

Depression and anxiety in the caregivers of mentally ill patients

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Objective. This research was a comparative study aimed at assessing the level of depression and anxiety among the caregivers of male and female patients with different psychiatric diagnosis.

Design: It was a Retrospective study.

Place and Duration of the Study: The data was taken from both In and Out patient departments Institute of Psychiatry Rawalpindi General Hospital, Rawalpindi from January 2004 to April 2004.

Subject and Method: The sample consisted of primary caregivers of 50 patients' of both genders, 25 male and 25 female patients. One primary caregivers of each patient was taken. Hamilton Rating Scale for depression (HAM-D) and HAM-A were used to assess depression and Anxiety. Sample was taken from the out patient department of Rawalpindi general Hospital.

Results: The result of study revealed that caregivers of the patients with psychiatric illnesses have significant high level of depression and anxiety and significant gender differences were also observed. Results showed that caregivers of young male patients have high level of depression as compare to older male patients and young female patient. No significant differences were observed between care givers of young male and female patients. The caregivers of patients carrying the diagnosis of schizophrenia have higher level of depression as compared to caregivers of depression and substance abuse. The duration of illness is also important dimension as care givers of the patients who were ill more that 18 months their family reported about being depressed and anxious.

Conclusion: It can be suggested that the care givers of young patients have higher levels of depression and anxiety as compared to older patients and duration of illness and gender are important parameters to this.

KEY WORDS: Depression, Anxiety, Care Givers

INTRODUCTION

Care giving and care receiving can occur at any point in the life-course, and is typically associated with chronic illnesses or disabilities, which result in losses of independence and functioning. There is no standard definition of family care giving, which can be used consistently from one study to another (National Alliance of Care Giving, 1997). What the term care giving means is not always clear and frequently varies with the purpose for which such definitions are used (Schulz et al., 1997). Successful management of major mental illness in the community relies significantly on an informal or non-professional network of caregivers. The needs and experiences of such caregivers have been little studied with respect to major chronic mood disorders (Dore & Romans, 1999).

Care giving does not cause depression, nor will everyone who provides care experience the negative feelings that go with depression. But in an effort to provide the best possible care for a family member, caregivers often sacrifice their own physical and emotional needs and the emotional and physical experiences involved with providing care can strain even the most capable person. Everyone has negative feelings that come and go over time, but when these feelings become more intense and leave caregivers totally drained of energy, crying frequently or easily angered by their loved one or other people, it may well be a warning sign of depression. Concerns about depression arise when the sadness and crying don't go away or when those negative feelings are unrelenting (Family Caregiver Alliance Fact Sheet, 2002).

Almost one-third of all caregivers is balancing employment and care giving responsibilities, and of this group, two-thirds report conflicts in roles that require them to rearrange their work schedules, work fewer than normal hours, and/or take unpaid leaves of absence. Because care giving is such an emotionally draining experience, caregivers have high rates of depression when compared to the general population. Research on family caregivers of mentally ill relatives has historically focused on negative aspects of care giving, often described as caregiver burden. Caregivers' perspectives on both negative and positive aspects of care giving in Canada. A qualitative approach was used. Data collection involved 20 in -depth, audio taped, semi structured interviews focusing on caregiver's positive and negative personal experiences with care giving to a relative with mental illness. Caregivers reported common negative impacts but also beneficial effects, such as feelings of gratification, love and pride. Main themes included stigma, systems issues, life lessons learned, and love and caring for the ill relative. This study counterbalance the predominantly negative consequences previously reported and add to emerging literature on positive aspects of care giving. Mental health professionals need to help care giving families make choices to improve their challenging situations & identify rewards of care giving & to advocate for increased systemic supports to ease caregiver burden. More than one quarter (26.6 percent) of the adult population has provided care for a chronically ill, disabled or aged family member or friend during the past year, (National Family Caregivers Association NFCA, 1997). Based on current census data, that translates into more than 54 million people. About three-fourths are women, many of whom

also juggle work and child-care responsibilities. According to a 1997 survey by National Family Caregivers Association, 61 % of caregivers reported feeling more depressed than before.

Some researchers use the concepts of objective and subjective burden. Objective caregiver burden refers to the practical problems associated with care giving (e.g. difficulties with neighbors and police, disrupted family relationships). Subjective caregiver burden refers to the caregiver's emotional reaction (e.g. reduce morale, anxiety and depression). Some researchers use the concepts of objective and subjective burden. Objective caregivers burden refers to the practical problems associated with care giving (e.g., difficulties with neighbors and police, disrupted family relationships). Subjective caregiver burden refers to the caregiver's emotional reactions (e.g., reduced morale, anxiety and depression).

