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Perceived Stress And Coping Styles Among Caregivers Of Psychiatric Patients In A Tertiary Care Psychiatric Hospital

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Abstract:
Background: *Caregivers of psychiatric patients often experience substantial psychological burden due to the chronic nature of mental illness, caregiving responsibilities, financial strain, and social challenges. High levels of perceived stress may influence the coping strategies adopted by caregivers, thereby affecting their psychological well-being and caregiving effectiveness.*
Objectives: *The primary objective of the study was to assess perceived stress levels and coping styles among caregivers of psychiatric patients. The secondary objectives were to examine the relationship between perceived stress and coping styles and to determine the association between selected demographic and clinical variables with perceived stress and coping styles among caregivers.*
Methods: *A cross-sectional descriptive study was conducted among 135 caregivers of psychiatric patients admitted to a tertiary care psychiatric hospital in South India. Participants were selected using convenient sampling. Data were collected using a socio-demographic and clinical proforma, the 10-item Perceived Stress Scale (PSS), and the Brief COPE inventory. Data were analyzed using descriptive and inferential statistics with SPSS version 17. Pearson correlation and chi-square tests were used to assess the relationship between perceived stress and coping strategies.*
Results: *The findings revealed that the majority of caregivers experienced moderate (55.6%) to high (31.9%) levels of perceived stress. Frequently used adaptive coping strategies included active coping (69.6%), emotional support (73.3%), planning (74%), acceptance (77%), religion (73.3%), and positive reframing (75.5%). Maladaptive coping strategies such as self-distraction (65.2%), behavioral disengagement (60.8%), and substance-related coping behaviors (75.6%) were also observed among participants. Perceived stress demonstrated strong positive correlations with planning ($r = 0.595$, $p = 0.001$) and religion ($r = 0.598$, $p = 0.001$), while moderate positive correlations were observed with active coping, venting, and self-blame. Humor showed a moderate negative correlation with perceived stress ($r = -0.468$, $p = 0.001$).*
Conclusion: *Caregivers of psychiatric patients experience considerable levels of stress and utilize both adaptive and maladaptive coping strategies. Early identification of caregiver stress and strengthening adaptive coping mechanisms through psychosocial interventions may improve caregiver well-being and the quality of care provided to psychiatric patients.*

Keywords: *perceived stress, coping styles, caregivers, psychiatric patients, mental illness, Brief COPE, psychiatric nursing*

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I. Introduction:

Mental health and mental illness exist on a continuum, where individuals may experience varying levels of psychological well-being and vulnerability to mental illness. Mental illness often imposes significant emotional, social, and financial challenges on both patients and their caregivers. Caregivers of psychiatric patients frequently experience high levels of stress, particularly during periods of hospitalization and symptom exacerbation (1, 2). This imposed changes in the life of the patient and their caregiver can be very distressing and stressful. Caregivers of psychiatric patients usually experience high levels of stress (2), especially during the hospital stay of the patient.

Perceived stress has emerged as a significant psychological construct influencing physical, emotional, and social well-being across populations. Stress is broadly understood as the body's response to demands or challenges that disrupt an individual's equilibrium. However, individuals differ considerably in the way they interpret and respond to stressful situations. Lazarus and Folkman conceptualized perceived stress as the degree to which situations in one's life are appraised as unpredictable, uncontrollable, and overwhelming (3,4). Unlike

objective stressful events, perceived stress reflects an individual's subjective evaluation of stress and their perceived ability to cope with environmental demands.

In recent years, stress-related psychological problems have increased considerably due to rapid social, occupational, academic, and economic changes. High levels of perceived stress have been associated with various adverse outcomes, including anxiety, depression, impaired concentration, sleep disturbances, reduced quality of life, and poor physical health (5). Among healthcare populations and caregivers, stress may also negatively affect caregiving quality, interpersonal relationships, and occupational functioning.

Coping styles play a significant role in influencing how individuals respond to and manage stressful experiences. Coping refers to the cognitive and behavioral efforts employed to manage internal and external demands that are appraised as taxing or exceeding an individual's resources (3). Coping styles are generally categorized into problem-focused coping, emotion-focused coping, and avoidant coping. Problem-focused coping aims to address the source of stress directly, whereas emotion-focused coping seeks to regulate emotional responses to stressors. Avoidant coping involves disengagement or denial and is often associated with poorer psychological outcomes.

