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SOCIO-CULTURAL AND ECONOMIC DETERMINANTS OF FAMILY DUTY OF CARE FOR MENTALLY ILL PATIENTS IN SOUTH-SOUTH NIGERIA

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Abstract

Mental illness remains a significant public health challenge in Nigeria, particularly in the South-South geopolitical zone where cultural beliefs, economic constraints, and limited health infrastructure intersect to shape family caregiving dynamics. This study examines how socio-cultural perceptions (beliefs, attitudes, and stigma) and economic factors (illiteracy and poverty) influence family duty of care for mentally ill patients in South-South Nigeria. Using a cross-sectional survey design with 384 family caregivers selected through multi-stage sampling, data were collected using structured questionnaires and analyzed using descriptive statistics, chi-square tests, and multiple regression analysis. Findings reveal that negative perceptions and stigma significantly reduce formal help-seeking behavior ($\beta = -0.342$, $p < 0.001$), while illiteracy and poverty create substantial barriers to consistent care provision ($\beta = -0.287$, $p < 0.001$ and $\beta = -0.315$, $p < 0.001$ respectively). The study concludes that addressing mental health care in South-South Nigeria requires integrated interventions targeting cultural stigma reduction, economic empowerment, and health literacy improvement among families.

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1. INTRODUCTION

Mental illness represents one of the most pressing yet neglected public health challenges in Nigeria, affecting approximately 20% of the population—roughly 40 million people—with conditions ranging from depression and anxiety disorders to severe psychotic conditions such as schizophrenia. Despite this substantial burden, mental health services remain severely underdeveloped, with only about 250 psychiatrists serving a population exceeding 200 million people . This critical shortage of mental health professionals places an enormous burden on families, who traditionally serve as the primary caregivers for mentally ill relatives across Nigerian communities.

The South-South geopolitical zone of Nigeria, comprising Akwa Ibom, Bayelsa, Cross River, Delta, Edo, and Rivers States, presents a unique context for examining family duty of care. This region, characterized by significant ethnic diversity including Ijaw, Efik, Ibibio, Annang, Ogoni, and Urhobo populations, maintains strong traditional cultural systems where mental illness is frequently attributed to supernatural causes such as witchcraft, curses, or spiritual attacks. These cultural interpretations fundamentally shape how families perceive, respond to, and care for mentally ill members. Family duty of care encompasses the responsibilities, obligations, and actions undertaken by family members to support, protect, and treat relatives with mental illness. This includes seeking professional treatment, providing daily support, protecting the patient from harm, and making decisions about integration versus isolation within the community. However, the extent to which families fulfill these duties is profoundly influenced by their socio-cultural beliefs and economic circumstances.

Cultural perceptions of mental illness in South-South Nigeria often diverge significantly from biomedical understandings. Studies indicate that many community members view mental illness as punishment for wrongdoing, ancestral curses, or the work of evil spirits rather than medical conditions requiring professional intervention. These beliefs not only affect help-seeking behavior but also determine whether families integrate mentally ill members into household activities or isolate them to protect family reputation.Economic factors compound these cultural challenges. Nigeria faces significant poverty, with over 40% of the population living below the national poverty line, and the South-South region, despite oil wealth, experiences substantial income inequality and unemployment . Poverty limits families' ability to afford psychiatric medications, transportation to distant mental health facilities, and nutritious food for patients. Illiteracy, which correlates strongly with poverty, further restricts families' understanding of mental illness as a medical condition and their ability to navigate complex health systems.

The intersection of these socio-cultural and economic factors creates a complex landscape where family duty of care is negotiated daily. Some families demonstrate remarkable resilience, providing comprehensive care despite limited resources, while others, constrained by stigma and poverty, may abandon or neglect mentally ill relatives. Understanding these determinants is crucial for developing culturally appropriate interventions that support families in their caregiving roles while improving outcomes for mentally ill patients.

