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KNOWLEDGE, ATTITUDES AND PRACTICES OF CAREGIVERS OF PATIENTS WITH SCHIZOPHRENIA IN PORT MORESBY, PAPUA NEW GUINEA

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ABSTRACT:

The purpose of this study was to investigate the knowledge, attitudes and practices of adult caregivers of schizophrenia patients in Port Moresby, Papua New Guinea. A semi-structured questionnaire was used to obtain the required data from consented caregivers accompanying the schizophrenia patients attending the consultation clinic at Port Moresby General Hospital (PMGH). Focus Group Discussion was held with consented caregivers of schizophrenia patients admitted in the Psychiatric ward of PMGH. A convenient sample of 79 caregivers with patients was selected for this study. Consents were obtained from 40 caregivers, which give a response rate of 50.6%. Most of the caregivers (75.0%) had no prior knowledge about schizophrenia; they became aware about schizophrenia from experience with their patients. The fathers (35.0%) and mothers (22.5%) were the major caregivers for the patients. Most of the caregivers indicated that the health workers did not give them adequate education about schizophrenia. Marijuana (47.5%) and psychosocial problems (45.0%) were the two major causes of schizophrenia indicated by the caregivers. Caregivers considered medical intervention to be the most important, but they also advocated supportive interventions such as church activities and family support. Most of the caregivers accepted their patients as part of the family and considered it their responsibility (52.5%) to care for them, and preferably to administer treatment at home (52.5%); the exception being during severely aggressive episodes. Financial problem was one of the factors that impacted negatively on follow-up of patients. Increased access to services and health education is recommended to further enhance the care of schizophrenia patients in Port Moresby, PNG.

Keywords: Schizophrenia, Caregivers, Knowledge, Attitudes, Practices, Papua New Guinea.

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INTRODUCTION:

The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted [1]. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficit may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms [1]. There are sub types of schizophrenia; paranoid, hebephrenic, also called disorganized, catatonic, undifferentiated, simple and residual schizophrenia [1]. Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perpetual disturbance. Catatonic schizophrenia is dominated by prominent psychomotor disturbance that may alternate between extremes such as hyperkinesias and stupor, or automatic obedience and negativism [1]. Hebephrenic schizophrenia is a form of schizophrenia in which affective changes are prominent, delusions and hallucinations fleeting and fragmentary, behaviour irresponsible and

unpredictable, and mannerisms common [1]. Undifferentiated schizophrenia is psychotic conditions meeting the general diagnostic criteria for schizophrenia but not conforming to any of the subtypes, or exhibiting the features of more than one of them without a clear predominance of a particular set of diagnostic characteristics [1].

Residual schizophrenia is a chronic stage in the development of a schizophrenia illness in which there has been clear progression from an early stage to the later stage characterized by long-term, though not necessarily irreversible, “negative” symptoms, e.g., psychomotor slowing; under-activity; blunting of affect; passivity and lack of initiative; poverty of quality or content of speech; poor nonverbal communication by facial expression, eye contact, voice modulation and posture; poor self-care and social performance [1]. Simple schizophrenia is a disorder in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance [1]. The characteristic negative features of residual schizophrenia (e.g. blunting of affect and loss of volition) develop without being preceded by any overt psychotic symptoms [1].

According to the WHO, schizophrenia is a severe form of mental illness affecting about 7

per thousand people, mostly in the age group 15-35 years [2]. Schizophrenia affects about 24 million people worldwide and 90% of the untreated cases of schizophrenia are in the developing world [2]. Schizophrenia is mainly characterized by chronic psychotic symptoms such as delusions, hallucinations and negative symptoms such as social withdrawal [3]. The aetiology of schizophrenia is multi-factorial, including genetics, structural brain abnormalities and neurotransmitter imbalance [3]. With prompt treatment, about a third of patients may recover fully from first episode and never have another episode, another third may improve with occasional relapses and others may follow a chronic, deteriorating course [3]. Without treatment the prognosis for most patients is poorer.

