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Forms of social support received by family caregivers of patients with schizophrenia in Sub-Saharan African urban settings: an integrative review of literature

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ABSTRACT

An integrative review was conducted to identify and describe forms of social support received by family caregivers of patients with schizophrenia in Sub-Saharan African urban settings. Sub-Saharan African region comprises of 49 countries and covers the area of the African continent that lies south of the Sahara. A search was performed in data bases of PubMed, EMBASE, PsycINFO, and CINAHL, and resulted in a total of 1,155 articles which were screened for inclusion, and 20 articles remained for review. Findings revealed that family caregivers received social support of different forms with emotional social support being the most frequently received. Findings provide essential insights that can be used by mental health practitioners and policy makers for strengthening social support networks for family caregivers in urban settings.

KEYWORDS

Mental health; social support; social work

Introduction

The terms family caregiver and informal caregiver refer to an unpaid family member, friend, or neighbor who provides care to an individual who has a chronic condition and needs assistance to manage a variety of tasks such as bathing and taking medications (Reinhard, Given, Petlick, & Bemis, 2008). Although family caregiving is generally considered a demanding task, some family caregivers have found it to be rewarding and often cite positive aspects of the experience. Family caregivers report that caregiving makes them feel good about themselves and needed, gives meaning to their lives, enables them to learn new skills, and strengthens their relationships with others (Kleinman, 2010).

Family caregiving plays a significant role in the management of schizophrenia. For example, the WHO indicates that globally up to 90% of schizophrenic patients

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live with their families (WHO, 2008), which suggests the need for family caregiving. The disabling nature of schizophrenia implies that patients are highly reliant on family caregivers to provide assistance with activities of daily living such as preparing meals and managing finances for a long period of time (Brain, Kymes, DiBenedetti, Brevig, & Velligan, 2018). Therefore, family caregivers for patients with schizophrenia usually experience chronic stress due to the progressively deteriorating nature of the illness. They are likely to exhibit symptoms such as mood swings, fatigue, headaches, joint and muscle pains which are associated with poor mental health conditions (Ae-Ngibise, Doku, Asante, & Owusu-Agyei, 2015).

Furthermore, family caregivers struggle to effectively care for patients with schizophrenia, due to inadequacy of knowledge regarding the illness and supportive resources in community (Magalhães, Lopes, Nobrega-Therrien, & Vasconcelos, 2018). Moreover, psychiatric services for mentally-ill patients at the community level are generally lacking in most low- and middle-income countries which contributes to the stigma that family caregivers and their patients' experience, and high relapse rates for patients (Iseselo, Kajula, & Yahya-Malima, 2016).

Family caregivers are key players in the recovery process for patients with schizophrenia yet most of them lack adequate knowledge about the illness. Moreover, family caregivers who live in urban settings have to meet the demands of a high cost of living, especially those with low paying jobs or who lack regular income (Rahmani et al., 2019; Yankuzo, 2013). Furthermore, family caregiving is more complicated in urban settings because of additional variables that arise in the environment such as different forms of violence, weaker social capital and unclear sources of social support. Therefore, for family caregivers to be able to continue playing their caregiving role as well as maintaining their wellbeing, they need social support of different forms from their informal social networks (Alyafei, Alqunaibet, Mansour, Ali, & J, 2021). Thus, in this article, we describe the forms of social support that family caregivers receive from the different social networks which are instrumental, emotional, informational, appraisal and companionship.

Although social support is fundamental for the wellbeing of family caregivers, many studies on family caregiving and schizophrenia have tended to focus on the burden of caring for patients (Brain et al., 2018; Clari et al., 2022). Other studies focused on the quality of life for family caregivers (Caqueo-Urízar et al., 2017; Díaz, Estévez, Momeñe, & Ozerinjauregi, 2019), but did not explore the different forms of social support that family caregivers in sub-Saharan African settings receive from their social networks to enhance their quality of life and facilitate their caregiving.

AIM of the review

This integrative review of literature forms part of a doctoral project about understanding social support for family caregivers of patients with schizophrenia in greater Kampala metropolitan area, Uganda. The aim of this review is to identify and describe the different forms of social support received by family caregivers of patients with schizophrenia in Sub-Saharan African settings. The Sub-Saharan African region comprises of 49 countries which include Gambia, Botswana, Uganda and Ethiopia (Ngouhouo & Nchofoung, 2022; World Bank, 2017).

Methods

We conducted an integrative review of literature to gain a better understanding of the different forms of social support that are available for family caregivers of patients with schizophrenia in Sub-Saharan African urban settings. Integrative literature review is a distinctive form of research that generates new knowledge about a topic reviewed. It reviews, critiques, and synthesizes representative literature on a topic in an integrated way such that new frameworks and perspectives on the topic are generated (Torraco, 2016).

