UNIVERSITY OF CAPE COAST

EXPERIENCES OF PERSONS LIVING WITH SCHIZOPHRENIA: A STUDY IN THE CAPE COAST METROPOLIS

BY

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Thesis submitted to the School of Nursing and Midwifery, of the College of Health and Allied Sciences, University of Cape Coast, in partial fulfilment of the requirements for the award of Master of Nursing Degree.

SEPTEMBER 2020

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this University or elsewhere.

Candidate's Signature..... Date: .....

Name: Isaac Commey Tetteh

Supervisor's Declaration

I hereby declare that the preparation and presentation of this thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Supervisor's Signature..... Date.....

Name: Dr. Mrs. Evelyn Asamoah Ampofo

ABSTRACT

Living with a chronic mental condition such as schizophrenia comes with its own challenges. Yet, there is little data on the experiences of individuals living with schizophrenia in Ghana. This study explored the experiences of persons living with schizophrenia in the Cape Coast Metropolis of Ghana. The study adopted a descriptive phenomenological study design using purposive sampling technique to select nine (9) persons living with schizophrenia for the study. Data collection was done through face-to-face audio-recorded in-depth interviews, transcribed verbatim, and analysed using Colaizzi's (1978) descriptive phenomenological analysis approach. The study revealed that participants maintained their Activities of Daily Living as long as they were in their lucid interval. Participants revealed that stigmatization, and lack of job opportunities were major challenges they faced. Hence, interventions that seek to promote maximum support, reduce stigmatization and promote medication adherence should be explored and promoted.

KEY WORDS

Coping

Experience

People

Relapse

Schizophrenia

ACKNOWLEDGEMENTS

First of all, I would like to express my deepest gratitude to my supervisor, Dr. Mrs. Evelyn Asamoah Ampofo, for her expert advice, invaluable contributions and guidance towards the successful completion of this thesis. I wish to also thank the Dean, the entire lecturers and the non–academic staff of the School of Nursing and Midwifery, University of Cape Coast for their support during my master's degree programme. To the entire administrative staff, nursing staff and my study participants in the Cape Coast metropolis, I say thank you all for accepting to answer questions during the interviews.

To Mr. Isaac Ewusie, I say a big thank you for your time devoted in assisting me with information on this work anytime I call on you. I believe strongly that, your labour will never be in vain. Finally, my very special thanks go to my wife, children and the entire members of the Commey Tetteh family for the pieces of advice and encouragement offered me throughout the period of my educational career.

DEDICATION

To my wife: Gifty Ampah Biney and my children: Ferdinand Christian Tetteh Commey, Laureen Dorothy Tetteh Commey and Isaac Komietteh Tetteh.

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LIST OF ABBREVIATIONS

CCM	Cape Coast Metropolis
CPN	Community Psychiatric Nurse
CPU	Community Psychiatric Unit
IRB	Institutional Review Board
MN	Master of Nursing
MOH	Ministry of Health
PLS	Persons living with Schizophrenia
UCC	University of Cape Coast
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION

Schizophrenia is a chronic and severe mental illness affecting the social and occupational lives of sufferers and posing a considerable burden on patients and their families. Furthermore, negative societal reactions and the internalization of these attitudes exacerbate the difficulties encountered. The condition is characterized by interferences in perceptions, thoughts, feelings and behaviors of the affected person (Nolen-Hoeksema, 2014). Persons living with schizophrenia generally experience difficulties in their social functioning and quality of life as a result of their condition such as difficulties in getting competitive jobs, marriage and living independently (Corrigan & Watson, 2002). The Mental Health Authority of Ghana in its 2019 end of year report, put Schizophrenia as the leading psychotic condition that is being managed in the various public psychiatric facilities across the country (Duah, 2017). Schizophrenia is among the top ten medical diagnoses of people occupying National Health Service (NHS) beds in England (Pillay & Moncrieff, 2011). Naber and Lambert (2009) posits that about one to two percent of all persons worldwide suffer schizophrenia.

There have been several interventions put in place to help persons suffering from schizophrenia to maintain some level of resilience (Morin & Franck, 2017; Chan, 2011). However, despite these interventions, a greater proportion of these persons do suffer relapse within the current episode of the condition. Relapse or reoccurrence of signs and symptoms of schizophrenia after treatment continues to dominate the lives of persons suffering from Schizophrenia. This period of recovery and remissions have contributed to the

phenomenon widely known in the field of mental health as the revolving door syndrome. Revolving door syndrome is a phenomenon which denotes a cyclical pattern of short-term readmissions to the psychiatric units of health care centres by young adults with chronic psychiatric disorders (Garrido & Saraiva, 2012). The experiences of people with schizophrenia have been both positive and negative.

Background to the Study

Mental illness particularly, schizophrenia, presents a serious health care problem in many African countries and other countries worldwide (Roberts, Mogan & Asare, 2014). Mental illness is among the prevalent non-communicable diseases worldwide. It negatively affects the economic and social wellbeing of the sufferer and family members (Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel & Üstün, 2009). Mental health has been shunned in Africa, and a number of reports reveal a higher prevalence of stigma and relapse in this part of the world (Barke, Nyarko & Klecha, 2011; Fournier, 2011; Kakuma, Kleintjes, Lund, Drew, Green, & Flisher, 2010; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009). Much attention has not been given to issues of mental health compared to other general medical conditions in this part of the world probably because most people are of the view that mental illness is not contagious or infectious. Similar to many other developing countries, management of mental health in Ghana is low and many facilities continue to rely on institutional care, which traces back to the colonial era (Ministry of Health [MOH], 2008).

Schizophrenia is a chronic mental condition that affects over 21 million people worldwide (World Health Organization, 2016). It is a serious mental

illness characterised by incoherent or illogical thoughts, bizarre behaviour and speech, and delusions or hallucinations such as hearing voices. Schizophrenia typically begins in early adulthood and normally runs a chronic course. The prevalence of schizophrenia is estimated to be four in 1000 persons (Saha et al., 2005; American Psychiatric Association [APA], 2009). Symptoms of schizophrenia include hearing internal voices, thinking that other people are reading one's mind, controlling one's thoughts, or plotting harm, which may leave a person feeling fearful and withdrawn. The disorganized behavior of affected persons can be perceived by family or friends as incomprehensible or frightening (Verma, 2005). Patients may not make sense when they talk, as well as sit for hours without moving or talking when they are in the acute stage of the illness.

In some cases, patients suffering from schizophrenia seem perfectly fine until they talk about what they are really thinking (Jungbauer & Angermeyer, 2002). Corrigan (2006) states that persons living with schizophrenia have experienced hardships in their social functioning and quality of life as a direct result of their illness such as difficulties in meeting job demands, maintenance of interpersonal relationship and receiving help from society. In addition to struggling with the symptoms and dysfunctions of schizophrenic illness, sufferers have also had challenges coping with adverse societal responses and expectations that chiefly stem from the misconceptions of mental illness (Corrigan, 1998; Corrigan & Watson, 2002b; Schulze & Angermeyer, 2003).

Additionally, “people have generally considered the experience and expression of persons with schizophrenia to be either unintelligible or fairly uninteresting and unimportant either beyond the pale of empathic understanding

or rational grasp, or lacking in the complexity and subtlety typical of normal mental functioning" (Sass, 2003, p. 427). Although positive and negative symptoms have characterised the lives of persons with schizophrenia, individuals living with the condition are often able to give a reasonable account of themselves when they are in their lucid state (Sass & Parnas, 2005).

Incidence of Schizophrenia have taken a global trend; occurring within countries and within various societies (Kirkbride, Fearon, Morgan, Dazzan, Morgan, Tarrant, & Mallett, 2006). Statistics from the United States indicate that schizophrenia affects about 7 per 1,000 of the adult population, most of them between the ages of 15 and 35 years (Chan, 2011). Furthermore, the World Health Organisation (2008) estimated that globally about 29 million people have schizophrenia. In Ghana, the 2015, 2016 and 2017 annual performance review reports from the three main public psychiatric hospitals (Ankaful, Accra and Pantang) put schizophrenia as the leading mental disorder that utilize mental health services in the country. It has been found that, persons in their lucid interval at a particular time are less than those who are experiencing psychotic symptoms of schizophrenia (Heaton, Gladsjo, Palmer, Kuck, Marcotte & Jeste, 2001; Wiersma, Nienhuis, Giel & Slooff, 1998).

Symptoms of schizophrenia mostly recur regardless of good initial response. The illness is associated with mortalities (Laursen, Munk-Olsen, & Vestergaard, 2012; Auquier, Lançon, Rouillon, Lader, & Holmes, 2006; Joukamaa, Heliövaara, Knekt, Aromaa, Raitasalo, & Lehtinen, 2006). These mortalities may be attributed to the stress attached to living with the symptoms of the condition and other physical complications associated with the intake of psychotropic medications by affected persons. Victims of schizophrenia are

said to have a 5 to 10% chance of dying through their own form of negligence and carelessness within ten years of diagnosis (Palmer, Pankratz, & Bostwick, 2005).

A return or worsening of symptoms following a period of remission is often referred to as relapse. The sooner the symptoms of a schizophrenia relapse are recognized, the greater the likelihood of the individual regaining control. Only about 10 to 20 percent of people treated for schizophrenia do not experience a relapse (Sariah, Outwater, & Malima, 2014). The issue of relapse associated with schizophrenia is particularly significant in mental health due to the relevance of wholistic health; thus, relapse is an issue of global concern (World Health Organization [WHO], 2013).

Chaurotia, Verma and Baniya (2016) defined relapse as a return of symptoms after a period of improvement or recovery occurring within the current episode of the condition. Alsherif and Elrahman (2013) posit that relapse has been observed to have been a major concern for caregivers because of its devastating consequences for family members of people living with severe mental illness such as schizophrenia. Reducing the risk of relapse is currently generally accepted as an important part of the management of schizophrenia (Wu, Ge, Dou, Wang, Wang, Li, Wang, & Gao, 2015).

Schizophrenic relapse is associated with poorer prognosis (Emsley, Chiliza & Schoeman, 2008) and decreased cognitive ability (Ogino, Miyamoto, Miyake & Yamaguchi, 2014), risk of injury, increased stigma, particularly following hospitalization, decreased quality of life, loss of self-esteem and social disruption (Taylor, Chaudhry, Cross, McDonald, Miller, Pilowsky & Strickland, 2005).

Non-adherence to medication has been implicated as one of the causes for the worsening or return of signs and symptoms of schizophrenia. Promotion of resilience among persons with schizophrenia is found to be vital because it reduces the adverse impact of mental illness on individuals, families and communities (Taylor et al., 2005). Again, it improves the quality of life of people with mental illness, enabling them to participate more fully in their work, recreational activities and relationships (Boyer, Millier, Perthame, Aballea, Auquier & Toumi, 2013).

People with the diagnosis of schizophrenia have had divergent views on relapse associated with the condition (Sariah, Outwater & Malima, 2014). Some hold the view that, reoccurrence of active signs and symptoms of the condition can be prevented when clients adhere to laid down protocols, such as medication adherence and regular visits to the mental health facilities. On the other hand, some clients also hold the view that, regardless of strict adherence to treatment protocols, schizophrenic relapse is bound to occur (Kazadi, Moosa & Jeenah, 2008).

Experiences of stigmatisation associated with mental illness as well, is another challenge that persons living with schizophrenia go through. From the point of view of Bos, Kanner, Muris, Janssen and Mayer (2009), almost all studies conducted on mental illness stigma have focused on people with disabling and persistent disorders, such as schizophrenia. Furthermore, these studies' results always indicate that mental health patients belong to one of the most stigmatised groups in our society (Corrigan, 2005). While medication has been efficient in decreasing the length of inpatient schizophrenia therapy (Bridge & Barbe, 2004), serial admissions continue to dominate schizophrenic

patients' lives. Just like other mental illnesses, schizophrenia at times interferes negatively with the affected person's perception, movement, emotion, thought and volition.

Despite the challenges that have characterized the lives of persons living with schizophrenia, these individuals have adopted some coping strategies which have helped them to maintain some level of resilience in their daily lives. Although it has been found that, individuals with schizophrenia in their lucid interval are far less than those experiencing psychotic symptoms, a considerable number of these individuals have been able to adopt some positive coping measures to maintain resilience. Coping strategies adopted by individuals with schizophrenia have been traditionally thought of as "adaptive" versus "maladaptive" or as "problem-focused" versus "emotion oriented" (Gerson, Wong, Davidson, Malaspina, McGlashan & Corcoran, 2011). Meanwhile, problem-focused coping (problem-solving, planning, taking action) has been seen as adaptive, however, on the other hand, emotion-oriented strategies (venting and denial) have been seen as maladaptive. Some clinicians have had divergent views on these categorisations, asserting that the adaptive function of coping strategies adopted by persons with schizophrenia to maintain resilience may depend primarily on environmental context, the perception of the illness and specific individual characteristics (Schennach, et al., 2012).

Although there seem to be enough literature on serious mental disorders such as schizophrenia, little is known in terms of the experiences of individuals living with schizophrenia. This study therefore sought to explore the experiences of persons living with schizophrenia in the Cape Coast Metropolis of the central region of Ghana.

Statement of the Problem

Opoku-Boateng, et al. (2017) indicated that, management of schizophrenia in Ghana is among the most expensive of all mental illnesses, with an estimated direct treatment cost which is around two-fold higher than the cost of major depression and more than four-fold higher than any anxiety disorder. It puts a lot of financial burden on families of these individuals. Living with schizophrenia poses a lot of challenges to sufferers (Kannappan, 2009). It is stated that, in regular care, 80% of patients with a diagnosis of a first episode of schizophrenia have experienced relapse, often multiple times, within 5 years of treatment or remission from their index episode (Kazadi, Moosa & Jeenah, 2008).

In Ghana, the concept of schizophrenia has been investigated from the point of view of healthcare practitioners, carers and families of persons suffering from schizophrenia (Pasadas & Manso, 2015; Omolayo, Mokuolu, Balogun, Omole & Olawa, 2013; Quinn & Evans, 2010; Li & Arthur, 2005). Some studies have also been carried out on the impact of schizophrenia on family members or relatives (Dadson, Annor & Yendork, 2018; Aryeequaye, 2016; Gerson et al., 2011; Teschinsky, 2000) and on care giver experiences in the management of persons living with schizophrenia (Gloria, Osafo, Goldmann, Parikh, Nonvignon, & Kretchy, 2018; Ae-Ngibise, Doku, Asante & Owusu-Agyei, 2015; Opoku-Boateng, 2016; Animwaa, 2013, McDonell, Short, Berry, & Dyck, 2003).

However, studies that have focused primarily on everyday experiences of individuals living with schizophrenia are hard to find. It is not clear what the experiences of these persons living with schizophrenia are regarding the

condition and the associated relapses and what meaning they make of their experience. It is argued that the service user is the primary source of data and the best person to verbalise recovery (Patterson, Mullen, Gale & Gray, 2011; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Till, 2007), hence, as health professional, there is the need to ascertain the meaning that sufferers attach to schizophrenic illness in order to tailor care to meet their health care needs. This study therefore sought to explore the experiences of persons living with schizophrenia in the Cape Coast Metropolis.

Purpose of the Study

The purpose of this study was to describe the experiences of persons living with schizophrenia who live within the Cape Coast Metropolis.

Research Objectives

The specific research objectives of the study are to:

1. explore the experiences of persons living with schizophrenia
2. inquire into how persons living with schizophrenia perceive relapse in relation to their condition
3. investigate client coping strategies which persons living with schizophrenia adopt to cope with the condition

Research Questions

This study sought to answer the following research questions:

1. What are the experiences of persons living with schizophrenia?
2. How do persons living with schizophrenia perceive relapse in relation to their condition?

3. What strategies do persons living with schizophrenia adopt to cope with the condition?

Significance of the Study

The significance of this research is to increase understanding of issues that concern the lives of persons living with schizophrenia. Information from this study would provide a deeper understanding of schizophrenic illness from the point of view of persons who are living with the condition. This knowledge will aid health practitioners within the discipline to understand issues surrounding the lives of people with schizophrenia in order to better appreciate their concerns when delivering care to them. The study outcome will potentially facilitate nurses' ability to develop effective improvement approaches to address the needs of persons living with schizophrenia. Furthermore, findings from this study will serve as a source of information to be considered by the Ghana Health Service, Ministry of Health and the Mental Health Authority when taking decisions regarding persons living with schizophrenia. The findings of the study will also add to the few studies on schizophrenia in Ghana and serve a foundation for future studies.

Delimitation of the Study

This study was delimited to persons who have been living in the Cape Coast Metropolis with the diagnosis of schizophrenia and are in their lucid state. The study was conducted in the Cape Coast Metropolis only.

Limitations of the Study

Qualitative research is often criticized for lacking generalizability and being too reliant on the subjective interpretations of researchers, therefore the

results of this study cannot not be generalized as the true reflection of all persons living with schizophrenia in Ghana. Again, considering the sample size that was chosen (9 persons) for the study, the opinions of study participants will not be generalized to represent views of all persons living with schizophrenic illness in the Cape Coast Metropolis. It was however not the aim of the researcher to make generalisations but to understand and describe the experiences of persons who are living with the diagnosis of schizophrenia in the Cape Coast Metropolis.

Definition of Terms

- Experience: Knowledge of events or occurrence which leaves an impression on someone over a period of time.
- Perception: How impulses are interpreted about an event to become meaningful experience.
- Relapse: Reoccurrence of signs and symptoms of an already treated mental condition such as schizophrenia.
- Coping: Dealing with and attempting to overcome problems or difficulties.
- Lucid interval: The period between recovery (resilience) and reoccurrence of signs and symptoms of an already treated mental condition (relapse) where the individual is deemed fit to give a reasonable account of him/herself.
- Resilience: Ability to live a life without the presence of signs and symptoms of a mental illness or being able to withstand the adverse effects associated with living with a severe mental illness.

Organization of the Study

Chapter one of the study described the introduction to the study including the background to the study, statement of the problem, objectives of the study, research questions, significance of the study, delimitation of the study and organization of the study. Chapter two reviewed related literature on the subject matter and the conceptual framework guiding the study while chapter three also concentrated on the methodology which included the study area, study design, population, sample and sampling technique and data collection instrument. Other items under chapter three included data collection procedure, data processing and analysis and ethical consideration. Chapter four dealt with data analysis and discussion of major findings. Finally, chapter five of the study dealt with the summary of the major findings, conclusion and recommendations of the study.

Chapter Summary

This chapter has brought to the fore, the background to the study, the statement of the problem, the purpose of the study, research objectives, research questions that guided the study, significance of the study, delimitations, limitations, organisation of the work, as well as definition of terms.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This chapter reviewed relevant previously published literature on living with schizophrenia. Theoretical and empirical data on the subject matter were explored in this section. Related and relevant literature search was conducted and reviewed from databases such as Cumulative Index for Nursing and Allied Health Literature (CINAHL), google scholar, EBSCOHOST and PUBMED, Francis and Taylor, among others. Other relevant sources were from textbooks, journals and other articles from the library's collection. Key words such as "mentally ill", "severe mental illness" (Abstract or Title), 'schizophrenia' (Abstract or Title), 'relapse' (Abstract or Title), 'resilience', 'community', 'challenges', 'condition', ''mentally stable", 'lucid', 'living', 'suffering', 'persons', 'individuals', 'experiences', 'perception', 'coping' and "qualitative inquiry" were searched either individually or in combination in order to identify relevant studies on the experiences of persons living with schizophrenia. The search identified some studies done in the area of severe mental illness including schizophrenia. Majority of the studies identified during the search focused on issues such as quality of life of persons living with schizophrenia, psychosocial challenges confronting relatives and carers of persons living with schizophrenia and the impact of schizophrenia on family members among others. However, there is a paucity of studies which focused exclusively on the experiences of persons living with schizophrenia.

This chapter of the study is organized to cover some key areas such as overview of schizophrenia, the clinical features of schizophrenia, aetiological factors of schizophrenia and effects of schizophrenia on sufferers. This chapter also looked at some theoretical explanations of schizophrenia, the experiences of persons who have lived with schizophrenia, their perception of schizophrenic related relapse in relation to their condition and also how these individuals cope with the condition (schizophrenia).

This study was guided by a conceptual framework that explains the key concepts in the study. The framework was developed by the researcher based on key concepts in literature on schizophrenic illness and the key concepts in this study such as Experience, Perception, Coping, Resilience and Relapse. Feelings of connection with the natural world are seen to promote physical health, and psychological wellbeing including mood state, and community cohesion (Shanahan et al., 2016). Therefore, in order to enter into the natural world of individuals in the study, there was the need to use questions and probes to elicit natural and rich responses of study participants on issues surrounding their experience with schizophrenia. It guided the study because, it helped to describe the rich and natural experiences of participants who have lived with schizophrenia over a period of time in their lives by adopting an effective questioning skills and probes to get responses to questions pertaining to the phenomenon under study.

Overview of Schizophrenia

Schizophrenia is a chronic and severe mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality (Roe & Davidson, 2005). Similarly,

schizophrenia is said to be a brain disorder that affects the way a person behaves, thinks, and sees the world. People with schizophrenia often have an altered perception of reality. Smith and Segal (2016) state that Schizophrenia is a complicated disease that makes it hard to differentiate between what is true and imaginary, to reason correctly, to control thoughts, to communicate to others, and to act normally. Schizophrenia is a devastating disorder which fits under the broader heading, psychosis, which is characterized by a loss of contact with reality. The disorder manifests in a variety of ways, including false beliefs (delusions), false perceptions (hallucinations), and irrational thinking and behaviour (Sadock & Sadock, 2007).