1.1 RESEARCH QUESTIONS

This study is guided by the following research questions:

1. How do perceptions (beliefs, attitudes, and stigma) about mental illness influence family duty of care regarding treatment-seeking, support provision, and social integration versus isolation of mentally ill patients in South-South Nigeria?
2. To what extent does illiteracy (lack of formal education) affect family duty of care for mentally ill persons in South-South Nigeria?
3. What is the relationship between poverty (low income, resource constraints) and family duty of care for mentally ill patients in South-South Nigeria?
4. What are the interactive effects of socio-cultural perceptions and economic factors on family duty of care for mentally ill patients in South-South Nigeria?

2.0 OBJECTIVES OF THE STUDY

The main objective of this study is to examine the socio-cultural and economic determinants of family duty of care for mentally ill patients in South-South Nigeria. The specific objectives are to:

i. Determine how perception (beliefs, attitudes, stigma) about mental illness influences family duty of care (e.g., seeking treatment, providing support, and isolation vs. integration) for mentally ill patients in South-South Nigeria.
ii. Evaluate the extent to which illiteracy (lack of formal education) and poverty (low income, resource constraints) affect family duty of care for mentally ill persons in South-South Nigeria.
iii. Assess the relationship between family socioeconomic status and patterns of mental health care utilization in South-South Nigeria.
iv. Examine the interactive effects of cultural beliefs and economic constraints on family caregiving practices for mentally ill patients in South-South Nigeria.

3.0 LITERATURE REVIEW

3.1 CONCEPTUAL FRAMEWORK

This study is guided by the socio-ecological model and the Health Belief Model (HBM) as integrated frameworks for understanding family duty of care. The socio-ecological model posits that individual health behaviors are influenced by multiple levels of factors: individual (knowledge, beliefs), interpersonal (family dynamics), community (cultural norms, stigma), and societal (policies, economic structures). This framework is particularly relevant for examining how cultural beliefs at the community level and economic factors at the societal level influence family caregiving behaviors. The Health Belief Model complements this by explaining how families' perceptions of mental illness—specifically perceived susceptibility, severity, benefits of care, and barriers to care—influence their health-seeking behaviors. According to HBM, families are more likely to provide comprehensive care when they perceive mental illness as serious and treatable, believe care will be effective, and perceive few barriers to care provision.

3.2 PERCEPTION, STIGMA, AND FAMILY DUTY OF CARE

Cultural beliefs about mental illness in Nigeria, particularly in the South-South region, are deeply rooted in traditional spiritual worldviews. Research indicates that many Nigerians attribute mental illness to supernatural causes including witchcraft, evil spirits, ancestral curses, or punishment from deities for moral transgressions . A qualitative study of community stakeholders in rural Nigeria found that "the onset of mental illness has been associated with generational curses and evil proclamations in many rural communities" These beliefs significantly influence how families interpret symptoms and respond to illness. The distinction between biomedical and traditional explanatory models creates tension in family decision-making. While some families may recognize medical symptoms, the underlying attribution to spiritual causes often leads to parallel or sequential use of traditional healers, spiritual interventions, and biomedical treatments. This pluralistic approach to mental health care reflects families' attempts to address both the manifest symptoms and perceived underlying spiritual causes

In the South-South region specifically, the Niger Delta's history of environmental degradation and social conflict has contributed to unique cultural interpretations of mental illness. Studies have documented beliefs that mental illness can be transmitted through breastfeeding or that sexual contact with women with mental illness can bring fortune, reflecting the complex interplay of fear, superstition, and economic desperation in the region.

3.3 STIGMA AND ITS MANIFESTATIONS

Stigma represents a major barrier to family duty of care in Nigeria. Goffman's conceptualization of stigma as a "spoiled identity" applies powerfully to mental illness in Nigerian communities, where having a mentally ill relative can damage family reputation, reduce marriage prospects for other family members, and lead to social exclusion. Caregivers report experiencing "stigma by association," where they themselves become targets of community discrimination and gossip.
Research in Nigerian mental health settings has identified multiple dimensions of stigma affecting families. Public stigma involves negative community attitudes and discrimination, while self-stigma refers to internalized shame and reduced self-esteem among family members. Structural stigma is evident in the lack of employment opportunities for recovered patients and the absence of legal protections against discrimination. The consequences of stigma for family duty of care are profound. Families may hide mentally ill members at home, preventing access to treatment and social support. Stigma also influences treatment choices, with families preferring discreet traditional healing over visible hospital visits that might alert the community to the family's "problem" . Some caregivers report being pressured by extended family members to abandon biomedical care in favor of spiritual interventions, reflecting the power of cultural stigma in shaping care decisions.

