

THE COMPARATIVE STUDY OF COPING STRATEGIES AMONG WORKING WOMEN AND HOMEMAKERS TAKING CARE OF PSYCHIATRIC PATIENTS

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Abstract

Introduction: In India, women are twice more likely to become caregivers than men. Despite emergence of men as caregivers, researchers have not taken into account this trend and continue to maintain its traditional focus on female caregivers. Caregiver burden is defined as the physical, psychological or emotional, social and financial problem that can be experienced by the members of family caring for impaired person.

Aim: To assess and compare various coping strategies among homemaker women and working women taking care of psychiatric patients

Methodology: This was a hospital based, descriptive, cross-sectional comparative study was conducted on the caregivers who were recruited from OPD of Psychiatry department of Government Medical College and Rajindra Hospital, Patiala. Women who were 30-45 years old, working or homemakers and who were taking care of of psychiatric patients diagnosed with Schizophrenia and Bipolar affective disorder (BAPD) of either sex. Caregivers were first degree relatives of patients. The estimated sample size was 140 (Group 1=70 homemaker women and Group 2=70 working women). Sociodemographic data were recorded using Sociodemographic Performa 1 and Coping Strategy Inventory (CSI) was used to assess coping strategies among caregivers.

Results: Coping strategy mean scores among Group 1 and Group 2 were 2.71, 2.58 for primary subscale items; 2.70, 2.59 for secondary subscale items and 2.72, 2.57 for tertiary subscale items respectively with statistical insignificance ($p>0.05$).

Conclusion: No significant difference was found in coping strategies of homemaker women and working women caregivers.

Keywords: Coping strategies, caregiver, Coping Strategy Inventory (CSI), homemaker women caregivers, working women caregivers.

1. Introduction

India is the second most populous economy in the world with a population of 1.236 billion.^[1] At the moment, about 450 million people suffer from mental or behavioural disorders across the world i.e., at least 1 out of 4 families is afflicted with a mental or behavioural disorder.^[2] Various epidemiological studies from India have estimated the prevalence of mental disorders between 5.82% and 7.3%.^[3,4]

Due to deinstitutionalization, treatment care of persons with mental illnesses by family caregivers helps in reducing the number of hospital admissions.^[5] Thus, there is a shift from institutional care to home care with proposed larger involvement of community. It may inadvertently lead to increased burden of care on family and relatives of psychiatric patients.^[6]

A caregiver is defined as a family member who lives with the patient and takes care of his/her activities of daily living (ADL), health care, and social interaction for more than a year.^[7] Whereas, caregiver burden is defined as “emotional, physical, financial demands, and responsibilities of an individual’s illness which are placed on the family members, friends, or other individuals but are outside the health care system”.^[8]

In our country, majority of the patients suffering from mental illness, e.g., schizophrenia or depression patients stay with their families.^[9,10] Although urbanization has led to progress in better modalities of treatment but cost of hospital services has increased, which cannot replace family environment. Thus, caregivers face immense physical, social, emotional, and financial burden.^[11]

The concept of domiciliary care giver’s burden for a mentally ill patient was first described by Grad and Sainbury in 1960s.^[12] The most common mental health consequences among caregivers observed were depression, anxiety and burnout. They reported burden in different areas including effects on family functioning, social isolation, financial problems, and health. The community-based studies proved that 18–47% of caregiver’s lands in depression.^[13] The perceived burden by caregivers of psychiatric illness has a prognostic value in the natural history of the disease, and had negative outcomes.^[14]

The burden placed on caregivers possibly leads them to seek for coping strategies. ‘Coping’ was defined by Lazarus and Folkman as a process where an individual responds to stress.^[15] The coping strategies can be broadly classified as emotion-focused and problem-focused.^[16] Emotion-focused coping (EFC) are aimed to minimize the negative emotional outcomes whereas problem-focused coping (PFC) is restored by withdrawing from the source stress.^[17] The caregivers use both adaptive and maladaptive coping strategies to deal with problems encountered while caring a person with mental illness.^[18,19]

The coping strategies are either positive or negative. Positive coping strategies are appropriate for social support from society, family and friends^[20] contrastingly negative coping strategies result into avoidance behavior and substance abuse.^[21]

The maladaptive coping strategies can affect disease outcomes of persons with mental illness e.g., relapse, readmission and QoL. Rammohan et al., 2002^[22] reported the risk of denial as a coping strategy emerged as a significant predictor of caregiver burden. It results in avoidance.

Therefore, understanding the coping strategies commonly used by caregivers can provide valuable information.

In India, women are twice more likely to become caregivers than men. Women in India have evolved in all aspects after independence. From just being skilled homemakers, they have acquired skills and capabilities at par with males.^[23]

Multitasking in women these days is inevitable as they perform more roles and constantly pursue their goals. Arizona's School of Family and Consumer Resources took a survey of 166 married couples and maintained a daily diary of the stressors over the course of 42 days. It was seen that women had "higher distress" than men. These women were just stressed out while experiencing the stressful events and didn't hold onto their stress longer.^[23]

Considering the effect of women's health on the overall family health and with regard to lack of coordination in shared responsibility of men and women in family, and considering women's employment as a minor role alongside the major role of housekeeping, this study was designed to compare various coping strategies among working women and homemaker women taking care of psychiatric patients.

