*IOSR Journal Of Humanities And Social Science (IOSR-JHSS)*
*Volume 27, Issue 9, Series 6 (September, 2022) 38-44*
*e-ISSN: 2279-0837, p-ISSN: 2279-0845.*
*www.iosrjournals.org*

# Stress and Coping Style among Caregivers of Mentally Ill Patients

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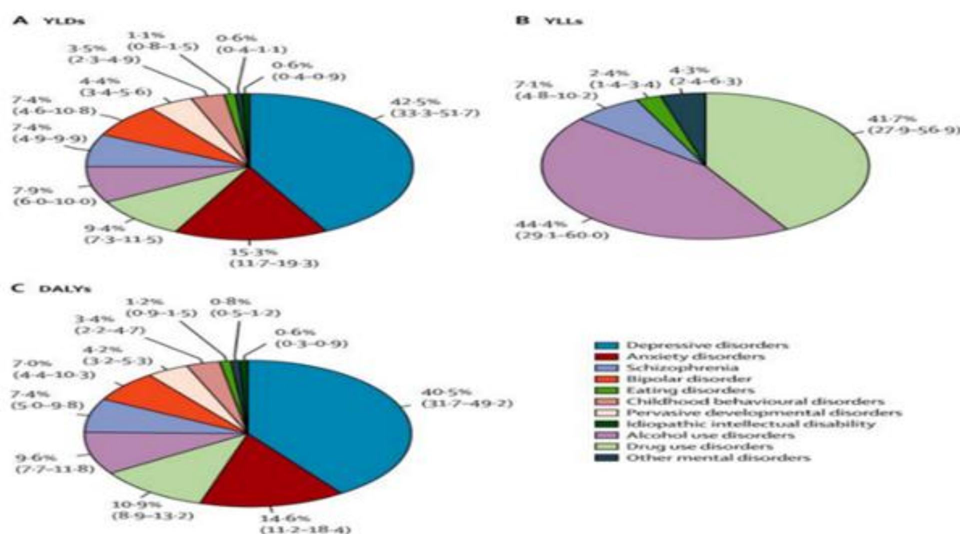
**Abstract:**
**Background:** Mental and behavioral disorders account for about 12% of the global burden of disease, The World Health Report 2013 has drawn attention to the fact that nearly 45 crores people estimated to be suffering from mental and behavioral disorders globally. WHO (2011) report stated by 2020, 15% of the Disability Adjusted Life Years (DALYS) lost would be due to mental and behavioral disorders, up from 10% in 2000 to 12% in 2010 and that about 24 million people suffer from schizophrenia and 21 million people from depression. Caregivers of the patients go through a great deal of pain and trauma as well along with the patients. Hence, we decided to conduct research whose sole purpose is to understand how much stress the caregivers go through and if they have adequate coping style deal with such problems.
**OBJECTIVE:** The objectives of the present piece of research were to find out the relationship between level of stress and coping style among caregivers of mentally ill patients and to find out difference among high stressed and low stressed caregivers with respect to their coping styles.
**MATERIALS AND METHODS:** A purposive sample of100 caregivers was taken from S.C.B Medical College and Hospital. This study was conducted using the perceived stress scale (PSS) by Cohen, Kamarck and Mermelstein (1983) and The Coping Scale by Hamley, Grych and Banyard (2013). Statistical analysis was done on the variables categorically. SPSS version 20 was used to analyze the data.
**RESULTS:** The result showed(r=-0.461) with significance level 0.01 level, to our first objective, which means when the level of stress increases the coping style decreases and vice versa. As to our second objective the result revealed that there is a difference with high stress and low stress caregivers with respect to their coping style. Result to the t test showed (t=-5.307) with a significance level of (0.000).
**CONCLUSION:** This study concluded that caregivers of mentally ill patients undergo a lot of stress and burden. Hence, there is a need to develop strategies that can help them such as providing them with a support structure such as therapies and counselling sessions.
**KEYWORD:** caregiver, coping style, stress, global burden