We have used different methods of data collection and analysis because of the diversity of Sub-Saharan Africa urban settings. Our choice of the integrative review approach was motivated by the aim of gaining in-depth understanding of social support as a concept in relation to family caregiving and schizophrenia. The scope of the review is work practices in a broader sense rather than to cover advice and suggestions on practices and interventions for particular problems or diagnoses (Lena & Kitty, 2018). In the case of family caregivers for patients with schizophrenia, the concept of social support requires a broader scope of understanding as its availability is dependant on the types of social ties they have in their networks, but also on the mental health status of their patients. We followed five different stages recommended for conducting an integrative review; (1) problem identification, (2) literature search stage, (3) data evaluation stage, (4) data analysis stage and (5) presentation of results stage (Whittemore & Knafl, 2005).

The search process

The search included the electronic databases in PubMed, EMBASE, PsycINFO, CINAHL and Google scholar. Backwards and forwards citation checking was conducted for all included articles. Search terms used were: “Family care burden AND schizophrenia in Sub-Saharan Africa,” “Schizophrenia AND Africa,” “Social support OR caregiving in schizophrenia," Social support AND schizophrenia in Africa", "Family caregiving AND mental illness in Sub-Saharan Africa." The search terms were selected to focus specifically on schizophrenia and family caregiving. Inclusion criteria were peer-reviewed articles reporting on family caregiving and schizophrenia. Qualitative, quantitative or mixed methods studies published in English were included. Studies which were conducted in African countries and which focused on schizophrenia were included. For studies which focused on social support and family caregiving in severe mental illness, we only included those which indicated that patients with schizophrenia had the highest percentage compared to other conditions. Studies conducted in western countries, and studies which clearly indicated that they were conducted in rural areas of African countries were excluded. Other studies which we did not read and thus excluded from the review were those written in French and Portuguese languages. Studies which focused on family caregiving and social support for patients with schizophrenia were excluded in the review because we wanted to understand social support for family caregivers. Other studies excluded were those that focused on family caregiving and social support for specified mental disorders such as bipolar, and studies with insufficient or unreliable information about how the study was conducted.

Results

The search process identified 1,155 potentially relevant articles. After screening for duplicates, 403 articles remained. Three hundred and fourteen studies were excluded for not meeting the inclusion criteria resulting in 89 studies which remained for the review, and through a further search, 55 studies were excluded leaving a total of 34 studies. The first author initially screened the titles and abstract of these articles to find out whether they met the inclusion criteria and discussed outcomes with the other authors. Consequently, the first author independently read the full text articles and discussed the eligibility of each article with the authorship team. After excluding 14 articles, 20 articles remained for this review. The process is presented as a flow diagram (Figure 1). A bibliography software program Mendeley 1.19.8 version was used to import and store all the articles.

Data evaluation

All the 20 articles were read over several times to identify study aims and methods. Whittemore and Knafl (2005), stated that there is no gold standard, for evaluating and interpreting quality in research reviews, and that how quality is evaluated in an integrative review will vary depending on the sampling frame. Thus, we adopted and modified 9 questions out of 10 from the Critical Appraisal Skills Programme (CASP), used as a check list in

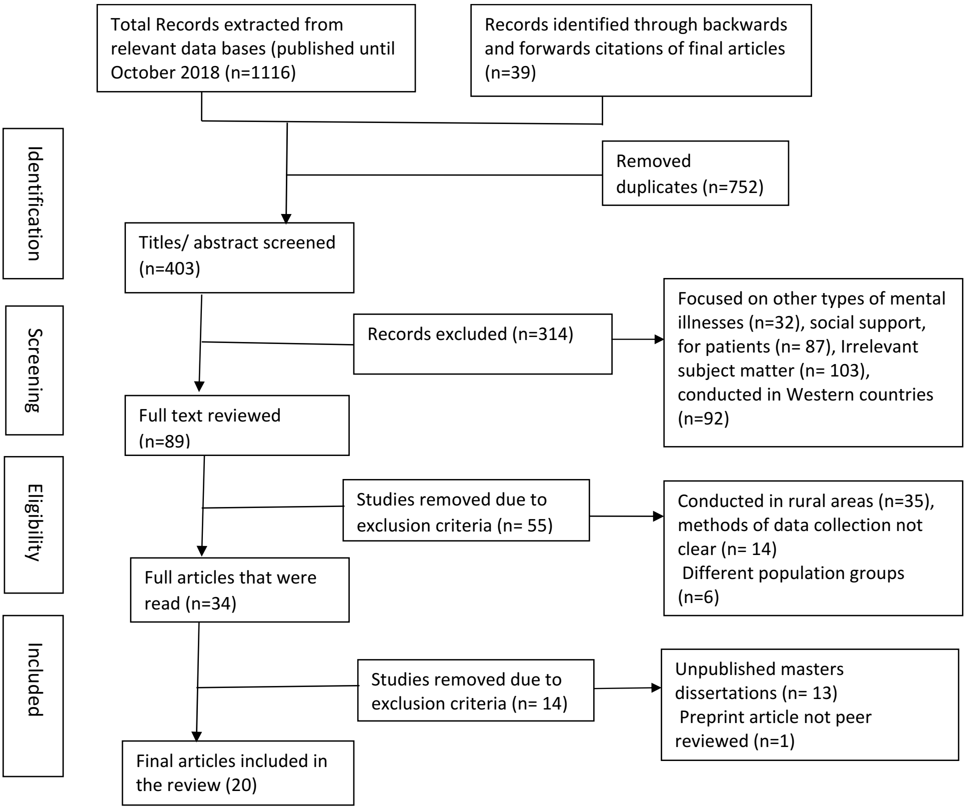

Figure 1. Flow diagram illustrating search process.