Individuals with a later age of onset (25-35 years) are more likely to be women who have less evidence of structural brain abnormalities and generally have better outcomes (American Psychiatric Association [APA], 2000). In contrast, it has been noted that the typical age for the onset of schizophrenia is the late teens and early 20s; however, cases of onset at age 5 or 6 have also been reported (APA, 2014). There is no gender difference in this disorder and both men and women with the disorder are equally affected; however, individuals with an early age of onset (18-25 years old), are most often men who have more signs of structural brain abnormalities and more prominent negative symptoms. These symptoms are characteristics of psychiatric illness expressed as withdrawn behavior, lack of expression, a lack of initiative and interest, slow and/or little speech, and slow thoughts and movements.

Although schizophrenia is not as common as other mental disorders, the symptoms can be very disabling (Roe & Davidson, 2005). This is because people with schizophrenia in their relapsed state can see or hear objects that do

not happen to exist, talk in unusual or misleading ways, assume that people are trying to hurt them, or feel like they are constantly being observed. This can make it impossible for them to come to terms with events of everyday life at times. In their relapsed state, they often lose contact with fact and can hence disconnect from the outside world or act out through uncertainty and terror (Collerton, Perry & McKeith, 2005). Smith and Segal (2016) note that, there is treatment available, although schizophrenia is a chronic illness. Many sufferers of schizophrenia may work individually and maintain rewarding lives with support, treatment, counseling, and care. As regards its onset, schizophrenia may appear suddenly and without warning. However, in most cases, the onset is slow; years before the first significant episode, with subtle warning signals and a steady deterioration in functionality.

Many friends and family members of schizophrenia victims mention knowing early on that their loved one was wrong; they just don't know what happened (Topor, Borg, Mezzina, Sells, Marin & Davidson, 2006). In the early onset, people with schizophrenia often seem to be self centred, emotionless, unmotivated and reclusive. They detach themselves, tend to ignore their presence, say odd things, and display a general indifference to life. They will neglect hobbies and activities and their success deteriorates at work or school. While these symptoms of alarm may arise from a variety of issues, they are cause for concern, not just schizophrenia. Schizophrenia is characterized with positive and negative symptoms. Positive symptoms of schizophrenia consist of ‘delusions, hallucinations, and disorganized behavior (Sadock & Sadock 2010, 149). Negative symptoms include affective flattening and alogia. Delusions are erroneous beliefs that usually involve a misinterpretation of perceptions or

experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose). The diagnostic and statistical manual of mental disorders fourth edition Test Revision (DSM-IV) (APA, 2000) touched on the distinction between a delusion and a strongly held idea and concluded that, it is sometimes difficult to make that clear distinction and that it depends in part on the degree of conviction with which the belief is held despite clear contradictory evidence regarding its veracity.

Signs and Symptoms of Schizophrenia

Schizophrenia is characterized by a mixture of positive, negative, cognitive, mood, and motor symptoms whose severity varies across patients and through the course of the illness. Positive symptoms usually first begin in adolescence or early adulthood, but are often preceded by varying degrees negative and cognitive symptoms (Tandon, Nasrallah & Keshavan, 2009). On the other hand, Smith and Segal (2016) described five cardinal features which are characteristic of schizophrenia and they include: delusions, hallucinations, disorganized speech, disorganized behavior, and " bad symptoms". The signs and symptoms of schizophrenia, however, differ significantly, both in pattern and severity, from person to person. Not all with schizophrenia may have all the symptoms, and the symptoms of schizophrenia can vary over time as well.

Delusions

Against plain and evident proof that it is not real, an illusion is a firmly-held belief that a person has. In schizophrenia, delusions are exceedingly normal, arising in more than 90 percent of those who have the condition (Shives,

2012 p.245). Sometimes, illogical or bizarre thoughts or fantasies are included in these illusions. Schizophrenic delusions commonly include:

Persecution delusions: Conviction that someone, sometimes an abstract is out to get him or her. Bizarre theories and schemes are also included in these persecutory fantasies (e.g. “dwarfs are trying to abduct me”).

Delusions of reference: It is assumed that a neutral environmental occurrence has a special and unique significance. An individual with schizophrenia, for example, may assume that an advertisement or an individual on TV sends a message explicitly designed for them.

Delusions of grandeur: The illusion that one, such as a head of state, is a prominent or significant figure. Alternately, delusions of grandeur may involve the belief that one has unusual powers that no one else has, for example, ability to read minds.

Delusions of control: Belief that one’s thoughts or actions are being controlled by outside forces such as aliens. Common delusions of control include thought broadcasting, where the person believe that their private thoughts are being transmitted to others, thought insertion which comes from a believe that Everyone plants ideas in their minds, withdrawing ideas that are marked by a feeling that someone is taking their thoughts from them.

Hallucinations

Hallucinations, when they occur only in the imagination of the victim, are sounds or other stimuli perceived as actual. "While hallucinations may comprise all of the five senses, in schizophrenia," auditory hallucinations (e.g. hearing voices or any other sound) are most prominent "(Shives, 2005, p. 245). Visual hallucinations are also relatively common. Some studies have suggested

that auditory hallucinations occur when people misinterpret their own inner self-talk as coming from an outside source (Wu, 2012; Kinderman, 2011). For the person witnessing them, schizophrenic hallucinations are typically significant. The voices are, many times, those of someone that they know. The voices are most often critical, vulgar, or violent. Hallucinations tend to be stronger when the subject is alone, too. People with schizophrenia appear to have problems keeping on a line of thought and sustaining it. With an irrelevant response, they may respond to questions, start sentences with one subject and end something entirely else, talk incoherently, or say illogical things. In schizophrenia, typical symptoms of disorganized expression include:

Loose associations: jumping quickly from subject to subject, with no relation between one thought and the next.

Neologisms: Words or expressions made up that have meaning only for the patient.

Perseverance: repetition of words and statements; repeating the same sentence endlessly.

Clang: Use of rhyming words without meaning ('I said the bread and read the shed and fed Ned at the head').

Disorganized Behavior

Schizophrenia interferes with goal-directed behavior, creating impairments in the ability of a person to take care of himself, to function, and to connect with others. “Disorganized behaviour occurs as:" decline in overall everyday functioning," "unpredictable or unwanted emotional reactions," "behaviors that are bizarre and serve no meaning, "and" lack of restraint and control of impulses (shives, 2005, p. 255).

Negative Symptoms (absence of normal behaviors) of Schizophrenia

Schizophrenia's so-called "bad" signs relate to the lack of normal habits present in healthy people. Schizophrenia's common negative signs include: Inexpressive face, including a flat voice, lack of eye contact, and blank or restricted facial expressions: lack of emotional expression.

Loss of desire or enthusiasm: Motivating problems; lack of self-care. Evident loss of confidence in the world: apparent environmental unawareness; social detachment.

Communication disorders and abnormalities: failure to talk; brief and often fragmented responses to questions; monotonous speech (Roe & Davidson, 2005).

Causes of Schizophrenia

As the most complex clinical psychosis, any particular hypothesis proposed to describe the origins of schizophrenia does not adequately justify the wide variety of dysfunctions generally observed in all forms of schizophrenia. There is more or less debate about recent results on the origins of schizophrenia (Tandon, Keshavan & Nasrallah, 2008). Nevertheless, numerous hypotheses have been championed to explain the aetiology of schizophrenia. Organic, practical, chemical, social and psychological ideas are included. The primary goal of progressing these triggers may lie in the treatment process.

Biologically, Emil Kraepelin (1917) originally classified psychoses and came to a conclusion that schizophrenia is caused by a metabolic condition in which the glands play a significant role. He believed that by observing people of schizophrenia disease, his researchers were able to come to this conclusion. Advancing a healthy approach, stress theories therefore hold that it is not a

particular abnormality that an individual inherits, but rather a predisposition to develop schizophrenic illness, provided the proper environmental conditions (stress). According to Mazzoncini, Zoli, Tosato, Lasalvia, and Ruggeri, (2009), some studies have concluded that schizophrenia can be spread in the forms of 'predisposition' through genetic causes, i.e. possessing some metabolic condition that when put under stress renders the person responsible or predisposed to schizophrenic reaction.

The mechanisms of schizophrenia are not well understood, according to Smith and Segal (2016). Schizophrenia, however, tends to commonly arise from a dynamic relationship of genetic and environmental influences. In the meantime, Bouthner (2015) notes that experts have still not suggested the exact cause of schizophrenia, because of the numerous experiments conducted over the years to figure out the causes of the condition. Instead, evidence has led some experts to conclude that persons with schizophrenia are born with a predisposition to inherit the disorder they have developed during their brain's early growth (Bouthner, 2015). This predisposition in the brain when accompanied by various other factors, then triggers the onset of schizophrenia. The most common factors and triggers responsible for the development of schizophrenia include: Brain chemical imbalance or Brain, Environmental causes, Hereditary causes etc.

Brain Chemical Imbalance or Brain Structure

There is irregular development or response in the brains of individuals with schizophrenia to the major chemical neurotransmitter dopamine and maybe others. Dopamine is responsible for transmitting information through the brain and determines how objects are seen by the brain (Bouthner, 2015). In

addition to abnormal brain chemistry, abnormalities in brain structure may also play a role in schizophrenia. Enlarged brain ventricles are seen in some schizophrenics, indicating a deficit in the volume of brain tissue. There is also evidence of abnormally low activity in the frontal lobe, the area of the brain responsible for planning, reasoning, and decision-making (Smith & Segal, 2016). For instance, some studies also suggest that abnormalities in the temporal lobes, hippocampus, and amygdala are connected to a schizophrenic person's positive symptoms. But despite the evidence of brain abnormalities, it is highly unlikely that schizophrenia is the result of any one problem in any one region of the brain (Smith & Segal, 2016).

Environmental Causes of Schizophrenia

Ecological causes such as peer control, physical or sexual violence, lack of loved ones, hormones, starvation, and early virus exposure are caused by stress. As a likely risk factor, the main brain changes that develop during puberty have also been reported. Stressors may have significant effects on the amount of development that takes place in the inflammatory immune system, and brain processing is influenced by the immune system. There is evidence that inflammation plays a part in developing schizophrenia (Bouthner, 2015).

Similarly, Smith and Segal (2016) states that twin and adoption research indicate that, inherited genes make a person prone to schizophrenia and that this susceptibility is mediated by external influences to cause the condition. As for the external factors involved, either during breastfeeding or at a later stage of development, more and more research points to stress. High stress levels are thought to cause schizophrenia by increasing the production of the hormone cortisol by the body. Research by the National Institute of Mental Health in the

US and others over the years, points to several stress-inducing environmental factors that may be involved in schizophrenia, including prenatal exposure to a viral infection, low oxygen levels during birth (from prolonged labor or premature birth), exposure to a virus during infancy, early parental loss or separation, and physical or sexual abuse in childhood (Smith & Segal, 2016).

Hereditary Causes of Schizophrenia

People who have a family history of schizophrenia have a higher probability for developing it. If one's mother, father, brother or sister has the illness, statistics show a 10 percent chance of developing it. If one twin, or both father and mother have the disorder then the probability of developing it rises to 40 percent, whereas the general population only has an overall one percent risk of developing schizophrenia (Bouthner, 2015). Smith and Segal, (2016) reinforces Bouthner, (2015) explanation by stating that schizophrenia has a strong hereditary component. Individuals with a first-degree relative (parent or sibling) who has schizophrenia have a 10 percent chance of developing the disorder, as opposed to the one percent chance of the general population. It is believed that schizophrenia is only influenced by genetics, not determined by it. While schizophrenia is noted to run in families, some individuals with schizophrenia do not have any family members with the condition. In addition, people who are not genetically predisposed to schizophrenia can still develop the disease. Studies on the hereditary factors have been revised by Kringlen (2013) who points out several flaws in these undertakings of research. Kringlen stated that the role of possible genetic factors in the development of schizophrenia and other functional disorders will remain in the field of speculation, commenting on his critical analysis of these research findings. He

therefore noted clearly that the psychosis under consideration is mainly determined by experiential factors.

In addition to being the product of deficient inheritance, schizophrenia-like statutory discrepancies may be attributed to early environmental factors. During the mother's pregnancy, toxins, viruses and many other strains may have powerful impacts on the growth of the embryo. The child's natural progress is equally arrested by early postnatal conditions. Such developmental errors cause the person to display incorrect answers to life circumstances. Nevertheless, due to the lack of research in the area, the specific role of constitutional defects in the development of schizophrenia is not very clear. In the meantime, researchers are in the process of getting specific answers to their haunches in relation to the role of constitution in schizophrenia development. In the case of identical twins, as opposed to fraternal twins, the concordance ratios are considered to be higher. Experimental studies have provided sufficient evidence to support the argument that genetically based variants of schizophrenia are evident (Allen et al, 2009; Cardno & Gottesman, 2000; Kringlen, 2000; Rosenthal 1971; Higgins, 1976). As far as inherited causes are involved, it has been proposed that a higher prevalence of schizophrenia has inspired many important researches on the genetic origin of schizophrenia in groups of individuals diagnosed with schizophrenia. Based on literature above, it can be concluded that, there has not been any single and concrete proof that has explained the course and aetiology of schizophrenic illness. The various accounts by theorists as far as schizophrenia is concerned have been divergent. There is however the need for further brain research on this subject area in order to have effective support for

the function of regulation of excitation inhibition and other related factors in the aetiology of schizophrenia.

Theoretical Explanations of Schizophrenia

Several theories have been propounded to give an insight into the course of schizophrenic illness over the years. Some of these theories include:

The Social Learning Theory and the Sociocultural Theory of Schizophrenia.

Persons living with schizophrenia according to social learning theory do not respond appropriately to the social environment like their healthy counterparts (Mednick, 2017). Thus, shortfall in attention to social environment normally accounts for lack of proper association and disturbances in the thought processes of persons living with schizophrenia. Moreover, lack of proper attention to the stimuli coming from the social environment is reported to make the individual appear withdrawn (Mednick, 2017). Salzinger and Pisoni (1958) also argued that, schizophrenia is primarily a reaction to the reinforcement it receives within the psychiatric hospital. The hospital staff attend to the patients more when their speech is incoherent and behaviour irrational. Attempts have been made to verify social learning theory by Bandura and Walters (1977) by conducting a study to examine whether hospitalised patients can manipulate to create an impression on others through the administration of Minnesota Multiphasic Personality Inventory (MMPI) which has been strongly criticised. On another breath, Hopper (2007) noted that persons living with schizophrenia are inflexible in their own social roles and uncomprehending of the role behaviour of others. They therefore create their own social role to protect themselves from social expectations and demands. However, though a split occurs between their outer and inner selves, their hopes, aspirations etc. in the

inner self may still remain intact. The social learning theory proposes that, an individual's behavioural acts and the environment in which an individual finds him or herself can contribute to the development of schizophrenia.

On the other hand, research findings point out the effect of socio-cultural and environmental life stresses on the development of schizophrenic reactions. Although schizophrenia is found in all societies and cultures, it has been observed that paranoid type of schizophrenia is most frequent in the United States of America (USA) but not common in Africa (Whaley, 1998). Similarly, Varma et al (1997) noticed that common signs of hebephrenic schizophrenia were displayed by people in rural areas, such as displaying unwanted laughter, smiling, standing still and still, jumping, humming, soiling and smearing, etc., and having illusions and hallucinations. Rin and Lin (1962) observed decades ago that, unlike the Aborigines of Formosa, a high prevalence of schizophrenia was found in rural Africans. Urbanization has contributed to the development of schizophrenia across the globe. For example, Van Os, Kenis, and Rutten (2010) claim that there is an unreasonably high schizophrenia prevalence in populations experiencing rapid social change. This may be attributed to the rising economic requirements in these communities.

After a lengthy survey undertaken in the U.S. over 10 years, Wu, Birnbaum, Shi, Ball, Kessler, Moulis and Aggarwal (2005) found that the prevalence of schizophrenia was 11 times as high in the low socioeconomic status (S.E.S) group as in the high socioeconomic status group. In addition, among women in low S.E.S. classes, this association was strong. Jaco (1960) recorded a higher prevalence of schizophrenia among women in professional occupations. From the viewpoint of Dohrenwend (1975), environmental tension

may contribute to an inability to cope with daily life that may lead to the creation of schizophrenic symptoms. The associations between social status and responses to schizophrenia were clarified by suggesting that the lower social class issues are immense (Koln, 1973). Essentially, they grow through social disorganisation, insecurity, poverty, unhealthy living conditions and poor nutrition, torture and severe frustration that arises out of unfavourable socio economic conditions. These persons lack educational opportunities because they are regarded as poor. So, they cannot afford early treatment neither can they develop the consciousness for early treatment. These stresses and strains of life make individuals prone to schizophrenia and therefore make them societally sidelined (Salleh, 2008; Furnham & Chan, 2004).

In the opinion of Wright, Gronfein, & Owens, (2000) patients in the lower class come often from families where they feel abandoned and sidelined. Therefore, they refuse to adapt to family and environmental situations. Howes, McCutcheon, Owen and Murray (2017) illustrated the association between tension (arising from family and social conditions) and the production of symptoms. Bearing in mind the view of Dohrenwend, there are indications that psychotic symptoms occur when individuals who are deemed "human" are subject to severe war pressures. If one has to assume in that line of reasoning, everyday life must be as traumatic as war to generate insanity, which may simply not be a fact. In addition, it is equally valid that many individuals suffer from schizophrenia, possibly because of biological causes, without suffering from major life pressures.

The precise and particular position of the social class in the aetiology of schizophrenia is therefore yet to be identified, and more study is required for this reason to provide a general hypothesis on the connection between social class and schizophrenic reactions. Consequently, it is concluded that, schizophrenia has been found in virtually all cultures and socio-economic classes. However, in the industrialised nations, the lop-sided proportion of individuals living with schizophrenia were found in lower socio-economic backgrounds. This may mean that, due to sickness, the afflicted people either shift to a lower socio-economic class or struggle to climb out of a lower socio-economic class. The aetiology of schizophrenia leads to industrialization, displacement, urbanization and rapid transition, as it becomes very difficult to respond to such sudden changes (Tandon, Keshavan, & Nasrallah, 2008).

As the correlation with technologically advanced society increases, the prevalence of schizophrenia tends to increase among third world populations (Turan & Besirli, 2008). In fact, it has been shown that schizophrenia is less obvious in countries where individuals are more correctly reintegrated into their cultures and families than in highly cultured western societies (Rössler, Salize, van Os, & Riecher-Rössler, 2005). This may account for the explanation why schizophrenia is often regarded as a polite culture disorder. It is considered that a person may have a special susceptibility to the condition whenever any traumatic external interaction indicates that the symptoms of schizophrenia are affected.

Effects of Schizophrenia on Persons

Smith and Segal, (2016) further states that, the consequences can be catastrophic, both for the person with the condition and for those around him or

her, whether the signs and symptoms of schizophrenia are missed or poorly treated. Four of schizophrenia's likely consequences are:

Problems of marriages or interpersonal relationships: marriages struggle when schizophrenic individuals frequently retreat and separate themselves. Paranoia can also cause a person with schizophrenia to be suspicious of friends and family members around.

Disruption of regular everyday activities: Because psychological problems and daily functions are difficult to deal with, if not impossible, creates major disturbances to daily functioning. The visions, hallucinations, and disorganized thinking of a schizophrenic personality usually prohibit him or her from doing everyday activities such as washing, sleeping, or running errands.

Alcohol and substance abuse: People with schizophrenia frequently develop alcohol or opioid disorders that are either exploited or relieved of symptoms in an effort to self-medicate. In addition, they may also be heavy smokers, a complicating condition as tobacco smoke may interfere with the effects of drugs prescribed for the illness.

Increased risk of suicide: There is a high risk of committing suicide in people with schizophrenia. It is necessary to take all suicidal voice, threats, or movements very seriously. In fact, individuals with schizophrenia are likely to commit suicide after psychotic episodes, after times of depression and in the first six months after therapy has begun (Smith & Segal, 2016). Anyone can get schizophrenia; irrespective of race, culture, background, and socioeconomic group (Bouthner, 2015). Bouthner recalls that treatment results reported by the United States of America's National Collaboration on Mental Disorders (NAMI). Specifically, approximately 80 percent of individuals with

schizophrenia are documented to be able to lead active and reasonably stable lives with care. Recovery in 50 percent of cases is substantial or even complete. Again, approximately 20 % of patients may undergo addiction and need a more formal recovery regimen in the longer term (Bouthner, 2015). Consequently, Recovery for persons seeking care for their illness is possible in half of the cases. NAMI describes healing as not having any symptoms and living in a group that interacts with family and friends in meaningful social experiences. Therapy also significantly decreases the severity of complications and also increases the quality of living in cases where a complete recovery is not reached (Bouthner, 2015).

The Concept of Relapse in Schizophrenia

Schizophrenia is a chronic and disabling illness, with the vast majority of patients experiencing multiple relapses during the course of the illness (Hong, Windmeijer, Novick, Haro & Brown, 2009). Reoccurrence of symptoms of a previously managed schizophrenia is often referred to as relapse. It is characterised by acute psychotic exacerbation, may have serious implications. For instance, there is a risk of patients injuring themselves or others, which in the long run has the tendency of jeopardising personal relationships, education or employment status (Schennach et al, 2012). This interference in interpersonal relationships may lead to further stigmatisation of the illness. Moreover, relapse may come with a biological risk. It has been noted that active psychosis reflects a period of disease progression in so far as patients may not return to their previous level of function and treatment refractoriness may emerge (Gleeson, Rawlings, Jackson & McGorry, 2005).

Multiple factors contribute to increasing the risk of relapse. In a systematic review and meta-analysis of longitudinal studies by Paz, Tardito, Atzori and Tseng (2008) it was found that non-adherence with medication, persistent substance use, carers' criticism and poorer premorbid adjustment significantly increased the risk for relapse in first-episode psychosis. In a prospective, five-year follow-up of first-episode psychosis patients it was found that the most common risk factor by far was antipsychotic medication discontinuation (Kane & Correll, 2010). In clinical settings discontinuation from treatment is common, even and perhaps particularly, in the early stages of illness. In recognition of the associated risks, improving medication adherence and relapse prevention have been emphasised as key components of the management of schizophrenia (Millier et al, 2011). Since schizophrenia has been associated with frequent relapses over the years, it is therefore not possible to investigate the experiences of living with schizophrenia without considering the influence of relapse on participants' experience.