Date of Submission: 07-09-2022 Date of Acceptance: 23-09-2022

## I. INTRODUCTION

Mental illness is the maladjustment in living and abnormal change in one's thinking, feeling, memory, perception and judgement which produce disharmony in person's ability to meet human needs effectively and function with culture. Mental illness is not easily cured as other physical disorders and it requires long treatment course and close supervision. Majority of mentally ill are taken care by their relatives with this change in care model it has been observed that burden of care has been shifted to family members who have assumed role of informal caregiver, irritated behavior of patient coupled with responsibilities of caregivers for long time results in exhaustion and stress among caregivers. Mental illness is increasing day by day due to competitive life, poverty, developmental changes and different physical disorder. According to WHO, one percent of population suffers from severely incapacitating mental disorder. In 2001, WHO has reported that major depression is leading cause of disability and rank fourth in ten leading causes of global burden of disease. Globally 70 million people suffer from alcohol dependance, about 50 million have epilepsy, other 24 million have schizophrenia and 10 – 20 million people attempt suicide every year. Mental disorder accounts for 13% global burden of diseases. About 1 in 17 people worldwide suffers from a serious mental illness. According to the, World Health Organization (WHO), mental illness is found in at least one member of any one of the four families.According to WHO report 2001, bipolar affective disorders and schizophrenia find a place in the list of most disabling illness for the most productive age group of 15-44 years. Until 1950s, a large number of patients used to be confined to the walls of the mental hospitals. With the advancements in the psychopharmacology and growing

emphasis on outpatient treatment in psychiatry, most patients with these disorders are being looked after by their family members thus deinstitutionalization become possible. However, the frequent relapse and remission directed attention to the psychological factors that were postulated as influencing the course of illness. Mental and behavioral disorders account for about 12% of the global burden of disease, The World Health Report 2013 has drawn attention to the fact that nearly 45 crores people estimated to be suffering from mental and behavioral disorders globally. WHO (2011) report stated by 2020, 15% of the Disability Adjusted Life Years (DALYS) lost would be due to mental and behavioral disorders, up from 10% in 2000 to 12% in 2010 and that about 24 million people suffer from schizophrenia and 21 million people from depression.




global burden of mental health disorders and substance use disorders

According to Ganguly (2008) the national prevalence rates of mental disorders are 73/1000 populations, with rural and urban rates of 70.5/1000 and 73/1000 respectively. The factors associated with occurrence of common mental disorders were female gender, poverty, unemployment and lower level of literacy.

**Coping strategies**

Coping strategies are behavioral and cognitive tactics used to manage crises, conditions, and demands that are appraised as distressing. An important development in coping research was the creation of Robert Folkman and Susan Lazarus' Ways of Coping scale. This scale was devised to assess the extent to which one uses one of two general types of coping. Problem-focused coping is directed at problem solving or taking action to change the source of the stress. Emotion-focused coping, in contrast, focuses on reducing or managing the emotional distress that results from the crisis. Some emotion-focused coping strategies include wishful thinking, distancing, avoidance, and positive reappraisal. The effectiveness of any particular coping strategy varies according to the situation, and there is not one generally accepted way for older adults to cope with stress. Moreover, most crises warrant both types of coping. Problem-focused strategies are typically invoked when constructive action can be taken, whereas emotion-focused coping is used when people feel that the situation cannot change and must be endured. In general, problem-focused coping strategies are considered more effective for managing crises than emotion-focused tactics. Persons who use active coping strategies typically view themselves as in control, hold positive self-views, and adopt a proactive, optimistic and self-reliant approach to managing life stressors. In contrast, those who rely on emotion-focused coping strategies, including self-blame, avoidance, or even the use of drugs or alcohol, cope less well than those who adopt active strategies, such as seeking social support. However, for older adults, problem-focused coping is not always effective when a loss is irrevocable. Rather, emotion-focused strategies such as the positive reappraisal of a permanent condition or situation are associated with enhanced mental health.

## II. MATERIAL AND METHODS

The prospective correlational study was carried out on the caregivers of mentally ill patients at S.C.B. Medical College and Hospital, Cuttack, Odisha from May-15 to June 15 2022. A total number of 100 subjects (both male and female) of age 20 to 75 years were for in this study.