qualitative studies to check for: methodological quality, informational value, and representativeness of all the articles. The questions adopted and modified were: (1) Clear statement on aims/objectives of the study; (2) Appropriate design (qualitative, mixed methods, Quantitative) in relation to research question; (3) Clearer statement on sampling procedure; (4) Clear statement on sample selection; (5) Statement on ethical considerations; (6) Appropriate data collection methods in relation to study design and research question; (7) Methods of data analysis appropriate to research design; (8) Clear description of study settings and (9) Findings relevant and in line with the research issue. The articles were scored a yes or no response, and all of the 20 articles included in the final review scored a yes, response.

Data analysis

Data were extracted from all the articles based on the aim of the review, sample characteristics and method as well as any reference to family caregiving and social support (Lavoie, 2018; Torraco, 2016). Analysis of data involved coding, organizing, and synthesizing. Initial analytic coding carried out by the first author involved careful reading of the findings of each study with concurrent decision-making about where to code each piece of information. Both deductive and inductive coding was used. As codes were developed and organized, the author wrote memos about patterns, meanings, and connections between codes. Different forms of social support emerged and became increasingly clear as evidenced by the following criteria for rigor: credibility (i.e., plausibility of findings supported by repetition of similar experiences cited by most studies); and confirmability (i.e., frequently cited experiences with common explanations from participants). Relevant data were coded under the different forms of social support as defined by different writers (Berkman, Glass, Brissette, & Seeman, 2000; Cohen, Underwood, & Gottlieb, 2000; Gottlieb & Bergen, 2010), who have written extensively on the topic. The different forms of social support that were also identified in the findings are; emotional social support which involves provision of empathy, love, trust and caring (Gottlieb & Bergen, 2010), instrumental social support; which involves provision of tangible aid and services that directly assists a person in need (Gottlieb & Bergen, 2010); informational social support which is the provision of advice, suggestions and information that a person can utilize to address particular problems (Cohen et al., 2000), appraisal social support which involves the provision of information that is useful for self-evaluation purposes (Berkman et al., 2000) and companionship social support which involves the availability of persons with whom one can participate in social and leisure activities such as trips, or recreational activities (Cohen et al., 2000).

We did not introduce new themes to describe forms of social support, but maintained the universally recognized and agreed upon definitions. Iterative reading of the articles was done by the first author who then typed findings directly into the computer using the Microsoft word program. The files were shared with a coauthor who independently coded all articles to validate the first author's coding. Consensus coding was used to reconcile differences between coders. The other authors independently appraised results and contributed to the development of the review. Discrepancies between the authors were discussed and consensually agreed.

Study characteristics

This review included 20 studies from Nigeria (n = 5), South Africa (n = 4), Ghana (n = 4), and Tanzania (n = 2). Zimbabwe, Botswana, Uganda, Malawi and Kenya contributed one study each.

Summary of findings from articles (Table 1)

Forms of social support received by family caregivers

In this section, we present results from the 20 articles that were reviewed. We followed our research question: What are the different forms of social support received by family caregivers of patients with schizophrenia in sub-Saharan urban settings? The forms of social support identified and how they are described are presented below:

Emotional social support

Fifteen studies indicated that family caregivers were able to cope much better with caregiving by talking to and sharing problems with family and friends (Ohaeri, 2001; Oshodi et al., 2012; Yusuf & Nuhu, 2011). Family caregivers with more numbers of people in their household experienced a more supportive environment and compliments from within the family as compared to caregivers with fewer numbers of people who had higher burden scores on the financial/physical strain, and time/dependence domains (Adeosun, 2013). Other family members took turns to care for the patients so as to relieve the primary family caregiver (Bishop & Greeff, 2015; Seloilwe, 2006). In other instances, members of the extended family took the patients to spend a few days over the weekend in their homes; and visited them whenever they were admitted in the hospital (Anab, Onyango, & Mwenda, 2018). These arrangements gave family caregivers a break from caregiving (Seloilwe, 2006). People in the family caregivers' social networks such as churches and mosques also supported family caregivers through paying home visits to give words of encouragement (Odue et al., 2018; Quinn, 2007). Similarly, family caregivers who believed in super natural causes for schizophrenia such as evil spirits, participated in prayer camps where they received emotional social support (Opoku-Boateng et al., 2017). For example, a study from Uganda reported that a 52 year old mother recounted that her son was an active member of the church before he fell sick, and occasionally his former friends from church would help in taking him to hospital when the mother was not at home (Olwit, Musisi, Leshabari, & Sanyu, 2015). In some instances, family caregivers relied more on the emotional support received from people in their religious circles than the support from their family members and friends (Wintersteen, Mupedziswa, & Winteersteen, 1995). For family caregivers who attended support groups, emotional social support was received from other family caregivers who were members of the groups (Asmal, Mall, Emsley, Chiliza, & Swartz, 2014; Bishop & Greeff, 2015). The members of the support groups shared their caregiving experience as reported by a 72 year old mother: "I started going to a support group and spoke to other family caregivers. Most of them had been through what I was experiencing and survived it. … it does

Table 1. Summary of included studies.