Schizophrenia, from the public health perspective, is a major concern as the onset of the illness occurs early (15-35 years of age) [2]. According to WHO reports it may affect about 1.0% of the general population in any given country [2]. This means that, in PNG with a population of 6.5 million, approximately 60 000 people may suffer from schizophrenia. It is a major public concern because it causes chronic disability, family disappointments, marital problems, financial disadvantages and destroys the education opportunities for those that are affected by the illness at early age. If the patient is a parent and the only bread winner

for the family, then it creates an atmosphere of disability for the whole family. The education of the children is usually affected because the sick parents are emotionally detached from the family unit. It destroys the families' hopes when the child they invest in is affected by the illness. The families may have more concern for the other children who are well and neglect the patient. Because of social stigma the communities may avoid the family members. The patients may be called names causing them to become violent or isolated in the community. There may be restrictions from community participation due to the disability that the illness causes. The impact of the stigma may prolong the duration of recovery of the patient. The illness may cause economic burden to the family as the patient may depend very much on financial support from close family members. The illness may create unemployment for the entire family. An employed patient may eventually lose his or her job because of stigma and low work performance. Hospital services usually have huge budgets to cater for the patients as the recovery periods are long.

Caregivers face problems of coping with the social withdrawal, awkward interpersonal behaviours and disruptive attitude of patients with schizophrenia. These behaviours may be unhealthy for the caregivers and may create a lot of stress and emotional discomfort in the

families [2]. Caregivers are usually close family members that take the responsibility of looking after the sick patient in the family. They report on any changes or abnormalities that are observed with the patients during the follow-up visits to the health facilities [4]. The causes of the changes or abnormalities seen with the patients may not be very clear to the caregivers but they may have their own interpretation of the abnormalities in their culture and they have some local names for the illness [4]. Caregivers may adapt to the environment of the schizophrenic patient and may live with them until there is a danger to the patient themselves or to the community; the caregivers have the responsibility of seeking help for the patient. In some cases schizophrenic patients are on the streets wandering aimlessly and surviving on what they find. This may be of concern to the caregivers who have the responsibility of caring for the patient; the schizophrenic patients are usually not considered responsible for their own actions. Schizophrenia patients, when discharged, are managed at home by caregivers and are followed up at consultation clinics for maintenance of treatment and assessment. Early intervention and treatment are critical to prevent long term effects of the illness. The treatment is more effective when caregivers are equipped with the proper knowledge, attitude and practices relating to schizophrenia [5]. There have not been any studies on the knowledge, attitudes and

practices (KAP) of caregivers of schizophrenia patients in PNG. Therefore, this study was done to assess the knowledge, attitudes and practices of caregivers of patients with schizophrenia, admitted in the PMGH in Port Moresby, PNG.

PATIENTS AND METHODS:

This was a cross-sectional descriptive study carried out in the psychiatric consultation clinic and the psychiatric ward (ward 6) in PMGH. The clinic is accessible to discharged psychiatric in-patients and new psychiatric outpatient referrals from health facilities in PNG. The study population was made up of caregivers accompanying schizophrenia patients to the psychiatric consultation clinic in PMGH. It was a convenient sample of 79 caregivers. The study was conducted between February and March 2010. Self designed semi-structured questionnaire was used to collect quantitative and qualitative data by interview during clinic sessions. Some of the information collected included: age, gender, marital status, employment status, level of education, religion, region of origin, relationship of caregiver to patient, and duration of the illness. Some of the data collected during the interview were written in the language that the caregivers preferred, in some cases the sessions were tape recorded. All data were thematically translated into English and analysed.

Ethical clearance and permission for this study were obtained from the ethics and research grant committee in the School of Medicine and Health Sciences (SMHS), University of Papua New Guinea (UPNG). Written consent was obtained from the Acting Chief Executive Officer of PMGH. Written consent was also obtained from caregivers before the interviews were conducted. Verbal consent was obtained from the guardians of schizophrenia participants before their participation in the focus group discussion.