2. Material and methods

This was a hospital based, descriptive, cross-sectional comparative study. The caregivers were recruited from out-door patient department (OPD) of Psychiatry of Government Medical College and Rajindra Hospital, Patiala according to the following criteria.

Inclusion criteria

1. Female participants who were either working or homemakers in the age group of 30-55 years and taking care of psychiatric patients diagnosed with Schizophrenia and Bipolar affective disorder (BAPD) of either sex brought to the psychiatry OPD.
2. Caregiver (Mentally and physically healthy) who is a first degree relative of the patient and staying with the patient at least for the last 2 years.
3. Caregivers who give written informed valid consent.

Exclusion criteria

1. Caregivers with significant medical, neurological and endocrinological disorders.
2. Pregnant women.
3. Caregivers with intellectual disability, mental illness or substance use disorder.

Institutional ethical approval was taken.

Sample size estimation

Latest data from India reported moderate to severe levels of caregiver burden in 62% of the caregivers of psychiatric patients.^[7] Taking the effect size of 10%, at 5% error and 80% power of the study, the estimated sample size is 135 using the formula:

$$n = (Z_{\alpha/2} + Z_{\beta}) \times PQ \times 2 / d^2, \text{ where}$$

n – Sample size

$Z_{\alpha/2}$ – Z value at 5% error (1.96)

P is the average prevalence of the character, Q is 1-P and d is the effect size.

So, by rounding off, we calculated the total sample size to be 140 and formed two groups. 70 caregivers were homemakers and 70 were working women.

Study Design

Diagnosis of psychiatric illness was made as per ICD-10 criteria. A brief explanation about the study was given to the caregivers and informed consent was taken. The patients and caregiver's identification data about socio-demographic status were recorded in Annexure-I

& II. For assessment of caregivers' burden, their coping strategies in handling stress and impact on quality-of-life subjects were administered "CAREGIVER BURDEN QUESTIONNAIRE" (Annexure-III), "COPING STRATEGIES INVENTORY" (Annexure-IV) and "WORLD HEALTH ORGANIZATION QUALITY OF LIFE – BREF" (Annexure-V). The study was conducted as per the good clinical practice guidelines and the declaration of Helsinki's Geneva with an approval of college ethical committee.

INSTRUMENTS

1. **SOCIO-DEMOGRAPHIC PROFORMA** (Annexure I and II): A Semi-structured proforma was used to obtain information about the participants and gather socio-demographic details including age, marital status, gender, educational status, economic status, history of substance use disorder and any psychiatric illness.
2. **COPING STRATEGIES INVENTORY (CSI)** (Annexure IV): It is a 73 item self-report questionnaire designed to assess coping thoughts and behaviors in response to specific stressor. The format of the CSI is adapted from the Lazarus "ways of coping" questionnaire (Folkman and Lazarus, 1981). The scale has good face validity, inter-rater reliability and internal consistency.^[24]

This instrument covers 14 subscales on the CSI including: 8 primary scales (problem solving, cognitive restructuring, express emotions, social support, problem avoidance, wishful thinking, self-criticism, social withdrawal) 4 secondary scales (problem focusing engagement, emotion focusing engagement, problem focusing disengagement, emotion focusing disengagement) and 2 tertiary scales (engagement, disengagement). Scoring system is based on Likert approach- never, rarely, sometimes, often and very often receiving the scores of 1,2,3,4 and 5 respectively.^[25]

3. Results

Table 1: Sociodemographic data of caregivers among Group 1 (Homemaker women) and Group 2 (Working women).

Age of caregivers (in years)	Group 1 (Homemakers)		Group 2 (Working Women)		Chi-Square	p value
	N=70	%	N=70	%		
30-35	14	20.00	15	21.43	1.78	0.21
31-40	8	11.43	11	15.71		
41-50	12	17.14	24	34.29		
51-55	36	51.43	20	28.57		
Relationship of caregiver with patient						
Bhabhi	3	4.29	4	5.71	1.46	0.28
Grandmother	4	5.71	6	8.57		
Mother	41	58.57	38	54.29		
Wife	22	31.43	22	31.43		
Marital status						
Single	0	0	0	0	0.89	0.67
Married	70	100	61	87.14		
Remarried	0	0	0	0.00		
Widowed	0	0	8	11.43		

Divorced	0	0	0	0.00		
Separated	0	0	1	1.43		

Table 1 shows the comparison of socio-demographic data of Group 1 and Group 2 caregivers. No significant difference was found between the two groups when compared in relation to age group, relation and marital status.

