A Study on Psychological Problems of Psychiatric Patients’ Caregivers

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Abstract: ***The family may want to help in the treatment of the individual but may not know how to do so and may feel helpless. The family may not have knowledge about schizophrenia or know the importance of complying with medication. They may feel they are being blamed for the affected members’ problems. They can become defensive***

Keywords: Care Givers, Psychiatric Patients, Medication

1. Introduction

The term caregivers refer to anyone who routinely helps others who are limited by chronic conditions. “Formal” caregivers are volunteers or paid employees connected to the social service or health care systems. The term “informal Caregiver” refers to family members and friends, who are the primary source of care for nearly three-quarters of the impaired older adults who live in the community. Caregivers assist with such basic tasks as bathing, dressing, preparing meals and shopping. Some have the added responsibilities of administering medications, making sure that an immobile person is turned frequently to avoid developing pressure sores, and other tasks related to the older person’s illness or disability.

Stress is often described as the body’s “fight or flight” response to danger. When the body goes on “high alert to protect itself, essential functions, like respiration and heart rate, speed up, while less essential functions, such as the immune system, shut down. Although the stress response is a healthy reaction, the body needs to repair itself once danger is removed. For caregivers, whose stress often results from fatigue and conflict that never go away, their bodies never get a chance to heal. If the immune system isn’t functioning fully, the caregiver is at greater risk for infections and disease. Some experts believe that stress causes hypertension, coronary disease or even premature death.

Making use of social and support services, including support groups, respite care, home delivered meals, adult day care and assessment services can reduce the stress associated with abuse. Learn to recognize and understand the causes of difficult behaviors and techniques for handling them more effectively. Develop relationships with other caregivers. Caregivers with strong emotional support from other caregivers are less likely to report stress or to fear that they will become abusive.

The family may want to help in the treatment of the individual but may not know how to do so and may feel helpless. The family may not have to do so and may feel helpless. The family may not have knowledge about severe psychiatric illness or know the importance of complying with medication. They may feel they are being blamed for the affected member’s problems. They can become defensive about their role in the affected member’s treatment. The presence of an affected member changes the routine family life. The family members will have extra household chores, as the affected member is unable to contribute.

Trying to keep the family life as normal as possible while simultaneously trying to help the affected member is frustrating research and practice for the foreseeable future. The family may fine the affected member’s behavior embarrassing and painful. They may avoid their normal socialization with others due to the stigma of having a mentally ill member.

They may feel angry with the affected member especially when they feel that the affected member is lazy or not trying to control their behaviors. The aim of the study was to study the relationship between cognitive deficits and the caregiver burden.

2. Review of Literature

Braithwaite (1992) the conceptual challenge had to do with the fact that the terms burden, stress and strain are often used interchangeably in the caregiver literature. For our need, it was important to differentiate among these three constructs. After reviewing the literature, we defined stress and burden as an individual’s physical and or emotional response to challenges in the caregiver’s role. In contrast, strain was considered the caregiver’s perception of enduring problems or an altered state of well-being. From a metaphorical perspective, we came to think of burden and stress as the forces that produces strain, the enduring change in the shape and integrity of a caregiver’s fabric of well-being. Even when the force is removed, lasting changes often remain.

Travis & Piercy (2002) not just dementia care and offered measurement economy for already overtaxed and busy caregiver respondents. It located a number of measures used in contemporary care giving research to measure stress, strain and burden. Our critique of instruments included an analysis of the strain domains that were included in the each measurement tool. Specifically, we were interested in seeing four generic strain domains that we believed fit our targeted population of family caregivers regardless of their situation.

3. Methodology

The researcher made to study on burden related problems among family members or caregivers of the mentally ill people. This study would help the researcher to understand the feelings and burden experienced by the caregivers. The researcher also found the family member's, relative's interest and their care given by them. Many people really have more burdens because of the mentally ill patient at home. So it is very much important to study about the caregivers.

1) Aim

To study the psychological problems faced by the caregivers of psychiatric patients

2) Objectives

a) To study the socio demographic details.
b) To find out the level of burden among the caregivers
c) To analyze the psycho-social problems encountered by the caregivers.

Sampling and Research Design

Caregivers who are stayed more than 7 days in the Athma the mind center are selected as respondent. In this hospital, they are treating more than 100 patients per day. In that, approximately 20-30 patients are admitted as in-patients depending upon their illness. During the research period, there is around 50 in-patients. So the researcher selected the first 25 inpatient's caregivers as respondents through Random Sampling Method. The researcher adopted descriptive research design for evaluating the burden among the caregivers. The researcher also used the Interview Schedule and self prepared Questionnaire as a tool for pertaining to burden experienced by the caregivers.