Author (year) Country	Aims/Objective	Design	Methods	Study settings	Sample	Main findings
Oshodi et al. (2012). Nigeria	To determine the prevalence of psychological distress and experience of burden of care among caregivers of mentally ill patients.	Cross sectional descriptive study	Semi- structured questionnaires to collect quantitative data	Institutional based	53 family caregivers	Caregivers felt adequately supported by the staff in the mental health facility. They also acknowledged having received support from family members and government agencies.
Adeosun (2013) Nigeria	To determine the correlates of caregiver burden among family members of patients with schizophrenia.	Cross-section descriptive	Questionnaires	Institutional based	181 family caregivers	Caregivers with more numbers of people in their house hold received more social support from within the family as compared to caregivers with fewer numbers of people, and had higher burden scores on the financial/ physical strain, and time/dependence domains.
Yusuf and Nuhu (2011). Nigeria	To assess the level of emotional distress among caregivers of patients and identify factors associated with high level of emotional distress.	Cross- sectional descriptive study	Questionnaires	Institutional based	129 family caregivers	There was close family cohesion and support associated with traditional extended family system in the community.
Ohaeri (2001) Nigeria	To understand the burden of caring for patients with schizophrenia	Cross- sectional study	questionnaires	Institutional based	75 family caregivers	Family caregivers lived in harmony with other family members and shared the caring roles.
Ohaeri and Fido (2001) Nigeria	To assess the opinion of family caregivers of patients with schizophrenia and major affective disorders	Cross- sectional study	Questionnaires	Institutional based	95	Other family members supported the primary caregiver which made family emotional ties among them closer at 80%. Family caregivers also received appraisal support from mental health workers which strengthened their caring role.

(*Continued*)

Table 1. (Continued).

Author (year) Country	Aims/Objective	Design	Methods	Study settings	Sample	Main findings
Quinn (2007) Ghana	To compare beliefs and family responses to mental illness in four contrasting sites.	Qualitative	Semi-structured interviews	Naturalistic community settings	80 family caregivers	Family caregivers in urban settings identified the extended family as the primary source of help. Members of the extended family who were either living out of the country or in another part of the country provided financial support. Support was also received from health care providers, neighbors and friends. Spiritual help was received from their religious communities.
Odue et al. (2018). Ghana	To explore the experiences of family caregivers of people living with schizophrenia and how they cope.	Qualitative	Semi-structured interview guide	Institutional based	60 family caregivers and 10 service providers	Caregivers perceived schizophrenia as a spiritually determined disorder and sought spiritual care.
Opoku-Boateng et al. (2017). Ghana	To estimate the economic burden and quality of life of family caregivers of schizophrenic patients.	Cross- sectional	Questionnaires were used to get Quantitative data	Institutional based	442 family caregivers	Caregivers who were married had higher quality of life scores than those who were unmarried. Support from other family members was associated with higher quality of life.
Animwaa et al. (2013). Ghana	To state the care giving experiences of informal caregivers in the provision of care to their schizophrenic family member.	Descriptive qualitative approach.	Semi- structured interview guides.	Institutional based	12 family care givers	Family caregivers who spoke well about the attitude of mental health staff stated that they think the staff are doing their best with the meager resource available to them and said that they are commended anytime they accompany the patients for review.
Asmal et al. (2014). South Africa	To assess the feasibility and acceptability of an interventional family study for people with schizophrenia and their families and to explore the contextual factors that could influence implementation of the intervention.	Cross- sectional	Semi- structured interviews with multi- family groups.	Institutional based	20 family caregivers	A multi-family group facilitated by a mental health nurse was thought to be a relatively low-cost format of implementing an intervention program for patients and their family caregivers.

(*Continued*)

Table 1. (Continued).