All schizophrenic patients that were not accompanied by caregivers were excluded from the study. The quantitative data were analysed statistically using EPI-Info. 6.02. The qualitative data were analysed using Thematic Method. The main categories used in this study were, knowledge of the caregivers of the information of schizophrenia and its types, attitudes of caregivers towards the patients and the practices of caregivers.

RESULTS:

During the two months duration of this study a total of 565 appointments were booked, of which 328 were bookings for schizophrenia patients. Further analysis of the data indicated that there were 216 clinic attendances by 108 confirmed schizophrenia patients, because some of them attended more than once during the study period. A total of 29 schizophrenia

patients were excluded from the study because they came alone to the clinic. The 79 caregivers and patients were enrolled for the study. Informed consent was obtained from 40 of the 79 caregivers, which gives a response rate of 50.6%. Gender distribution of the caregivers indicated 60.0% males and 40.0% females. Most of the caregivers (72.0%) were over 40 years of age. Information on marital status indicated that 80.0% of the caregivers were married, 10.0% were single, 7.0% widowed and 2.0% were divorced. For their residential status, 90.0% of the caregivers were home owners and 10.0% lived with their relatives. The caregivers were mostly from the southern region (75.0%), followed by the highlands region (15.0%), Niugini Islands (7.5%) and Momase (2.5%). Table 1 shows the relationship of the caregivers to the patients, the level of education and religion of the caregivers. The parents (57.5%) were the major caregivers, with the fathers (35.0%) playing the leading role compared to the mothers (22.5%). There was great variation in the educational level of the caregivers, with the majority having primary (27.5%) and tertiary/university (27.5%) education. Most of the caregivers were in the United Church (50.0%), followed by Catholic Church (22.5%). When caregivers were asked about their knowledge of schizophrenia and the source of their information, 75.0% had no prior knowledge about the illness and got the

information first hand by patients experience; however 12.0% got the information from friends, 10.0% got it from health workers and 3.0% from the local news paper. When the caregivers were asked if the illness is only one type or different types, 90.0% indicated that there were many types of the illness, 7.5% indicated that there was one type and 2.5% were not sure. To assess their knowledge of recognizing schizophrenia, caregivers were asked to describe the different symptoms of their patients. Table 2 shows the different symptoms indicated by the caregivers. Physical aggression (65.0%) and antisocial behaviour (65.0%) were the most frequent, followed by hearing voices, talking to self (60.0%), isolation and withdrawal (47.5%). Table 2 also shows the supportive interventions that caregivers recommended for the patients. Church (42.4%) and family support (40.0%) were highly recommended, followed by others such as, rehabilitation, stopping smoking, awareness and counselling. The caregivers were asked what they think caused the patient's illness. Marijuana (47.5%) and psycho-social problems including divorce and others (45.0%) were the most frequently suggested causes; spirit (5.0%) and sorcery (2.5%) were the others suggested. When asked about the importance of medication for the patients, 92.5% of the caregivers indicated that medication was important. In response to question about awareness, 52.5% of the caregivers said there

was enough awareness about schizophrenia, compared to 47.5% that said there was not much awareness in the community. Table 3 shows the response of caregivers on questions relating to their attitude to the patients. Most of the caregivers (27.5%) felt comfortable discussing the illness of the patient with others. The caregivers feel more comfortable talking to the family members (60.0%), communities (40.0%) and relatives (32.5%) when the patient relapses. Table 3 also show the attitude and reactions of caregivers when the patients make bizarre statements or bizarre actions. Being upset, calming and giving medication to the patient making bizarre statement or acting abnormally were highly expressed by the caregivers. When asked about witchcraft intervention, 75.0% of the caregivers do not believe in the witchcraft intervention, 7.5% said they have tried but failed and 5.0% said its long time intervention. Failed efforts included giving of herbs to the patients by the magicians. The caregivers were also asked about the preferred place for the patient to live; 52.5% said they would like the patient to stay in the house at home, 25.0% preferred the hospital and 22.5% preferred the village. Almost all people living in Port Moresby also have homes back in their traditional village. Therefore, some would keep the patient with them in their current home in Port Moresby. Others preferred to get them out of the city and take them back to the village. The question, "How you feel about caring for