**Study Design:**The present study is a quantitative study based on correlational research design. In this study the examiner studies the level of stress and coping strategies among the caregivers of mentally ill patients. This

would help us to collect relevant data to work effectively and have a deeper understanding about the stress level and coping style of the caregivers. Correlational research design is used in this study.

**Study Location:**The experiment has been done in a medical institution named S.C.B. Medical College and Hospital, Cuttack, Odisha.

**Study Duration:**May 15 to June 15 2022.

**Sample size:**The sample is both necessary and advantageous. In this study the sample was selected by using purposive sampling method. The sample consisted of 100 caregivers of mentally ill patients. The age ranged between 20 to 75 years.

**Test Used:**The perceived stress scale (PSS) by Cohen, Kamarck and Mermelstein (1983) and Coping Scale by Hamley, Grych and Banyard (2013) are the two tests that have been used in this research.

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. In each case respondents are asked how often they felt a certain way.The Perceived Stress Scale (PSS) is a classic stress assessment instrument. The tool, while originally developed in 1983, remains a popular choice for helping us understand how different situations affect our feelings and our perceived stress. The questions in this scale ask about feelingsand thoughts of the subject during the last month. In each case, the subject is asked to indicate how often they felt or thought a certain way. Although some of the questions are similar, there are differences between them and subject should treat each one as a separate question. The scale consists of 10 items in the form of questions to which the subjects are required to respond on a 5-point scale. PSS scores are obtained by reversing responses (e.g., 0=4, 1=3, 2=2, 3=1, 4=0) to the four positively stated items (item 4,5,7,8) and then summing across all scale items.The second test is the coping scale. The coping scale was developed by Hamby, Grych and Banyard in 2013 and partially adapted from Hoahan, Moos (1987), Spitzberg & Copach in (2008). This coping questionnaire assesses cognitive, emotional, and behavioral methods of dealing with problems. Some items, focusing on cognitive and emotional approaches, were adapted from Holahan and Moos's (1987) widely-used Coping Strategies Scale (items 2, 3, and 4), while other cognitive and emotional items were original (1, 5, 6, and 8). The remainder of the items were adapted from Spitzberg and Copach's (2008) framework for assessing coping in response to stalking. Adapted items were reworded to focus on general coping patterns (versus a response to a specific situation) and simplified to suit a community sample in which some have limited reading levels and educational attainment. Scoring: Each answer category was assigned a value from 4 to 1. The total score can be a sum or mean of all the items. Higher scores indicate higher levels of coping.

**Procedure Methodology:**

The investigator selected samples purposely for data collection and administered the test individually in a calm and noise free environment. Before proceeding for the data collection, the investigator established good rapport with the subjects (the caregivers of the mentally ill patients). The instruction of each part of the questionnaires were adequately explained in the preferable language of the subjects and specific care was taken into consideration that they clearly understood the questionnaire. There were two questionnaires. They were the perceived stress Scale by Cohen, Kamarck & Mermelstein (1983) and the other one was The Coping Scale by Hamley, Grych & Banyard (2013). Each participant was requested to respond to each item in the questionnaire freely and honestly without any hesitation. After giving the instructions, the investigator recorded the name, age, sex, date of birth and educational qualification. The participants were first asked to answer the stress questionnaire, in which there were 10 items afterwards the participants were asked to answer the coping style questionnaire in which there are 14 items in total. After all the fifty caregivers were interviewed the scoring was done. In the perceived stress scale, there were 10 items in total and each participant were required to answer to a 5-point scale. The five options for each item were

| 0 | Never |
|---|---|
| 1 | Almost never |
| 2 | Sometimes |
| 3 | Fairly often |
| 4 | Very often |

The score was obtained by reversing responses like (0=4, 1=3, 2=2, 3=1& 4=0) to the four positively stated items (item 4, 5, 7 & 8) and then summing across all scale items. For the coping questionnaire there were in total 14 item and the scoring were to be done in 4-point rating scale. The four options for each item were

| Mostly true about me | 4 |
| --- | --- |
| Somewhat true about me | 3 |
| A little true about me | 2 |
| Not true about me | 1 |

The data collected from 100 caregivers of mentally ill patients regardless of their age, gender or ethnicity. Each participant was administered both the questionnaires individually. It took around 30 to 45 minutes for each participant to complete their session and it took around 30 days for the completion of the whole data collection process. Strict confidentiality was ensured. We used correlation to find out the relationship between level of stress and coping style among caregivers of mentally ill patients. Then we did median split to form high stressed and low stressed group, then we used independent t-test to find out the difference between these group with respect to their coping style. The study was conducted in compliance with ethical principles and moral manner.