Author (year) Country	Aims/Objective	Design	Methods	Study settings	Sample	Main findings
Bishop and Greeff (2015). South Africa	To identify family resilience qualities in families in which a member was diagnosed with schizophrenia.	Cross-sectional study	Mixed methods	Naturalistic settings in the community.	42 family caregivers who were members of a support group.	Family members took turns to look after the patients' needs. Through support group meetings, family caregivers shared experience with other caregivers. Mental health workers educated caregivers about schizophrenia, and church members provided spiritual support. Family caregivers with a low-income received financial support from their communities which helped them meet their needs.
Hogan and John-langba (2016). South Africa	To explore the coping mechanisms of caregivers of persons diagnosed with severe mental illness and to gain a better understanding of caregivers' experiences and the barriers and challenges encountered in fulfilling their role.	Qualitative research design	In-depth interviews using a semi-structured schedule	Institutional based	18 family caregivers who were members of a support group	Support was obtained from other family members, friends, faith or religious affiliations and listening to other people's stories. Support was received from support groups and mental health professionals.
Mokgothu et al. (2015). South Africa	To explore and describe the strengths of families in supporting mentally-ill family members.	Qualitative	Unstructured interviews	Institutional based	9 family caregivers	Family caregivers were helped by members of the extended family who advised them to handle their caregiving roles with a positive attitude.
Wintersteen et al., 1995 (Zimbabwe)	To paint a ”broad brush” picture of the service needs of both mentally ill persons and their families and to determine under what burdens, if any, families labor as caretakers.	Cross-sectional study	Structured interview schedule	Naturalistic settings	34 family caregivers	Family caregivers relied on support from other family members, religious activities which included prayer and attending worship services, as well as support from friends.

(*Continued*)

Table 1. (Continued).

Author (year) Country	Aims/Objective	Design	Methods	Study settings	Sample	Main findings
Olwit et al. (2015). Uganda	To explore the experience of chronic sorrow among caregivers of schizophrenic individuals.	Descriptive qualitative study	In- depth interviews and focused group discussions	Institutional based	22 family caregivers	Family caregivers were supported by relatives and friends. Friends included neighbors, church members, and area Local leaders. Social support was in form of sympathy, giving advice, company and prayers for divine healing.
Iseselo et al. (2016). Tanzania	To determine the psychosocial problems of mental illness on the family including the coping strategies utilized by family caregivers of a patient with mental illness.	exploratory qualitative	In- depth interviews and focused group discussions.	Institutional based/ naturalistic settings	14 family caregivers	Family caregivers received support from religious people as the only means of hope and encouragement.
Sariah et al., (2014). Tanzania	To explore perspectives on risk and protective factors influencing relapse of patients with schizophrenia and their caregivers.	qualitative study.	In-depth interviews	Institutional based	7 family caregivers and their patients	Caregivers confirmed that the services they received from mental health facilities helped them and their patients a lot. They acknowledged that, if those services were not available the condition of the patients would not have improved.
Sefasi et al. (2008). Malawi	To determine the relationship between schizophrenia knowledge and burden of care among caregivers of people with schizophrenia.	Cross sectional	Questionnaires	Institutional based	90 family caregivers	Family support reduced burden levels. The large household sizes distributed the burden of care among several family members, so that the primary caregiver did not have sole responsibility of caring for the patient.
Anab et al. (2018). Kenya	To assess the caregiver knowledge and attitude regarding care of patients with Schizophrenia.	cross-sectional mixed method.	Structured questionnaires	Institutional based	303 family caregivers	Members of the extended family supported family caregivers in the caring role. They helped in visiting patients in hospitals, provided material and emotional support to family caregivers.
Seloilwe (2006). Botswana	To describe the experiences and demands of families who care for patients with schizophrenia at home.	Qualitative	In-depth interviews, focus group, discussions and field observations.	Naturalistic settings	20 family care givers	Multiple caregiving situations enabled family caregivers time for relief and rest from caregiving responsibilities. Sometimes patients rotated and spent time in homes of other relatives.

help without a doubt" (Asmal et al., 2014). Family caregivers who attended support groups coped better and were more able to resolve difficulties than those who did not attend the groups. The family caregivers acknowledged that the groups were frequently the only form of support available for them (Asmal et al., 2014). The opportunity to share experiences with other family caregivers helped to decrease the sense of isolation that many of them were experiencing. Close friends to family caregivers were also sources of emotional social support. A 59 year old family caregiver stated: "I have been open with my friends from the very start. I never hid the illness of my patient from them, so they have always been incredibly supportive." Fourteen out of the eighteen participants in one study (Hogan & John-langba, 2016), said that the encouraging words they received from their family and friends made a significant difference in their caregiving. Emotional support was also received indirectly from listening to inspiring radio and television programs as stated by a 42 year old single mother: "I am a religious person, I have faith in God, and I know that He cares about all my needs. While at home, I tune in to Christian radio stations and listen to inspiring messages and songs. I am encouraged after listening to other people's stories and I get to know that am not alone in suffering with caring for my son" (Olwit et al., 2015).