Research indicates that the effectiveness of coping styles varies depending on the nature of the stressor and the individual's personal and social resources. Adaptive coping strategies, such as active problem-solving, positive reframing, and seeking social support, have been associated with lower stress levels and better psychological adjustment (6). Conversely, maladaptive coping strategies, including substance use, behavioral disengagement, and denial, are linked with increased psychological distress and reduced resilience.

Several studies have demonstrated a significant relationship between perceived stress and coping styles across different populations, including students, healthcare workers, caregivers, and patients with chronic illnesses. Individuals experiencing high perceived stress are more likely to adopt maladaptive coping mechanisms, which may further exacerbate stress and negatively affect mental health outcomes (7). Understanding the relationship between stress perceptions and coping strategies is therefore essential for developing effective psychological interventions and stress management programs.

In the Indian context, sociocultural expectations, family responsibilities, academic pressures, and economic challenges may further influence stress perception and coping behaviors. Despite increasing recognition of mental health concerns, access to coping resources and formal stress management support remains limited in many settings. Exploring perceived stress and coping styles can provide valuable insights for mental health professionals, educators, and policymakers in designing targeted interventions to enhance psychological well-being.

Given the growing burden of stress-related problems and the importance of coping mechanisms in mental health outcomes, the present study aims to assess perceived stress and coping styles among the study population and to examine the relationship between these variables. Understanding these factors may contribute to the development of targeted psychosocial interventions and effective mental health promotion strategies for caregivers of psychiatric patients.

II. Objective Of The Study:

The primary objective of the study was to assess the perceived stress levels and coping styles among caregivers of psychiatric patients. The secondary objectives were to examine the relationship between perceived stress and coping styles and to determine the association between selected demographic and clinical variables with perceived stress and coping styles among caregivers of psychiatric patients.

III. Materials & Methods:

Study design:

A cross-sectional descriptive study was conducted among caregivers of psychiatric patients admitted to a tertiary care psychiatric hospital in South India.

Sample size:

The sample size was calculated using a 95% confidence interval and 7% precision, resulting in a final sample size of 135 participants.

Data collection tools:

The data collection tools included:

1. A socio-demographic and clinical proforma,
2. The 10-item Perceived Stress Scale (PSS) developed by Cohen et al., which uses a 5-point Likert response format, and
3. The Brief COPE inventory consisting of 28 items assessing 14 coping subscales.

Method of data collection:

Participants were informed about the purpose of the study, and written informed consent was obtained prior to data collection. Participation in the study was voluntary, and anonymity and confidentiality were maintained throughout the study. Ethical clearance was obtained from the Institutional Ethics Committee.

Data analysis:

Data were analyzed using SPSS version 17. Descriptive statistics were used to summarize perceived stress levels and coping styles among participants. Pearson correlation analysis was performed to examine the relationship between perceived stress and coping styles. Chi-square tests were used to determine the association between selected demographic and clinical variables with perceived stress and coping styles.

IV. Results:

The study findings revealed that the majority of caregivers were female (60%), with a mean age of 46.95 ± 13.73 years. Nearly half of the participants were parents of the patients (42.2%), and most belonged to the Hindu religion (68.1%). A majority of caregivers (60.7%) and patients (72.6%) had no history of medical illness. Most psychiatric patients had socio-occupational dysfunction (70.4%), were on regular treatment (69.6%), and had been institutionalized one to three times (74.1%). The majority of participants reported no family history of psychiatric illness (85.9%). Other demographic and clinical characteristics are presented in Table 1.