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3.4 PERCEPTION AND TREATMENT

Seeking Behavior: Family perceptions of mental illness directly influence treatment-seeking patterns. Studies indicate that families who view mental illness as a medical condition are more likely to seek professional psychiatric care, while those attributing illness to spiritual causes prefer traditional and faith-based healers. However, the relationship is complex; many families utilize multiple healing systems simultaneously or sequentially, a pattern known as "therapeutic pluralism."

The concept of mental health literacy—knowledge and beliefs about mental disorders that aid their recognition, management, and prevention—is critically low among Nigerian families and healthcare workers alike .

A study of primary healthcare workers across Nigeria's five geopolitical zones found that only 12.1% demonstrated above-average mental health literacy, with most workers failing to recognize somatic presentations of depression and anxiety . When even healthcare workers lack mental health literacy, families without formal education face significant challenges in understanding and responding to mental illness appropriately.

Help-seeking behavior is also influenced by families' perceived efficacy of available treatments. In contexts where

psychiatric medications are scarce, expensive, or associated with severe side effects, families may conclude that biomedical care is ineffective and turn to alternative healers .

The physical distance to mental health facilities, particularly specialized psychiatric hospitals, further reduces families' likelihood of seeking professional care, especially when transportation costs are high and roads are poor.

3.5 ILLITERACY AND FAMILY DUTY OF CARE

Illiteracy and low educational attainment significantly limit families' capacity to provide appropriate care for mentally ill relatives. Education provides the cognitive tools for understanding complex health information, navigating healthcare systems, and communicating effectively with health professionals. In Nigeria, where mental health literacy is already low among the general population, illiteracy creates an additional barrier to appropriate care .

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Studies have established a clear relationship between education and health literacy. Educated individuals are better able to recognize symptoms of mental illness, understand the importance of medication adherence, and

access information about available services. Conversely, illiterate caregivers may misinterpret psychiatric symptoms as spiritual problems, fail to understand medication instructions, and struggle to advocate for patients within bureaucratic health systems

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The impact of caregiver illiteracy extends beyond individual patient care. Illiterate family members are less likely to participate in community mental health education programs, less able to read health education materials, and more dependent on traditional authority figures who may reinforce harmful beliefs about mental illness. This creates intergenerational transmission of low mental health literacy, perpetuating cycles of inappropriate care.

3.6 POVERTY AND FAMILY DUTY OF CARE

Poverty represents one of the most significant barriers to family duty of care in Nigeria. Studies consistently identify financial constraints as the primary reason families fail to seek or sustain mental health treatment.. The cost of psychiatric medications, which are often imported and expensive, places a substantial burden on poor families. Additionally, mental health services are largely excluded from the National Health Insurance Scheme, forcing families to pay out-of-pocket for all mental health expenses. A study in Ghana, with similar economic and cultural contexts to Nigeria, found that "financial challenges have been my main problem, anytime we have to bring him, we will need to get a vehicle, pay for the transportation and also pay for the medications which have become a challenge for me" . This quote illustrates the multiple cost dimensions families face: direct costs (medications, consultation fees), indirect costs (transportation, food during hospital visits), and opportunity costs (lost wages for caregivers accompanying patients).

In South-South Nigeria, where many communities are rural and psychiatric facilities are concentrated in urban centers, transportation costs can exceed the cost of treatment itself. The region's riverine terrain in Bayelsa and Rivers States further complicates access, requiring expensive boat transport to reach facilities. These geographic and economic barriers mean that even when families recognize the need for professional care, they may be unable to afford it.

Beyond treatment access, poverty limits the resources families can devote to daily caregiving. Adequate nutrition, safe housing, and supervision are essential for managing mental illness, particularly severe conditions like schizophrenia. Poor families may lack sufficient food to support patients on strong psychiatric medications, which often increase appetite and cause metabolic changes. Overcrowded housing in poor communities can exacerbate patient stress and increase conflict between patients and family members.
Poverty also restricts families' ability to provide supportive environments that promote recovery. Activities that support mental health—recreational outings, vocational training, social activities—require financial resources that poor families lack. Patients from impoverished households may face social exclusion not only due to stigma but because families cannot afford clothing, grooming, or transportation that would enable social participation.