Instrumental social support

Twelve studies indicated that family caregivers had received instrumental social support from other family members (Bishop & Greeff, 2015; Olwit et al., 2015; Yusuf & Nuhu, 2011). Instrumental support in form of food stuffs and other consumable goods received from other family members reduced burden levels on the side of family caregivers (Adeosun, 2013; Sefasi et al., 2008). Other family members also contributed to financial costs of caring for the patients (Ohaeri, 2001). One family caregiver said that if there was anything to be paid for, her aunt contributed to the financial cost (Odue et al., 2018). Financial support also came from a variety of other sources (Odue et al., 2018). The most significant help came from members of the extended family, who lived either in another part of the country they lived in or out of the country. One family caregiver said that her uncle was an important source of financial support, given his important role in a matrilineal society (Quinn, 2007). In other families, family members supported primary caregivers and the patients financially by pooling resources together, and by providing material things such as clothing and food stuff (Seloilwe, 2006). Some family caregivers received assistance from their neighbors, for instance, on one occasion, a neighbor helped to transport back home a patient whom they realized that she was not well and moving aimlessly on the road (Mokgothu, Du Plessis, & Koen, 2015). At certain times, family members helped primary caregivers either to pick the patients medication from the health facility, or to escort patients for review (Anab et al., 2018; Iseselo et al., 2016). Other family members supported the primary caregiver by taking over some practical tasks such as looking after the patients by making sure they eat and drink well and monitoring them to ensure their safety (Quinn, 2007). Churches and mosques provided material support, to the primary family caregivers by often giving them food and clothing (Quinn, 2007).

Informational social support

Four articles reported on informational social support obtained from support groups. One of the articles reported that a multi-family support group was designed to implement an intervention program for patients with schizophrenia and their family caregivers (Asmal et al., 2014). Patients and their family caregivers agreed that a psycho-educational frame that was being followed in the group helped to address gaps in their knowledge of schizophrenia and its treatment (Asmal et al., 2014). One family caregiver stated that: I found the hospital staff a huge support, and the information they gave me has helped in caring for my patient a great deal (Hogan & John-langba, 2016). However, (Iseselo et al., 2016), indicated that despite the information given by health workers, there were family caregivers who still felt that it was not adequately addressing their needs, and communities still stigmatized them and their patients. They wished mental health services could be extended closer to their communities than only being provided at the hospital level.

Appraisal social support

Only four studies reported on appraisal social support which was received from other family caregivers in a support group. Family caregivers in the support groups commended each other for caring for their patients, and there was a strong sense of “we” that strengthened the caregivers’ capabilities (Bishop & Greeff, 2015; Ohaeri & Fido, 2001). Mental health workers also appraised the family caregivers for caring for the patients and bringing them for review on the appointed date (Animwaa, Arhinful, & Nyaledzigbor, 2013; Ohaeri & Fido, 2001). In exploring other psychological factors faced by the caregivers in the course of fulfilling their roles, (Oshodi et al., 2012), found out that in a study of a sample of 53 family caregivers, more than half of them felt adequately supported by mental health staff who were welcoming and encouraged them to continue caring for the patients.

Companionship social support

Companionship social support involves the availability of persons with whom one can participate in social and leisure activities such as trips, or recreational activities (Cohen et al., 2000).

Three articles reported on companionship social support which is obtained from close persons such as spouses with whom one can share intimate life experiences or leisure activities. In a study that was measuring quality of life scores, family caregivers who were married had higher scores than those who were not married, implying that they received companionship social support from their spouses (Opoku-Boateng et al., 2017). Primary family caregivers and other family members spent leisure time together by going on holidays, picnics and doing certain things together (Bishop & Greeff, 2015). Fourteen out of the 18 family caregivers in one study said that support of their family and friends made a significant difference in their caregiving, and one family caregiver commended her husband for being a wonderful person and a great help (Hogan & John-langba, 2016).

Discussion

The aim of this review was to identify and describe the different forms of social support received by family caregivers of patients with schizophrenia in Sub-Saharan African settings. The discussion for this review will follow the forms of social support as presented in the findings above.

Fifteen studies indicate that family caregivers received emotional social support from close family members and the different people they interacted with in their social networks (Adeosun, 2013; Bishop & Greeff, 2015). Immediate family members recognize when primary caregivers are overwhelmed with caregiving, which prompts them to respond positively (Oshodi et al., 2012). Both immediate and extended family members still support primary caregivers emotionally despite urbanization which has brought changes in the traditional African family structure. Due to urbanization, many people have moved to urban settings in search of employment opportunities and improved standards of living (Okyere-Manu, 2015). However, the culture of shared values among people of Africa such as visiting or calling on family members to check on how they are faring has not totally been negated.

Magezi, Theology, Society, Africa, and Magezi (2013), stated that when individuals migrate to cities, they adopt to life in the urban settings, however, the instructions, norms and values received from the parents and other elders in their home communities are kept at heart. People still cherish their cultural values even when they immigrate to urban settings (Magezi et al., 2013). Technology has made communication in urban settings much easier than it was before (boyd & Ellison, 2007). Thus, family caregivers are able to easily connect with other members of the extended family who also live in the urban environment though not necessarily in the same locality. Close friends and neighbors who have known family caregivers for some time can also provide emotional social support. The number of neighbors in the social network is larger for people who have been living at the current address for a longer time than others (van den Berg & Harry, 2015). Emotional social support can be provided either physically by visiting and sharing encouraging words with family caregivers or virtually by calling them on phone.