A recent study conducted by the National Alliance for Care giving found that more than half of those who provide major care for their parents (and one in four who provide any care) experienced stresses and burden. This is a major concern because prolonged stress can have serious emotional consequences. Emotional impact of any psychiatric disorder on family or primary caregivers can vary from frustration, anxiety, fear, depression and guilt to grief. Depression is one of the emotion, which is experienced by caregivers. Four types of caregiver burden resulting from stress have been identified (Select Committee on Aging, 1987); emotional burden, physical burden, financial burden and family burden, the 1982 long-term care study demonstrated that the self-assessed health status (or physical burden) of caregivers was poorer than a comparison groups of non-care giving age peers in the general population. In contrast, other studies found that caregiver's self- assessed health status is compare able to (George & Gwyther, 1986) or better than (Danis, 1978) comparison group of on-caregivers.

Deimling and Bass (1986) reported that self assessed change in caregiver's health since becoming a caregiver was best explained by patient's daily activities' limitations, suggestions that those who provided the highest level of care had the greatest change in physical heath. A new Yale study looks more deeply at family caregivers' mental health - specifically, at the effects on caregivers when their patient suffers frequent distress. Severe pain, delirium, choking, vomiting — all these can leave family caregivers feeling frightened and helpless (Bradley, 2003). For most caregivers, helplessness — rather than fear — was the overwhelming emotion attached to their experience. The study by Bradley (2003) "demonstrates that caregivers not only experience the burdens of providing essential care to their terminally ill loved ones, but that they also extensively and frequently witness their loved ones in serious distress". More attention should be given to these detrimental effects.

Close to one-third of caregivers surveyed said that the emotional and behavioral symptoms of the illness caused them extreme hardship. Drug abuse, suicide threats and violent behavior, while not necessarily daily realities, exist as constant sources of anxiety and are cited by more than half of caregivers as their most pressing concerns. Researchers have also explored another dimension, the effect of race on caregiver's depression, Flanagan (1994) conducted interviews to explore the relationship among race, caregiver depression and global role strain with African American and white spouse caregivers. Although African American caregivers were less likely to report depression and role strain, there was no interaction by race in the process influencing caregiver distress.

According to the literature on stress and coping, the burden of care giving to a mentally ill partner might have an impact on the mental health of spouse. As part of a study on the burden of care giving to a mentally ill family member. Smith (1998) conducted a structured psychiatric interview with spouses of the patients suffering from depression, anxiety disorders and schizophrenia (N=151) in university of Leipzig Germany. A significantly increased prevalence of depressive disorders was found. It was concluded that psychiatric patients' partners are at a high risk of developing a depressive disorder. It appears necessary to develop special interventions for spouses reducing stress and the risk of getting depressed.

Caregivers reported significant difficulties in their relationships with the patient when she or he was unwell, with considerable impact on their own employment, finances, legal matters, co-parenting and other social relationships. Violence was a particular worry for partner/parent caregivers of both male and female patients when the patient was severely depressed. The caregiver's own mental health appeared unaffected. Despite this, the caregivers appeared emotionally committed to the patients and showed considerable tolerance of problem behaviors, which they rank-ordered for difficulty. Among non family partners, knowledge of the illness before cohabitation was poor.

SUBJECTS AND METHODS

In the present research primary care givers of 50 (25male, 25female) patients carrying the diagnosis of schizophrenia, substance abuse, and depression (age range 16—70 in which young and old patients with duration of illness of 2 weeks to 24 weeks were selected. Patients were selected from the out patient department of the Rawalpindi General Hospital Rawalpindi, with the help of consultant psychiatrist, through the technique of non-

probability purposive sampling. Caregivers with prior history of any psychiatric ailment, caregivers of inpatient department and those using depression-inducing drugs were not included in the study sample. Following instruments were used for the data collection.