the patient?” was used to partly assess the attitude and responsibility of the caregivers towards caring for the patient. The responses of the caregivers are presented in Table 3. Most (52.5%) of the caregivers said that they were responsible to the patients. Figure 1

shows the responses of the caregivers when they were asked who do they see first when the patient relapses. The health worker was the first person seen by most (77.5%) of the caregivers, only 5.0% indicated that the police was seen first.

Table 1: Relationship to patients, educational level and religion of caregivers (n = 40)

	Percent (n)
Relationship of caregivers with patients	
Father	35.0 (14)
Mother	22.5 (9)
Brother	10.0 (4)
Relative	10.0 (4)
Husband	5.0 (2)
Sister	5.0 (2)
Son	5.0 (2)
Wife	5.0 (2)
Daughter	2.5 (1)
Level of education of caregivers	
Tertiary / University	27.5 (11)
Primary School	27.5 (11)
High School	22.5 (9)
Elementary School	17.5 (7)
Secondary School	2.5 (1)
No education	2.5 (1)
Religion of caregivers	
United Church	50.0 (20)
Catholic Church	22.5 (9)
Seven Days Adventist (SDA)	15.0 (6)
Pentecostal Church	12.5 (5)

Table 2: Symptoms of illness and supportive intervention suggested by caregivers (n = 40)

	Percent (n)
Describe the symptoms of the illness of the patients	
Abnormal belief	2.5 (1)
Scared	2.5 (1)
Sleep a lot	7.5 (3)
Verbal aggressive	12.5 (5)
Abnormal speech	15.0 (6)
Smoking	15.0 (6)
Insomnia	15.0 (6)
Abnormality of mood	20.0 (8)
Roaming/ wandering	20.0 (8)
Self neglect	25.0 (10)
Isolation/withdrawn	47.5 (19)
Hearing voices/taking / laughing to self	60.0 (24)
Antisocial behavior	65.0 (26)
Physical aggression	65.0 (26)
What supportive intervention is needed for the patient?	
Finance	2.5 (1)
Give smoke	5.0 (2)
School	5.0 (2)
Counseling	5.0 (2)
Awareness	7.5 (3)
Stop smoking	10.0 (4)
Rehabilitation	12.5 (5)
Family support	40.0 (16)
Church	42.5 (17)

NB: All items are multiple response so do not add up to 100%

Table 3: Caregivers responses to attitude towards the patients (n = 40)

	Percent (n)
How do you feel about discussing the illness of the patient with others?	
Discuss if asked	2.5 (1)
Ashamed	5.0 (2)
Relieve pressure	12.5 (5)
No discussion	17.5 (7)
Discuss for assistance	17.5 (7)
Awareness	20.0 (8)
Comfortable to discuss	27.5 (11)
Which people do you feel comfortable talking to about the patient?	
Bosses	2.5 (10)
Health workers	15.0 (6)
Church members	27.5 (11)
Relatives	32.5 (13)
Communities	40.0 (16)
Family members	60.0 (24)
How do you react when the patient makes bizarre statements, comments or action?	
Give medicine	5.0 (2)
Scared	10.0 (4)
Ashamed	10.0 (4)
Sad	30.0 (12)
Upset	30.0 (12)
Feel responsible calmly correct them	30.0 (12)
How do you feel about caring for the patient?	
Upset	2.5 (1)
Repay what he has done	7.5 (3)
Happy	7.5 (3)
Burden	7.5 (3)
No problem	10.0 (4)
Tiring	12.5 (5)
Our responsibility	52.5 (21)

NB: Some items are multiple response so do not add up to 100%

Table 4: Willingness and barriers to attending consultation clinics; and home supervision of medication for patients (n = 40)