**Statistical Analysis**

Data was analyzed using SPSS version 20. For our first objective, to find out difference between the level of stress and coping style among caregivers of mentally ill patients, correlation was used and for the second objective, to find out difference between high stressed and low stressed caregivers with respect to their coping style, t-test was used. The level $p < 0.05$ was considered as the cutoff value of significance.

## III. Result

We have presented the collected data with the help of tables. This also helps in suggesting appropriate statistical test over the data to validate the statistical hypotheses which helps in interpreting data, to explain the level of stress and coping style among caregivers of mentally ill patients. The collected data are analyzed through two different statistical tests to find out two different objectives of the research. To find out the relationship between level of stress and coping style among caregivers the investigator used correlation (Pearson) and to find out difference among high stressed and low stressed caregivers with respect to their coping style the investigator used t-test in SPSS-20 version.
The relationship between level of stress and coping style among caregivers is presented in Table 1.

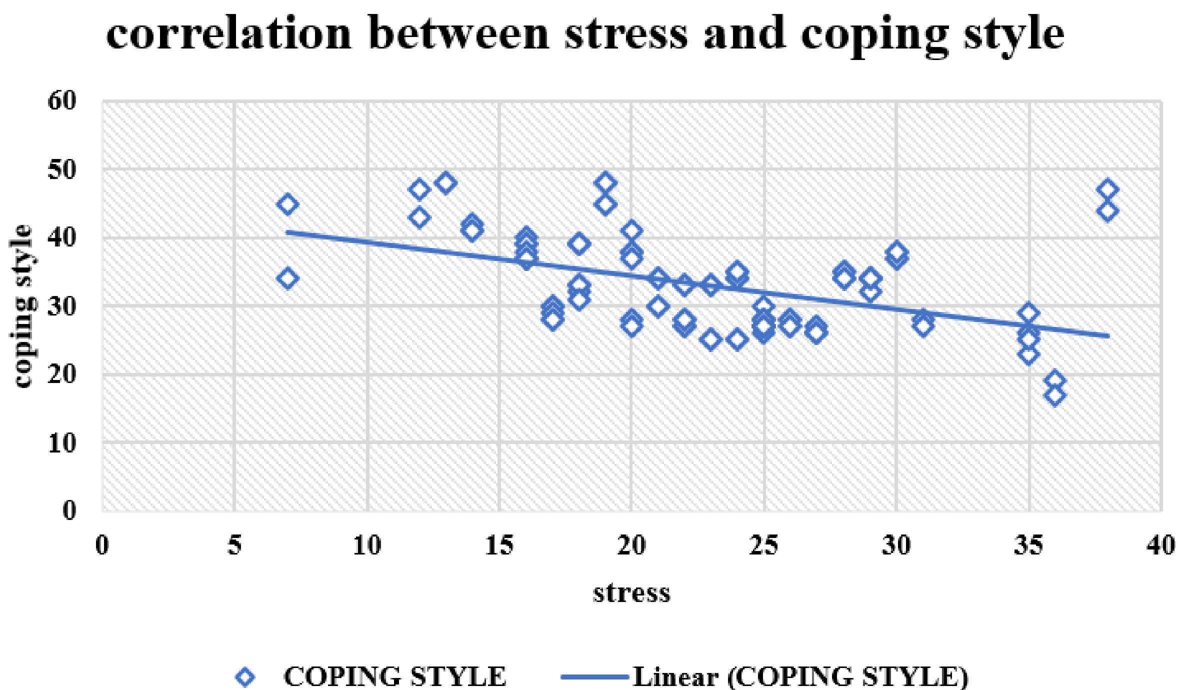
**Table no-1**
**Correlation between stress and coping style**

| VARIABLE | N | MEAN | SD | r | LEVEL OF SIGNIFICANCE |
| --- | --- | --- | --- | --- | --- |
| STRESS | 100 | 22.87 | 6.451 | -0.461 | 0.01** |
| COPING STYLE | | 33.01 | 6.870 | | |