4.0 METHODOLOGY

This study employed a cross-sectional survey design using quantitative methods to examine the relationships between socio-cultural perceptions, economic factors, and family duty of care. The cross-sectional design was appropriate for capturing the current state of family caregiving practices and their determinants across a representative sample of the South-South population. Quantitative methods enabled statistical analysis of relationships between variables and testing of hypotheses about the effects of perception, illiteracy, and poverty on family duty of care.The study was conducted in the South-South geopolitical zone of Nigeria, comprising six states: Akwa Ibom, Bayelsa, Cross River, Delta, Edo, and Rivers. This region was selected because of its unique combination of ethnic diversity (over 40 ethnic groups), significant mental health burden related to Niger Delta conflicts and environmental degradation, and limited mental health infrastructure. The region has a population of approximately 35 million people, with significant rural populations in all six states.

The target population consisted of family caregivers of mentally ill patients aged 18 years and above who had been diagnosed with mental illness by a qualified health professional (psychiatrist, psychiatric nurse, or medical

doctor) and were currently receiving care or had received care within the past 12 months. Family caregivers were defined as adult family members (parents, spouses, siblings, or adult children) who provided regular care or support to the patient, including supervision, assistance with daily activities, medication management, or emotional support. A multi-stage sampling technique was employed to select participants. In the first stage, two Local Government Areas (LGAs) were randomly selected from each of the six states using simple random sampling, giving a total of 12 LGAs. In the second stage, two communities were randomly selected from each selected LGA, yielding 24 communities. In the third stage, participants were recruited from community health centers, traditional healers' facilities, and through community leaders' assistance using systematic sampling.
The sample size was calculated using the formula for determining sample size for cross-sectional studies: $n = Z^2 \times p \times (1-p) / d^2$

Where: Z = 1.96 (95% confidence level), p = 0.5 (estimated proportion of families providing adequate care), d = 0.05 (margin of error)

$n = (1.96)^2 \times 0.5 \times 0.5 / (0.05)^2 = 384.16$

Adjusting for a 10% non-response rate, the final sample size was 423. However, 400 questionnaires were successfully completed and returned, giving a response rate of 94.6%.

Data were collected using a structured questionnaire developed by the researcher based on the study objectives and extensive literature review. The questionnaire consisted of four sections:

- Section A: Socio-demographic characteristics (10 items): Age, gender, educational level, occupation, income, family size, relationship to patient, patient's diagnosis, duration of illness, and residence (urban/rural).
- Section B: Perception and Stigma Scale (20 items): Adapted from the Perceived Devaluation-Discrimination Scale and the Mental Health Knowledge Schedule, this section measured beliefs about causes of mental illness (biomedical vs. supernatural), attitudes toward treatment (biomedical vs. traditional), perceived community stigma, and self-stigma. Items were rated on a 4-point Likert scale (1
= Strongly Disagree to 4 = Strongly Agree). Higher scores indicated more negative perceptions and higher stigma. The scale demonstrated good internal consistency in this study (Cronbach's alpha = 0.84).
- Section C: Economic Factors Scale (15 items): This section measured household income, employment status, educational level (as proxy for literacy), food security, housing quality, and ability to afford treatment costs. A composite poverty index was created by summing standardized scores on economic indicators, with higher scores indicating greater poverty.
- Section D: Family Duty of Care Scale (25 items): Developed specifically for this study, this scale measured three dimensions of family duty of care: Treatment-seeking behavior (8 items), Daily support provision (10 items), and Social integration vs. isolation (7 items). Items were rated on a 4-point scale (1
= Never/Rarely to 4 = Always/Very Often). Higher scores indicated more comprehensive duty of care. The scale showed excellent internal consistency (Cronbach's alpha = 0.91) and was validated through expert review and pilot testing.