Empirical Review on Experiences of Individuals with Schizophrenia

Human beings have their own rich and natural experiences of life and every day events. It can therefore be said that, no two individuals are the same; they have specific characteristic that are unique to each one at every point in time. Each person tells a particular story based on how he/she experiences it. Schiff, Saunderson, Mountian and Hartley (2017) describe experience in its most basic form, as "the perception of something else" and "ultimately information about what we have perceived." This is however not limited to only human beings in particular because some animals such as dog, cats and insects

perceive things. Even plants can perceive when the sun is shining. Perception is the most basic of life's survival tools for virtually all humans and creatures. Wentlandt, Toupin, Novosedlik, Le, Zimmermann and Kaya (2018) asserts that to be human is a social construct. Schiff et al (2017) built on that notion by suggesting that culture affects experience when we start to share it, because "the words, associations, and priorities we attach to the shared experience define how we understand the world we live in. Experience is often said to be shared more now than it has ever been because of the experiential platform (Carù & Cova, 2013, p. 17).

Persons living with schizophrenia have lots of stories to tell. These stories are both negative and positive. For instance, Chemomas, Clarke and Chisholm (2000) studied the perceptions of women with schizophrenia or schizoaffective disorder about their illness in the context of their life stages and corresponding health needs using qualitative methods. This study was conducted in Spain with 12 women as participants. The results showed that these women led marginalized, deprived lives in the face of multiple losses, social stigma, limited interpersonal contacts and poverty. Also, the study revealed that individuals with schizophrenia were mostly rejected and stigmatized in the community in which they live.

Also, a study by Kinderman and Cooke (2000) gave detailed account on the social exclusion experiences of people living with schizophrenia. The study was conducted in Canada involving 18 participants with the condition of schizophrenia. It was observed that people with schizophrenia are subjected to discrimination and prejudice. They are excluded from the society in various ways. Their economic status is bad and have to depend on family to meet their

basic needs. The unemployment rate in people living with schizophrenia is also high since they do not get job opportunities. People living with schizophrenia do not have a wider social network due to stigmatization. The findings further revealed that social exclusion results from problems in social functioning or due to the diagnosis with schizophrenia. The study recommended that social inclusion can be promoted through community education, strengthening social roles, paid employment, recreation, community care, and movements by people living with schizophrenia.

Another study was conducted in Japan by Minato and Zemke (2004) which aimed to explore the time use of people with schizophrenia living in the community. The study was a qualitative study with 15 participants. The findings showed that people with schizophrenia spend a greater amount of time sleeping than people without schizophrenia. The study attributed this to the medicine administered to individuals with schizophrenia at the mental facilities. In a related study conducted in England to examine the time use of adults diagnosed with schizophrenia, the findings indicated that only few of the participants could engage in active leisure, work, education or volunteer occupation. The findings further showed that majority of people with schizophrenia are preoccupied with sleeping, personal care and passive leisure.

Bejerholm and Eklund (2006) conducted a research in Sweden that sought to describe the engagements in daily occupations of people with schizophrenia. The study adopted the qualitative paradigm. The sample size of the study was 20, of which 10 were male whereas 10 were female with age ranging from 20 to 60 years. The findings of the study indicated that being

diagnosed with schizophrenia does not necessarily lead to an impoverished lifestyle rather individuals with schizophrenia could have normal lifestyle.

The experiences of people living with schizophrenia in the community was again explored by Bradshaw, Armour and Roseborough (2007) in New York, United States of America. In all, 15 individuals with schizophrenia participated in the study. The researcher used a qualitative descriptive case study design. Interviews served as the instrument for the study. The findings showed that people with schizophrenia struggled to make friends, lacked job opportunities, and do not have sufficient financial support to afford good housing, transportation and other leisure activities. Similar results were found in an exploratory study conducted in Norway by Granerud and Severinsson (2008). The sample size for the study was 17. The findings indicated that schizophrenic individuals suffer a sense of loneliness, struggled financially, experienced shame, have a fear of exclusion and struggle for job. The findings further revealed that people with schizophrenia felt marginalized and do not have a sense of belonging in the community.

Another study by Davis (2010) explored the experiences of individuals with schizophrenia in Denmark. The study adopted the open-ended interviews, checklist and projective techniques as the data gathering instruments. It was found that people with schizophrenia experienced or had united and close interactive living with family members. The study further revealed that the family was a source of emotional support to the individuals with schizophrenia because supportive relationship exists between family and individuals with schizophrenia.

On the issue of medication experience among persons living with schizophrenia, Gayelene (2012) conducted a study that investigated the experience of persons suffering from schizophrenia. The study primarily focused on the schizophrenic adherence to medication. The study was conducted in Melbourne, Australia involving 22 participants all with the condition of schizophrenia. The study was a mixed method comprising a time–series design and semi structured interviews. Thematic analysis was used to develop themes from follow-up-peer interviews. The study found that participants adhere to medication and that medication improve their state and quality of life. Participants were satisfied with medication generally. The findings further revealed that participants experience enduring or coping with serious medication side effects which included difficulty concentrating, restlessness, sexual dysfunction, insomnia, weight gain and drowsiness. Similar results were found by Gray, Rofail, Allen, and Newey (2013) in a study conducted in Spain with a sample size of 25. The study examined schizophrenic patients' satisfaction and experiences with taking antipsychotic medication. The findings indicated that about 54% of participants reported having side effects, and of these, 34% found them intolerable. Tiredness, poor concentration, lack of emotion, and parkinsonism-like effects were the most common side effects that respondents experienced from medication. In addition, 64% of participants in the study reported that no written information about the possible side effects had been given when commencing treatment, and 46% were not informed about the side effects they could expect. It can therefore be argued that, despite the adverse side effects of antipsychotic medications being taken by persons with

schizophrenia, most of these individuals have had no option than to adhere to the medication regimen in order to stay healthy.

Gill (2013) also explored the lived experiences of people with schizophrenia. The purposive sampling technique was used to select 19 individuals diagnosed with schizophrenia. The study utilized a combination of data collection techniques which included patients' dairy-keeping and individual face-to-face interviews. The findings indicated that people with schizophrenia have loss of identity and control over their lives. The study further revealed that individuals with schizophrenia are highly discriminated against and that stigma from the public and media continues to greatly affect the quality of life of schizophrenic patients.

In exploring the personal experience of persons living with schizophrenia, it is evident that these persons go through challenges both at home and outside their homes. Alexandra (2017) explored adults' experiences of schizophrenia in Britain. The study used a sample size of 11. The participants were asked about their experiences living with schizophrenia. The study used an in-depth interview to collect data. The data was analysed using thematic analysis. The findings of the study revealed that participants faced multiple and prolong challenges at work place, home, hostile peer interactions, and societal pressures relating to appearance and behaviour. Some individuals living with schizophrenia have had to isolate themselves from the public due to this social exclusion and stigmatization in the public domain.

Stigmatization has been noticed to have characterised the lives of persons living with schizophrenia. In the light of this, Owoo (2017) conducted a study that sought to find out the experiences of people with schizophrenia in

terms of stigmatization. The study was conducted in the Okaikoi south Districts of Ghana. The qualitative research approach was employed using two focus group discussion (n=18) among schizophrenic patients. Purposive sampling technique was used to select the study participants. All interviews were recorded and transcribed verbatim after which manual thematic content analysis was used to generate themes. The study revealed that people with schizophrenia are the most stigmatized mental conditions because of its perceived dangerous and unpredictable nature. The study further revealed that due to stigma, persons with schizophrenia in the study area avoid social gatherings such as funerals, wedding and naming ceremonies. The study concluded that individual with schizophrenia always resort to spiritual healers for health care due to stigmatization in the community. It is common in Ghana for persons with varied degrees of mental health issues to resort to spiritual sources rather than the main stream mental health institutions mainly due to fear of stigmatization (Opare-Henaku, 2013).

Additionally, persons with schizophrenia have been at the receiving end of name calling, insults and discrimination over the years. There have been some negative comments, assessment and discrimination attributed to persons living with the diagnosis of schizophrenia by people who come into contact with them. Dickerson, Sommerville, Origoni, Ringel, & Parente, (2002) conducted a study on stigma experiences of outpatients living with schizophrenia in China. Their study revealed that, 70 out of 74 patients had worries about being viewed unfavourably due to having a psychiatric disorder and receiving psychiatric treatment. Also, many participants verbalised their experiences of being treated as less than competent in making life choices and hearing others making

offensive statements about people with mental illness. The capabilities of many persons living with schizophrenia have been downplayed by societies due to their situation. It is worth noting that, despite the condition in which these persons find themselves, many people living with schizophrenia can make some wonderful contributions to the growth and wellbeing of communities when given the opportunity.

Furthermore, in exploring how persons living with schizophrenia view people's perception about them, it came out in a study carried out by Karanci et al., (2019) among people living with schizophrenia in Turkey that, the world has a negative perception about people living with schizophrenia. An account of one participant states that "People do not investigate adequately; they label people with schizophrenia as crazy. Schizophrenia is not madness. It is a disorder, perhaps we have a deficiency or excess of some chemicals in our brains, we try to balance them with medication".

Persons who have lived with schizophrenia have expressed divergent views as far as their experience of living with the condition is concerned. For instance, Karanci et al., (2019) in exploring the experiences of persons living with schizophrenia in Turkey opined that Few positive outcomes were also reported by some of the patients, amid all the negative effects of the illness on sufferers. They claimed that their relationship with their families improved because of the disease they got early disability retirement, and they encountered recognition and support from their relatives and teachers; the disease gave them an opportunity to build new viewpoints in their lives. One participant described his relationship with his family as follows: My family cares a lot about me, and I do care about them as well. We became also further attached to this disease. I

have been deeply related to my family. This is actually the value of the disorder. "It is worth remembering that while some have had negative schizophrenia experiences, some have had positive experiences to share." Sleep disturbances are much more common in people with serious mental illness than in the general population (Faulkner & Bee, 2017; Harvey, Murray, Chandler & Soehner, 2011). On the experience of sleep among individuals with schizophrenia, a study was conducted in Japan by Minato and Zemke (2004). The study explored the time use of people with schizophrenia living in the community. The study was a qualitative study with 15 participants. The findings showed that people with schizophrenia spend a greater amount of time sleeping than people without schizophrenia. The study attributed this to the medication administered to individuals with schizophrenia at the mental health facilities. In a related study conducted in England to examine the use of time by adults diagnosed with schizophrenia, the findings indicated that only few of the participants could engage in active leisure, work, education or volunteer occupation. The findings further showed that majority of people with schizophrenia are preoccupied with sleeping, personal care and passive leisure. It is evident that, participants either sleep for less hours in the night and more hours in the day or sleep for more hours in the night to the point of missing some morning appointments due to oversleeping. Some participants asserted that, their sleep pattern has changed ever since they were diagnosed of suffering from schizophrenia (Harvey et al, 2011). On the other hand, one could argue that, certain factors can contribute to sleep problems which may not necessarily be due to the effects of the condition in which suffers of schizophrenia find themselves. Further research in different settings may be required to understand the influence of schizophrenia on sleep.

Negative and positive personal experiences have characterized lives of people living with schizophrenia. Karanci et al., (2019) in a study dubbed "Living with schizophrenia: Insights from two Turkish people with schizophrenia on how the disorder impacts their lives" found that, participants living with the condition (schizophrenia) asserted that, the condition has rather made them more sociable than before. In one account a participant indicated that "In the past, I was more introverted; I wasn't social; these medications have transformed me; they have altered every part of me. My world has changed. In this way, I claim it is nice. From the study findings above, it can be seen that whereas schizophrenia gives some people a negative experience, some people give a positive account of their experience of living with schizophrenia. Additionally, In India, Feldman and Crandall (2007) explained that, people with severe mental illness particularly schizophrenia often experience a reduction of social contacts, become socially withdrawn and social rejection which may lead to detachment from society.

On the issue of nurse-client interaction, it can be said that, the quality of life of individuals with schizophrenia is influenced by their relationships with people around them. In a pilot study carried out by Kertchok (2014) in Massachusetts, using community mental nurses and persons living with severe mental illness in studying nurse-patient relationship, it was found that, Individuals with schizophrenia have difficulty forming social relationships. Although, these persons wish to maintain close contact with nurses, they feel that their condition may not permit that. It is therefore evident that, persons living with schizophrenia have had negative experiences with nurses as far as nurse-patient interpersonal relationship is concerned.

However, research to date has shown that one symptom of the disorder is the inability to establish such connections (Green & Leitman, 2008; Greene, Olivier, Crawley, Penn, & Silverstein 2005; Stahl & Buckley, 2007). Sung and Puskar (2006) also described the qualitative themes that emerged during face-to-face interviews with twenty-one Korean college students diagnosed with schizophrenia. During the first two years after diagnosis, the study participants reported challenges in social interactions, medication adherence, and class attendance. Study participants verbalized having challenges combining treatment adherence and maintain social interactions with their immediate environment. One participant opined that "my condition has affected my relationship with my class mates, it's worrying me a lot". Furthermore, Mingrone et al., (2016) opined that, individuals living with schizophrenia with a low self-esteem also have marked tendency towards depression as well as increased level of uneasiness when confronting any new situation. Because of the low self-esteem that sufferers of this condition go through, they tend to shy away from society, derby making them withdrawn and thinking about their life problems.

Initiating and maintaining a marital life has been a challenge for persons with schizophrenia. They wish to be married just like any other persons they see around them but it is always not the case. The diagnosis of schizophrenia has the potential to negatively affect a person's opportunity for marriage. A study was conducted in South Korea by Yu and Shim (2009) to explore the perception and experiences of marriage among couples with schizophrenia. A semi structured interview guide was used to collect data from ten (10) participants. They indicated in the study that, although persons living with schizophrenia

often have very realistic views of marriage and are able to recognize benefits as well as demerits, participants had difficulties initiating and maintaining a marital life. Females in the study verbalized experiencing restrictions and oppressions by their spouses that led to the termination of the relationship.

Addressing the issue of care received by people with schizophrenia, Johansson and Lundman (2002) did a study in Tasmania (Australia), and reported negative aspects of care received by persons living with schizophrenia. The aim of the study was to obtain a deeper understanding of this experience. The interview text was analysed by means of a phenomenological hermeneutic method using twelve participants. The result of the analysis gave a complex picture of both support and violation. On one hand was experiences of not being seen or heard, of loss of liberty and of violation of integrity were found whilst on the other hand, there were experiences of respect, caring and opportunities to take responsibility for oneself were offered. Participants engaged in the study asserted specifically that; they were ignored by health professionals, care was being dominated by rules and lack of flexibility, coercion in having to receive treatment one did not agree with, lack of participation and information, and the feeling of being neither seen nor heard.

It can therefore be concluded that, since these persons have lived the condition for a period of time, they are better placed to give an accurate description of the signs of symptoms of the condition in which they find themselves.

Perception of Relapse in Relation to Schizophrenia

One's perception goes a long way to influence the experience one may have about a phenomenon. Vernon (2017) posited in his article "perception

through experience" that, an individual's experience influences his perception about such experience. In other words, what an individual has seen or gone through in life may influence how he/she perceives that phenomenon. On the other hand, it can also be said that, how a person perceives an event may also affect his experience with that phenomenon.

Xiao, Mi, Li, Shi and Zhang (2015) conducted a large, multicenter, retrospective, observational study in ten psychiatric hospitals throughout the People's Republic of China. Nine hundred and ninety-two outpatients with schizophrenia aged 18–65 years discharged from these hospitals between September 2011 and February 2012 with recovery/improvement of their condition were engaged in the study. Information about relapse and correlative factors during the year after discharge was collected by telephone interview using a questionnaire. Xiao et al (2015) concluded that there is a high relapse rate in the Chinese outpatient population with schizophrenia. The most outstanding factor associated with schizophrenic relapse, per their study was poor medication adherence, which was perceived to be due to a negative attitude toward medication. Participants reiterated the role of psychosocial support in the prevention of schizophrenic relapse. It was echoed among respondents in the study that, lack of psychosocial support and a complicated disease history could increase the risk of relapse among the population.

Persons living with schizophrenia have experienced periods of recovery and relapses over the years. What specifically brings about the reoccurrence of symptoms of schizophrenia is not readily known to them, although most of them have perceived medication non-adherence to be one of the variables contributing to schizophrenic relapses. In a study by Chaurotia et al., (2016) to

investigate the temporal properties of early warning signs of schizophrenic relapse self-reported weekly via a telemedicine system using history obtained for 61 relapses resulting in hospitalization involving fifty-one 51 patients with schizophrenia in the Czech Republic revealed that, persons living with schizophrenia can perceive signs and symptoms of schizophrenic relapse within weeks before they actually occur. It can be said that, persons living with schizophrenia perceive relapse as a phenomenon that is associated with living with the condition and therefore early warning signals of relapse helps them to adhere to treatment plan to remain resilient.

Csernansky and Schuchart (2002) conducted a qualitative research that sought to describe the experiences of persons with schizophrenia in their relapse stage. The study was conducted in Russia. A sample of twelve (12) persons living with schizophrenia was used in the study. Out of these, five were females and the remaining seven were males. The results indicated that participants in their relapse stage dance, sing, hear voices and engaged in inappropriate laughing and smiles. A related study was conducted by Alsherif, and AbdElrahman (2013) in Turkey. This study assessed the experiences of schizophrenia persons during relapse. The researchers used a qualitative descriptive case study design. Data collection was done through a face-to-face interview. The study used a sample size of twenty (20). The findings showed that persons with diagnosis of schizophrenia hear voices, laugh excessively and talk alone during relapse.

Sariah, Outwater, Malima (2014) conducted a descriptive study that explored the perceived factors for relapse in people with schizophrenia. The study was conducted in Dares Salaam Region, Tanzania. The study used a

sample size of seven. The findings showed that patients perceived non-adherence to antipsychotic treatments that do not meet the treatment regimen or bargain treatments almost inevitably contributes to a relapse and may potentially be a stressor that induces serious and fast relapse. Findings suggest that the presence of a co-morbid depressive mood, inadequate attention to treatment due to loss of understanding into side-effects by patients tend to be the most possible causes for relapse. In relation to the same subject matter, Sharif and Ogunbanjo (2003) conducted a study in South Africa that sought to find out from patients suffering from schizophrenia the leading factors for relapse. Using a qualitative research approach, ten participants were recruited for the study. Findings indicate that the presence of a co-morbid depressed mood, poor medication adherence due to lack of patients' insight on side-effect appear to be the most likely reasons for relapse.

Additionally, Colleen (2005) conducted a study in Spain focusing on the perception of schizophrenic persons on relapse. Using a qualitative approach and a semi structured interview guide, ten participants were interviewed. Key findings indicated that sufferers of schizophrenia perceived relapse as the reoccurrence of symptoms of schizophrenia similar to those that they previously experienced.

Abdelsalam and Gaber (2017) have both discussed the relapse process as viewed by schizophrenia patients. In the analysis, a descriptive correlational design was used. The socio-demographic data sheet, the medical data sheet of the patient and the questionnaire on relapse factors produced by the researchers used three methods. A deliberate research group of 90 schizophrenia-diagnosed patients was selected. The research was carried out at El Manial University

Hospital, Egypt, in the Psychological Medicine and Drug Prevention Hospital. Using the 'SPSS 22' Statistical Package for Social Sciences (Windows version 22.0) program, statistical analysis was carried out. For qualitative factors, descriptive statistics like numbers and percentages were used and for quantitative results, mean and standard deviations were used. The findings found that the majority of the sample accepted that the causes associated with social isolation and lack of clinical recovery resources, in addition to reduced patient compliance with the drugs, were the most reported relapse causes. The study concluded that many variables, such as lack of social and cultural care, non-compliance with treatment, and stigma, can interfere with the rehabilitation phase of patients with schizophrenia. The study proposed that applying mental health education and offering reliable and affordable comprehensive mental health care to patients with schizophrenia could help minimize relapses.

Although studies have been able to elicit responses on schizophrenic relapse in response to questions asked during data collection procedure, there is the need to ascertain views of persons living with schizophrenia using a face to face interview techniques and probes in order to better understand the natural meaning that persons living with schizophrenia attach to the concept of relapse in relation to schizophrenia.

Coping with Schizophrenia

Living with schizophrenia comes with some challenges. It affects the physical, psychological, social, spiritual and economic wellbeing of sufferers. The Schizophrenia Research Institute (2013) further opines that the impact of schizophrenia on sufferers is often distressing and disruptive. It is imperative to state that, social and personal support appear to influence successful adaptation

in the community, and persons living with schizophrenia cope more effectively. Nonetheless, there may be strong objective evidence of social and personal support and people may still feel unsupported, view their life negatively and not cope in the community. The participants' perception of their lives is an important factor. It is suggested by these authors that mental health nurses need to help people with schizophrenia to develop life skills, positive perceptions of their lives and help them overcome feelings of loneliness and their daily challenges (Browne & Courtney, 2005). Nurses are required to work collaboratively with these people, using psychosocial interventions. Adeosun (2013) asserts that schizophrenia is a leading contributor to the global burden of disease accounting for about 1% of disability-adjusted life year, 3% of year lived with disability and is the 8th leading cause of disability in people aged 15 to 44 years. The impairment caused by schizophrenia makes patients reliant on various domains of psychosocial functioning.

Family support has shown to be an effective means by which persons living with schizophrenia cope with the condition. A qualitative study involving 15 participants conducted in India by Harrison (2001) explored the coping strategies persons with schizophrenia adopt to manage the condition. The findings showed that patients with diagnosis of schizophrenia depend on many strategies in coping with the condition. This include regular medication where participants believed in the efficacy of medicine. The family also encourages regular medication adherence in patients and tolerate their behaviour at home. The findings further indicated that, the family of study participants support persons with schizophrenia in maintaining self-care, personal hygiene and also involved patients in routine family activities. The findings also established that

persons with schizophrenia adopt other strategies such as social support and skills training which help reduce relapse.