Thus, it is possible to find people from the same locality in the rural areas identifying and connecting with one another, though not living in the same locality. There are even cultural associations which have been formed with the aim of bringing people together who come from the same locality in rural areas and settled in urban settings (Houston, Wentzel, Yu, & Vivier, 2013). These associations can be a leverage for mobilizing emotional social support for a member who is going through a challenging experience such as caring for a patient with schizophrenia. Emotional social support is also received from people who attend the same places of worship with family caregivers. For countries with a well-organized mental health care system such as South Africa, service delivery has been extended to the community level where there are support groups from which family caregivers can receive emotional social support (Asmal et al., 2014).

Although Sub-Saharan Africa is generally a low resource setting, family caregivers received instrumental social support from other members of their families both immediate and extended, as well as other people in their social networks. Studies indicate that primary family caregivers lived in harmony with other family members who also contributed to financial costs of caring for patients (Ohaeri, 2001; Quinn, 2007). However, these studies were conducted some years back as the family structure in urban settings has become more of a nuclear type where people are only concerned about their personal needs. Thus, instrumental social support from members of the extended family is no longer relied upon. Even for those family caregivers who have members of their extended family living in urban settings, do not receive much from them because of the high cost of living coupled with high levels of unemployment. Iseselo et al. (2016), indicated that in a nuclear family, the welfare of family members has become the sole responsibility of the bread winner. Yet all is not lost because there are a few family caregivers who have family members who have migrated to work in other countries such as the United States of America and United Arab Emirates. These migrant workers remit finances to their families back home and this is a possible source of sustainable instrumental social support for family caregivers. The flow of remittances to Africa in general, and sub-Saharan Africa in particular has been a steady and significant increase in recent years (Lartey, 2016).

Studies also indicated that other family members supported primary caregivers with the practical tasks of looking after patients while the primary caregiver was away (Anab et al., 2018; Quinn, 2007). It is easy for other family members to monitor patients whose mental state has stabilized on medication and do not exhibit disruptive symptoms of schizophrenia. Most importantly, they need to learn that patients with schizophrenia can live a normal life if they continue to take treatment (Videbeck, 2011).

Instrumental social support also comprised of assistance from neighbors who occasionally helped to transport patients to the hospital for reviews or re-hospitalizations (Anab et al., 2018; Iseselo et al., 2016; Mokgothu et al., 2015). Such support indicates a closeness that family caregivers share with their neighbors. People are also slowly getting to appreciate that patients with schizophrenia are not always dangerous and should not be stigmatized together with their family caregivers. Churches and mosques were also an important provider of material help, to the family caregivers by often giving food and clothing (Quinn, 2007). Both Christianity and Islam teach people to identify and help others who are in need, thus the reason family caregivers and their patients were helped by members of their congregation.

Studies in this review indicated that few family caregivers received informational social support from mental health workers at the hospital level. Yet, even for those family caregivers who received informational social support, it wanted as they expressed a wish to have services extended to their communities (Iseselo et al., 2016). Molefi and Swartz (2011) reported that family caregivers wanted to know more about schizophrenia however, mental health workers never provided them with the information they needed. Family caregivers have a right to holistic information such as how to care for their wellbeing and that of their patients. Where possible it should be translated in their local languages although much of it is in scientific terms which are not easy to translate. Promoting the welfare of family care givers and all other family members is in line with the United Nations 2030 sustainable development goals, specifically goal number three which focuses on ensuring healthy lives and promotion of well-being for all at all ages (United Nations, 2015). Other family members besides primary family caregivers should be included in the treatment plan and be educated on the needs of patients by mental health workers. Family psycho education is an effective way for incorporating different family caregivers and their friends into ongoing treatment and rehabilitation for patients with psychotic disorders such as schizophrenia (Pepin, Williams, Anderson, & Qualls, 2013). Communities should also be equipped with information on mental health so as to be able to understand and appreciate the experience of family caregivers. Iseselo et al. (2016) indicated that family caregivers believe that information regarding mental illness should be provided to people in the community in order to reduce stigma and discrimination toward people with mental illness and their family caregivers.

Appraisal social support addresses the psychological needs of family caregivers by enabling them to have a positive attitude toward caring for their patients and reduces on the subjective care burden (Sippel, Pietrzak, Charney, Mayes, & Southwick, 2015). The disabling nature of schizophrenia and unpredictable behaviors of patients cannot be over emphasized. Thus, it is only people who understand the illness who can appreciate and appraise family caregivers of patients. As the studies indicated, members of support groups and mental health workers were the only ones who appraised family caregivers for caring for their patients (Animwaa et al., 2013; Asmal et al., 2014; Bishop & Greeff, 2015). The objectives of the World Health Organization action plan for mental health include enabling people with mental illness to continue living with their families, and advocate the empowerment and involvement of families in mental health care (WHO, 2013). Yet family caregivers and their patients continue to experience stigma from their community members who also judge them for not being able to manage their patient's illness better, rather than appraising them for the efforts they put in to care for the patients (Asmal et al., 2014; Molefi & Swartz, 2011).