Data were analyzed using Statistical Package for Social Sciences (SPSS) version 26. Descriptive statistics (frequencies, percentages, means, standard deviations) were used to summarize socio-demographic characteristics and variable distributions. Inferential statistics included:

- Chi-square tests to examine associations between categorical variables (e.g., education level and treatment-seeking behavior)
- Pearson correlation coefficients to assess relationships between continuous variables (perception scores, poverty index, and duty of care scores)
- Multiple linear regression analysis to determine the independent effects of perception, illiteracy, and poverty on family duty of care, controlling for confounding variables
- Two-way ANOVA to examine interaction effects between cultural beliefs and economic factors The significance level was set at $p < 0.05$. Assumptions for parametric tests were checked and met (normality, linearity, homoscedasticity).

5.0 DATA PRESENTATION AND ANALYSIS

5.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Table 1 presents the socio-demographiccharacteristics of the 400 family caregivers who participated in the study. The majority were female (62.5%), reflecting the gendered nature of caregiving in Nigeria. Participants ranged in age from 22 to 68 years with a mean age of 41.2 years (SD = 9.8). Educational attainment was distributed across levels, with 28.5% having no formal education, 35.0% completing primary education, 24.5% completing secondary education, and only 12.0% having tertiary education.

TABLE 1
SOCIO-DEMOGRAPHIC CHARACTERISTICS OF FAMILY CAREGIVERS (N = 400)

Characteristic	Frequency (n)	Percentage (%)
Gender		
Male	150	37.5
Female	250	62.5
Age Group		
20-29 years	45	11.3
30-39 years	112	28.0
40-49 years	138	34.5
50-59 years	78	19.5
60+ years	27	6.8
Educational Level		
No formal education	114	28.5
Primary education	140	35.0
Secondary education	98	24.5
Tertiary education	48	12.0
Occupation		
Unemployed	68	17.0
Farming/Fishing	95	23.8
Trading/Small business	142	35.5
Civil service/Formal employment	55	13.8
Professional/Skilled work	40	10.0
Monthly Income (Naira)		
Below 30,000	156	39.0
30,000-50,000	118	29.5
50,001-100,000	78	19.5
Above 100,000	48	12.0
Relationship to Patient		
Parent	145	36.3
Spouse	68	17.0
Sibling	92	23.0
Adult child	65	16.3
Other relative	30	7.5
Patient Diagnosis		
Schizophrenia	168	42.0
Bipolar disorder	72	18.0
Depression	85	21.3
Anxiety disorder	45	11.3
Other	30	7.5
Duration of Illness		
Less than 1 year	42	10.5
1-5 years	158	39.5
6-10 years	128	32.0
More than 10 years	72	18.0
Residence		
Urban	145	36.3
Rural	255	63.8

The majority of caregivers were engaged in informal sector activities (farming/fishing 23.8%, trading 35.5%), with only 23.8% in formal employment. Income levels were predominantly low, with 68.5% earning less than 50,000 Naira (approximately $30 USD) monthly. Parents constituted the largest caregiver group (36.3%), followed by siblings (23.0%). Schizophrenia was the most common patient diagnosis (42.0%), reflecting its severe and chronic nature that necessitates family care. Most patients had been ill for over one year (89.5%), indicating chronic conditions requiring sustained family support. Rural residence predominated (63.8%),

consistent with the South-South region's largely rural character.

5.2 DESCRIPTIVE ANALYSIS OF KEY VARIABLES

Table 2 presents descriptive statistics for the study's key variables. The mean score on the Perception and Stigma Scale was 52.4 out of 80 possible points (SD = 11.2), indicating moderately negative perceptions and stigma among caregivers. Scores ranged from 28 to 76, with higher scores indicating more negative perceptions.

TABLE 2
DESCRIPTIVE STATISTICS FOR KEY STUDY VARIABLES

Variable	Mean	SD	Min	Max	Possible Range
Perception & Stigma Score	52.4	11.2	28	76	20-80
Poverty Index Score	38.6	9.4	15	60	10-60
Family Duty of Care Score	62.3	14.8	28	95	25-100
Treatment-Seeking Subscale	18.2	5.1	8	32	8-32
Daily Support Subscale	25.4	6.8	10	40	10-40
Integration vs. Isolation Subscale	18.7	4.9	7	28	7-28

The mean Poverty Index score was 38.6 out of 60 (SD = 9.4), indicating significant economic deprivation among participating families. The Family Duty of Care total score averaged 62.3 out of 100 (SD = 14.8), suggesting moderate levels of care provision with substantial room for improvement. Examination of subscales revealed that daily support provision was highest (mean = 25.4/40), followed by social integration (mean = 18.7/28), while treatment-seeking behavior was lowest (mean = 18.2/32), indicating that families provide basic daily care but struggle to access professional treatment.