4. Analysis and Interpretation

Table 1: Distribution of respondents based on details of the patient

S.No	*Varriables*	*No. of Respondents*	*Percentage*
1.	**Age**		
	a) 21-30 yrs	10	40
	b) 31-40 yrs	4	16
	c) 41-50 yrs	4	16
	d) 51 & above	7	28
Total		**25**	**100**
2.	**Sex**		
	a) Male	14	56
	b) Female	11	44
Total		**25**	**100**
3	**Educational Qualification**		
	a) Primary		
	b) Intermediate	10	40
	c) Secondary	5	20
	d) And above	7	28
		3	12
Total		**25**	**100**
4	**Occupation**		
	a) Coolie	1	4
	b) Business	11	44
	c) Private	8	32
	d) Govt. Job	5	20
Total		**25**	**100**
5	**Type Of Illness**		
	a) Schizo	4	16
	b) Addict	6	24
	c) Depression	15	60
Total		**25**	**100**

Table 2: Distribution of respondents based on details of the caregivers

S.No	*Variables*	*No. Of Respondents*	*Percentage*
1.	**Age**		
	a) 21-30 yrs	8	32
	b) 31-40 yrs	9	36
	c) 41-50 yrs	5	20
	d) 51 & above	3	12
Total		**25**	**100**
2.	**Sex**		
	a) Male	11	44
	b) Female	14	56
Total		**25**	**100**
3.	**Educational qualification**		
	a) Primary	2	8
	b) Secondary	3	12
	c) Higher secondary	5	20
	d) Illiterate	15	60
Total		**25**	**100**
4.	**Relationship with caregiver**		
	a) Spouse	8	32
	b) Sibling	7	28
	c) Mother	7	28
	d) Father	3	12
Total		**25**	**100**
5.	**Oocupation of the caregiver**		
	a) Housewife	11	44
	b) Daily Labour	3	12
	c) Service	4	16
	d) Collie	7	28
Total		**25**	**100**
6.	**Marital status of the**		
	caregivers	5	20
	a) Unmarried	19	76
	b) Married	1	4
	c) Widow		
Total		**25**	**100**
7.	**Monthly household income**		
	a) Below Rs. 2000	2	8
	b) Rs. 2001 – 3000	5	20
	c) Rs. 3001 – 5000	12	48
	d) Rs. 5001 & above	6	24
Total		**25**	**100**
8.	**Type of family**		
	a) Nuclear	19	76
	b) Joint	6	24
Total		**25**	**100**

Table 3: Distribution of respondents based on their emotional reactions of caregivers

S. No	*Varriables*	*No. Of Respondents*	*Percentage*
1.	**Become Angry During Care**		
	a) Very often	4	16
	b) Sometime	6	24
	c) Rarely	3	12
	d) Never	12	48
	Total	**25**	**100**
2.	**Become Critical**		
	a) Very often	2	8
	b) Sometime	4	16
	c) Rarely	6	24
	d) Never	13	52
	Total	**25**	**100**
3.	**Express Rejection towards Patient**		
	a) Very often	1	14
	b) Sometime	4	16
	c) Rarely	5	20
	d) Never	15	60
	Total	**25**	**100**
4	**Express Chronic Fatigue**		
	a) Very often	3	12
	b) Sometime	3	12
	c) Rarely	8	32
	d) Never	11	44
	Total	**25**	**100**

5. Major Findings

1) More than one third of the patients belong to the age group of 20-30.
2) More than half of the patients are Male.
3) More than one third of the patients are completed primary education.
4) More than one third of the patients' major occupation is business.
5) More than one third of the patients are belonging to depression.
6) More than half of the caregivers are Female.
7) More than one third of the patients belong to 31 - 40 age group.
8) One third of the caregivers are spouse.

6. Suggestions and Conclusions

In the long term the interventions like group program and home visits together contributed to the main goals of this study. Increasing caregivers' knowledge, increasing the use of active coping strategies, and increasing social support received by caregivers. The long-terms effects were small and medium. Younger female caregivers appear to benefit the most from interventions. They showed a greater increase in confidence in knowledge about patient care and the amount of social support they received compared with other caregivers. The interventions had no effects on caregivers' physical or mental wellbeing. Some differences were found between the short-term effects and long-term effects.

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