Ano and Vasconcells (2005) conducted a qualitative study in Sweden that sought to explain the management strategies of patients with schizophrenia. Ten (10) patients with schizophrenia participated in the study. The researcher used interviews in collecting the data. The findings implicated religious coping as the most common approach used by patients with schizophrenia to cope with the condition. This was because, religious coping to the participants enhance self–esteem, reduces negative effects associated with the conditions. Religious faith also served as a source of strength for the persons with schizophrenia and provided assurance that they can survive difficult events in their life. The findings further pointed that participants belief in their maker improve their relationship with family and other people in their community.

Another research conducted by Weisman (2005) explored the coping strategies people with schizophrenia adopt in managing their condition in Britain. Data was collected through in –depth interviews and analysed following Attride- Stirling's (2001) thematic analysis using NVivo 11. The sample size for the study was 23. The findings revealed that patients with schizophrenia employ the use of media (listening to Christian preachings and watching programmes), adhering to prescribed medication and drawing on faith and the support of family members especially spouses, siblings and uncles as strategies to cope with conditions. The study concludes that the precise impacts of the experience on the lives of the individual influence the kind of strategies they adopt to manage their health, social and economic conditions.

Borras et al (2007) investigated the relevance of religious beliefs in schizophrenia in terms of adherence to treatment. The study was conducted in Italy. This study found that religion, including both spirituality and religiousness, was helpful for patients whose social life and personal identity were impaired by the course of the disease. Findings of this study were congruent with other research indicating that being religious increases patient's satisfaction and adherence to treatment. The positive impact of spirituality on adherence to treatment was explained by an improved quality of life, a better social support, and more positive representation of the illness by believers. Also, these patients stressed the importance of community support in coping with the condition schizophrenia. Participants also identified that siblings and other relatives provided additional supports to them in terms of providing them with their basic needs like financial support and ensuring that they adhere to the treatment plan administered to them by health professionals.

Wasserman and Asch (2010) conducted a research that explored the coping strategies of persons living with schizophrenia in Florida. The study was a qualitative type of research using a sample size of twelve (12). The researcher adopted a semi-structured interview guide in collecting data for the study. Interviews were recorded both manually and electronically. The data was transcribed and translated to identify themes. Findings indicated that participants of the study depend solely on the family in coping with the condition. That is, the family provides them with monies for medication, engaged them in family functions such as funeral, wedding and naming ceremonies. The family also administers and monitors medications given to them at the mental health facilities.

Wang, Chun, and Xiong (2013) investigated patient adaptation to schizophrenia using interview as the data collection instrument. The research took place in China using 18 participants as sample size. It was concluded that, despite the challenges posed by the condition to patients with schizophrenia, patients develop approaches for adapting to the illness and enhancing their wellbeing. The findings identified strategies for coping shared by study participants. These include social support strategies, like nurturing connection family members and building relationships with health professionals, and religious bodies like the church. It was further noted that some participants relied on adherence to prescribed medication, support from their social groups and other family members, selling of farm products and support from government. The findings also established that persons with schizophrenia depend on God or spiritual upliftment, social interactions, rest or sleeping, listening to music, preaching and reading both religious and secular books.

Furthermore, Cheng (2017) explored the feelings and coping strategies of persons with schizophrenia in Taiwan. Twenty-five adults with schizophrenia were used for the study. The researcher used interviews for data collection. The findings established that participants utilized a variety of strategies based on their beliefs and habits when they experience unusual sensory experience. The findings further proved that participants cope through religious activities such as exorcism or sacraments which they believed could restore their mental and physical well–being. Other participants also established that they cope through the help of health professionals such as doctors, nurses and other medical practitioners. The findings indicated that participants resorted to seeking professional advice and education from the health professionals to cope with the

condition. Furthermore, the findings also showed that health professionals offer them hope, support, encouragement and the strength to cope with the condition.

The major manifestations of personal resilience are social competence, problem solving, autonomy and sense of purpose (Bozikas & Parlapani, 2016). Personality strengths that relate to resilience include high self-esteem, extroversion and optimism. Internal assets and personal competencies comprise the so called "phenomenological resilience" that can be measured by scales. Bozikas and Parlapani, again noted that, understanding of human strengths could contribute to prevention or lessening of psychiatric disorders' devastating consequences, since optimism, sense of personal control and many other positive processes promote psychological health.

Mingrone et. al., (2016) in their study involving 89 persons suffering from schizophrenia found that, patients living with schizophrenia mostly report severe difficulty in coping effectively with both major and minor stresses. They have been found to resort to the use of less frequently problem-focused coping strategies to deal with stress than non-psychiatric interventions. Most persons living with schizophrenia generally use more passive emotion-focused coping strategies, such as avoiding, ignoring, and not thinking about the problem (Jansen, Gispen-de Wied & Kahn, 2000; Wilder-Willis, Shear, Steffen & Borkin, 2002; Aghevli, Blanchard & Horan, 2003; Phillips, Francey, Edwards & McMurray, 2009). Coping by avoidance was further established by Karanci et al. (2019) as a technique that proved to be beneficial for individuals dealing with the disorder. In order to prevent stigmatization, not worrying too much about the disorder, resting a lot and embracing the disorder, the research participants assumed that shielding their diagnosis from others or providing a

new name for their condition rather than schizophrenia is beneficial ways to deal with their disease.

Conceptual Framework

This study was guided by a conceptual framework that explains the key concepts in the study. The framework was put together by the researcher based on the key concepts which were found in literature relating to the subject matter. They include: Experience, Perception, Coping, Resilience and Relapse. Sub concepts under the concept of Experience included the following; personal care, social support, interpersonal relationship, employment opportunities, medication adherence and stigmatisation. Key sub concept under Perception included schizophrenia. Also, there were sub concepts under coping which included family support, organisational support, personal strategies, medication management and religious coping. Completing the framework were the construct of resilience and relapse. The write up below explains how the conceptual framework guided the study.

An individual's life experience has a strong influence on how sensory stimuli are processed and perceived. It is argued that, a person's previous experience in life shapes his perception in different sensory modalities (Snyder, Schwiedrzik, Vitela, & Melloni, 2015). The information human senses receive is often ambiguous, incomplete, and discontinuous. Nevertheless, human beings perceive their environment as a unified whole. Human brains achieve this using prior information (Heffner, Dilley, McAuley, & Pitt, 2013). The study is backed by the notion that, one's lived experiences with a particular phenomenon may influence how the person interpret impulses about the phenomenon. One's interpretation of these impulses becomes a meaningful experience in the

person's life which is mostly referred to as perception. Again, an individual's perception about a situation or event might also inform the experiences he or she may have after a period of time. Being able to withstand the negative effects that come with living with a phenomenon, may give one the opportunity to adopt the most suitable coping strategy in order to deal with the negative consequences associated with the phenomenon. It could be noted that, an individual's perception of the condition (schizophrenia) may tell whether the individual will be able to maintain resilience (recovery) or suffer relapse. Again, negative or positive experiences with schizophrenia could contribute to the maintenance of resilience or the occurrence of relapse in the affected person.

It is therefore anticipated that, the experience one has about living with schizophrenia coupled with his/her perception of the condition will influence his/her coping strategy in dealing with the signs and symptoms associated with the condition. Again, it is estimated that, the coping strategy an individual adopts in living with schizophrenia may either help him/her to maintain some level of resilience or suffer episodes of schizophrenic relapse.

It was demonstrated in a study by Teschinsky (2000) that, persons with positive experiences of living with schizophrenia coped well with the condition. On the other hand, persons who have had negative experiences such as stigmatization and lack of family support are not able to cope well with schizophrenia (Yen, Huang & Chien, 2020) and are therefore likely to encounter frequent episodes of schizophrenic relapses.

Additionally, how individuals perceive the condition and the associated relapse may contribute to their adherence behaviour to treatment regimen. Individuals who hold the view that, strict adherence to medication will help

them to maintain resilience are likely to follow prescribed treatment plan (Sariah, Outwater & Malima, 2014); this according to them will prevent relapse episodes among the population.

The framework helped to link together the three main research objectives (experiences of living with schizophrenia, the perception of schizophrenic relapse and coping strategies of persons with schizophrenia) which eventually helped in generating the themes during the analysis. It helped to study the experience, perception and coping strategies of study participants.

The experience of study participants influenced their perception of the phenomenon (living with schizophrenia) and the associated coping mechanisms in dealing with the negative effects of the condition. It was projected that, the negative perception of schizophrenia and the experiences these persons go through contributed to relapse at some point in their lives, whereas the positive perception and experiences may have helped them to maintain resilience.

Diagrammatic Representation of the Conceptual Framework

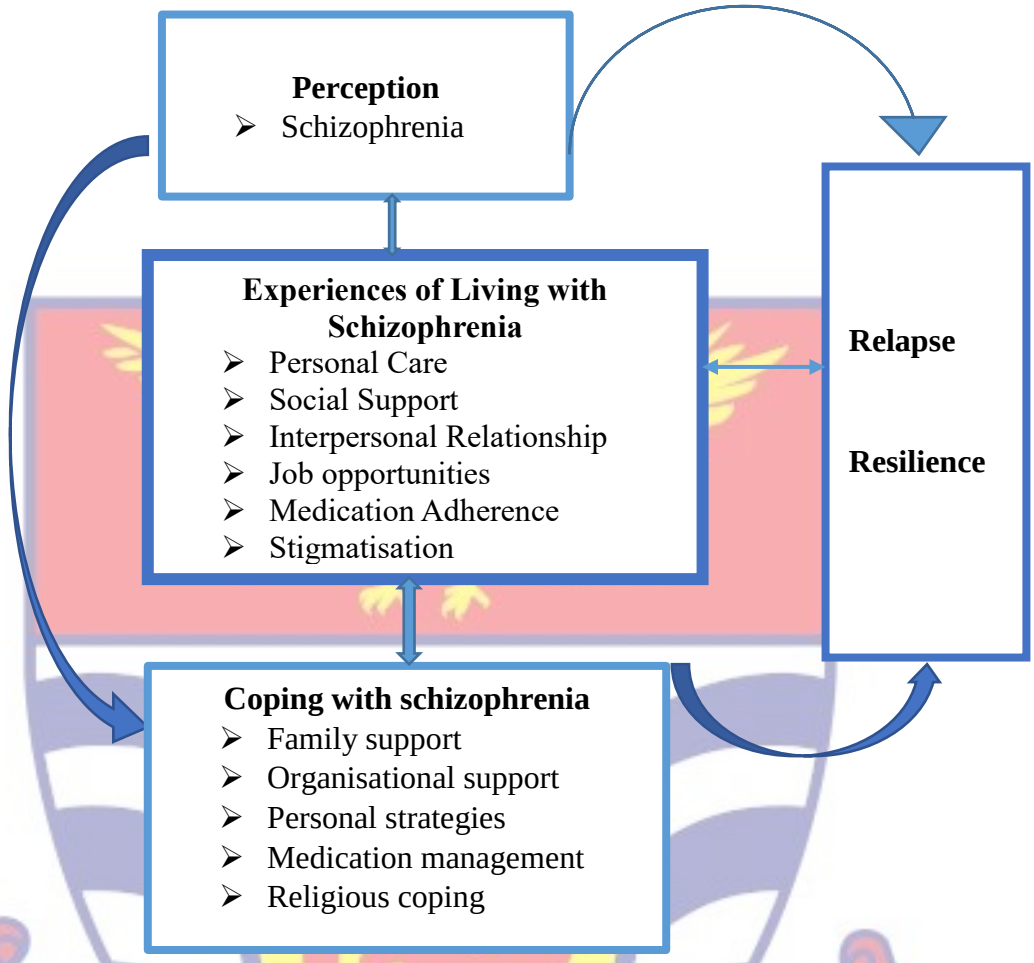

***Figure 1*: Conceptual framework explaining the experience, perception, and coping with schizophrenia**

Source: Researcher's own construct

Chapter Summary

This chapter of the study covered some key areas such as the overview of schizophrenia, the clinical features of schizophrenia, aetiological factors of schizophrenia and effects of schizophrenia on sufferers. This chapter also looked at some theoretical and empirical explanations of schizophrenia, experiences of persons who have lived with schizophrenia, their perception of schizophrenic related relapse in relation to their health and living condition and also how these individuals cope with the condition (schizophrenia). Literature

on experience of living with schizophrenia revealed that, persons living with schizophrenia had negative experiences with work, were mostly rejected or ignored and stigmatized by society. Literature again explored both negative and positive experiences with medication adherence, sleep, activities of daily living, family support, and other support outside the family. On the issue of perception of relapse among persons with schizophrenia, literature search indicated that, precursors to schizophrenic recurrence are lack of social care, non-adherence to medicine and stigma. Additionally, literature search found that adopting personal measures such as sticking to review dates, adherence to medication, positive family support and support from other organisations such as the church and health professionals and religious coping were some of the means by which persons with schizophrenia cope with the condition. These measures help them to maintain resilience. The chapter ended with a conceptual framework that backed the study which focused on aspects of human experience, perception, coping, relapse and resilience.

CHAPTER THREE

RESEARCH METHODS

Introduction

The study explored the experiences of persons living with Schizophrenia. This chapter discusses the methodological approach of the study. It seeks to provide an understanding of the methodology that was used for the study, why and how it was appropriate for the study. Explicitly, the chapter describes the research design, the study area, population of the study as well as the inclusion and exclusion criteria of the study. Additionally, the sample and sampling technique, research instrument, data collection procedure, and data analysis approaches are discussed.

Study Design

Quantitative and qualitative are the two main approaches used in research (Polit & Beck, 2010; Newman & Hitchcock, 2011). The goal of the quantitative research approach is to discover laws that explains, predicts or controls individuals or groups of individuals, and also leads to arithmetical or information (Sarantacus, 2005; Newman & Hitchcock, 2011). Quantitative study, therefore, deals with objective data by avoiding use of personal opinions and values which sometimes occur in qualitative studies. Newman and Hitchcock (2011) indicated that it is best to use quantitative approach when a lot is known about a phenomenon of concern. This study sought to describe the experiences of persons living with schizophrenia. Since little is known about the phenomenon, the researcher did not opt for the quantitative approach because it is believed it would not help to achieve the objectives of the study. A qualitative approach with descriptive phenomenological study design was used

since this allowed the researcher to meet the set objectives. Qualitative approach was chosen because it enables researchers to describe the rich and natural everyday experiences of a phenomenon (Creswell, 2007). Therefore, the aim of the research involved subjective knowledge from participants, including personal experiences. This study adopted a descriptive phenomenological approach. Phenomenology is a philosophical tradition which aims at exploring and understanding people's everyday experiences (Wojnar & Swanson, 2007). There are two main schools of thought in phenomenology. These are descriptive phenomenology by Husserl and interpretive phenomenology by Heidegger (Mapp, 2008). Descriptive phenomenology involves four key steps. These steps included bracketing, intuiting, analysis and description. In bracketing, the researcher identifies and lays in abeyance every preconceived idea or knowledge about the phenomenon under study in order to confront the data in an objective and pure manner. Under intuiting, which is the second step in descriptive phenomenology, the researcher remains open as much as possible to the meanings attributed to the phenomenon by those who have experienced it. Again, the researcher analyses the data collected by extracting significant statements, categorizing, and making sense out of the essential meaning of the phenomenon. Finally, descriptive phase occurred where the researcher defines the phenomenon of concern.

Descriptive phenomenological studies usually employ the use of open-ended questions to explore the views of participants on a subject matter (Brown & Cordon, 2009). The Husserlian descriptive phenomenological design was employed in this study due to the sensitive nature of the su bject matter and the need to break new grounds as far as the subject matter is concerned. This

qualitative approach is deemed ideal for the study because in phenomenology, ideas are generated from rich amount of data by the means of induction and human interests (Connelly, 2010). Descriptive phenomenology is mostly employed in qualitative research when little is known about a phenomenon or when there is little existing research (Morrow, Rodriguez & King, 2015). The method is applicable in this study because of the limited literature on the subject matter in Ghana.

From the point of view of Holden and Lynch (2004), although phenomenology has the demerit of data gathering taking up a great deal of time and resources, phenomenology helps to understand people's meaning into situations or events, to look at change processes over time, it helps to adjust to new issues and ideas as they emerge, contribute to the development of new theories and gather data which is seen as natural rather than artificial. Furthermore, despite the strengths of descriptive phenomenology discussed above, it is worth noting that, descriptive phenomenology is highly labour intensive and requires developed language skills to identify constructs, themes, and patterns in verbal data and to write a report that brings the case alive for the reader. Also, the design makes it very challenging to apply the findings to other situations around the world (Berg, 2004).

Study Area

Burns and Grove (2011) noted that the study setting is the location where a study took place. This research was carried out within the Cape Coast Metropolis in the Central Region of Ghana. The Central Region is one of the two regions with a public psychiatric hospital. This is a main stream psychiatric hospital known as the Ankaful Psychiatric Hospital. It is the only psychiatric

hospital in the region that provides mental health services to persons living with severe mental illness on outpatient and inpatient basis. The hospital admits and discharges persons living with mental disorders including schizophrenia into the various communities within and outside the Central Region. The Cape Coast Metropolis is one of the main areas where community mental health services are provided for persons living with schizophrenia as part of continuity of care following their discharge from Ankaful Psychiatric Hospital.

There are five community psychiatric units attached to five healthcare facilities in the Cape Coast Metropolis. These facilities offer community mental healthcare to discharged persons suffering from mental illness in the metropolis. These are the Ewim Polyclinic, Efutu Health Centre, Adisadel Health Centre, Metropolitan Hospital and the University of Cape Coast Hospital. Persons with mental illness including schizophrenia who have been managed at a public psychiatric institution in the country such as the Ankaful psychiatric and have been discharged into their various homes in the metropolis, utilize mental health services at the various community psychiatric units in the metropolis in order to maintain resilience or recovery.

Cape Coast has a population of approximately 169,894 (Ghana Statistical Service, 2010) which represents 7.7% of the Central Region's total population. Males constitute 48.7% whilst females represent 51.3%. The Cape Coast Metropolis was divided into North and South in the year 2012 by the government of Ghana. The metropolis can boast of several junior, senior high and tertiary schools including the University of Cape Coast.

The study focused on persons (clients) who are in the catchment area of the five community psychiatric units. The Cape Coast Metropolis was chosen

for this study because, statistical data from the Metropolitan Health Directorate in 2019 put schizophrenia as the leading psychiatric condition that was managed by mental health professionals in the Cape Coast Metropolis. Again, schizophrenia is the leading psychiatric condition that requires periodic visits by community mental health personnel in the Cape Coast Metropolis. It worth noting that, persons living with schizophrenia who are in their lucid interval within the Metropolis are less than those experiencing psychotic symptoms of the condition.

Population

A population is defined by Polit and Beck (2010) to mean the entire collection of cases that follow a prescribed criterion. A population may be any size and would have at least one (and occasionally several) features defined that will set it apart from all other population. The target population for this research included all persons who are 18 years and above living within the Cape Coast Metropolis with schizophrenia who are in their lucid interval and have experienced one or more schizophrenic relapse events. Again, the target population comprised persons who could speak Fanti and English language. The rationale for recruiting people with schizophrenia who are 18 years and above is to maintain the focus of getting responses from adolescents and adults who can volunteer information to help achieve the research objectives (Creswell, 2007). Additionally, the researcher was interested in persons who have had at least one-year experience of living with schizophrenia and were lucid enough to help share their rich and natural experience on the phenomenon of concern. Lucid interval is the period where persons with schizophrenia are deemed fit to give a better account of themselves (Sass & Parnas, 2005). Again, persons who

could speak English language and any Akan language formed part of the characteristics of the chosen population. This was taken into consideration because, these are languages that the researcher could speak and write and was comfortable to use as a medium of communication in interacting with the study participants during the interviews.

Inclusion Criteria

For a participant to be eligible for the study, he/she must meet the following criteria:

- Persons in the Cape Coast Metropolis who were living with the diagnosis of schizophrenia for at least one year and were in their lucid interval.
- Persons with the diagnosis of schizophrenia who have had at least one episode of schizophrenic relapse but were in their lucid period
- Persons living with schizophrenia who could speak English or Akan language.
- Persons who had lived in the Cape Coast Metropolis for at least one year.

Exclusion Criteria

Participants who met the following criteria were not included in the study:

- All persons in the Cape Coast Metropolis living with schizophrenia who were experiencing psychotic sign and symptoms of the condition
- All persons living with schizophrenia for more than one year but resided outside the Cape Coast Metropolis.
- Persons with diagnosis of schizophrenia who were in their lucid interval but could not speak English or any Akan language.

Sampling Procedure

A sample is a representative selection of a population in a research (Kadam & Bhalerao, 2010; Sarantakos, 2012). Thus, a sample is a subgroup of a population (Frey, Botan & Kreps, 2000). A sample size is also thought of to be the number of participants in a sample (Kadam & Bhalerao, 2010). In this study, a purposive sampling technique was used in selecting participants because it helps in identifying and selecting participants or groups of individuals that are especially knowledgeable about or have experienced the phenomenon of interest as postulated by Creswell and Clark (2011). Because of the characteristics the informants possess, the purposeful sampling method, often called judgmental sampling, helps to gather information from a well-defined group of people (Polit & Beck, 2008). For this study, however, purposeful sampling was necessary because the author wanted to specifically interview individuals with the diagnosis of schizophrenia in their lucid state. The researcher believed that using purposive sampling method would help identify and invite persons who have experience of living with schizophrenia and could provide rich data that describe their experiences (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2015).