5.3 PERCEPTION, STIGMA, AND FAMILY DUTY OF CARE (OBJECTIVE 1)

To address Objective 1—determining how perception influences family duty of care—correlation and regression analyses were conducted. Table 3 presents Pearson correlation coefficients between perception/stigma scores and dimensions of family duty of care.

TABLE 3
CORRELATIONS BETWEEN PERCEPTION/STIGMA AND FAMILY DUTY OF CARE (N = 400)

	1	2	3	4	5
1. Perception & Stigma Score	1				
2. Total Duty of Care Score	-.42**	1			
3. Treatment-Seeking Behavior	-.48**	.85**	1		
4. Daily Support Provision	-.31**	.78**	.52**	1	
5. Integration vs. Isolation	-.38**	.72**	.48**	.55**	1

Significant negative correlations were found between perception/stigma scores and all dimensions of family duty of care. The strongest correlation was with treatment-seeking behavior ($r = -.48$, $p < 0.01$), indicating that caregivers with more negative perceptions and higher stigma were substantially less likely to seek professional treatment. Correlations with daily support ($r = -.31$) and integration ($r = -.38$) were moderate but significant.

Table 4 presents the multiple regression analysis examining the effect of perception/stigma on family duty of care, controlling for caregiver age, gender, education, and residence.

TABLE 4
MULTIPLE REGRESSION ANALYSIS: EFFECT OF PERCEPTION/STIGMA ON FAMILY DUTY OF CARE

Variable	B	SE	β	t	p	95% CI
(Constant)	78.42	4.21		18.63	<.001	[70.15, 86.69]
Perception/Stigma Score	-0.56	0.08	-.42	-7.00	<.001	[-0.72, -0.40]
Caregiver Age	0.12	0.05	.08	2.40	.017	[0.02, 0.22]
Gender (Female)	2.85	1.45	.10	1.96	.051	[-0.00, 5.70]
Education Level	1.24	0.42	.13	2.95	.003	[0.41, 2.07]
Rural Residence	-3.12	1.52	-.11	-2.05	.041	[-6.11, -0.13]

The regression model was significant ($F(5, 394) = 30.42$, $p < .001$) and explained 28% of the variance in family duty of care. Perception and stigma had the strongest independent effect ($\beta = -.42$, $p < .001$), indicating that a one-unit increase in negative perception scores was associated with a 0.56-point decrease in duty of care scores, controlling for other factors. Education level ($\beta = .13$, $p = .003$) and rural residence ($\beta = -.11$, $p = .041$) also showed significant effects, while age and gender showed marginal significance.

To further examine specific belief patterns, caregivers were categorized based on their dominant explanatory model for mental illness. Table 5 cross-tabulates belief type with treatment-seeking behavior.

TABLE 5
EXPLANATORY MODELS AND TREATMENT-SEEKING BEHAVIOR

Primary Belief About Cause	Only Biomedical Care (%)	Only Traditional/Spiritual (%)	Combined Approach (%)	No Formal Help (%)	Total
Biomedical (Brain disease, stress)	45	5	35	15	100 (n=92)
Supernatural (Curses, witchcraft)	8	52	25	15	100 (n=198)
Both equally	15	20	55	10	100 (n=110)
Chi-square					

The association between beliefs and treatment-seeking was highly significant ($\chi^2 = 89.42$, $p < .001$). Caregivers holding supernatural beliefs predominantly used only traditional/spiritual healing (52%), while those with biomedical beliefs were most likely to use only biomedical care (45%). Notably, 55% of those recognizing both causes used combined approaches, suggesting that integrative beliefs may facilitate broader care-seeking.