	Percent (n)
How regularly are you able to attend the consultation clinic?	
Always	55.0 (22)
Most times	40.0 (16)
Some times	5.0 (2)
What are some of the problems that stop you from coming to the consultation clinic?	
Forget dates	2.5 (1)
Other illness apart from schizophrenia	2.5 (1)
No escort	5.0 (2)
Distance	5.0 (2)
Non compliance	5.0 (2)
Aggressive	7.5 (3)
Surplus of antipsychotic	7.5 (3)
No problem	20.0 (8)
Patient refuses	27.5 (11)
Finance	27.5 (11)
Transport	27.5 (11)
Who supervises the treatment at home?	
Respondent caregivers	57.5 (23)
Parents of patients	25.0 (10)
Patients themselves	12.5 (5)
Siblings of patients	5.0 (2)

NB: Some items are multiple responses so do not add up to 100%

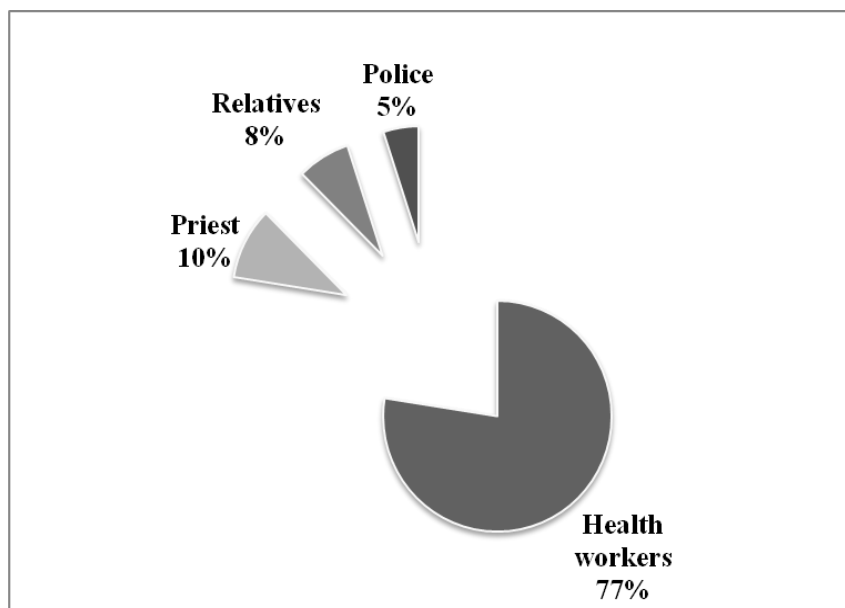
Fig. 1: Who do you see first when the patient relapses? (n = 40)

Table 5: Difficulties for caregivers and supportive interventions for patients recovery (n = 40)

	Percent (n)
What are some of the difficulties you face with your caregiver role?	
Wander/ roaming streets	2.5 (1)
Very old	2.5 (1)
Demand food	5.0 (2)
Doesn't listen	5.0 (2)
No problem	10.0 (4)
Non compliance	17.5 (7)
Money	20.0 (8)
Demand smoke	20.0 (8)
Aggressive/violent	47.5 (19)
What are some of the activities that you think can support recovery of the patients?	
Early detection of break down	2.5 (1)
Clean environment	2.5 (1)
Awareness	10.0 (4)
Stop smoking	12.5 (5)
Counselling	12.5 (5)
Finance	12.5 (5)
Church involvements	12.5 (5)
Employment	12.5 (5)
School	17.5 (7)
Rehabilitation	20.0 (8)
Family support	25.0 (10)
Medicine	37.5 (15)