Table 2: Diagnostic classification of the psychiatric illness as per ICD-10

ICD 10 Diagnosis of Patients	Group 1 (Homemakers)		Group 2 (Working Women)		Total	Chi-Square	p value
	N=70	%	N=70	%			
F20 (Schizophrenia)	28	40	29	41.43	57 (40.71%)	0.11	0.82
F31 (Bipolar affective disorder)	42	60	41	58.57	83 (59.29%)		

Table 2 shows the diagnostic classification of the psychiatric illness as per ICD 10. F20 (Schizophrenia) and F31 (Bipolar affective disorder) was reported among 40%, 60% and 41.43%, 58.57% of the subjects among Group 1 and Group 2, respectively. Overall, the study comprised of 57 Schizophrenic patients (40.71%) and 83 (59.29%) Bipolar affective disorder patients. The difference between the groups was statistically non-significant at $p>0.05$.

Table 3: Coping strategies comparison of caregivers among Group 1 and Group 2

Items	Coping strategies of caregivers	Group 1 (Homemakers)		Group 2 (Working Women)		t Test	p value
		Mean	SD	Mean	SD		
Primary Subscale Items	Problem solving	3.73	0.75	3.61	0.75	0.41	0.69
	Cognitive restructuring	2.71	0.75	2.60	0.75	0.48	0.61
	Express emotions	2.90	0.75	2.74	0.75	0.44	0.63
	Social support	3.54	0.75	3.41	0.75	0.46	0.65
	Problem avoidance	1.64	0.72	1.52	0.73	0.46	0.66
	Wishful thinking	2.44	0.75	2.31	0.75	1.08	0.42
	Self criticism	2.99	0.75	2.83	0.74	1.23	0.36
	Social withdrawal	1.73	0.72	1.62	0.73	0.45	0.65
Secondary Subscale Items	Problem focusing Engagement	3.17	0.31	3.22	0.75	0.34	0.71
	Emotion facing Engagement	3.35	0.69	3.02	0.72	0.48	0.62
	Problem focusing Disengagement	1.96	0.83	1.90	0.75	0.42	0.67
	Emotion facing Disengagement	2.33	0.68	2.22	0.73	0.41	0.68
Tertiary	Engagement	3.29	0.67	3.09	0.75	0.46	0.65

Subscale Items	Disengagement	2.15	0.73	2.06	0.72	0.89	0.52
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Table 3 shows the coping strategies of caregivers among Group 1 and Group 2. No significant difference was found between them in relation to primary, secondary and tertiary subscale items of coping strategies ($p > 0.05$) in Group 1 (homemakers) and Group 2 (working women).

4. Discussion

In the present study, approximately 55% of the caregivers were mothers of PMI while 31% were wives. Similarly, Aggarwal et al. (2011)^[26] and Darlami et al. (2015)^[27] also reported that majority of the caregivers were married (76%) and only 36% of persons with mental illness were taken care by their spouses. Mohammed et al., (2018)^[28] also revealed that more than two-fifths of caregivers were parents, less than one-third were son and daughter, one-fourth were spouses and only 4% of caregivers were siblings. The reason behind this can be implicated due to the fact that mental illnesses begin at an early age and it is a common Indian mindset that if someone who is mentally ill is married off, his mental condition will improve. Moreover, Indian societal values are such that if a person becomes mentally ill, spouses might leave him, but their parents rarely abandon them.

It was observed in this study that on Coping Strategy Inventory, among the primary subscale items, maximum mean score was found for problem solving and social support coping strategies while in secondary and tertiary subscale items, maximum score was reported for emotion facing engagement and engagement, respectively. No significant difference was found between caregivers of Group 1 (Homemakers) and Group 2 (Working women) when compared in relation to primary, secondary and tertiary subscale items of coping strategies in the present study. Narasipuram et al., (2012)^[29] also revealed that caregivers in general perceived greater burden when persons with mental illness had more functional impairments in vital activities of daily living such as preparation of meal, taking medication, managing money, performing household chores, being supervised, and the potential to wander.

It was shown by Hassan et al., (2011)^[30] study that caregivers used a wide variety of coping strategies, both problem and emotion-focused. In their study, the most coping strategies used by caregivers of schizophrenic patients were self-controlling, positive reappraisal and escape-avoidance. However, the study by Chakrabarti and Gill (2002)^[31] contradicts this finding. Their observation was that problem-focused coping strategies were more common in caregivers of bipolar patients and emotion-focused strategies in caregivers of schizophrenic patients. In same way, Chandrasekaran et al., (2002)^[32] reported that an emotion-focused coping strategy was found to be more commonly employed by the relatives, than other strategies. Contrastingly, Scazufca and Kuipers (1999)^[33] found that problem focused coping was the strategy used more often at inclusion than at follow-up.

Limitations of study

The study was limited by small sample size and its cross-sectional design. Patients were screened for presence of psychiatric disorders through a clinical interview, however no formal assessment was done.

Strengths of study

In India, there are a lot of studies on caregiver burden, however there is a limited research on

coping strategies among women caregivers. Present study is an attempt to explore the same.

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