Table 1: Distribution of participants based on their demographic and clinical variables

Demographic and clinical variables	Frequency (N)	Percentage (%)
Education of relative		
Illiterate	16	11.9
Schooling	59	43.7
Intermediate or diploma	15	11.1
Graduate & above	45	33.3
Total	135	100
Occupation of relative		
Unemployed	56	41.5
Unskilled worker	18	13.3
Semi-worker	26	19.3
Clerical/shop keeper/farmer	26	19.3
Semi-professional	9	6.7
Total	135	100
Family debt		
Present	66	48.9
Absent	69	51.1
Total	135	100
Age of onset of illness		
Less than 20 years	43	31.9
20 to 30 years	66	48.9
30 to 50 years	26	19.3
Total	135	100
Duration of illness		
1 to 2 years	34	25.2
3 to 10 years	49	36.3
11 to 15 years	19	14.1
More than 15 years	33	24.4
Total	135	100

General well-being of caregivers

Most caregivers reported difficulty in feeling calm and relaxed (65.9%) and experienced sleep disturbances (66.7%). However, the majority were able to concentrate on their daily activities (Figure 1).

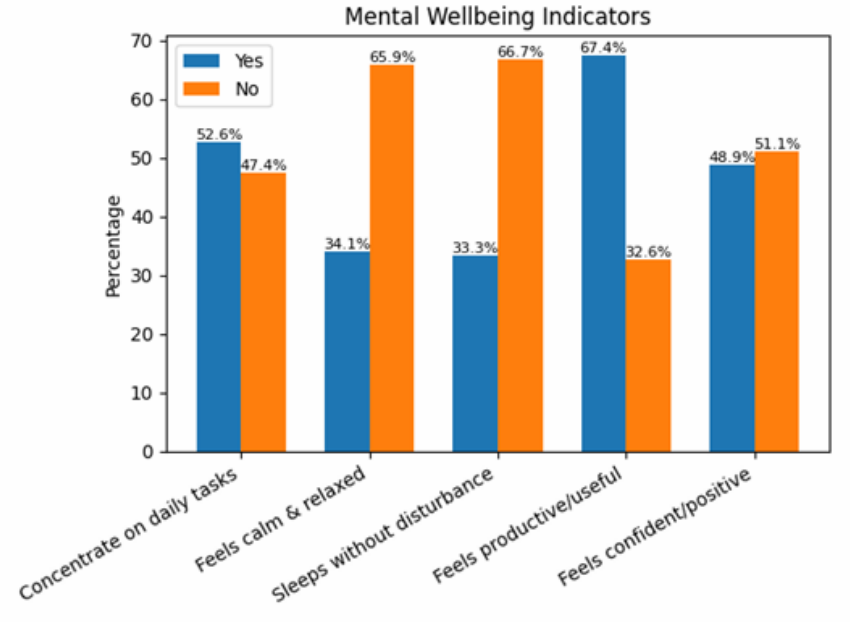

Figure 1. Distribution of general well-being among caregivers

Ability to meet household needs by caregivers

A majority of caregivers reported difficulty in meeting household needs related to food, shelter, medical care, and financial stability due to the burden of caregiving. Approximately 61.5% of caregivers were unable to meet family needs, while 84.4% reported difficulty purchasing food during the previous month because of treatment-related expenses (Figure 2).

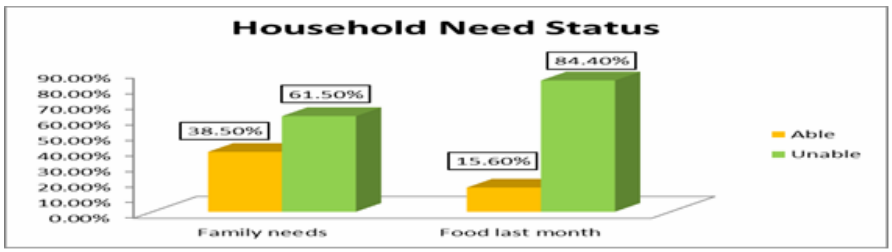

Figure 2. Distribution of caregivers' ability to meet household needs

Table 2a: Distribution of Perceived stress scores among caregivers

Perceived stress	Frequency (n %)
Low	17 (12.6)
Moderate	75 (55.6)
High	43 (31.9)
Total	**135 (100)**

The majority of caregivers experienced moderate (55.6%) to high (31.9%) levels of perceived stress (Table 2a).