NB: Some items are multiple responses so do not add up to 100%

The responses of caregivers to questions related to willingness and problems or barriers to attending consultation clinics are presented in Table 4. Fifty five percent of caregivers said they attended the clinic always, compared to 40.0% who attended most times and 5.0% that only attended sometimes. The major problems that prevented some caregivers from bringing their patients to the consultation Clinics, included finance (27.5%), transport (27.5%) and refusal by the patients (27.5%). Having surplus of antipsychotic drugs at home (7.5%) and aggressive behaviour of patients (7.5%) were other problems mentioned. Responses to supervision of medications for patient at home are also presented in Table 4. The caregivers (57.5%) were mostly responsible for the supervision of medication at home. The patients themselves supervised their own treatment in 12.5% of cases. However in some cases, supervising medication was not the responsible of the respondent who had brought the patient to the consultation clinic, but was the responsibility of other family members such as parents of patients (25.0%) and siblings (5.0%) of patients. Table 5 shows the responses of caregivers to questions about the difficulties they faced and suggested activities to support recovery of the patients. Aggression and violence (47.5%) were the most common difficulties faced by caregivers. Demand for

cigarettes (20.0%) and money (20.0%) and also non compliance with medication (17.5%) were other difficulties mentioned. Medication (37.5%), family support (25.0%), rehabilitation (20.0%) and school (17.5%) were seen to be the most support activities for recovery.

Results of the focus group discussion (FGD):

FGD was conducted in ward six at PMGH. There were eleven inpatients during the time of FGD, but only five were schizophrenia patients. Prior to the FGD, the five guardians were approached and all agreed to participate. All the respondents were males, the mean age was 29.6years and the age range was 20 to 50 years. Each of the five respondents had different occupation: farmer, principle, pastor, apprentice and student. Each respondent was closely related to the patient, father, uncle, aunty and brother. During the FGD the participants were asked the same questions as caregivers at the consultation clinic but in a group setting. The answers in general were similar to those given by the caregivers; the same points were raised and generally agreed upon by the participants in the FGD.

DISCUSSION:

The interviews and FGD were conducted by a trained mental health professional who is a Health Extension Officer that is conversant with

the cultural settings and local languages in the study area. This minimises the negative impact of translation and interpretation of expressions used by the caregivers and participants in the FGD. It was also easy to understand slangs and colloquial terms used by the respondents.

Results obtained in the present study are similar to the findings reported in other studies conducted in India [6], Cambodia [7], Asia [8], Nigeria [9] and Australia [10].

Our data indicate that schizophrenia patients accessed the consultation clinic more often than patients suffering from other mental illnesses. Caregivers' knowledge on schizophrenia illness indicates that they understand the general idea of the illness as mental sickness. The term schizophrenia to them was 'longlong" (mental illness). Eighty percent of caregivers said that, they had heard of schizophrenia, however the real knowledge on the impact of the illness cannot be significant as the caregivers described the illness as many forms.

Most respondents said that they knew of the illness from the patient's experiences, some from the health workers and others through friends. The term schizophrenia was new to them but the understanding of the illness from the caregivers' perspective was not restricted to the term schizophrenia but to general mental illness. The caregivers said that living with the

patient taught them many things about the mental illness.

The respondents said that there were many types of schizophrenia. Three of the caregivers were not sure of the diagnosis while one said there was only one type. This finding illustrates that caregiver's lack accurate knowledge of schizophrenia.

Descriptive classification is one of the systems mostly used in the case of diagnosing of schizophrenia and other mental disorders [11]. Most caregivers in this study can identify the acute stage and the prolific stages. They have described the negative and positive symptoms of schizophrenia well with all symptoms that are seen in the patients. They agreed that there are many types of schizophrenia with only three out of forty respondents being unsure of the illness. All respondents described the different forms of schizophrenia in many ways. Physical aggression together with anti social behaviour, hearing voices, taking to self, laughing to self and isolation were regularly mentioned in descriptions of schizophrenia. Self neglect, roaming the streets, abnormality of mood, sleepless nights (insomnia), smoking, abnormal speech and verbal aggression were also stated. The other least described features were sleeping a lot, feeling scared and abnormal belief. The respondents were of the view that medication was the only necessary intervention for this illness. Apart from medicine being the

major intervention, the other supportive interventions that can support the patients were church activities, family support, rehabilitation, and stopping smoking, counselling and going back to school. Others responded that giving of smoke and money to the patients was also a helpful intervention.