$P > 0.01$ level of significance

Table 1 reveals the result of our first objective, which is to find out the relationship between the level of stress and coping style among the caregivers. We used correlation for this purpose. As a result, to our research, we found that there is a significant negative relationship between stress and the level of coping style of caregivers ($r = -0.461$). Our result led us to negative correlation, which means there is a relationship between two variables in which one variable increases as the other decreases, and vice versa. As the table shows the level of stress is lower than the coping style among the caregivers having us known that when coping style increases, the level of stress decreases.

**Figure 1**




The scatter plot in the above figure shows there is a negative correlation between stress and coping style among caregivers.

The figure above shows that there is a negative correlation between stress and coping style giving a complete detail of the level of stress and coping strategies among the caregivers and how their coping style increases when their stress level decreases hence negative correlation. After we have derived the result of our first objective, we split the stress score with the median getting high stress and low stress to help us move forward to our second objective that is to find out difference among high stressed and low stressed caregivers with respect to their coping style. For that we have used t- test, presented in table 2 below.

**Table no- 2**

Difference between high stressed and low stressed caregivers with respect to their coping style

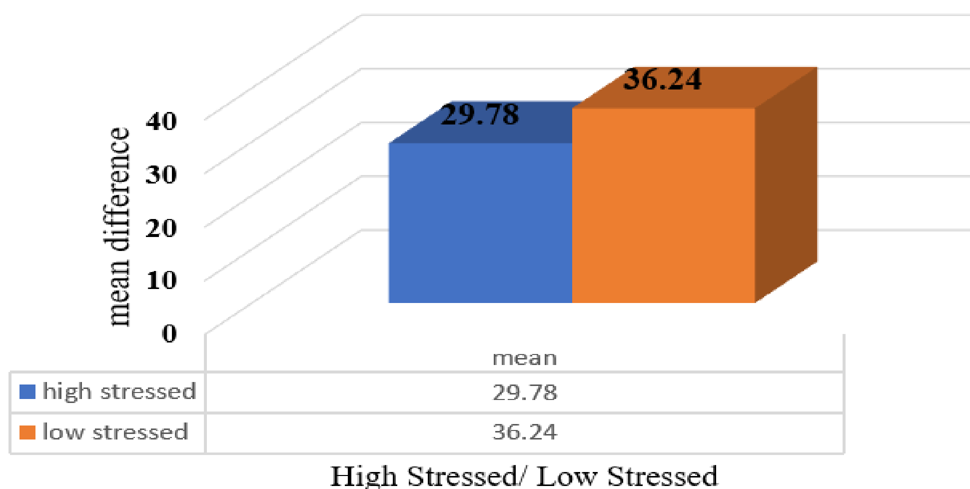
coping style

| VARIABLE | N | Mean | SD | t | Level of Significance |
|---|---|---|---|---|---|
| High stressed | 50 | 29.78 | 5.701 | -5.307 | .000** |
| Low stressed | 50 | 36.24 | 6.448 | | |

P > 0.000 level of significance

Table 2 reveals that there is a significant negative difference in sleep quality among caregivers with high coping style and caregivers with low coping style. The above result shows that high coping style caregivers have lesser stress level and high coping skills (5.701) and low coping style caregivers have higher stress level and lesser coping skills (6.448) compared to the higher coping style caregivers. Coping score is higher in high coping caregivers (5.701) in comparison to low stress caregivers (6.448) and the significant difference was found in both groups (p > 0.005).

**Figure 2**




The bar diagram above shows there is a difference between high stressed and low stressed caregivers with respect to their coping style.

## IV. Discussion

This section is organized around the research question posed in chapter III. In particular it relates the result and implication.

Major finding

1.There is a significant negative correlation between stress and coping style among caregivers. Which implies when the coping style increases, the stress level decreases and vice versa.