1. Demographic Sheet
2. Hamilton Rating Scale for Anxiety
3. Hamilton Rating Scale for Depression

RESULTS

Table 1. Comparison for HAM-D between the Caregivers of Younger Male and Older Male Patients

<i>Groups</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t-value</i>	<i>p-value</i>
Younger male	13	18.92	3.09	1.957	.063
Older male	12	16.17	3.93		

Note: df =23 and HAM-D = Hamilton Rating Scale for depression

The result presented in table 1 indicates that there is significant difference in the level of depression among the caregivers of young male patients and older male patients ($t = 1.957$, $df=23$, $p < .063$). The mean score of the caregivers of young male patients are ($M=18.92$, $SD= 3.09$) while the mean score of the caregivers of older male patients are ($M =16.17$, $SD =3.93$).

Table 2. Comparison for HAM-A between the Caregivers of Younger Male and Older Male

<i>Groups</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t-value</i>	<i>p-value</i>
Younger male	13	26.77	3.30	1.218	.236
Older male	12	24.75	4.90		

Note: df =23 and HAM-A= Hamilton Rating Scale for anxiety

The result presented in table 2 also indicated that there is no significant difference in the anxiety level of caregivers of young male and older male patients ($t= 1.218$, $df=23$, $p < .236$). The mean score on HAM-A of caregivers of young male patients are ($M=26.77$, $SD=3.30$) while the mean score of the caregivers of the older male patients are ($M=24.75$, $SD=4.90$).

Table 3. Comparison for HAM-D between the Caregivers of Younger Female and Older Female

<i>Groups</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t-value</i>	<i>p-value</i>
Younger female	13	16.08	3.01	.339	.737
Older female	12	15.67	3.03		

The result presented in table 3 indicate the there is little difference in the level of depression among the caregivers of young female and older female patients ($t=.339$, $p=.737$). The mean score of the caregivers of young female patients are ($X=16.92$, $SD=3.01$) while the mean score of the caregivers of older male patients are ($X=15.67$, $SD=3.03$).

Table 4. Comparison for HAM-A between the Caregivers of Younger Female and Older Female

<i>Groups</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t-value</i>	<i>p-value</i>
Younger female	13	25.15	5.30	0.0941	.926
Older female	12	25.33	4.16		

The result presented in table indicated that there is no difference in the anxiety level of caregivers of young female and older female patients. ($t=.094$, $p < .926$). The mean score on HAM-A of caregivers of young female patients are ($M=25.15$, $SD=5.30$) while the mean score of the caregivers of the older female patients are ($M=25.33$, $SD=4.16$).

Table 5. Comparison for HAM-D between the Caregivers of Young Male and Young Female Patients

<i>Groups</i>	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t-value</i>	<i>p-value</i>
Younger male	13	18.92	3.09		

Young female	132	16.08	3.01
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The result presented in table 5 indicate the there is significant difference in the level of depression among the caregivers of young male and young female patients ($t=2.376$, $p=.026$). The mean score of the caregivers of young male patients are ($M=18.921$, $SD=3.09$) while the mean score of the caregivers of young female patients are ($M=16.92$, $SD=3.01$).

Table 6. Comparison for HAM-A between the Caregivers of Young Male and Young Female Patients

Groups	N	M	SD	t-value	p-value
Young male	13	26.77	3.30	0.933	.360
Young female	13	25.15	5.30		

The result presented in table 6 indicate the there is minor difference in the level of anxiety of young female and young male patients ($t=.933$, $p<.360$). The mean score of the caregivers of young male patients are ($M=26.77$, $SD=3.30$) while the mean score of the caregivers of young female patients are ($M=25.15$, $SD=5.30$).

Table 7. Comparison of HAM-D Scores for Schizophrenia, Depression, and Substance Abuse

Group of Diseases	M	SD
Schizophrenia	18.56	3.00
Depression	15.35	3.10
Substances Abuse	14.00	2.20
Total		

Score across three different groups of diseases indicate differences among these groups. These differences were further analyzed by applying the One Way Analysis of Variance (ANOVA).

Table 8. Difference on the HAM-D Scores between the Caregivers of Schizophrenia, Depression, and Substance Abuse

Source of Variance	SS	df	MS	F	P
Between groups	175.598	2	87.789	10.218	.000
Within groups	404.042	47	80597		
Total	579.620	49			

df=49, *** $p<.000$

Table shows the one way analysis of variance of HAM-D scores of the caregivers for different groups of diseases. To see the difference with in-groups post hoc test was used.

Table 9. Multiple Comparison with in the group of three diseases.

(I)Illness	(J)Illness	Mean difference(I-J)	Std.Error	Sig.
Schizophrenia	Substance Abuse	3.21	.92	.001
	Depression	4.56	1.19	.000

Table shows that there is significant difference in the level of depression among the caregivers of schizophrenic patients as compare to caregivers of depression and substance abuse.