Fifty two percent of caregivers said that health workers were doing enough education on schizophrenia during consultation while 48% said that not much education on schizophrenia was done during consultation. The response to the education on schizophrenia awareness by the caregivers did not differ very much as nearly half (48%) felt health workers were not giving them enough education. The similar findings were reported in the National alliance of Mental Illnesses in 2008.

Most respondents said they felt very comfortable to discuss the patient's illness with others. The reasons for discussing patients' issues were for the reasons of awareness and assistance. Others felt that discussing the patients' illness with others relieved them from the problems that they keep within themselves. Others didn't want to discuss with others unless they were asked. Others were ashamed to discuss the patients' illness. Most of the respondents felt very comfortable talking about the patients' illness to close family members, communities, relatives, church members and health workers. The importance of this is that

caregivers with less stress help the patient in whatever way they can, more than the stressed caregiver who is under pressure and does not help the patient. The patient whose caregiver is under pressure is most likely to be neglected and the patient is most likely to relapse [12].

Behavioural problems in patients are the most common difficulties that caregiver encounter. The most difficult that they face is aggression, anti social behaviours like demanding cigarettes, money, food, wandering on the streets and the patient not obeying the caregivers. Other problems noted were that caregivers felt they were too old to care for the patient. The greatest difficulty that is faced by the caregivers as mentioned is aggressiveness. Frequently violent behaviour is aggravated by the caregivers as they try to control the patients. The patients demand much from the caregivers which the caregivers don't have, so they have to explain the reasons for not providing what the patients need. Disagreement causes irritability of the patients. The difficulties faced by the caregivers to sustain the demands for the patients are real. We depend on whatever we sell to sustain ourselves and the family or receive donations from neighbours. The first people to be consulted when the patient relapses are health workers. The respondents also said that close relatives, police and priests or pastors were consulted when the patients relapsed.

Caregivers living in the city are aware of the health care that is provided for the patients. Unfortunately easy access to psychiatric hospitals is only possible for a minority of the population as most of the population live in rural areas.

The reasons for not bringing the patients to the consultation clinic were transport, finance and patients refusing to come to the clinic. Patient refusing to come to the clinic means lot of things such as non compliance, long waiting time at the clinic or maybe due to staff approaches to the patients. The other constraints were surplus of medicine, distance, no escorts, forgetting of the dates and being sick with other physical illnesses. With or without the above mentioned problems, the respondents said that they are happy to attend to the consultation clinic.

Most caregivers said that they were responsible for supervision of the treatment at home. Other said that patients used to supervise their own treatment. The respondents said that they preferred to supervise treatment. Maintenance of treatment and rehabilitation at home is important and should be encouraged. Caregivers should be made aware of the early signs of relapse so that when a patient shows the signs he or she should be brought to the clinic or nearby health facility for the patient to be referred.

CONCLUSIONS:

This study set out to investigate knowledge, attitudes and practices of caregivers of schizophrenia patients. Most caregivers had heard about schizophrenia; patient experience was the main source of information in understanding schizophrenia; marijuana and psychosocial factors were identified as the main causes of schizophrenia; medication was the most important intervention and not intervention such as witchcraft; supportive interventions included church activities, family support, rehabilitation, school, employment and finance; not much awareness has been done on schizophrenia illness in communities; it was comfortable to discuss their relative's illness with others for the sake of awareness and assistance; it is important to share experiences with family members, communities, church members and health workers; it is necessary to take responsibility for the patient and supervise their treatment at home, with the exception of patients that are aggressive and could not be handled at home; Financial limitations, transport, patient's refusal, surplus of antipsychotic medication, noncompliance were the main factors for non attendance to the consultation clinics; Responsible caregivers should not be denied the truth that their family member is suffering from schizophrenia; health workers should be encouraged to share their knowledge, skill and experience with communities. The caregivers are willing to take

the responsibility of looking after their loved ones but the responsibility of imparting the knowledge, shaping the attitude and practice relies heavily on the service providers.

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