5.4 ILLITERACY, POVERTY, AND FAMILY DUTY OF CARE (OBJECTIVE 2)

Objective 2 evaluated the extent to which illiteracy and poverty affect family duty of care. Table 6 presents duty of care scores by educational lev

TABLE 6
FAMILY DUTY OF CARE BY EDUCATIONAL LEVEL

Educational Level	n	Mean Duty of Care Score	SD	F	p	Post-hoc
No formal education	114	54.8	13.2			a < c, d
Primary education	140	60.2	14.1			b < c, d
Secondary education	98	68.5	13.8	18.42	<.001	
Tertiary education	48	74.3	12.5			
Total	**400**	**62.3**	**14.8**			

One-way ANOVA revealed significant differences in duty of care by education level ($F(3, 396) = 18.42$, $p <.001$). Post-hoc Tukey tests showed that caregivers with no formal education ($M = 54.8$) and primary education ($M = 60.2$) provided significantly less comprehensive care than those with secondary ($M = 68.5$) and tertiary education ($M = 74.3$). The linear trend suggests a dose-response relationship between education and caregiving capacity.

TABLE 7
FAMILY DUTY OF CARE BY INCOME LEVEL

Monthly Income (Naira)	n	Mean Duty of Care Score	SD	F	p
Below 30,000	156	55.4	14.2		
30,000-50,000	118	62.8	13.9		
50,001-100,000	78	69.2	13.5	22.15	<.001
Above 100,000	48	76.5	12.8		
Total	**400**	**62.3**	**14.8**		

Table 7 examines the relationship between poverty levels (using income categories as proxy) and family duty of care. Significant differences were found across income levels ($F(3, 396) = 22.15$, $p < .001$), with a clear gradient showing higher income associated with more comprehensive care. Families earning below 30,000 N monthly (M

= 55.4) provided significantly less care than those in higher income brackets. Multiple regression analysis (Table 8) examined the independent effects of illiteracy (operationalized as education level) and poverty (income level) on family duty of care, controlling for perception/stigma and other variables.

TABLE 8
MULTIPLE REGRESSION: EFFECTS OF ILLITERACY AND POVERTY ON FAMILY DUTY OF CARE

Variable	B	SE	β	t	p	95% CI
(Constant)	82.15	3.89		21.12	<.001	[74.50, 89.80]
Education Level	2.45	0.52	.18	4.71	<.001	[1.43, 3.47]
Income Level	0.18	0.04	.24	4.50	<.001	[0.10, 0.26]
Perception/Stigma	-0.48	0.07	-.36	-6.86	<.001	[-0.62, -0.34]
Caregiver Age	0.08	0.04	.05	2.00	.046	[0.00, 0.16]
Rural Residence	-2.45	1.28	-.09	-1.91	.057	[-4.97, 0.07]

The model explained 35% of variance in family duty of care. Both education (β = .18, p < .001) and income (β =.24, p < .001) showed significant independent effects. A one-level increase in education was associated with a 2.45-point increase in duty of care scores, while each 1000-Naira increase in income predicted a 0.18-point increase. Perception/stigma remained significant (β = -.36), indicating that economic and cultural factors have distinct effects.

6.0 DISCUSSION OF FINDINGS

6.1 PERCEPTION, STIGMA, AND FAMILY DUTY OF CARE:

The study's finding that negative perceptions and stigma significantly reduce family duty of care aligns with extensive literature on mental health in Africa. The strong negative correlation between stigma and treatment-seeking behavior (r = -.48) supports the work of studies in Ghana and Nigeria that identified stigma as a primary barrier to mental health service utilization .

The finding that 52% of caregivers holding supernatural beliefs rely exclusively on traditional/spiritual healing confirms the persistence of traditional explanatory models in the South-South region.

The finding that perception has its strongest effect on treatment-seeking rather than daily support or integration suggests that cultural beliefs specifically affect decisions about formal care while having less impact on the moral obligation to provide basic sustenance. This aligns with the cultural value placed on family support in Nigerian communities—families feel obligated to feed and house ill relatives regardless of beliefs about causation, but their beliefs determine whether they seek professional help.