Table 10. Comparison of HAM-A Scores for Schizophrenia and Substance Abuse

Group of Diseases	N	M	S.D
Schizophrenia	25	25.08	3.87
Depression	17	27.06	3.85
Substances	8	23.63	6.35

Scores across three groups of diseases indicate differences among these groups. These differences were further analyzed by applying the One Way Analysis of Variance (ANOVA).

Table 11. Difference on the HAM-A Scores between the Caregivers of Schizophrenia, Depression, and Substance Abuse

Source of Variance	SS	df	MS	F	P
Between groups	73.824	2	836.912	1.974	

0.150			
Within groups	878.656	47	18.695
Total	952.480	49	

df=49, ***p<.150

Table shows the one way analysis of variance of HAM-A scores of the caregivers for different groups of diseases.

Table 12. Multiple Comparisons with in the group of three diseases.

(I)Illness	(J)Illness	Mean difference(I-J)	Std.Error	Sig.
Schizophrenia	Substance Abuse	1.98	1.36	.152
	Depression	1.45	1.76	.412

The findings indicate that there is little difference in the level of anxiety among the caregivers of depression and substance abuse.

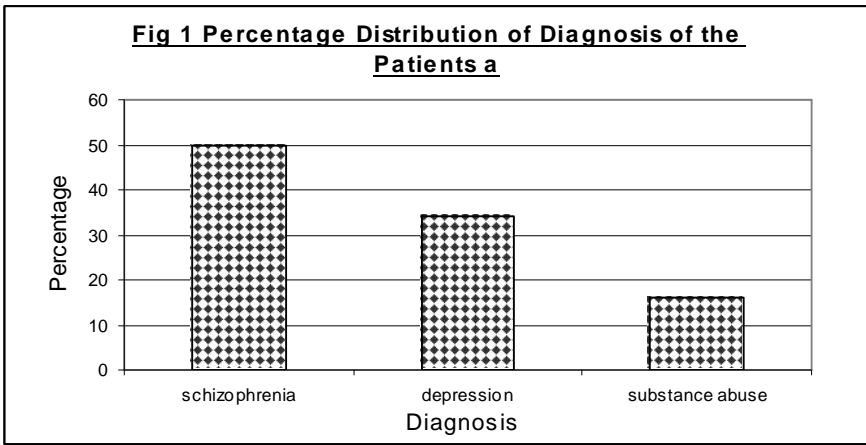


Table 13. The Duration of Illness and Caregivers Scores on HAM-D and HAM-A

Scales	Duration	N	M	SD	t-value	p-value
HAM-D	1-18 months	26	15.96	3.14	1.698	.96
	>18 months	24	17.58	3.61	1.688	.98
HAM-A	1-18 months	26	25.46	5.43	.097	.92
	>18 months	24	25.58	3.06	.099	.92

Table shows the impact of duration of illness on the caregivers. Table indicate caregivers of those patients who had illness more than 18 months had little higher depression level as compare to those who had illness less than 18 months. There is also very little difference in the level of anxiety, so there is no mark able difference in both groups.

DISCUSSION

A term in the mental health literature that is frequently used to describe the impact of mental illness on families is "family burden." Some argue that this term is problematic because it conveys that families will naturally find caring for the patient "burdensome".

There are four kinds of people in the world—those who have been caregivers, those who currently are caregivers, those who will be caregivers and those who need caregivers. Emotional burden is the most pervasive negative consequence of care giving; parameters of emotional burden described in relationship to care giving include symptoms of depression, emotional exhaustion, and feelings of anxiety, helplessness, and lowered morale (Danis, 1978; Frank father, Smith, & Caro, 1981).

The Pakistani scenario presents a disregard, fair, avoidance or ridicule by the general public with shame, embarrassment, and concealment on the part of the family. Mainly religious and superstitious reasons shroud the thinking and attitude of people. A disability is seen as an invasion of evil spirit, curse, or a punishment form a God for some sin committed by the family or the individual in the past. According to Miles (1980a, 1982) and Shah (1982) disabled persons have not yet achieved much publicity within Pakistan nor have their opinions being given due consideration.