Table 2b: Frequency distribution of coping strategies n=135

COPE Subscale	Rarely/Not used (n %)	Sometimes (n %)	Often (n %)	Very frequently (n %)
Self-distraction	23 (17.0)	24 (17.8)	57 (42.2)	31 (23.0)
Active coping	10 (7.4)	31 (23.0)	38 (28.1)	56 (41.5)
Denial	42 (31.1)	22 (16.3)	65 (48.1)	6 (4.4)
Substance use	11 (8.1)	22 (16.3)	90 (66.7)	12 (8.9)
Emotional support	6 (4.4)	30 (22.2)	72 (53.3)	27 (20.0)
Instrumental support	17 (12.6)	24 (17.8)	63 (46.7)	31 (23)
Behavioral disengagement	31 (23)	22 (16.3)	48 (35.6)	34 (25.2)
Planning	10 (7.4)	25 (18.5)	38 (28.1)	62 (45.9)
Venting	26 (19.3)	17 (12.6)	68 (50.4)	24 (17.8)
Humor	68 (50.4)	16 (11.9)	29 (21.5)	22 (16.3)
Acceptance	12 (8.9)	19 (14.1)	59 (43.7)	45 (33.3)
Religion	12 (8.9)	24 (17.8)	67 (49.6)	32 (23.7)

Self-blame	42 (31.1)	16 (11.9)	53 (39.3)	24 (17.8)
Positive-reframing	19 (14.1)	14 (10.4)	50 (37)	52 (38.5)

Caregivers utilized a combination of adaptive and maladaptive coping strategies. Frequently used adaptive coping strategies included active coping (69.6%), emotional support (73.3%), instrumental support (69.7%), planning (74%), acceptance (77%), religion (73.3%), and positive reframing (75.5%). Maladaptive coping strategies such as self-distraction (65.2%), behavioral disengagement (60.8%), and substance-related coping behaviors (75.6%) were also observed among participants (Table 2b).

Table 3: Association between Perceived Stress Levels and Selected Coping Strategies (n=135)