After receiving ethical clearance for the study, the researcher contacted the nurse in-charge of the out-patient unit of each of the five community psychiatry units within the Cape Coast Metropolis to explain the purpose of the study to them. The contact nurse in each community psychiatric unit identified persons who met the inclusion criteria for the study by assessing them using a mental status examination guide, informed them about the study and sought their permission to give their phone numbers to the researcher. After receiving

the contact numbers of potential participants, all those who met the inclusion criteria were put together into a single document (journal) to form the population under study, all within the Cape Coast Metropolis. The researcher personally contacted them one by one through telephone calls and home visits to explain to them in detail what the study was about and invited them to be part of the study. Participants were made aware that participation was voluntary. Time, date and place for the interview was negotiated with persons who consented to be part of the study. All participants who were contacted chose to be interviewed in their homes. The rationale for recruiting from the local community of the target participants was to gain individual views and generate findings which were likely to be relevant to local mental health care provision.

Ajjawi (2013) postulated that, the quality of the data, useful information from participants, the number of interviews per participant, and even the nature of the research topic are all ways by which researchers can determine the sample size. In this work, because a descriptive phenomenological research approach was adopted, a total number of nine (9) persons who have lived with schizophrenia for at least one year and have ever experienced schizophrenic relapse in their lives were interviewed for this study. A sample of nine (9) persons were used for the study because, Morse (1994) suggested that at least six participants can be used for a phenomenological study. This is because, the researcher intended to explore the rich and natural experiences of people regarding a particular phenomenon. Creswell (1998) further recommended that, for phenomenological studies, a sample range of five (5) to twenty-five (25) participants could be used.

Although the determination of the sample size was backed by authorities (Morse, 1994 & Creswell, 1998), data collection ended at the point where it was gathered that, no significantly new information was being gathered. This phenomenon is often referred to as data saturation in qualitative studies (Morse & Field, 1998). Again, considering the volume of data that the researcher was confronted with after interviewing the ninth person, it was deemed appropriate to work with the information gained from the nine persons who met the inclusion criteria for the study.

Data Collection Instruments

In qualitative studies there are different methods that can be used to collect data; the most common are interviews, focus group discussions, observational methods and document analysis (Creswell & Creswell, 2017). Semi-structured, in-depth, one-on-one interviews are the most popular method to elicit rich, detailed, and first-person accounts of experiences and phenomena under investigation (Pietkiewicz & Smith, 2014). Hence, Self-developed semi-structured interview guide was used to collect data for this study. It allowed for broad and open-ended inquiry that elicited direct and personal responses. Additionally, because of its flexible nature, participants were able to express themselves freely as the researcher probed into specific areas of interest for clarity. The interview guide had four sections. Section one of the interview guide assessed the demographic characteristics of participants. Section two assessed the experiences of persons living with schizophrenia. Section three focused on the perceptions of persons suffering from schizophrenia about relapse in relation to their condition. Finally, the fourth section explored the strategies persons living with schizophrenia adopt to cope with the condition.

Pre Testing

The data collection instrument (interview guide) was pretested on two persons living with schizophrenia in the Komenda Edina Eguafo Abirem (KEEA) municipality in the central region. The KEEA municipality was chosen for pretesting because, it has similar population characteristic as the Cape Coast Metropolis. The interview guide was pretested in order to check clarity of items, ambiguity of language and feasibility of the data collection instrument. The exercise was found to be useful because it provided the opportunity to make changes to the guide because it helped to check for clarity of items on the guide and helped to restructure some of the questions on the guide.

Data Collection Procedures

Before recruitment and data collection, the researcher obtained ethical clearance from the Institutional Review Board of the University of Cape Coast (**UCCIRB/CHAS/2020/37**). Informed consent was sought directly from the participants of the study. The participants were informed about the purpose of the investigation and were free to withdraw from the study at any given time if they wished because participation was voluntary. Each participant who agreed to be part of the study was given a consent form to read and sign. Those who had literacy challenge and therefore could not read and sign had the content read to them by the researcher after which they signed or thumb printed. In all, one month (25th May to 22nd June, 2020) was used for data collection exercise. The researcher conducted a total of nine tape-recorded interviews with the nine (9) persons living with schizophrenia. Each interview location was chosen by the participant based on his or her convenience and that reduced interference. The

interviews were conducted in the homes of the respondents on specific days that were convenient to them. The medium of communication between the researcher and study participants was through English language, Twi and Fanti, since all the nine participants were able to speak and understand those languages.

To maintain confidentiality and anonymity, each participant was given a pseudonym during the interview and was used throughout the study. The data was secured on the computer with password protection and was only accessible to the researcher. Recordings were erased from the recorder after transcription and subsequent transfer unto the computer. Data collection took place from 25th May to 22nd June, 2020 with an average length of interviews lasting 40 minutes. Field notes that captured nonverbal cues of some of the study participants were also taken during the engagement. Instances where participants nodded their heads or kept silent in response to certain questions, were captured as field notes. A reflective journal was also kept to keep track of all that transpired from the first participant to the ninth participant.

Data Processing and Analysis

The interviews were transcribed into written text for analysis. After each interview, the researcher listened to the audio recording over and over to make sense of what the participant said and also to determine whether some clarification was needed. There were instances where study participants were reached on phones to seek clarification on certain responses given during the interview. The interviews from the audio recorder were reviewed several times to obtain verbatim accounts of the interviews. The seven steps in descriptive phenomenological data analysis by Colaizzi (1978) were adopted for analysing

the data collected. The first step is familiarization. To achieve this, the researcher familiarized himself with the collected data by carefully reading through all the participants' accounts several times. The second step is about identifying significant statements which were of direct relevance to the phenomenon under investigation (excerpts of significant statement attached as Appendix B at the back of the work). The significant statements were generated by means of listening to the audio recordings of each study participant and reading the transcribed data several times to identify statements that were of direct relevance to the phenomenon of concern. The third step focuses on formulating meanings by identifying meanings relevant to the phenomenon that arose from careful consideration of the significant statements. Several meanings were formulated from the significant statements which were generated at the second step.

The fourth step centres on clustering of themes, where the researcher clustered the formulated meanings into themes that were common across all participants 'accounts and were of directly significant to the phenomenon under study. At this stage, bracketing was ensured so that the researcher's assumptions, presuppositions and what is known pertaining to the phenomenon was put aside during the data analysis (Ahern, 1999; Gearing, 2004; Speziale & Carpenter, 2007). All that was known about schizophrenia and individuals who have lived with the condition over a period was written down and the researcher made sure he did not jump into conclusions based on what was known about the phenomenon prior to the study. As much as possible, the voice of the study participants was given the needed attention during the study. The fifth step is about developing an exhaustive description, where the researcher wrote a full

and inclusive description of the phenomenon incorporating all the themes produced in step four. The sixth step of the analysis talks about production of the fundamental structure where the researcher condensed the exhaustive description down to a short, dense statement that captured just those aspects deemed to be essential to the structure of the phenomenon. Essentially, the sixth step is where the report of the study was generated. Finally, the seventh step talks about seeking verification of the fundamental structure. This is where the fundamental structure statement (report) was returned to all study participants to ask whether it captured their experience. This was done via telephone calls and was duly recorded with the consent of the participants. Earlier steps in the analysis were modified in the light of this feedback. Consequently, the data were analyzed using the seven steps stated above. Below is a display of the step by step approach employed in the analysis of this work:

Purposive sampling of study participants and assigning pseudonyms to them

Semi-structured in-depth interview

⇓

Audiotape recording of interviews

⇓

Verbatim transcription of audiotaped recordings

⇓

Reading of each transcript and listening to audiotaped recordings for accuracy

⇓

Reading through all the transcribed data for understanding of the phenomenon

⇓

Extraction of significant statements from the transcribed data

⇓

Formulating meanings related to the phenomenon of interest from the transcripts

⇓

Clustering of themes by grouping similar statements and naming them with sub-themes describing the phenomenon

Developing an exhaustive description by writing a full and inclusive description of the phenomenon incorporating all the themes

Producing the fundamental structure where the researcher condensed the exhaustive description down to a short, dense statement that captured just the aspects that were essential to the structure of the phenomenon. This was done by combining related sub-themes into themes to address the study objectives

Seeking verification of the fundamental structure by returning the fundamental structure report to all participants to ask whether it captured their experience. This was done via telephone calls and was duly recorded with the consent of the participants. The researcher modified earlier steps in the analysis with regard to this feedback.

Methodological Rigor

Lincoln and Guba (1985) first addressed the issue of rigor in their model of trustworthiness of qualitative research. Trustworthiness is used as the central concept in their framework to appraise the rigor of a qualitative study. Trustworthiness denotes quality, authenticity and truthfulness of findings in qualitative research. It relates to the degree of trust or confidence which readers have in results (Schmidt & Brown, 2017). Yin (1994) also describes trustworthiness as a criterion to judge the quality of a research design. Trustworthiness addresses methods that can ensure one has carried out the research process correctly. Lincoln and Guba (1985) refer to trustworthiness as

something that evolved from four major concerns that relate to it in which the set of criteria were based on. The four major traditional criteria are summarized into four questions about value of truth, applicability, consistency, and neutrality. From these, they proposed four terms within the naturalistic paradigm to replace the rationalistic terms: credibility, transferability, dependability, and confirmability (Schwandt, Lincoln, & Guba, 2007).

Credibility, the accurate and truthful depiction of a participant's lived experience, was achieved in this study through continued engagement and persistent observation to describe the context of the phenomenon and to minimize distortions that might interfere with the data. Transferability was also enhanced by using purposive sampling method, to purposefully select individuals who met the inclusion criteria and were willing to provide a rich description to come out with a robust data with a wide range of information through detailed and accurate descriptions of participants' lived experiences of schizophrenia by continuously returning to the texts. The researcher immersed himself into the phenomenon to know and describe it fully, comprehensively, and thoroughly. Special care was given to the collection, identification, and analysis of all data relevant to the study. Furthermore, the audiotaped data was meticulously transcribed for further analysis.

Review of each participant's account was carried out by reviewing the participants' answers and interpretations at the end of each interview before drawing final conclusions from the results. Dependability was also achieved by having an expert qualitative nursing researcher to review the transcribed material to validate the themes and descriptors identified. The aim here was that, both analysts agree on the findings related to themes and meanings within the

transcribed material. Confirmability was achieved by documenting the procedures for checking and rechecking the data throughout the study. Bracketing was also conducted to separate the researcher's assumptions and biases about persons living with schizophrenia from the realities as verbalized by study participants and therefore achieve a clearer description of the phenomenon as experienced by the participants. The collected and analyzed data was presented to the study participants, to ascertain whether the narrative was accurate and a true reflection of their experiences.

Ethical Considerations

The thesis study began after permission was given by the University of Cape Coast Institutional Review Board (IRB). The introductory letters and approval letters were received from the University of Cape Coast School of Nursing and Midwifery to introduce the researcher to the various unit heads of the five community psychiatric units and the study population as a student researcher. Before any information was gathered from them, informed consent was received from all participants. Participants were ensured that their privacy and secrecy rights would be respected and adhered to properly. The names and reactions of the participants were kept secret. Participants chose to be granted pseudonyms to protect secrecy. The first participant, in consultation with the researcher, chose to be referred to as Bella, whilst the remaining participants chose to be referred to as Beauty, Favour, Terry, Mercy, Forgive, Sheila, Shallom, and Godswill in that order. These were pseudonyms used for the purpose of engaging the study participants throughout the study.

Participation was solely voluntary; thus, participants were notified that, without any penalty or effect, they could withdraw from the study at any time.

Participants were again informed that the interview was anticipated to last between a period of 45 and 60 minutes at a venue and at time considered suitable for both parties. Again, research participants were educated that they could opt not to answer any questions if they desired.

Finally, to avoid violation of secrecy, the research data was adequately handled. The raw data obtained from the participants was moved from the audio recorder and encrypted to a password-based device, with only the researcher having access to the password. After the conclusion of the study, by saving the information on a pen drive, the researcher backed up the data and anonymously locked it in a locker with a key. The research information will be preserved for at least five years after completion and publication of study findings before it will be destroyed.

Chapter Summary

The chapter dealt with the discussion of the methodology that was adopted for the study. A descriptive phenomenological design by Husserl (1980) was employed for the study ensuring that the four steps involved in descriptive phenomenology were inculcated in the study. These steps included bracketing, intuiting, analysis and description. The study was conducted in the Cape Coast metropolis among persons living with schizophrenia. The researcher used a semi structured interview guide to collect the data from the participants. The interviews were audio-recorded and transcribed verbatim. The study used a sample size of nine (9). Colaizzi's (1978) steps in descriptive phenomenological data analysis were used to analyse the data obtained from the in-depth interviews. The next chapter focused on discussion of the key findings from the data collected in accordance with identified themes.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

This chapter presents the results and discussion of the study. This study sought to describe the experiences of persons living with schizophrenia who live within the Cape Coast Metropolis. Data from the interviews have been examined according to the objectives of the study which were: the experiences of persons living with schizophrenia, perception of relapse in relation to schizophrenia and the coping strategies which persons living with schizophrenia adopt to cope with the condition. Data collection and analysis were guided by a conceptual framework developed by the researcher based on key concepts found in literature. The framework covered people's experiences of living with schizophrenia, their perception of the condition and the associated relapse and resilience and finally the coping strategies of persons living with schizophrenia. In this research, three main themes are used to present the findings. These are:

1. Living with schizophrenia
2. Perception and experience of schizophrenic relapse
3. Coping with schizophrenia

The first theme describes the experiences of participants with regard to living with schizophrenia. This theme produced the following six sub themes:

1. Maintaining daily activities of living
2. Building and maintaining relationships
3. Experiences with prescribed medication
4. Seeking and receiving support
5. Being seen as different: Experience of stigmatization

6. Acquiring and maintaining a working life

The second theme describes how participants perceived and experienced relapse in relation to schizophrenia. This theme also produced two sub themes:

1. The perception of relapse as illness reoccurrence
2. Experience of schizophrenic relapse

Finally, the third theme recounts the strategies participants used to cope with living with schizophrenia. This theme is also supported by four sub themes:

1. Coping through personal strategies
2. Coping through medical measures
3. Coping through family support system
4. Coping through religious support

Demographic Characteristics of the Respondent

The table below displays the demographic characteristics of study participants

Table 1: Results of Demographic Data (N=9)

Demographic Information	Frequency	Percentage (%)
Marital status		
Married	2	22.22
Single	7	77.78
Age (in years)		
20-30	1	11.11
31-40	3	33.33
41and above	5	55.56
Gender		
Male	3	33.33
Female	6	66.67
Religion		
Christianity	8	88.89
Islamic	1	11.11
Educational background		

Table 1 continued

B.E.C.E	4	44.44
WASSCE/NVTI	4	44.44
Diploma	1	11.11
No. of Years with Schizophrenia		
1-10	12	22.22
11-20	5	55.56
21 and above	2	22.22

Source: Fieldwork, Tetteh (2020)

The table above shows that, out of nine participants, seven were single while two were married. On the age range of participants, the data revealed that one of the participants was in the age range of 20 -30 years. This was followed by three who were in the age range of 31-40 years. Also, the remaining five of the participants were in the age range of 41 years and above. Concerning the gender of the participants, six were females whilst three were males.

As part of the demographic characteristics of the respondents, the religious affiliation of the respondents was considered. Again, eight of the participants were Christians except one who declared that he was a Muslim. For the educational background of the respondents, four were holders of BECE certificate. Also, four of the respondents were holders of WASSCE /NVTI certificates with one being a holder of Diploma certificate. The study also took into consideration the number of years respondents have lived with the diagnosis of schizophrenia. Two of the respondents have experienced the condition for 21years and above years while five respondents have lived with schizophrenia for 11 to 20 years. The remaining two were diagnosed with schizophrenia 10 years ago.

Theme One: Living with Schizophrenia

The objective of this theme was to explore the experiences of persons living with schizophrenia. Thus, the research question was posed as "What are your experiences of living with schizophrenia?" Under this section, six sub themes emerged. This includes, experiences of maintaining daily activities of living, building and maintaining relationships, experiences with medication, seeking and receiving support, being seen as different (experiencing stigmatization) and acquiring and maintaining working life.

Experiences of Maintaining Daily Activities of Living

Study participants expressed their views on maintaining daily activities of living. All nine participants disclosed that having lived with schizophrenia for a number of years, they have come to accept that, the condition is part of them and something to live with them for the rest of their lives. They indicated that despite their condition they are able to take care of their daily activities such meeting their personal hygiene needs, nutritional demands and sleep. Bella, Mercy and Sheila had this to say:

Bella

> *"Living with this condition you call schizophrenia has not affected the way I eat, sleep, bath, wash, among others. I eat very well, enjoy my sleep and always take care of myself very well. Before I eat, I wash my hand with soap. I also wash my clothes and even bath twice a day."*

Mercy

> "…*The condition has not affected my daily activities at all. I do everything normal in the house. For example, I wash my clothes, sweep the compound and even arrange my brother's room nicely for him anytime his room is dirty. This has become my normal routine in most times. I also observe personal hygiene especially in this time of pandemic where hygiene protocols have become the issue of the day."*

Sheila

> *"It has not affected my daily activities in any way. This morning, before you came, I did some washing of clothes, I scrubbed the bathroom, swept the whole compound and went to take my bath. I do it every day."*

The responses by participants indicate that, being diagnosed with schizophrenia does not mean that the individual cannot take care of his or her basic daily needs. Participants' accounts suggest that although they have accepted their condition of having schizophrenia. They live a normal life and could perform certain activities such as sweeping, washing, cooking etc. on their own just like their counterpart who have no mental conditions. Terry gave an account to support this assertion:

> *"……I have been living with this condition for several years without any interferences in the discharge of my daily activities both at home and when I go to school to teach. I do my things as expected of every human being. I maintain my home very well before going to school, I teach the children as usual and interact with colleague staff in the school and carry out my responsibilities as the head of my family. It is only when the condition comes that I see some changes in the way I play these roles in the house and school."*

Mercy also narrated how she takes care of her needs and extends that support to her brother. These points are important to show that, living with schizophrenia does not mean that the person would become a complete burden to the family.

Building and Maintaining Relationships

Relationship with Family

In exploring the relationship between study participants and their family members, the study findings indicated that, participants were able to maintain a good and positive relationships with people around them.

To the study participants, family members have good relations with them and have been supportive since they were diagnosed with schizophrenia. It is significant to note that mothers were seem to have had a good and positive relationship with most (six) of the participants compared to other family members. The accounts by participants revealed that these family members, especially mothers, show love towards them at all times and understand their condition. Below are narratives of how participants recounted the relationship they shared with family members:

Terry

> "*Family members especially my parents and my siblings did not abandon me when I was diagnosed with schizophrenia. They rather encouraged and supported me in providing with some basic needs for my upkeep. I can say for a fact that they have all been good to me, especially my mum. My mother doesn't want people to know that I am mentally ill; she always cares for me and check up on me.*"

Godswill also had this to say:

> *"…. I am very close to my brothers, father and other siblings…we relate very well. My mother, for example, is the one who collects my medicine from the hospital for me and administers them to me when it is time to take my medication. She's my best friend."*

Forgive recounted:

> *"…. I don't stay with my siblings but they have been very supportive. I stay with my mother who always assists me anytime I go to the hospital. I remember the last time when I was admitted at the Nightingale ward, Ankaful, my two brothers visited me and brought provisions and money to me…. if my relations with them was hostile, I don't think they would have even come to the hospital to visit me. This shows that my siblings and my mother are on good terms with me even with this condition."*

Mercy added:

> *"…. My family members know I am a mentally ill person but there has not been any problem living with them. My mother, for example, understands me better than any other siblings. She offers me help in terms of finances and other basic needs such as helping me to buy my medication when they get finished, providing food and shelter and encouraging me to stick to the treatment plan."*

It is worth noting that, although six participants verbalized having a positive relationship with family members right from the first day of their diagnosis, three of the participants indicated having challenges initially with family members when they first got to know that they were living with schizophrenia.

Beauty also recounted:

> *" .... At first, my family members, including my own parents did not want to accept me. They initially did not want to allow me to stay in the house. They thought I had been cursed by someone, that is why I have become a mentally ill person. In fact, they did not want to eat with me when I came home. They were of the view that, if they ate with me, they could also become mentally ill persons. It took the intervention of the nurses at Metro hospital who came to my house to educate them on my condition before they accepted to relate well with me."*

Shallom added that:

> *".... Hmmmm. My people did not want me to return to the house after I was discharged from Ankaful hospital oo. They wanted me to remain in the psychiatric hospital forever. It took sometime before they accepted me in the family. As for me I don't have any problem with anybody. I greet them and do what I am supposed to do all the time."*

Relationship with Mental Healthcare Providers

Participants also described their relationship experiences with mental health practitioners like nurses, doctors and other health workers in the mental health facilities. According to the participants, caregivers like nurses and doctors show a lot of concern about their conditions especially when they visit the mental health facilities. Participants revealed that in most cases, nurses and doctors complement what family members do for them.

Forgive had this to say in relation to her relationship with care givers:

> *".. As for the nurses and doctors, I think they are praying and wishing that I become completely free from this illness. This is because they call me on the phone to check up on me. They also offer advice and even when my medicine is about to finish, they call to*

remind me of the number of days more for my next review…. The nurses are very good and caring. They are even part of the reasons why am feeling fine. They have been supportive and I am proud of them."

Shallom also added that:

"*Good relation exists between the nurses and myself. The nurses, for example, do not joke with me at all especially when I visit the mental health facility. I don't know where I would have been by now had it not been the support of the nurses at the mental facilities. The nurses take good care of me and even pray for me as well. Due to the friendly nature that exists between us, I also pray for them so that they will always be there to care for people living with schizophrenia."*

Favour said this:

"……The nurses and doctors at the mental facilities are very good to me. I remember any time I go to the hospital for example, the nurses will quickly attend to me and arrange a doctor to see me. I like the way nurses attend to me at the hospital."

Sheila also recounted her experience with care givers:

"……They have helped me a lot. They call me, visit me, and at times schedule a meeting with my father just to see how I am faring. The staff have been also supportive in many ways, at times they help me to get my medications and pay when I have the money. In fact, they have been a blessing to me all these years. They are the people I first call anytime I see changes in my life."