Caring for patients with schizophrenia can affect family caregivers' intimate relationships especially for those who are married. Thus, few family caregivers received companionship social support which is normally provided by persons with whom one has a close relationship and can participate in social and leisure activities such as a spouse. When a family member becomes ill with schizophrenia, it creates strain in the family (Lenga, Xub, Nicholas, Nicholas, & Wanga, 2019). For some couples, when an off-spring is diagnosed with schizophrenia, there is a breakdown in communication between the parents and in some instances the marriage ends up in divorce leaving in most cases the female parent feeling socially isolated. Women can be blamed for mental illness in the family thinking that it is from the mother's side of the family, or that the husband is not the biological father of the mentally ill of the off-spring (Verity, Turiho, Mutamba, & Cappo, 2021). A male parent, especially in a polygamous marriage may disown a child with schizophrenia claiming that he is not the biological father, because in his linage there is no history of mental illness. It is less likely therefore that family caregivers will receive companionship social support from other family members especially their spouses. Yet, companionship social support was found to increase the quality of life family caregivers (Lenga et al., 2019; Opoku-Boateng et al., 2017).

Moreover, in urban-based families there are couples who cohabit for many years and even produce children without formalizing their marriage either traditionally or with the state. Okyere-Manu (2015), stated that cohabitation is becoming more popular in African urban settings due to the high price tag attached on bride wealth, modernization and urbanization. Single parent families are also on the increase in Sub-Saharan African urban settings due to the HIV/AIDS pandemic which is more prevalent in urban than in rural settings (Montgomery, 2009). Moreover, the HIV/ AIDS is more prevalent in women than men, yet, the former are in most cases the primary family caregivers of patients with schizophrenia (Díaz et al., 2019; Montgomery, 2009). These are among the factors that affect availability of companionship social support among urban based family caregivers in sub-Saharan Africa.

Limitations of the review

Although Sub-Saharan Africa is a region of 49 countries World Bank, 2017, only nine countries were represented in the review. Thus, data from other countries remain largely unknown. Moreover, due to the current of dearth of research in this area, only a small number of studies were included. Studies written in French and Portuguese were excluded because we did not have researchers with proficiency ability in those languages. As such, there is a need for further research on this topic from the region. The search strategy excluded gray literature and may have overlooked other studies indexed elsewhere. While this review provides insight into forms of social support received by family caregivers of patients with schizophrenia in urban settings, experiences of family caregivers in rural settings are not represented. Yet with globalization both settings are increasingly being transformed and have a lot of similarities. Thus, experience of family caregivers in rural settings also needs to be understood. The search was also limited to family caregivers of patients with schizophrenia with no comorbidity. However, considering the disabling nature of the illness, it is very likely that patients will develop other chronic conditions such as heart diseases and substance use disorders which are also on the increase in urban settings. Thus, social support for these family caregivers also need to be explored.

Implications to social work practice

This review revealed that family caregivers in urban settings have sources of social support which should be strengthened. Thus, by applying principles of the strength perspective and the principle of client self-determination, social workers should empower family caregivers to fully utilize their social support system. Empowerment should also involve enabling family caregivers to explore more of their potential sources of social support at different levels of society. Being urban based, family care givers should be guided on how to embrace modern technology such as the print media, electronic media, and the internet to increase their sources of social support. Social workers and other mental health workers should facilitate family caregivers to form community-based support groups. The support groups should empower family caregivers to mobilize, advocate and sensitize members of their communities to stop stigmatizing them and their patients.

Religious organizations are key in mobilizing social support of different forms for family caregivers. Thus, social workers should work with those religious organizations and any other organizations in their intervention strategies. Community based support groups have been very instrumental in providing different services for people with chronic conditions. A very good example of community based support groups that have been successful are those that support people living with HIV. In these groups, it is the people living with HIV themselves who are at the fore front of managing different activities in the groups. As a result of the demanding nature of caregiving, some family caregivers have lost their jobs, or have an increased expenditure. Thus, developmental social workers can work with family caregivers to scan their environment and identify opportunities for starting up income generating activities to substitute on their income.

Conclusion

Social support has a profound impact on the wellbeing of family caregivers and their ability to handle the demands of caregiving. This review has revealed that there are different forms of social support available for family caregivers of patients with schizophrenia at different levels of society. Emotional social support and instrumental social support were the most forms available because they can be provided by different people in the family caregivers social networks from both the strong and weak ties. Appraisal and companionship social support were among the least forms of social support provided. For appraisal social support being among the least forms of received social support, it is attributed the disabling nature of schizophrenia, stigma and cultural beliefs attached to mental illness, as well as lack of information regarding schizophrenia. Schizophrenia being the most disabling of all mental illnesses, social support for family members should be sustainable. Sustainable social support requires joint efforts of family caregivers and deferent people in their social networks as well as the government. Thus governments should increase mental health education especially for attitude change toward patients with schizophrenia and their family caregivers. However, economies of all governments everywhere especially in Sub-Saharan Africa have been badly affected by the corona virus pandemic thus, funding for mental health services is likely to reduce even further from what it has been. There is therefore an urgent need to empower family care givers especially using modern technology to take charge of their wellbeing/welfare and strengthen their sources of social support as well as exploiting potential ones.

Disclosure statement

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