Coping Strategy / PSS Level	Low n (%)	Moderate n (%)	High n (%)	Total	p-value
Self-distraction					
Rarely/Not used	0 (0.0)	10 (7.4)	13 (9.6)	23 (17)	0.001*
Sometimes	6 (4.4)	18 (13.3)	0 (0.0)	24 (17.8)	
Often	4 (3)	31 (23)	22 (16.3)	57 (42.2)	
Very frequently	7 (5.2)	16 (11.9)	8 (5.9)	31 (23)	
Active coping					
Rarely/Not used	4 (3)	5 (3.7)	1 (0.7)	10 (7.4)	0.001*
Sometimes	3 (2.2)	19 (14.1)	9 (6.7)	31 (23)	
Often	10 (7.4)	14 (10.4)	14 (10.4)	38 (28.1)	
Very frequently	0 (0.0)	37 (27.4)	19 (14.1)	56 (41.5)	
Planning					
Rarely/Not used	4 (23.5)	6 (8.0)	0 (0.0)	10	0.001*
Sometimes	9 (52.9)	16 (21.3)	0 (0.0)	25	
Often	4 (23.5)	29 (38.7)	5 (11.6)	38	
Very frequently	0 (0.0)	24 (32.0)	38 (88.4)	62	
Instrumental-coping					
Rarely/Not used	4 (3)	13 (9.6)	0 (0.0)	17 (12.6)	0.001*
Sometimes	3 (2.2)	13 (9.6)	8 (5.9)	24 (17.8)	
Often	6 (4.4)	26 (19.3)	31 (23)	63 (46.7)	
Very frequently	4 (3)	23 (17)	4 (3)	31 (23)	
Venting					
Rarely/Not used	6 (4.4)	20 (14.8)	0 (0.0)	26 (19.3)	0.001*
Sometimes	4 (3)	13 (9.6)	0 (0.0)	17 (12.6)	
Often	7 (5.2)	35 (25.9)	26 (19.3)	68 (50.4)	
Very frequently	0 (0.0)	7 (5.2)	17 (12.6)	24 (17.8)	
Religion					
Rarely/Not used	7 (5.2)	5 (3.7)	0 (0.0)	12 (8.9)	0.001*
Sometimes	10 (7.4)	13 (9.6)	1 (0.7)	24 (17.8)	
Often	0 (0.0)	48 (35.6)	19 (14.1)	67 (49.6)	
Very frequently	0 (0.0)	9 (6.7)	23 (17)	32 (23.7)	
Positive-reframing					
Rarely/Not used	0 (0.0)	9 (6.7)	10 (7.4)	19 (14.1)	0.001*
Sometimes	6 (4.4)	4 (3)	4 (3)	14 (10.4)	
Often	11 (8.1)	29 (21.5)	10 (7.4)	50 (37)	
Very frequently	0 (0.0)	33 (24.4)	19 (14.1)	52 (38.5)	
Self-blame					
Rarely/Not used	10 (7.4)	32 (23.7)	0 (0.0)	42 (31.1)	0.001*
Sometimes	7 (5.2)	5 (3.7)	4 (3)	16 (11.9)	
Often	0 (0.0)	18 (13.3)	35 (25.9)	53 (39.3)	
Very frequently	0 (0.0)	20 (14.8)	4 (3)	24 (17.8)	
Denial					
Rarely/Not used	10 (7.4)	24 (17.8)	8 (5.9)	42 (31.1)	0.007*
Sometimes	3 (2.2)	8 (5.9)	11 (8.1)	22 (16.3)	
Often	4 (3)	37 (27.4)	24 (17.8)	65 (48.1)	
Very frequently	0 (0.0)	6 (4.4)	0 (0.0)	6 (4.4)	
Substance-use					
Rarely/Not used	4 (3)	6 (4.4)	1 (0.7)	11 (8.1)	0.001*
Sometimes	6 (4.4)	12 (8.9)	4 (3)	22 (16.3)	
Often	7 (5.2)	45 (33.3)	38 (28.1)	90 (66.7)	
Very frequently	0 (0.0)	12 (8.9)	0 (0.0)	12 (8.9)	
Behavioral-disengagement					
Rarely/Not used	10 (7.4)	21 (15.6)	0 (0.0)	31 (23)	0.001*
Sometimes	0 (0.0)	12 (8.9)	10 (7.4)	22 (16.3)	
Often	4 (3)	26 (19.3)	18 (13.3)	48 (35.6)	
Very frequently	3 (2.2)	16 (11.9)	15 (11.1)	34 (25.2)	

Table 3 demonstrates significant differences in coping strategies across stress levels. Caregivers with high perceived stress reported greater use of planning, religion, venting, denial, self-blame, behavioral disengagement, and substance-related coping behaviors. All observed associations were statistically significant ($p < 0.01$).

Table 4: Correlation between perceived stress and coping strategies

Coping styles/Perceived stress	r value	p value
Self-distraction	-0.186	0.031*
Active-coping	0.375	0.001**
Behavioral-disengagement	0.245	0.004**
Venting	0.334	0.001**
Planning	0.595	0.001**
Humor	-0.468	0.001**
Acceptance	0.194	0.024*
Religion	0.598	0.001**
Self-blame	0.457	0.001**

Pearson correlation analysis revealed significant positive correlations between perceived stress and active coping ($r = 0.375$, $p = 0.001$), venting ($r = 0.334$, $p = 0.001$), planning ($r = 0.595$, $p = 0.001$), religion ($r = 0.598$, $p = 0.001$), self-blame ($r = 0.457$, $p = 0.001$), behavioral disengagement ($r = 0.245$, $p = 0.004$), and acceptance ($r = 0.194$, $p = 0.024$). Humor demonstrated a moderate negative correlation with perceived stress ($r = -0.468$, $p = 0.001$), while self-distraction showed a weak negative correlation ($r = -0.186$, $p = 0.031$) (Table 4).

V. Discussion:

The present study explored perceived stress and coping styles among caregivers of psychiatric patients admitted to a tertiary care psychiatric hospital. The findings revealed that a majority of caregivers experienced moderate to high levels of perceived stress, indicating the substantial psychological burden associated with psychiatric caregiving. The study also demonstrated that caregivers utilized a combination of adaptive and maladaptive coping strategies to manage caregiving-related stress.