Marital Experience

On issue of marriage, the study sought to find out how living with schizophrenia has influenced participants' experiences with marriage and marital relationships. Findings from the study revealed that, only two (Terry and Forgive) out of the nine participants were married and were living at peace

with their spouses. The married ones indicated that they had a positive marital relationship. The other seven who were not married shared various experiences with regards to marriage.

Terry reiterated:

> *"…. You see, my current wife at times makes some funny comments about me but she does not use my condition to insult me or look down on me. We are living peacefully here."*

Forgive added that:

> *"….. If you get someone who really understands you, you will enjoy your marriage. In my case, my husband really understands me. He has been my source of encouragement. I used to think that, this illness is not hospital illness. At times, I think it has some spiritual linkage but my husband keeps telling me to trust in God that one day, it will go and will never come back".*

Out of the seven participants who were not married at the time of data collection, two (Sheila and Mercy) explained how potential suitors upon finding out about their mental illness withdrew from them.

Sheila

> *"Then he said, is this mental drug? I responded yes. Then he asked me if I am suffering from mental illness, which I said yes. Since then, he has not called me again….I remember some time ago, there was this handsome gentleman who came and proposed but just the following day, I took to the streets following the voices and seeing strange beings. When I became ok, I was told that I said was going to look for the man on the streets. It is a problem oooo. I thought I was seeing a human being going, so I followed him. So, I realized it was the condition that came back at the time."*

Mercy

> *"……I had a man who came to marry me but just before the time was due, they said I run away from the house. And the man never came back to the house. This condition scares men from me… they don't want to marry someone with mental illness."*

The two participants' accounts above suggest that the diagnosis of mental illness has the potential to negatively affect a woman's opportunity for marriage.

In summary, participants' accounts above demonstrates that most of the study participants have cordial relations with family members as well as mental health practitioners like nurses and doctors and that they received great care and support from them. Participants shared personal encounters and fond memories of their experience with staff who render mental healthcare services to them. Almost all the study participants had very positive experiences with mental health staff. Finally, participants shared diverse experiences regarding marriage possibilities and marital relationships.

Experiences with Prescribed Medication

Four of the respondents (Bella, Sheila, Shallom, and Godswill) indicated that taking medicine to support them had been part of them since they were diagnosed with schizophrenia. They explained that medicines are always given to them to help them feel healthy and comfortable. They recounted that the medicine has been part of their optimism because it is the only thing that suppresses the impact of the illness on them.

Bella reiterated that:

> *".... Oooo the medicines are very good and it has been supporting me in staying healthy, I sleep well and perform my job without any*

problem whenever I am on medication. I only experience relapse if I do not take my medicine on time."

Sheila added that:

"…. I am okay anytime I take my medicine. This is because the medicine given me at the health facilities are good. They are my source of hope. Due to this, I don't joke with my medication intake"

Shallom also recounted that:

"...since I was put on the psychiatric medications, I don't hear voices again. I am now able to live a better life. The medication has helped me a lot."

Godswill also added that:

"*…But the Olanzapine works for me very well. It has contributed to my recovery all this while."*

The responses imply that medicine intake has been of great help to the study participants as far as the condition is concerned. It could be suggested that medicine intake suppresses the impact of the condition on the study participants.

Another basic thing derived from the responses of the participants was that although some had it a bit easier adhering to the medication intake, some participants found the intake of the medication a bit challenging. In other words, some participants recounted some adverse side effects associated with the medication. The side effects varied from one individual to the other. For example;

Beauty asserted that:

"……I feel hungry whenever I take my medicine. Also, anytime, I take the medicine in the night, I cannot teach the following day in school because I will feel drowsy throughout the day. I am sometimes unable to move about with my normal daily activities."

Favour also recounted:

> *"……The medicine makes me very weak and dizzy. Due to that, I sleep a lot. I will sleep for hours in a day without doing any work. Sometimes too I find it difficult to sleep when I take my medicines."*

Terry added:

> "*…. The medicines make my eyes go round, and I experienced things like restlessness, sexual dysfunction, insomnia, weight gain."*

It was noted from study that, although respondents had both negative and positive experiences with their prescribed medications, they continued to stick to treatment plan in order to remain healthy.

Seeking and Receiving Support

Family Support

Favour, Terry, Forgive and Shallom reiterated that, the family especially their mothers offer them some support while living with schizophrenia.

Favour

> *"…… my mother especially tries very hard to encourage me not to think negatively about this condition."*

Terry added:

> *"……as for my family, they always check on me to see how I am faring. At times they can tell that there are changes in the way I do things at home. When they notice that, my wife especially will tell my uncle to come and find out if how she sees me is okay."*

Forgive recounted:

> *"…… I don't have any problem with family support. The people in my house have been very supportive. They even remind me of my review dates and give me transport fare to the clinic at times."*

Shallom indicated:

> *"..... I am a student and my family, especially my mother has been very supportive. She buys all my medication for me and encourages me when she sees that I am quiet or moody."*

Support from other Institutions

Four participants (Favour, Terry, Forgive and Shallom) asserted that their main source of support was from family. However, some institutions have been of great support to them. These institutions according to the respondents included the church and social welfare department They provide certain basic needs to supplement what they received from family as well as mental healthcare practitioners. Again, the four study participants indicated that, they sometimes offer help in cash and sometimes in kind to them. The following responses illustrate this assertion.

Favour asserted:

> *"...the social welfare department offered financial support to me last year. They came to visit me with some mental health nurses, then I told them of my challenges in life. It is even my mother who went to withdraw the money on my behalf. The money was used in purchasing some of my medicine. I used part of the money in my petty trade also."*

Terry added:

> *"... The church has been a great source of help to me. They pay regular visits to check how I am faring. I remember some time ago; it was the church that offered me money to pay my hospital bills.... My church sent a delegation to my house the first time I was diagnosed of this condition. They also send a delegation to my house to check on me if they do not see me in church for some time. At*

times, I go to the priest and some members of my church for financial assistance and they are always there to support me."

Forgive again recounted:

"……. It is only my church that offers support to help me in this condition. My church helps me financially and sometimes too offer food items for my general up keep..... Personally, I am an usher in my church, so I take part in most of the church activities. So, the church does not joke with me at all; they come to my aid anytime I call on them. They at times help me with money to buy my drugs."

Shallom added that:

"*… the social welfare department in Cape Coast once supported me. It was in cash. I even used some of the money for both medication and my general upkeep. It was nurses who introduced me to them for assistance."*

The responses suggest that participants receive financial and other forms of support from the social welfare department and the church. This means that apart from family members who offer support to these individuals with schizophrenia, other institutions like the church and social welfare departments have taken upon themselves to put a simile on the faces of individuals living with schizophrenia by showing them care and love.

Seen as Different: Experience of Stigmatization

On the issue of stigmatization, the respondents indicated that stigma is one major negative experience they have had in relation to living with the condition of schizophrenia. Almost all the participants were of the view that people in their community are the very ones who stigmatize against them. Five of the study participants (Beauty, Mercy, Sheila, Forgive and Godswill) shared their stories of how people in their various communities point fingers at them

calling them with different names. They explained that people point fingers at them because they believe they are mentally retarded, public nuisance and dangerous to the community. They, therefore, labelled them being different. The following accounts of study participants support the issue of stigmatization:

Beauty

> *"..... People in my area call me a mentally ill person. I was going to town one day and saw some people in a salon. As soon as I passed by, there was a lady in the salon who started telling others that they should look at the mad person passing... the lady started telling them that I am mad because I wanted to kill someone with my witchcraft which failed and that resulted in my condition.....the name calling is too much for me especially outside my home. I thank God for giving me the patience to contain some of the abusive words people utter when I go outside."*

Mercy

> *"..... Stigmatization is what kills my spirit. One day, whilst I was teaching, I could hear the children giggling behind me in the classroom. When it happened, I didn't feel happy at all. I had a teacher friend who told me that the students like staring at me a lot, so, one day whilst teaching, I had combed my hair in a particular way that had made the hair very long. Then, I heard the students saying that it is her hair, others said it is not her hair, she is wearing artificial hair. Then, I turned and held my hair and untied it for them to make their own judgement. It was that day they got to know that I had a natural hair which were very long. When I did that, I left the classroom and went to my bungalow. So, the principal came to me and asked why I left the class and I explained to her."*

Sheila

> *"..... Stigmatization is the major negative experience associated with this condition... my colleagues at work point fingers at me and*

say all sort of negative things about me. They say my mind is not working etc. Even at my area where I stay, people point fingers at me to the extent that a taxi driver refused to pick me on the way to town. Hmmmmm….it has not been easy with me on this issue of stigmatization. One day I was going to church, I stopped a car and when I was about to board the car, one person in my area quickly run to inform the driver that I am a mad person so the driver should not pick me oooooo…. the driver left because of what he heard and I had to walk to church that day."

Forgive

"……People tell me that, as for me, my mind is not correct. They say I am mentally sick. Due to this, people sometimes fail to sell items such as food to me. I sometimes send people to buy things in the area for me because if I go myself, they will not sell for me. People have labelled my house as mad people house. Visitors in the area are even aware that my house is labelled as mad people house. This is serious ooo…hmmm. My friends do not want to associate with my family members because of me. "

Godswill

"…… For instance, if I you call me to come and do a particular work for you and it is your turn to pay me but you don't do so, I come to you to get my money. When I go there like two or three times, they will say that as for me I am a mad person. You see how people treat me? People see me as a different person.

Participants' accounts above suggest that stigmatization is associated with schizophrenia just like any other mental illness, however, the accounts point to the fact that most of the name calling and negative comments come from outsiders but not within their immediate homes. This has serious negative impact on participants' effort to maintain resilience.

Acquiring and Maintaining a Working Life

The participants noted that living with the condition of schizophrenia has affected them negatively in terms of work and other job opportunities. In other words, the condition has interrupted their work, especially at the relapse stage. This is because, during relapse, people with schizophrenia lose control of themselves, therefore they are unable to be active at work. Two participants (Terry and Mercy) verbalized being absent from work most of the time when they experience relapse. They further indicated that, long periods of absence from work often led to a reduction in their income, financial constraints and low job satisfaction.

Terry

> *"As a teacher, I always had a sick leave to stay out of work as soon as there is a change in behaviour at the workplace. In those days, when the principal noticed changes in my behaviour like singing and laughing unnecessarily while in school, she would quickly ask me to go home. I would be asked to stay in the house for some time before I would be called back. There was a day while in school, I experienced relapse. Hmmmm…it was an embarrassing situation because students were making fun of me. It was a friend who brought me to the house. This in a way is affecting my work because I have to be in school and teach the students so they can pass their examination."*

Mercy

> *"…. This illness has made me inactive in terms of working. I cannot do any work. The sickness has made me lazy to the extent of lacking the urge to do any meaningful work. I am a farmer and whenever I experience the condition, I cannot go the farm. This illness hmmmm… has affected my output as a farmer. I sometimes sell porridge in the morning but as soon as the sickness comes, I become*

weak and unable to go and sell. I have to depend on someone to help me sell my porridge if I become weak as a result of the condition. I have to stay indoors for the whole period. You see, it is the mind that will help you to do the work but if this same mind has "issues", you cannot do anything better. This is because the mind controls the body and if this mind is affected by this condition, you cannot work."

Another meaning derived from the response was that some individuals living with this condition lose their job and other job opportunities. According to two other respondents (Sheila and Godswill), persons who suffer from schizophrenia sometimes lose their jobs because of the interruptions associated with the illness. Others are also denied of jobs because of this condition, thereby making them unemployed at some point in their lives.

Sheila

"...I used to work in the aviation department as a security staff. One day, while at the post, I started seeing signs of relapse so I was rushed to the hospital by the manager of Ghana Aviation. I was subsequently admitted at the hospital. They were very much aware that I was okay and that I could report back to work. I was told to go home and that I would be called back. I did not hear from them again. This means I lost my job because of this condition. It was a painful experience. I have not been able to secure any job till now."

Godswill

"……I lost my job because of this condition. I was working with a certain company but they said I was talking to myself and threatening people at the workplace so they sacked me. Since then, I have not been able to get any job to do except going to the seaside to get some fish to sell sometimes."

The responses suggest that study participants with schizophrenia are denied job opportunities and are sometimes sacked from their jobs due to the condition. Some of them also become absent from their work due to the challenges associated with the condition. Again, some of the study participants suffered discrimination at work due to the condition.

Theme Two: Perception of Schizophrenic Relapse

The objective of this second theme was to inquire into the perception of relapse by persons living with Schizophrenia. Under this section, two sub themes emerged from the data. They are; the perception of relapse as illness reoccurrence and experiences of schizophrenic relapse.

The perception of relapse as illness reoccurrence

Data from the respondents regarding their perception of schizophrenic relapse indicated that schizophrenic relapse is the reoccurring of their condition. To most of the participants, schizophrenic relapse occurs when they fail to take their medication. According to five participants (Bella, Favour, Terry, Forgive and Sheila), this condition has reoccurred several times in their lives. They saw relapse as the reoccurrence of signs and symptoms of their condition which were once under control. The following are accounts of five study participants:

Bella

> *"……Relapse is the coming back of this illness they call schizophrenia. Hmmmm…. that is how this sickness has been oooo… it goes and comes back….it is supposed to go completely but when it goes, it comes back again."*

Beauty

> *"……Relapse means my condition has come back. It is when a person is treated and discharged of schizophrenia but the person*

is later seen on the streets exhibiting some traits that previously was shown when the person was being nursed in a hospital. When this happens, I usually get the impression that the sickness has come back. It has happened to me several times but now I am okay."

Favour

".....I believe that, there is schizophrenic relapse when the condition reoccurs several times in my life."

The responses showed that the study participants perceived schizophrenic relapse as the reoccurring of schizophrenia to the individual who has been diagnosed with schizophrenia.

Another inference made from participants' accounts was that individuals experienced schizophrenic relapse when they fail to constantly adhere to the treatment plan prescribed for them by mental health practitioners. Three of the participants (Beauty, Shallom and Godswill) noted that, they experienced relapse when they stopped taking their medication. This suggests that strict adherence to medication can reduce the risk for relapse.

Beauty noted that:

".... I usually experience a relapse when I stop taking my medication. For example, after 13 years of resilience, I thought I was fine so I stopped taking my medicine without any medical advice. Suddenly, I started experiencing some strange things in my life. I took to the street, started talking and doing all manner of things like singing, laughing unnecessary, dancing etc. until I was rushed to Ankaful hospital……I was disturbed but blamed myself for not adhering to the treatment plan."

Shallom added:

> *"……. To me, relapse occurs if I don't take my medication. At times, I sense it but I cannot control myself unless I take my medication. So, I know that if I don't take my medication, I will suffer from relapse. Due to this, I usually take my medication.*

Godswill reiterated that:

> *"……. Anytime I stop taking my medication without advice from professional, I see those signs that led to my previous admission……. I talk unnecessarily, blame people without any cause, argue with people and sings a lot. I know it is because I stopped taking the medication."*

Furthermore, it was evident from almost all the participants that they experienced relapse as a result of stigmatization. They attributed their relapse to excessive thinking following a stigmatizing experience. Two participants (Favour and Mercy) explained that schizophrenia had to do with the mind so if an individual always thinks and worry about how he or she has been stigmatized in the community, the possibility of experiencing relapse becomes very high even if the person strongly adheres his or her medication plan .

Favour noted that:

> *"……. I experience relapse anytime I think about how I am treated in my community. I think a lot because this condition has made people in my area point fingers at me. People don't come closer to me because they think I am mentally sick…. I find it difficult to forget about this condition. This thing makes me think excessively thereby resulting in relapse."*

Mercy added:

> *"……When people say all those negative things about me, I find it very hard to forgive them. It leaves me thinking about my condition; sometimes throughout the night. I don't sleep at all."*

The responses indicate that participants viewed failure to adhere to their prescribed medication and stigma as the major causes of schizophrenic relapse.

Experience of Schizophrenic Relapse

Participants shared their opinions on some of the experiences they go through in their relapse state. The data indicated that participants have varied experiences as far as schizophrenic relapse is concerned. The common thing almost all of the study participants go through during relapse is change in behaviour. Five participants (Mercy, Favour, Terry Sheila and Shallom) explained that individual differences exist; so, what someone experiences during relapse may not be the same as the other person as far as relapse is concerned.

Mercy

> *"……Any time I suffer from relapse, I sing at a point, hear voices telling me about the death of my younger sister which is not true. There will be a lot of things going on in my mind. I cannot recollect all. I sometimes walk on the streets carrying loads on my head, talking alone and my whole body will be dirty."*

Favour

> *".... I usually isolate myself from people. I also roam about and hear voices telling me to get up and go to a woman sitting somewhere and attack her. Even if I decide not to go, the voice will be stronger and then I feel like some people are whipping me for being disobedient so, I have to go and roam and sometimes sing alongside*."

Terry

> "…. *In relapse state, I become quiet, talk to myself, sometimes strip myself naked in the streets and do not stay in my own house. I sometimes roam, laugh excessively and stay quite without talking to anyone*."

Sheila

> "……*As for me, when I relapse, I don't talk to anybody in the house. I remain indoors, sometimes without food for days. However, when my mother comes to force me to eat, a voice will tell me to attack her*."

Shalom

> "…*When this illness comes, I leave home. I walk for a long distance. I don't know what tells me to walk for that long distance but I can walk for the whole day*."

The responses suggest that participants have varying experiences during the relapse stage. It was indicated that, although participants give account of what happens to them when they experience relapse, most of them do not have control over what they do.

Theme Three: Coping with Schizophrenia

This theme presents participants' accounts of coping with schizophrenia. Thus, the research question was posed as "what strategies do persons living with schizophrenia adopt to cope with the condition?" Under this section, four sub themes emerged. These included personal coping strategies, using medical measure, coping through family support system as well as religious support.

Coping Through Personal Strategies

The data revealed that respondents adopt personal measures in coping with schizophrenia. These measures according to the respondents, help them to maintain resilience. Most of the participants (Bella, Beauty, Forgive, Mercy, Sheila, Shallom and Godswill) expressed that the personal strategy they adopt most often to cope with their condition is deliberately trying to take their mind off the condition. In other words, participants were able to prevent schizophrenic relapse by avoiding excessive thinking or worrying about their condition and its associated impact on their living condition. Bella for example believes that accepting her condition and refusing to worry about it is a way to cope.

Bella

> *"I have come to accept that I have this condition and so I don't worry myself with thinking about the condition to experience a relapse. I even forget sometimes that I have this sickness. I have come to realise that anytime I worry myself with thinking excessively about the condition, I experience relapse so I have stopped thinking about it. This has helped me to stay healthy."*

Forgive added:

> *"……..This sickness has come to stay with me so I have purposed in my heart not to think about the negative things associated with this sickness. I know that, no matter how long I think about my condition, it will not change…I therefore go about my normal activities observing personal hygiene and engaging in activities that take my mind from the condition. This has been my chief secret of staying healthy."*

Shallom also recounted:

> *"……. I don't worry myself with what people say about my condition. I know it will not change who I am. I have gone through worst things in my life. I have now decided not to listen to what people say about me. I only do what will help me to be healthy."*

Godswill

> *……. The negative things associated with this illness do not worry me. I have come to accept that schizophrenia has become part of me so I don't bother myself with the negative things people say about me. This keeps me going because I encourage myself that one day all will be well with me".*

This finding indicates that study participants living with schizophrenia adopt personal strategies that enable them to stay healthy.

Using Medical Measures to Cope

Participants submitted that apart from their own strategy, medical measures also help them to stay healthy. All participants except Shallom and Godswill were of the view that one of the major coping strategies has been the medical strategy. In this regard, participants adhere to the treatment plan given to them at the mental health facilities. They explained that failure to adhere to the treatment plan results in schizophrenic relapse.

Terry asserted:

> *"……The use of psychiatric medication has been my source of relief. It has helped me to stay healthy. It is the regular medication that has prevented me from suffering from a relapse. With the regular intake of the medicine, there is hope for me and I know that there will be a day this whole condition will come to an end."*

Sheila added that:

> *"……taking my medication has been a source of hope in coping with this condition. This is because, without it, I don't think I will even be of sound mind to provide you with this information. I know it is the adherence to the treatment plan that has sustained me. The medicine has helped me to eat and sleep as well. The benefit associated with the medicine makes me to quickly rush to the hospital for some whenever I notice that I am short of medicine."*

Forgive also opined:

> *"... The medication has helped me a lot; it is my food. I do not skip my medication for any reason because, it has saved my life. Despite the bad side effects associated with the medication at times, I still think it is what keeps me from experiencing relapse."*

Another medical strategy that Shallom and Godswill stressed that they have adopted to remain resilient all these years was support system provided to them by the mental health practitioners. They believed that mental health practitioners encourage them, visit them and offer them the needed education on the need to follow treatment plan. The practitioners also do follow-up checks on them to ensure they cope well with the condition. They also educate them on the essence of medication and personal hygiene.

Shallom further verbalized that:

> *"……. Mental health practitioners encourage people living with this condition. They made me, for example, aware that I am not the only one with this condition because others are in the same condition as mine. They sometimes visit me and talk to me. Their words of encouragement prevent me from unnecessary thinking. To be honest, anytime I see them around or have a phone call with them, I get relieved. This has helped me in coping with this condition."*

Godswill

> *"……. I have received a lot of education about my medication and condition from the mental health practitioners. This has helped me in staying strong. They always visit me and sometimes help me financially in purchasing my medicine. I was touched on the education given to us on one of the days I went for review. In that review, there was an education on the dangers associated with taking wrong medication and the effects of drug/substance abuse. They sometimes schedule a meeting with me just to come and see how I am faring. Their support has been great so far; I think it has been very beneficial to me."*

The responses suggest that medical support system is of great importance to the study participants. This implies that adherence to medication and directions offered by mental health practitioners provide a lot of support to participants living with schizophrenia in coping with the illness.