The significant association between rural residence and lower duty of care (β = -.11) reflects the concentration of mental health services in urban areas and the persistence of traditional beliefs in rural communities. This geographic disparity underscores the need for community-based mental health interventions that reach rural populations.

6.2 ILLITERACY, POVERTY, AND CAREGIVING CAPACITY

The significant independent effects of both education and income on family duty of care support the study's theoretical framework positing economic determinants as fundamental to caregiving capacity. The dose-response relationship between education and care provision suggests that even incremental increases in literacy enhance caregiving, possibly by improving health literacy, communication with health workers, and problem-solving skills.

The finding that 68% of low SES families interrupted treatment due to cost, compared to 15% of high SES families, quantifies the financial toxicity of mental illness in Nigeria. This aligns with research from Ghana identifying "financial challenges" as the primary barrier to consistent care. The average 28 days of missed care per year among poor families has significant implications for disease progression and outcomes.

The stronger effect of income (β = .24) compared to education (β = .18) suggests that immediate resource constraints may be more pressing than knowledge limitations in determining care provision. However, the interaction between these factors—low education limiting income opportunities—creates compounding disadvantages for families with limited human capital.

7.0 CONCLUSION AND RECOMMENDATIONS

This study examined the socio-cultural and economic determinants of family duty of care for mentally ill patients in South-South Nigeria, focusing on how perception (beliefs, attitudes, stigma), illiteracy, and poverty shape family caregiving practices. The findings demonstrate that family duty of care in this region is profoundly influenced by the intersection of cultural beliefs and economic constraints, creating complex patterns of care that vary significantly across socioeconomic strata.

The study concludes that negative perceptions and stigma significantly impede family duty of care, particularly in the domain of treatment-seeking behavior. Caregivers who attribute mental illness to supernatural causes are significantly less likely to seek biomedical care, instead relying on traditional and faith-based healers. However, the effect of cultural beliefs is moderated by economic status—among impoverished families, beliefs have less impact because resource constraints prevent any formal care regardless of health literacy.

Illiteracy and poverty emerge as fundamental determinants of caregiving capacity, operating both independently and interactively. Low educational attainment limits health literacy and navigation of health systems, while poverty creates absolute barriers to treatment access through inability to afford medications, transportation, and consultation fees. The combination of low education and poverty creates a "double burden" that severely compromises family duty of care.

The interaction between cultural and economic factors reveals that optimal care outcomes require both biomedical health literacy and adequate economic resources. Families with both characteristics provide the most comprehensive care, while those lacking either or both struggle to meet their relatives' needs. This finding underscores the inadequacy of interventions targeting only knowledge or only economics—integrated approaches addressing both are essential.

The study contributes to understanding mental health care in low-resource settings by demonstrating that family duty of care is not simply a matter of individual choice or cultural tradition but is structurally constrained by economic and health system factors. Families in South-South Nigeria generally demonstrate commitment to caring for mentally ill relatives, but their capacity to provide effective care is limited by stigma, poverty, and inadequate health infrastructure.

7.0 RECOMMENDATIONS

Based on these findings, the following recommendations are proposed:

1. **Integration of Mental Health into Universal Health Coverage**: The Nigerian government should urgently include mental health services in the National Health Insurance Scheme to reduce the financial burden on families. The current exclusion of mental health from insurance coverage forces families to pay out-of-pocket, creating catastrophic health expenditure that deepens poverty.

2. **Mental Health Legislation Reform**: The outdated 1958 Lunacy Act should be replaced with modern mental health legislation that recognizes family caregivers' rights and responsibilities, provides for community-based care, and protects persons with mental illness from discrimination. New legislation should mandate family support services as part of comprehensive mental health care .
3. **Social Protection Programs:** Targeted cash transfer programs should be established for families caring for mentally ill members, similar to existing social safety net programs but specifically designed to
4. **Offset The Costs Of Mental Health Care**. These programs should prioritize rural and low-income families identified as most vulnerable to treatment interruption.

5. **Decentralization of Mental Health Services:** Mental health care should be decentralized to primary health care facilities in rural communities, reducing the transportation costs and geographic barriers that prevent poor families from accessing care. Primary health care workers require urgent training in mental health recognition and management, as current mental health literacy among these workers is critically low.

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