In the present study, more than half of the caregivers experienced moderate stress (55.6%), while nearly one-third reported high stress (31.9%). These findings are consistent with previous studies reporting elevated stress levels among caregivers of individuals with mental illness due to prolonged caregiving responsibilities, emotional burden, social stigma, and financial strain (1,2). Psychiatric caregiving often requires continuous supervision, management of unpredictable patient behaviors, and support for socio-occupational dysfunction, which can significantly affect caregivers' psychological well-being.

The current study identified several factors contributing to caregiver burden. A considerable proportion of caregivers reported inability to meet household needs (food, shelter, medical needs and financial stability) and difficulty purchasing food due to expenses related to patient care. These findings emphasize the significant financial burden associated with psychiatric illness and caregiving responsibilities are supported by earlier literature indicating that economic strain is a major determinant of caregiver stress (2). Additionally, the majority of patients had socio-occupational dysfunction and repeated institutionalizations, which may further increase caregiving demands and emotional exhaustion.

Regarding coping styles, caregivers frequently used adaptive coping mechanisms such as active coping, planning, emotional support, acceptance, religion, and positive reframing. These findings suggest that caregivers attempt to manage caregiving challenges through constructive behavioral and emotional strategies. Similar findings were reported by Carver et al., who emphasized that problem-focused coping and positive reframing are associated with better psychological adjustment and resilience (6). The high utilization of religious coping observed in the study may reflect the sociocultural context of India, where spirituality and religious practices are commonly used to manage stress and adversity.

However, the study also identified the use of maladaptive coping strategies such as self-distraction, behavioral disengagement, denial, and substance-related coping behaviors, which have been associated with poorer psychological outcomes and increased emotional distress (7). Particularly, the frequent use of substance-related coping among caregivers may indicate emotional exhaustion and inadequate psychosocial support systems. The coexistence of adaptive and maladaptive coping strategies suggests that caregivers may fluctuate between constructive coping efforts and emotional withdrawal depending on the intensity of stress experienced.

The study demonstrated significant associations between perceived stress and several coping strategies. High stress levels were significantly associated with increased use of planning, religion, venting, denial, self-blame, behavioral disengagement, and substance use. Interestingly, planning and active coping showed positive correlations with stress levels. This finding may suggest that caregivers experiencing higher levels of stress actively attempt to regain control over stressful situations through problem-solving approaches and coping

efforts. Similar observations have been reported in stress and coping literature, where increased stress may trigger greater coping efforts (4).

Religion demonstrated one of the strongest positive correlations with perceived stress. In the Indian sociocultural setting, religious practices often serve as emotional support systems and sources of hope during periods of crisis. Previous studies have similarly identified religion as a commonly utilized coping strategy among caregivers of chronically ill patients (1).

The negative correlation between humor and perceived stress suggests that humor may function as a protective coping mechanism that reduces emotional distress and promotes resilience during stressful situations (7). Humor has been recognized as an adaptive coping strategy that promotes emotional regulation and resilience in stressful situations (7).

The findings of the present study have important implications for psychiatric nursing practice. Psychiatric nurses play a key role in identifying caregiver stress, assessing coping patterns, and providing psychosocial support. Psycho-education, caregiver support groups, counseling services, and stress management programs may help caregivers develop healthier coping strategies and reduce maladaptive coping behaviors. Early screening for caregiver distress is essential to prevent long-term psychological complications and to improve the quality of care provided to psychiatric patients.

The study has certain limitations. Since the study employed a cross-sectional design, causal relationships between stress and coping styles could not be established. The use of self-reported instruments may have introduced response bias. In addition, the study was conducted in a single tertiary care center, which may limit the generalizability of findings.

Despite these limitations, the study provides important insights into the stress experiences and coping behaviors of caregivers of psychiatric patients within the Indian context. Future research may explore longitudinal changes in caregiver stress and evaluate the effectiveness of targeted psychosocial interventions aimed at improving caregiver well-being and coping outcomes.

Conflict Of Interest:

The authors have no conflicts of interest regarding this investigation.

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