Coping through Family Support System

Most of the study participants submitted that, as part of their coping strategies about their condition, their respective family members especially their immediate family provide support which complements other strategies as far as coping with this condition is concerned. According to Beauty, Favour, Mercy, Forgive and shallom, their families, especially mothers have supported them in providing their needs, encouraging and seeing it to that they are always safe. These, according to them have helped them to stay healthier. They added that their respective families provide financial support which aids them in purchasing their prescribed medicine in managing the condition. This money provided by their family is used for regular reviews to mental facilities are all.

Beauty for instance, recounted how her father supports her by paying her medical bills and offering words of encouragement.

Beauty

> *"…. My family, especially my father and mother, help me with money to pay my hospital bills. As for their words of encouragement, I cannot talk about it because they have been doing enough. They go an extra mile by checking if am following the treatment plan given to me by the health professionals at the mental health facility."*

Forgive added:

> *"…My family members especially siblings have provided a lot of help. They help me by encouraging me a lot. In terms of finances for medication and transportation for reviews, it is my siblings as well as my husband who assist me by providing me with monies. It was even my husband who paid my medical bills last year when I was admitted at the hospital. My family ensure that I adhere to the treatment plan given to me at the hospital."*

Mercy also recounted:

> *"……. My mother has been of great help in coping with this condition. She provides me with food, shelter, money for my medicine and general upkeep. My other siblings from time to time come around to check up on me. On their visit, they sometimes provide me money for buying medicine…hmmm…this sickness, if you don't have money to purchase the drugs, it will not be easy but thanks to my family who are there to provide me with this need."*

Shallom opined:

> *"…My mother supports me with my medication. She has been my source of hope from the first day I was diagnosed with this condition. She has been encouraging me to stick to treatment plan all the time."*

This finding suggests that participants received emotional and financial support, attention and care from family members, especially mothers. This implies that family members are likely to contribute greatly to the maintenance of resilience among study participants.

Coping through Religious Support

Beauty, Favour, Terry, Mercy, Forgive, and Godswill all expressed that, their belief in God keeps them going. This according to them prevents them from experiencing relapse. In other words, their religious faith has been a source of hope in keeping them healthy.

Beauty

> *"…… I pray to my God and put my trust in Him all the time. When I lost my son, I thought about it too much and it affected me, but when I decided to leave everything to God, I had some kind of joy within me. So, with that experience, I believe one day, my God will heal me completely."*

Forgive

> *"……I pray to God all the time for healing. My trust is in him all the time. With God all things are possible. The word of God serves as joy and hope and I believe one day my God will heal me completely. Prayers give me some form of relief and I believe I have not suffered from relapse for some time due to my prayers. God has the healing power so surely; he will heal me from this illness."*

Godswill

> *".... I am a good Christian. The bible teaches that nothing is too hard for God to do so I pray to God to have mercy on me and heal me. I know God listens to his children therefore he will listen to my prayers and answer them for me. I have faith in God and this has been my source of hope all these years."*

Another meaning derived from the data as far as a religious support system is concerned, had to do with the support participants received from the church. Bella, Shallom and Sheila submitted that, the church and the mosque as institutions provide a lot of support in terms of money, food stuff and prayers. This according to the participants help them to cope with the condition."

Bella

"...My church has been very supportive since I was diagnosed with this condition. My church has encouraged me a lot in staying healthy through prayers. They visit me, share the word of God with me and pray with me. They also provide me with some foodstuffs and money."

Sheila

"……The church has been of great support in coping with this condition. The priest and some church members, for example, offer me money for my medication. They invite me to prayer programmes of the church. They sometimes come home to pray with me."

Shallom

".... My faith Allah tells me that God is the true healer. Although I take my medications as ordered, I believe that, Allah is the true healer who can heal me of this condition. Anytime I go to my fellow Muslim brothers, they offer me the needed help in terms of finances, food items and prayers. I experience brotherly love anytime I go to the mosque to pray."

The responses showed that religious beliefs, the mosque and the church as institutions help people with schizophrenia with spiritual and material support in coping with the condition.

Discussion of Results

This aspect of the chapter four seeks to discuss the study findings in relation to empirical data. The objectives of the study were: the experiences of living with schizophrenia, perception of relapse in relation to schizophrenia and the coping strategies persons living with schizophrenia adopt to cope with the condition. The discussion of results was guided by a conceptual framework developed by the researcher using key concepts in the study.

Theme One: Living with schizophrenia

The findings of the study revealed that participants have similar, yet unique experiences of living with schizophrenia. These experiences are seen in various ways. They include ability to maintain daily activities of living, experiences of building and maintaining relationship, experiences with medication, seeking and receiving support, experiences of stigmatization, as well as acquiring and maintaining a working life. Pertaining to maintenance of activities of daily living, the findings showed that participants living with schizophrenia perform activities just as any other person can perform. This means that participants with the diagnosis of schizophrenia can do things in their rightful sense. It also suggests that they can do things on their own without necessarily depending on others in discharging of duties such as bathing, eating, washing and other household chores. It is not surprising that a previous study supports this assertion. For instance, research conducted by Bejerholm and Eklund (2006) asserted that being diagnosed with schizophrenia does not necessarily lead to an impoverished lifestyle. Rather, individuals with schizophrenia have a normal lifestyle and performed activities such as washing, bathing etc. and even observed personal hygiene.

With regard to experiences of building and maintaining relationship with family members and care givers, the findings showed that cordial relations exist between the study participants and their family members including care givers. This study shows that individuals with the condition have friendly relations with their family members and received critical support from family members. Since their relatives are compassionate, this assistance helps to reduce the stigma on individuals with schizophrenia. This support also boosts their self-esteem thereby reducing psychological problems that may lead to relapse. Also, with healthy relations with family members and mental health workers, participants with schizophrenia may receive any kind of support that they may need both at home and at the various health centres. This finding corroborates with the findings of Davis (2010). Davis found that people with schizophrenia had united and close interactive living with family members. The study further revealed that the family was a source of emotional support to individuals with schizophrenia because a supportive relationship exists between family and individuals with schizophrenia.

Also, a study by Wang, Chun, and Xiong (2013) concluded that persons with schizophrenia build friendly relationships with mental health professionals like doctors and nurses. This enables them to receive greater support from them especially when they visit the health facilities. A study by Karanci et al. (2019) confirms the previous finding that persons living with schizophrenia had an improved relationship with their family and experienced acceptance and love from their relatives and health professionals. Even though the findings of this study find support in the literature as discussed so far, other previous studies (Johansson and Lundman 2002; Bradshaw, Armour & Rosenborough, 2007;

Feldman & Crandall, 2007; Alexandra, 2017) contradict the current findings. For example, Johansson and Lundman (2002) study concluded that patients with the diagnosis of schizophrenia in Tasmania were ignored by health professionals. Also, a study by Alexandra (2017) added that patients with schizophrenia faced a lot of challenges which include hostile interactions with family members. There is contradiction possibly due to the study setting and also, health professionals in Ghana are likely to benefit from proper orientation with regard to caring for people with mental disorders at the various mental health facilities.

Findings of this study also showed that medications remain the cornerstone of treatment for this condition. This is because medications seem to be of great importance to study participants with schizophrenia as far as their survival is concerned. The findings showed that the study participants adhere to regular medication in order to remain resilience. Regular medication was said to keep them healthier, thereby preventing them from frequent relapses. Regular medication relieves them of the negative effects associated with schizophrenia that they are likely to experience without medications. This finding concurs with Gayelene's (2012) assertion that medication improves the quality and state of persons with schizophrenia. Also, a study by Karanci et. al, (2019) concluded that medication changed the general wellbeing of persons with schizophrenia from bad to good and is generally good for persons with schizophrenia.

However, the findings showed that participants with schizophrenia experienced side effects in the course of adhering to their medication. This means that just like any other medicine, antipsychotic drugs have side effects. Thus, study participants have antipsychotic drug side effects. The common side

effects verbalized by participants include dizziness, headache, nausea, loss of sexual drive, sleepiness or having a problem with sleeping. This shows that participants may experience these side effect so far as they continue with medication. This confirms the research findings of Gayelene (2012) which revealed that the common side effects of medicine persons with schizophrenia consume included difficulty concentrating, restlessness, sexual dysfunction, insomnia, weight gain and drowsiness. Also, Gray, Rofail, Allen, and Newey (2013) added that schizophrenic patients experienced tiredness, sexual dysfunctions, sleeping difficulties among others. They associated these experiences to the medicine because they were seen as side effects of medicine administered to persons with schizophrenia.

Concerning seeking and receiving support, the findings revealed that institutions like the church and organisations such as the social welfare, support study participants living with schizophrenia. The benefits received from these institutions help them to live a better life. This support served as a source of relief for participants. It suggests that the church and organisations like the social welfare provide welfare services for individuals with chronic conditions of which schizophrenia is not an exception. This support may also reduce the financial burden of the family especially, those who do not have adequate resources to cater for individual with schizophrenia. This finding is incongruent with the finding of Wang, Chun, and Xiong (2013). In their study, it was concluded that government, as well as religious bodies, provide adequate and regular support in caring for people with schizophrenia. These organisations provide them with monies and other basic needs to complement the support received from their family members.

With regard to the experiences of stigmatization, the findings indicated that participants with schizophrenia are highly discriminated against especially in the community in which they live. The findings showed that participants living with schizophrenia are stigmatized because the community perceived them to be mentally ill and a threat to the community. Thus, the community does not see the essence of associating with the "mad" people in the community. One possible reason why people stigmatize against these individuals may be due to the symptoms people with schizophrenia exhibit, especially in the relapse stage. Such manifestations are seen to scare people around especially the people in the catchment area of where study participants reside. Hence, most people in the community may consider them to be highly violent and can even kill people who may get closer to them. With these in mind, the community may always stigmatize against them. Stigma affects the wellbeing of people with schizophrenia because it leads to isolation and rejection of people with schizophrenia.

Similar results have been found in other studies (e.g., Kinderman & Cooke, 2000; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Granerud & Severinsson, 2008; Gill, 2013; Owoo, 2017). For example, Owoo (2017) concluded that persons with schizophrenia are highly discriminated against in their community. Owoo further explained that stigma has prevented persons with schizophrenia from taking part in community social gatherings like wedding, naming ceremonies and funeral ceremonies. This suggests that the findings of this study are consistent with those of earlier studies that indicated that persons with schizophrenia are highly discriminated against in the community.

Moreover, the study findings indicated that schizophrenia affects the acquisition and maintenance of a working life of study participants. The findings also showed that participants with schizophrenia at times lose their jobs. Others are even not employed at all because of the condition. This affects the livelihood of the individual with schizophrenia. This is because employment does not only provide income, but also improves social contact for patients with schizophrenia. It also fosters financial benefits and reduces the burden on the family. This means that participants with schizophrenia may not enjoy these benefits since they lose their jobs and are denied jobs. This finding corroborates with the findings of Kinderman and Cooke (2000). Kinderman and Cooke asserted that unemployment rate and loss of job among individuals with schizophrenia is very high. The study further pointed out that people with schizophrenia do not get a job due to the limited social network they have. In a related study conducted by Bradshaw, Armour and Roseborough (2007), patients with schizophrenia lacked job opportunities due to perceived limited social network. This finding suggests that individual with schizophrenia are likely going to suffer from obtaining employment.

On the experiences of marriage and marital life, it was evident among study participants that, people terminated their relationship with them when they got to know that they were living with schizophrenia. The participants' accounts suggest that the diagnosis of schizophrenia has the potential to negatively affect a person's opportunity for marriage. This finding goes in line with a study conducted in South Korea by Yu and Shim (2009) who explored the perception and experiences of marriage among couples with schizophrenia. They indicated in their study that, although persons living with schizophrenia

often have very realistic views of marriage and are able to recognize benefits as well as demerits, participants had difficulties initiating and maintaining a marital life. Some females in the study verbalized experiencing restrictions and oppressions by their spouses that led to the termination of the relationship.

Theme Two: Perception and Experience of Schizophrenic Relapse.

The findings showed that study participants with schizophrenia regard relapse as worsening and reoccurrence of signs and symptoms of their condition. The findings showed that participants perceived relapse to be the reoccurring of the condition in the life of someone who has been diagnosed with schizophrenia. Participants suggested that they were bound to experience a relapse if they don't stick to treatment plan. Study participants again reiterated that, just as any other chronic mental illness, they are likely to experience relapse even if they stick to treatment regimen. This finding confirms the assertion made by Colleen (2005) who opined that schizophrenic persons perceived relapse to be the reoccurrence of symptoms of schizophrenia similar to those that the individual previously experienced. He further explained that, individuals at relapse stage perceived to be going back to the onset of the condition. This shows that persons with schizophrenia perceived relapse as the reoccurrence of the illness.

Furthermore, the findings indicated that individuals with schizophrenia experience relapse due to nonadherence of medications or poor adherence to treatment plan on the part of the individual with the condition and stigmatization. About nonadherence to medication, the findings showed that nonadherence to medication is the major precursor for relapse. As indicated earlier, all the study participants believed that adherence to medication has

become their major means of survival with the condition. This makes it clear that persons living with schizophrenia experience relapse largely due to the nonadherence of medications Previous studies (Sharif & Ogunbanjo, 2003; Sariah, Outwater & Malima, 2014) have shown that in people with schizophrenia, nonadherence tends to be one of the causes most likely to raise the likelihood of relapse. Medication noncompliance and under-compliance continue to be a problem in the treatment of schizophrenia. One potential explanation for this behaviour is undoubtedly that, it has become a hardship for these people to take medicine every day, and it is made worse by the side effects of these medications. Individuals avoid taking their daily medicine to get rid of these discomforts, which in turn leads them to suffer relapses. It will encourage these people to be responsible for the drug treatment process by having education with a focus on the value of drug. This finding confirms the findings of previous study (Sharif & Ogunbanjo, 2003). For instance, a research work conducted by Sharif and Ogunbanjo (2003) concluded that nonadherence to antipsychotic medication or discounting medications certainly leads to a relapse and maybe a stressor that causes severe and rapid relapse in persons with schizophrenia. They again asserted, that poor medication adherence due to lack of patients' insight on side-effect appears to be the most likely reasons for relapse. This implies that nonadherence to medications coupled with the side effects of these medications is the major cause for relapse.

Apart from nonadherence to medications, the findings also showed that participants with schizophrenia experience relapse as a result of stigma. The findings showed that participants stress themselves a lot with a lot of thinking about the issue of stigmatization. This makes them prone to schizophrenic

relapse. This suggests that the negative attributes associated with the condition like stigmatization are likely to be responsible for relapse in the individual with schizophrenia. As mentioned earlier participants with the diagnosis of schizophrenia are highly stigmatized in their community. Research has found that, patients with strong stigma criticism have a slightly higher discharge risk and longer median period of stay in mental institutions than patients with low stigma criticism. It is obvious that if the study participants found themselves in such a situation, relapse is possibly bound to happen. This finding corroborates with the findings of Abdelsalam and Gaber (2017). Abdelsalam and Gaber asserted that a lack of community support and stigma contributes mostly to the occurrence of relapse in persons with schizophrenia.

Moreover, the findings highlighted the experiences of an individual with schizophrenia in the relapse state. Generally, the findings showed that participants living with schizophrenia exhibit different experiences during relapse. The findings showed that study participants exhibit signs of an inappropriate laughter, smiles, singing, talking alone, isolate themselves, dancing, hallucinate, delusions, standing still and mute among others. This finding confirms Csernansky and Schuchart's (2002) findings that, individuals with schizophrenia experience behaviours such as dancing, singing, delusions, hallucination, soiling and inappropriate laughing. In a related study by Alsherif and AbdElrahman (2013) it was found that persons with schizophrenia always hear voices, laugh excessively, and talk alone. It can be concluded from the study that, that relapse experiences of people with schizophrenia are the same as the signs they experienced at the onset of the schizophrenic illness.

Theme Three: Coping with Schizophrenia

The findings showed that participants with schizophrenia adopt several strategies in managing the condition. These coping strategies are adopted by the individual depending upon how the person perceives the condition. The findings identified coping strategies which include personal strategies, using medication to cope, coping through family support, as well as coping through religious support. Regarding personal strategy, the findings revealed that study participants with schizophrenia have their own strategy they adopt in coping with the condition. Study participants believed that the condition had become part of their daily lives, therefore they do not stress themselves about the negative manifestations associated with the condition. This presupposes that, if an individual with schizophrenia does not stress him or herself with the condition, the possibility of having relapse is minimal because it is believed that stress as a result of thinking excessively about the condition can lead to frequent relapse. Also, participants expressed that, they maintain a healthy environment by observing personal hygiene. This, according to participants, makes them healthy. This finding confirms the findings of a research conducted by Weisman (2005) who opined that persons with schizophrenia depend on personal strategy through observing personal hygiene, engaging in other activities just to divert their attention from the negative aspects of the condition as strategies to cope with the condition.

In terms of medication, the findings suggest that participants with schizophrenia depend on prescribed medications for survival. Participants expressed that they manage the condition with regular intake of medication hence medication was seen to be a strong factor that can protect individuals

from schizophrenic relapse. This means that, with effective adherence to medication, participants with schizophrenia were able to maintain a level of resilience and felt more comfortable to go about their normal daily activities. Participants with schizophrenia who adhered to their medications had a quality of life compared to those who did not follow their treatment plan. This finding is in line with the findings of previous studies. For example, Harrison (2001) opined that patients with the diagnosis of schizophrenia manage their condition through regular adherence to medication. This, according to Harrison makes them strong and prevent them from experiencing frequent relapses. Weisman (2005) confirmed this in a study that concluded that, adherence to prescribed medication is the major coping strategy of patients with schizophrenia. This implies that regular medication helps persons with schizophrenia to cope with the condition.

Furthermore, the findings established that the mental health practitioners also provide support which enables participants to cope with the condition. According to the study participants, mental health practitioners especially nurses and doctors support them in their bid to manage the condition. All the participants confirmed that mental health practitioners help them a lot; that is, they provide essential service such as regular visit, advice on adherence to medication and regular home visits among others. This support aids participants living with schizophrenia in diverse ways, serving as a form of relief for them. This may imply that good nurse-client relationship exists between mental health practitioners and persons with schizophrenia. This assertion by study participants contradicts a similar study done in Australia by Johansen and Lundman (2002). In their study, it was evident that, persons living with

schizophrenia were ignored and not respected by health professionals. Their study reiterated that, care received by study participants was dominated by strict rules and lack of flexibility

Relationships plays an important role in the development of trust, thus, when persons with schizophrenia receive good mental health services, it builds trust, which fosters a sense of belonging and a feeling of wellbeing leading to positive motivation regarding care. A good relationship between patients with schizophrenia and mental health professionals is important for adherence to antipsychotic medication. All these according to study participants, enable them to cope with the condition. This finding concurs with the research finding of Wang, Chun, and Xiong (2013). Their study established that people with schizophrenia build a good relationship with health professionals. They further established that this relationship has been a strategy most people with schizophrenia adopt in addition to regular medication to cope with the condition. Cheng (2017) affirms this in a study that suggested that persons with schizophrenia cope with the condition through the help of health professionals such as nurses and doctors.

Additionally, the findings showed that participants relied on family support in coping with the condition. Thus, participants received diverse support from the family which contributes to their survival with the condition. Support from family promotes the wellbeing of people with schizophrenia. This is because the family receives resources such as financial prescription assistance, supervision, substance use tracking and routinely taking people to mental health services. It is not strange that all the participants in this research identified the family support networks as very powerful. Participants were very grateful for

the help they received from their families while visiting the clinics for follow-up appointments, guidance and monitoring while taking their medicine and in meeting other basic life needs, especially during their disease episodes. With the provision of this support, persons with schizophrenia will stay healthy (resilient) and possibly prevent them from relapse. Such conclusions are in accordance with a report conducted by Minato and Zemke (2004) which found that more than 80% of the families supported the patients with schizophrenia in the management of the condition and daily living such as observation of the condition and taking drugs. In a related study conducted by Borras et al, (2007), the family provides support in terms of providing the basic needs like financial support, ensuring they adhere to medication among others to people with schizophrenia. This according to Borras et al, enables persons with schizophrenia in coping with the condition. This was also confirmed by the assertion made by Wasserman and Asch (2010). According to them, the person with schizophrenia depends on family support in coping with the condition. This means that people diagnosed with schizophrenia get a lot of family care that helps them to deal with the disorder. The findings also showed that participants with schizophrenia relied on religious support in coping with the condition. The findings showed that religion enables persons with schizophrenia to cope with the condition. This is because participants identify the beneficial impacts of religion in the course of their illness. They added that religion, including taking part in church activities, creates a sense of belonging, enables them to deal with difficult situations and gives them the strength to move on despite their condition. This may then imply that; religion possibly provides positive coping to patients with schizophrenia and subsequently help in recovery. The church as

a religious institution also supports study participants with schizophrenia by providing some basic needs to them. This will promote healing by instilling optimism, meaning and value in life. The support provided by the church reduces the burden of the family since participants with schizophrenia do not solely depend on the family in terms of provision of basic needs. All these helped study participants to cope well with the condition.

The finding above is in line with previous findings in the literature. For example, Ano and Vasconcells's (2005) study concluded that religious coping was the most common strategy used by patients with schizophrenia to cope with the condition. This was because, participants indicated that religious coping enhances self-esteem and reduces negative effects associated with schizophrenia. Religious faith also serves as a source of strength for persons with schizophrenia and gives them assurance that they can survive difficult events in their life. The findings further pointed out that participants' belief in their maker improves their relationship with family and other people in their community. This was again confirmed by a study conducted by Cheng (2017). Cheng opines that persons with the diagnosis of schizophrenia cope well through religious activities such as exorcism or sacraments which they believed could restore their mental and physical wellbeing to normalcy. The implication is that persons with schizophrenia will always depend on religion in managing the condition.