Many families will say the illness just came out of the blue. However, it may be that the signs were already there, but were ignored because of the stigma associated with schizophrenia. Family members will usually view and talk themselves in believing that the bizarre and unusual behavior is only temporary. Eventually, the patient's symptoms will escalate to the point where family members become concerned, and the symptoms will no longer be regarded as temporary. At this juncture, some may get professional help; some will try to reach the patient, encouraging them to

seek assistance; and other will entreat the patient to "snap out of it," "stop being lazy," or "get his/her life back on track.

The results supporting the idea that caregivers of young male patients have higher levels of depression as compared to caregivers of older male patients on measures higher scores were reported on HAM-D (Roychoudhuri (1995) in his studies assessed subjective and objective burden of the carers of schizophrenia and bipolar affective disorder patients. Burden was found to be higher among the schizophrenic, young, male low income patients. The present research findings are well-matching with the result of Several patients in caregiver variables have been found to contribute to the family burden. Greater burden is associated with patients who are male, younger in age (Martyns-Yellowe, 1992; Roychoudhuri et al., 1995), and who have poorer levels of functioning.

Families often experience financial strain when they have a family member with a chronic illness. This is particularly the case when a family member must leave the workforce to care for the ill family member, and incur costs for home nursing, and non-reimbursable medical expenses. Financial problems may be worse when the caregiver is a spouse and the patient formerly earned a good income and had good pre-morbid function.

Level of anxiety is also very high in the caregivers of younger male patients as compared to the caregivers of older male patients. In the light of present findings it is said that family of young male patients have high level of anxiety and depression. They experience different level of stress, burden as compared to caregivers of older male patients. Reason may be to see their child as a hope for future. On the other hand care-giving may affect their relationship with different dimensions like they were facing financial problems or facing problems in their daily functioning like consistency, neglecting other family members, , compromise etc.

The results indicate that there is a little difference in the level of depression and anxiety among the caregivers of young female patients and older female patients. The result shows that there is significant difference in the levels of anxiety and depression in the caregivers of young male patients and young female patients. Care givers of young male patients have high level of anxiety and depression as compare to caregivers of young female patients. Reason may be the illnesses more severe in males, is associated with higher suicidal rates, more negative symptoms and more hospitalization. Female schizophrenics are less frequently hospitalized; appear more responsive to neuroleptic medication and have more benign life time disease course (Goldstein, 1993).

Another factor related to schizophrenia is gender of the patient. The reaction by the patient as well as their family members towards the disorder may affect the process of improvement; particularly in Pakistan where males are give more importance. This is because males are usually earning hands, and in case of schizophrenia to a male member not only the earning terminates but a mouth is added for feeding a well. The burden of looking after him is increased. In the case of female feeling victim to schizophrenia, her duty as mother, wife or helping hand becomes restrained giving way to negative feeling from rest of the family members or the caregivers.

The results supporting the idea that caregivers of schizophrenic patients have high level of depression as compared to the caregivers of depression and substance abuse. Family care givers of bipolar patients more often use healthier strategies than care givers of patients with schizophrenia. Possible reason includes improved inter-episode functioning. As reported in research by (Roychoudhuri, 1995), it was found that caregivers of schizophrenic patients have higher level of burden as compared to caregivers of bipolar patients. The result of present study also supports that idea.

Families are an integral part of the care system for persons with a chronic mental illness, such as schizophrenia (Shankar & Menon, 1993). The demands of being involved in the care of a seriously mentally ill relative have both an emotional and a practical impact on the caregiver (Chakrabarti et al., 1995; Provencher, 1996). The costs that families incur in terms of economic hardships, social isolation and psychological strain, are referred to as family burden.

The relationship of the primary caregiver to the patient may also mediate the experience of burden. Several researchers have documented the concerns experienced by parent caregivers such as the patient's difficulty in achieving normative life-span goals e.g., finding a job, getting married and raising children. An additional concern for parents is who will take over the care giving role after them (Hatfield & Lefley, 2000).

“Not only victims but also families and friends are effected by schizophrenia, each in different ways. Their sufferings are immeasurable, as are the social and financial costs to communities at large”. Results indicate that there are significant levels of depression in the care givers of those patients which are ill more than 18 months as compared to those whose duration of illness is less than 18 months.

Helping professionals tend to forget the impact of the chronic aspects of mental illnesses such as when the patient decompensate. It becomes very strainful for the caregivers to get along with the stride. Families, often report that

they need support with the more chronic phases of the illness such as the day-to-day care giving activities, decisions, and strains to get a relief from the stressful situation. Therefore strategies and coping plans should also be designed for the caregivers to help them release their mental tensions.

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