</td>
</tr>
<tr>
<td>How effective is ability to use social media to create awareness about stigma against psychological disorders in combating social alienation</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.48</td>
<td>.501</td>
</tr>
<tr>
<td>How effective is the ability to lobby for the rights of families affected by psychological disorders in combating social alienation</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.60</td>
<td>.492</td>
</tr>
<tr>
<td>How effective are skills in communicating the effects of stigmatizing behaviour to perpetrators of stigma in combating social alienation</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.60</td>
<td>.492</td>
</tr>
<tr>
<td>How effective is being able to join social support groups in their campaign against stigma of psychological disorders in combating social alienation</td>
<td>157</td>
<td>4</td>
<td>5</td>
<td>4.62</td>
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<td>Valid N (listwise)</td>
<td>157</td>
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Information in Table 7 about the mean perceptions of the family caregivers on effectiveness of advocacy skills in combating self stigma against psychological disorders indicated an
overall mean of 4.5475. This means that advocacy skills were effective in combating self stigma among family caregivers to persons with psychological disorders. These findings confirm the post-test paired samples t test statistic results in Table 6 that indicated statistically significant mean differences between the experimental and control groups. This meant that advocacy skills were effective in combating self stigma among family caregivers to persons with psychological disorders.

As indicated in table 7, ability to use social media to create awareness about stigma against psychological disorders was effective in combating negative emotions and social alienation among family caregivers to persons with psychological disorders. NSW Mental Health Commission 2014 affirmed that the use of modern technologies as advocacy tools tended to build positive relationships and safe spaces to live in because members of communities developed a common understanding and mutual resolutions regarding stigma against psychological disorders. Therefore social networking platforms which are vastly accessible through mobile phones are possible advocacy tools for combating self stigma against psychological disorders.

Being able to communicate the effects of stigmatizing behaviour to perpetrators of stigma against psychological disorders was also perceived as being effective in combating negative emotions and social alienation among the family caregivers. Tanis 2008 suggested that psychoeducational programs enhanced communication channels. These communication channels may be used to mitigate stigma among family caregivers to persons with psychological disorders.

5.2.8 Counsellors’ Views on Advocacy Skills and Self Stigma
Counsellors were interviewed in order to obtain more information regarding the effectiveness of advocacy skills in combating self stigma against psychological disorders among family caregivers. Responses to interview questions were represented in Excerpt 1.

Excerpt 1
Researcher: How effective are advocacy skills in combating negative emotions and social alienation among family caregivers to persons with psychological disorders?
Probes:
   i. Ability to use social media to create awareness about stigma against psychological disorders
   ii. Ability to lobby for the rights of families affected by psychological disorders
   iii. Skills for communicating the effects of stigmatizing behavior to perpetrators
   iv. Ability to join social support groups in their campaign against stigma of psychological disorders

Counsellor A: Family caregivers experience self stigma because of holding onto self defeating beliefs brought about by public stigma. Some family caregivers believe that they do not deserve fair treatment by neighbours because of the intrusive behaviour of the sick relative. They give excuses and apologize on behalf of the patient. This causes feelings of frustration, helplessness and self pity among the family caregivers. Learning how to effectively communicate the effects of stigmatizing behaviour to perpetrators helps in minimizing the negative emotions experienced by the family caregivers.

Counsellor B: They are effective because being able to lobby for the rights of families affected by psychological disorders like the right to be understood helps family caregivers to
have a sense of belonging. For example, a mother whose grownup son had developed schizophrenia felt embarrassed and frustrated because the son had run naked to the market place hauling insults to and threatening women on his way. Her distress had been made worse because rumours had it that she was the cause of the sudden mental condition of her son by not respecting a family taboo. This mother felt relieved when she gathered enough courage and shared her predicament at a local church whose congregation responded with much support. The reassurance and comfort she received from church members brought about a sense of belonging.

Counsellor C: Very effective! When family caregivers join social support groups that campaign against stigma of psychological disorders, their emotional wellbeing improves. They are also able to interact with other people outside of the social support setup because these social support groups encourage socialization both within and away from the group settings. Sharing common experiences among themselves makes the group members to realize that they are not alone because others are going through similar or even worse experiences.

Counsellor D: Advocacy skills are effective in combating negative emotions and social alienation. There are social media groups dedicated to creating awareness about psychological disorders. Members also share their experiences regarding stigma and how they cope. Family caregivers who actively participate in such groups feel less alienated socially and are also able to ventilate negative emotions.

Counsellor F: Advocacy skills enable family caregivers to work in partnership with mental health providers by clearly communicating pertinent issues surrounding the condition of the patient and its effects on the family psychosocial environment. Mental health providers such as psychiatrists and clinical psychologists are able to offer relevant and specific interventions based on the information provided by the family caregiver.

An examination of information provided in Excerpt 1 reveals that the counsellors perceived advocacy skills to be necessary in combating self stigma in form of negative emotions and social alienation among family caregivers to persons with psychological disorders. Consistent with these findings is the observation that family caregivers who are able to advocate for the rights and needs of persons with psychological disorders and their families support the ailing relatives who may not have the ability to intellectually and emotionally express distressing experiences emanating from the disorders (Hailemariam, 2015).

The ability to utilize social media to create awareness about stigma against psychological disorders was affirmed to combat negative emotions and social alienation among family caregivers by the counsellors. Quinn and Chaudoir, 2009 noted that concern by family caregivers about stigma against psychological disorders led to the concealment and confinement of the stigmatized identity who is the ailing family member (Quinn & Chaudoir, 2009). While concealing family association with psychological disorders may work to attenuate social effects of stigma, the emotional agony of ever being found out can be overwhelming. Thus advocacy skills by use of social media to create awareness about stigma against psychological disorders instead of concealment and confinement of the stigmatized identity served to mitigate the emotional pain.

The use of advocacy skills was highlighted as a means of helping mental health providers in diagnosing and designing relevant treatment plans. When family caregivers air views and
experiences of self stigma against psychological disorders, mental health personnel get to understand the cognitive processes involved in the invention and advancement of self stigmatizing complexities (Stuart, 2008). This helps the mental health providers to customize the treatment plans based on the acquired insight in the presenting problem. In support of this argument, Corrigan, Druss and Perlick (2014) found out that effective communication skills served to expand social support for both family caregivers and persons with psychological disorders in addition to creating a collaborative therapeutic relationship with mental health professionals.

6. Recommendations

i. There is need for efficient psychoeducational information systems that conveniently avail accurate knowledge on advocacy skills aimed at combatting self stigma against psychological disorders among family caregivers to persons with psychological disorders.

ii. The ministry of health may initiate ways of creating awareness about the effects of stigmatizing attitudes and behaviour against persons with psychological disorders and their families.

iii. Advocacy outlets are necessary to enable family caregivers to persons with psychological disorders lobby for the rights of families affected with psychological disorders.

References