Chapter Summary

This chapter has brought to fore the results and discussion of the study. The chapter established that participants engaged in the study have varied experiences as far as the condition is concerned. These experiences include

maintenance of daily living activities, building and maintaining relationships, experiences with medication, seeking and receiving support, experiences of stigmatization as well as acquiring and maintaining a working life. The chapter has also established that participants living with schizophrenia are bound to experience relapse despite sticking to treatment plan. It again identified nonadherence to medication and stigma as the risk factors for relapse. Also, the findings indicated that common things persons with schizophrenia experience in the relapse state include excessive laughter, standing still, singing, casting insinuations and hallucinating. Finally, the findings showed that, common strategies participants adopt in coping with the condition include personal support, medical support, family support, and religious support.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

This chapter presents a summary of the research process and its findings. It draws conclusions and makes recommendation for practice.

Summary of the Study

The study sought to explore the experiences of persons living with schizophrenia in the Cape Coast metropolis of the republic of Ghana. The following research questions guided the study.

1. What were the experiences of persons living with schizophrenia?
2. How did persons living with schizophrenia perceive relapse in relation to schizophrenia?
3. What strategies did persons living with schizophrenia adopt in coping with the condition?

The study adopted a descriptive phenomenological approach. Purposive sampling technique was used to carefully select the participants for the study. Through a face-to-face semi-structured interview, data were collected from nine participants, transcribed verbatim, and analysed using the steps in descriptive phenomenological data analysis by Colaizzi (1978) in analysing data. This was done to put the views of respondents into perspective. The participation of respondents was done voluntarily. Respondents who were willing to participate were included in the investigation. The validity and reliability of data were achieved through prolong and sustained engagement in the field. Also, trustworthiness (credibility, transferability, dependability and confirmability) constructs were taken into consideration.

Summary of Key Findings

The key findings have been presented in line with the research questions posed in the study.

Research Objective One: The experiences of persons with schizophrenia.

The findings revealed that, so long as participants were in their lucid state, they lived a normal life and could take care of their basic needs. They were well able to maintain daily activities of living successfully. Yet again, the study revealed that, most participants maintained a cordial and peaceful relationship with family, and healthcare providers. However, opportunity for marriage relationships was a challenge for some, with majority being single. Two who were married indicated that they enjoyed a positive relationship with their spouse. Study participants verbalized being labelled and seen as different within the communities in which they reside. Furthermore, study participants verbalized losing their jobs as a result of the negative consequences associates with living with schizophrenia.

Research Objective Two: The perception of relapse by persons living with schizophrenia

The findings revealed that persons engaged in the study perceived relapse as the reoccurrence of their condition. The findings further revealed that non adherence of medication and stigma are the common risk factors for episodes of relapse among study participants. The findings also indicated that participants often hear voices, laugh excessively, insult people close to them, talk excessively and sing day and night among others during the period of relapse.

Research Objective Three: Strategies which persons living with schizophrenia adopt to cope with the condition

The findings revealed that study participants cope with the condition by adopting measures which include strict adherence to prescribed medication, personal strategies, religious coping and support system from family and mental health practitioners.

Conclusions

This study has helped to explore daily living experiences of study participants with schizophrenia who reside in the Cape Coast Metropolis of the republic of Ghana. Study participants had both positive and negative experiences with the schizophrenia. The positive experiences include friendly relationship with family, mental health practitioners, support from religious bodies like the church, other government agencies as well as good personal care. However, participants verbalised that, they suffer greatly from stigma in the community in which they live and lack job opportunities. Some of them also lose their job as soon as they are recognized by their employers as suffering from the condition.

Again, on how participants perceive schizophrenic relapse and their experience with relapse, it can be concluded that study participants view relapse as a phenomenon which is bound to happen once they fail to adhere to laid down treatment modalities. Therefore, they verbalized that, they are bound to experience schizophrenic relapse especially when they fail to adhere to medications plan and also go through stressful situations.

Finally, respondents verbalized that; they depend on several measures in coping with the condition. The effectiveness of these measures helps them to

maintain resilience and therefore prevents the occurrence of schizophrenic relapse. These measures include strict adherence to medication, supportive family and mental health practitioners as well as religious coping.

Recommendations

Based on the findings and conclusions outlined, the following recommendations are made for consideration in nursing education and practice.

Education and Training:

1. The mental health authority (MHA) should intensify health education on issues relating to schizophrenia. This would create awareness on issues affecting the lives of persons with schizophrenia.
2. Again, the MHA should liaise with government to create more skills training for persons with schizophrenia to assist them to work on their own so as to reduce the burden on their families.
3. Furthermore, the MHA should intensify their education on medications used in the management of schizophrenia in the country to encourage persons with schizophrenia to see the essence of adhering to their treatment plan.

Policy and Planning:

Authorities at Cape Coast metro health directorate should establish a counselling centre within its premises to house accredited religious ministers and professional psychologists to provide the needed assistance to meet the needs of clients with schizophrenia and their families. This will help address certain challenges that occur in communities where these individuals live, in

order to create a serene atmosphere that promotes recovery and prevents relapse in persons living with schizophrenia.

Clinical Nursing Practice:

1. The study revealed that, an effective nurse client relationship has contributed positively in the lives of persons with schizophrenia. In this regard, community psychiatric nurses should continue to intensify their home visits to persons living with schizophrenia in their catchment area.
2. Stigmatisation has contributed to the occurrence of schizophrenic relapse according to participants' accounts from this study. In the light of this, it is recommended that, mental health practitioners must hold periodic durbars in the communities where persons with schizophrenia live in order to educate the entire populace on the effects of stigma on persons living with schizophrenia.
3. Mental health nurses must continually educate persons with schizophrenia who visit the clinical areas to adhere strictly to treatment plan in order to maintain resilience and prevent schizophrenic relapse.

Suggestions for Further Research

A similar research on a nationwide base by any interested organisation or Ghana Health Service will be commendable. The findings of such a study will either confirm the findings of this study or do otherwise. Another research can be conducted on gender differences with regard to the experience of people living with schizophrenia to find out whether differences exist between males and females living with the condition.

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APPENDIX A

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
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C/O Directorate of Research, Innovation and Consultancy

21ST MAY, 2020

Mr. Isaac Commey Tetteh
Department of Maternal Health
University of Cape Coast

Dear Mr. Tetteh,

ETHICAL CLEARANCE – ID (UCCIRB/CHAS/2020/37)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Experiences of Persons Living with Schizophrenia: A Study in the Cape Coast Metropolis.** This approval is valid from 21st May, 2020 to 20th May, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB.

Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

APPENDIX B
EXCERPTS OF SIGNIFICANT STATEMENTS

Significant Statements	Participant	Page No.	Lines No.	Formulated Meaning
"I used to sell before this illness. Even now, I still go around selling pure water but I only find it difficult to sell when the illness comes back and when it comes too, nobody wants to buy from me".	Bella	3	11-13	Cannot do business when signs and symptoms of illness reappear
"This illness has really affected my work because if it had not been this illness, I am sure where I wanted to be in future would not have been this. I am a seamstress and I think I would have reached very far in my small business I do. Anytime I think of going forward in life, then the illness will return and things will get worse again.	Beauty	10	25 – 28	Living with schizophrenia affects one's career
"I don't get any support anywhere. There is a particular woman outside who supports me with some rice and sugar so that, when I get money I will pay. She has stopped doing that because, I owe a lot. Apart from that, there is no	Godswill	80	10 – 12	Lack of external support

other support from anywhere".				
"MY mum and my Aunt have been helping me with my medication. They have been with me all this while. No other family member has offered any support to me in this situation"	Shallom	77	17 – 18	Parents especially, mothers have been the main source of support
"They should continue with their visitation, calling and checking up on me. They do it already but they can do more. The visitation will help them know what is going on in various homes"	Shallom	79	5 – 6	Mental health practitioners contribute to the maintenance of resilience among persons with schizophrenia by their regular visit and encouragement
"When I pray and rely on God, I get some relief. I believe in my God that one day, I will be totally healed from this illness".	Sheila	52	33 - 35	Prayer and faith in God help in coping with the condition
"The church has been a blessing to me. Priests and some church members have been helping me. For example, some priests even give me money for my medications every month"	Favour	24	10 – 13	Religious agencies such as the church offer spiritual and social support

"What I have noticed is that, when you have this illness, people don't respect you. They say all sort of things about me. However, I don't mind them when they say those negative things about me".	Beauty	10	15 – 18	People with schizophrenia lack respect from the general public
"People think I cannot be engaged to do any meaningful work because they don't know when the illness will suddenly come back again when I am working with them. I have learned a lot from people, I will work with people, they will pay them well but when it gets to my turn, they will either not pay me or they will reduce the amount. They don't consider me at all. When I say something, they don't take it. "	Godswill	62	8 – 12	Participants with schizophrenia can be engaged to do any meaningful work
I believe that, God will heal me one day whilst taking my medication. So, although I don't go to church, I pray to my God. I believe that it is not church that makes one a good Christian. They	Terry	44	30 – 33	Faith in God and religious coping help to cope with schizophrenia and maintain resilience

have taken me to several places but I don't believe in such places, my belief is in God. So, I believe that, it is God who heals and one day I will be completely healed".				
"I remember in the Catholic church, I used to belong to a group and I was in charge of eight districts in the Central Region. One day, some of the choristers started talking about my condition, they said I am mentally sick and I am still leading them in the group. It was a Saturday, and I had gone to take them through the song we would be singing on the following Sunday, I realized that they were not listening to the instructions I was giving them. Then one of them gathered courage and said, madam, we hear you are a mad woman who has been to Ankaful. Suddenly, I broke down in tears and I left the group"	Mercy	58	25 – 30	Stigmatization dampens the spirit of persons living with schizophrenia It reduces self-esteem of affected persons predisposes them to relapse

"I was in a relationship with a guy and one day, he called and I told him I was going for my medication at the clinic. Then he asked me whether I was sick and I said no, I going for them to review my medication. Then he asked, is it the mental drugs? I responded yes. Then he asked me if I am still taking them, which I said yes. Since then, he has not called me again. it is a big problem my brother; because if I look at myself and compare with some women who are married, I think I am not bad at all but this condition may be scaring the men"	Sheila	50	13 - 17	Living with schizophrenia affects one's marriage by driving away suitors
"As for me, I know that, the condition is real and you need to take your medications to stay healthy. So, for a person to suffer relapse, it means he/she stopped taking the medications. If you stop taking the medication, you will suffer relapse.	Forgive	69	21 - 24	Schizophrenic relapse occurs if one fails to adhere to medication regimen

APPENDIX C

EXCERPTS OF THEME CLUSTERS

Meaning unit	Theme clusters
"I used to sell before this illness. Even now, I still go around selling pure water but I only find it difficult to sell when the illness comes back and when it comes too, nobody wants to buy from me" (Bella)	Schizophrenic relapse interferes with work
"This illness has really affected my work because if it had not been this illness, I am sure where I wanted to be in future would not have been here. I am a seamstress and I think I would have reached very far in my small business I do. Anytime I think of going forward in my business, then the illness will return and things will get worse again" (Beauty)	
"My mum and my Aunt have been helping me with my medication. They have been with me all this while. No other family member has offered any support to me in this situation" (Shallom)	Persons with schizophrenia lack external support
"I don't get any support anywhere. There is a particular woman outside who supports me with some rice and sugar so that, when I get money I will pay. She has stopped doing that because, I owe a lot. Apart from that, there is no other support from anywhere" (Godswill)	
"Although people don't believe in it but my faith has helped me in coping with this condition…" (Favour)	Religious faith helps in coping with schizophrenia
"The church has been a blessing to me. Priests and some church members have been helping me. For example, some priests even give me money for my medications. There is a particular priest who gives me money every Sunday" (Shiela)	
"I believe that, it is God who heals and one day I will be completely healed" (Godswill)	
"What I have noticed is that, when you have this illness, people don't respect you. They say all sort of things about me" (Beauty)	Loss of respect in society
"It makes me lose respect from people. People think I cannot be engaged to do any meaningful	

work because they don't know when the madness will suddenly come back again when I am working with them (Godswill)	
"Anytime I see the nurses around me, I get relieved. If you cannot come, you can still call either my phone or that of my husband. It is good to hear from you all the time" (Forgive) "Mental health nurses have really helped me to remain healthy. They have helped me a lot. They call me, visit me, and at times schedule a meeting with my father just to see how I am faring" (Sheila) "They have really helped me with education on healthy lifestyles and adherence to medication. They have been my source of hope because anytime I go there, I am attended to and given the needed attention" (Godswill)	Mental health practitioners have helped persons with schizophrenia to cope well with the condition
My colleagues at work were pointing fingers at me and saying or sort of negative things about me. Even in my community where we were living, Taxi drivers will stop to pick me, but somebody around my area will just come and tell the driver that I am a mad woman, so he should not pick me" (Sheila) "One day, some of the choristers started talking about my condition, they said I am mentally sick and I am still leading them in the group. It was a Saturday, and I had gone to take them through the song we would be singing on the following Sunday, I realized that they were not listening to the instructions I was giving them. Then one of them gathered courage and said, madam, we hear you are a mad woman who has been to Ankaful. Suddenly, I broke down in tears and I left the group" (Mercy)	Stigmatization against persons with schizophrenia
So, for a person to suffer relapse, it means he/she stopped taking the medications. If you stop taking the medication, you will suffer relapse. "So, I know that, if I don't take my medication, I will suffer relapse" (Terry) "I have now noticed that, once you stop taking your medications, the illness will come back" (Forgive)	Non adherence to medication causes schizophrenic relapse

"I believe that, if I take the prescribed medications as ordered, I will not suffer any relapse" (Sheila)	
"A voice told me that the baby is a witch and so, I should kill her" (Beauty) "I sing and park clothes in my room throughout the night when I experience relapse" (Terry) "The last time I experienced relapse, I insulted my mother and fought with her" (Mercy)	In relapse state, persons with schizophrenia hear voices, sing unnecessarily at night, insult and fight people
"I believe it has been my source of relief. With that, I always know that, there is hope for persons living with mental illness" (Bella) "Medications helps to cope with the negative effects of the condition" (Favour)	Sticking to prescribed medication helps people with schizophrenia to cope
"I have been able to come this far because of good family support. Apart from my son who gives me headaches all the time, I have had a good family support which has sustained my life so far" (Favour) "It is only my mother who has been supporting me all these years. I don't get any support from anywhere. My mother is the only person who helps me all these years" (Mercy)	Family support helps in coping with schizophrenia

APPENDIX D

PARTICIPANT INFORMATION AND INFORMED CONSENT FORM

Title: Experiences of persons living with Schizophrenia: A study in the Cape Coast Metropolis

Principal Investigator: Isaac Commey Tetteh (BSc, RMN)

Address: Department of Mental Health, School of Nursing and Midwifery, College of Health and Allied Sciences, University of Cape Coast, PMB, Cape Coast, Ghana.

General Information about Research

This research project is aimed at providing evidence of the experiences of persons living with schizophrenia. This is a way of understanding schizophrenia from the point of view of sufferers who have lived with the condition over a period of time. The study will also explore strategies these persons have used to cope with schizophrenic relapse. The findings will help practitioners in the mental health discipline to understand issues surrounding the lives of persons who are living with schizophrenia.

To work towards this aim, the study seeks to meet the following research objectives, which are to:

1. Explore the experiences of persons living with schizophrenia
2. Investigate the perceptions of relapse among persons living with in relation to their condition
3. Determine strategies which persons living with schizophrenia adopt to cope with the condition.

Procedures

To find answers to some of these questions, I invite you to take part in this research project. You are being invited to take part in this discussion because I feel that your experience as a client can contribute much to this discussion. If you accept, you will be required to participate in an interview with a team of trained professionals including myself. The interview will include questions such as "Tell us about your experience with schizophrenia", "what are your perceptions about relapse in relation to schizophrenia?", "In your opinion what are some of the strategies you have adopted to cope with schizophrenic relapse?". Specific probes will be used to cover relevant areas such as (1) Stigma associated with schizophrenia, (2) Inability to maintain resilience for a long time, (3) Once diagnosed of schizophrenia, one is bound to have multiple relapses, (4) Marital life of persons with schizophrenia, (5) Employment opportunities for individuals with schizophrenia and (6) Range of activities geared towards coping with schizophrenic relapse.

One question will be asked at a time and minimal prompts will be used to allow you to express yourself freely. This will be done in the either English, Twi or Fante language based on which one you choose. If you need help with understanding any of the questions, please let us know, so we can rephrase the question to your understanding. Your reactions both verbal and nonverbal will also be observed.

If you do not wish to answer any of the questions posed during the interview, you may say so and the interviewer will move on to the next question. The interview will take place in a private room set aside for this purpose, and no one else but the interviewer will be present. This is to make you feel comfortable enough to discuss the issues without others hearing what is being said. The information that will be recorded will be treated confidentially, and no one else except the researcher will

have access to the information documented during your interview. The expected duration of the interview is about 45-60 minutes.

Possible Risks and Discomforts

If you decide to participate, you will be asked personal questions such as your feelings about living with schizophrenia. Due to the private nature of such questions, you might find it uncomfortable answering such. However, be assured that privacy and confidentiality will be ensured at every phase of the project and your responses will not be linked to your name in any way as you will be assigned a unique pseudonym. Please, also note that, the questions may take a bit of your time.

Possible Benefits

This project will be beneficial in so many ways. It is hoped that the findings from this study will form the basis for the development and implementation of guidelines that will help improve the lives of persons living with the diagnosis of schizophrenia. Specifically, much attention will be placed on the findings to provide appropriate and more realistic activities/strategies that will enable mental health practitioners to promote resilience in persons living with schizophrenia.

Confidentiality

I will protect information about you to the best of my ability. All your responses will remain private and stored under a unique participant's ID number and so you will not be named in any report or publications from this study. However, please note that as part of our responsibility to conduct this research properly, a few officials from the University of Cape Coast - the officials of the ethics committee - may sometimes look at the progress of this research and may be allowed to look at your records. In any instance, your identity will not be revealed and will remain a hidden.

Compensation

All procedures will be carried out at your own convenient time. As part of your participation in this project, you shall be provided with a refreshment package as you wait. In situations when you are called over for any activity outside your own convenient time, a token of 10-20 Ghana Cedis (depending on where you are coming from) to cover transportation cost to and from the interview site, will be given.

Voluntary Participation and Right to Leave the Research

Your participation in this study is entirely voluntary. You can withdraw consent to participate and end participation at any time if you so wish. This decision will not affect you or the healthcare services you receive in anyway.

Contacts for Additional Information

If you have any question concerning, please do not hesitate to contact Mr. Isaac Commey Tetteh on phone number 0244163060 or email me at isaac.tetteh2@stu.ucc.edu.gh

Your rights as a Participant

This research was reviewed and approved by the Institutional Review Board of University of Cape Coast (UCCIRB). If you have any questions about your rights as a research participant you can contact the Administrator at the IRB Office between the hours of 8:00 am and 4:30 p.m. through the phone lines 0558093143/0508878309/0244207814 or email address: irb@ucc.edu.gh.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title ***(****Experiences of relapse among persons living with schizophrenia)* has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Name and signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Date Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ _____

Date Name Signature of Person Who Obtained Consent

APPENDIX E

PARTICIPANTS' INTERVIEW GUIDE

EXPERIENCES OF PERSONS LIVING WITH SCHIZOPHRENIA: A STUDY IN THE CAPE COAST METROPOLIS

Data Collection Instrument

Interview Guide

Interview no.: …… Start time: ……

End: ……

Note**:** I am a second-year master of nursing student of the University of Cape conducting a study on the above topic. Thank you for accepting to share your experience with me on the subject matter above. I would want to assure you that this interview will be kept confidential and will be used for academic purpose only. Your name and other identities will not be linked to this interview.

Our conversation will take between 45 to 60 mins. I will like to seek your permission if you agree, so that I can record this interview in order to listen to it again afterwards to make sure I get your responses correctly. Please do I have your permission to start the interview and to record? (Interview will continue if client gives his/her consent).

Thank you for accepting to participate in this exercise. Before I start to record, I will ask some general questions.

A: Demographic Information of Participant

1. Tell me about yourself
    - Marital status- Please are you married?
    - Age in years- and how old are you?
    - Sex …… (To be indicated on the form)

- Religious affiliation – can you please tell me which religious group you belong to?
- Educational background- please, what is your highest level of education?
- Number of years of living with this condition (schizophrenia)……

SECTION B: EXPERIENCES OF LIVING WITH SCHIZOPHRENIA

1. What can you tell me what you know about this illness (schizophrenia)?
2. How did you feel initially when you were diagnosed with this condition?
3. What are some of the experiences you have had living with this condition?

   (Positive and negative experiences)

4. How has this condition affected you in the following areas?

   i. work

   ii. marriage

   iii. interpersonal relationship (care givers, family members, friends etc.)

   iv. medication and their side effects

   v. stigma

   vi. social support system

   vii. activities of daily living (personal hygiene, rest and sleep, eating, grooming, sweeping, washing, etc.)

SECTION C: PERCEPTION OF RELAPSE IN RELATION TO SCHIZOPHRENIA

1. What do you know about relapse?
2. How many times have you suffered schizophrenic relapse in your life?
3. Can you tell me your understanding of relapse in relation to your condition?
4. Do you think relapse is an inevitable part of the condition?
5. Can you share your views on schizophrenic relapse?
6. What do you think about persons living with schizophrenia and relapse?
7. In what ways has relapse affected your life in general?

SECTION D: Coping strategies

1. How do you cope with the condition?
2. What do think you can do to prevent you from experiencing relapse?
    a. What has been your experience with using any of these measures (Medication, mental health care, friends, religious faith, family support, work, life style or other) to maintain resilience (stay healthy)?
3. What do you think mental health practitioners can do to help better the lives of people living with schizophrenia and help them cope with the adverse effects of the condition?
4. Is there anything else you would like to share with me regarding what we have discussed so fars?