2.There is a significant difference among high stressed and low stressed caregivers with respect to their coping style.

3.Caregivers of patients with severe mental illness have higher level of stress and lower level of coping style than those of patients with mild mental conditions.

The caregivers are affected just as much as the patients because of their physical and emotional involvement with the patients, which causes the deterioration of their mental and physical health. Here in this research, we found there is a negative correlation between the stress and coping style among caregivers, which implies to the fact that when their coping style is sturdy and good their stress level is low and when their coping style is low their stress level is increased.

Table 1 reveals the result of our first objective, which is to find out the relationship between the level of stress and coping style among the caregivers. We used correlation for this purpose because correlation is a statistical measure that describes the size and direction of a relationship between two variables. Here we had taken 50 caregivers of mentally ill patients such as schizophrenia, Bipolar disorder, Substance abuse, Dhat syndrome, A.D.H.D, Depression, Anxiety etc. As a result, to our research, we found that there is a significant negative relationship between stress and the level of coping style of caregivers ($r = -0.445$). Our result led us to negative correlation, which means there is a relationship between two variables in which one variable increases as the other decreases, and vice versa. As the table shows the level of stress is lower than the coping style among the caregivers having us known that when coping style increases, the level of stress decreases. In our research the caregivers had greater coping strategies which helped them keep their stress level under control, which was particularly helpful for the patients, because when caregivers have good coping strategies that ultimately help the patient to deal with their condition as well. However, it could be said that caregivers of patients who have major psychological illness have less coping style and more stress level than the caregivers of patients with mild psychological condition. The figure1 showed that there is a negative correlation between stress and coping style giving a complete detail of the level of stress and coping strategies among the caregivers and how their coping style increases when their stress level decreases hence negative correlation.

After we have derived the result of our first objective, we split the stress score with the median getting high stress and low stress to help us move forward to our second objective that is to find out difference among

high stressed and low stressed caregivers with respect to their coping style for that we have used t-test, which is mentioned in the table 2.

Table 2 reveals that there is a significant negative difference in sleep quality among caregivers with high coping style and caregivers with low coping style. The above result shows that high coping style caregivers have lesser stress level and high coping skills (6.193) and low coping style caregivers have higher stress level and lesser coping skills (6.104) compared to the higher coping style caregivers. Coping score is higher in high coping caregivers (6.193) in comparison to low stress caregivers (6.104) and the significant difference was found in both groups ($p > 0.005$). The figure 2 shows that there is a significant difference among high stressed and low stressed caregivers in respect to their coping style.

## V. Conclusion

The objectives of the present piece of research were to find out the relationship between level of stress and coping style among caregivers and to find out the difference among high stressed and low stressed caregivers with respect to their coping style. The sample consisted of 50 caregivers of mentally ill patients from S.C.B. medical college and hospital, Cuttack, Odisha. The Perceived Stress Scale (PSS)by Cohen, Kamarck and Mermelstein (1983) and Coping Scale by Hamby, Grych and Banyard (2013) were used for the assessment. For the purpose of our first objective, we used correlation and as result we got negative correlation showing when the level of stress among caregivers increases the coping style decreases and vice versa. Here we reject null hypothesis(H0) and accept Alternative hypothesis(H1) However, for our second objective we used independent t-test and the result revealed significant difference among high and low stressed caregivers with respect to their coping style. Here we reject null hypothesis(H0) and accept Alternative hypothesis(H1). Caregivers with high coping strategies showed less level of stress thus good performance in their lives but caregivers with low coping strategies showed high level of stress thus affecting their own health conditions and daily life activities as well. It’s understood that taking care of patients who are our own gives us stress as it is not easy to see someone, we care about in a great deal of pain whether physically or mentally. Therefore, sessions of therapies or counselling that would help caregivers restore their abilities to perform well and to help developing their coping styles to deal with difficulties gets as equally important as taking care of the mentally ill patients.

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Padmaja Dash, et. al. “Stress and Coping Style among Caregivers of Mentally Ill Patients.” *IOSR Journal of Humanities and Social Science (IOSR-JHSS),* 27(09), 2022, pp. 38-44.