ASSESSMENTOF THE LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA AT A SELECTED SETTING IN CHENNAI

Dissertation submitted to

THE TAMIL NADU DR.M.G.R.MEDICAL UNIVERSITY

CHENNAI

In partial fulfilment of requirement for the degree of

MASTER OF SCIENCE IN NURSING

OCTOBER 2015

A STUDY TO ASSESS THE LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA AT A SELECTED SETTING IN CHENNAI

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LIST OF ABBREVIATIONS

BAS	Burden Assessment Schedule
BPRS	Brief Psychiatric Rating Scale
DALYs	Disability Adjusted Life Years
DSM-IV-TR	Diagnostic Statistical Manual-4th -Text Revision
ICD	International Classification of Diseases
OPD	Out Patient Department
QOL	Quality of Living
SCARF	Schizophrenia Research Foundation
WHO	World Health Organization
YLDs	Years Lived with Disability
YLLs	Years of Life Lost
ZBS	Zarit Burden Scale

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ABSTRACT

ABSTRACT

This study was performed to assess the level of stress, family burden and coping among family care providers of clients with schizophrenia.

The objectives of the study were:

1. To assess the level of stress, family burden and coping among the family care providers of client with schizophrenia
2. To correlate the level of stress, family burden and coping of the family care providers of client with schizophrenia
3. To associate the level of stress, family burden and coping with the selected demographic variables of the family care providers of client with schizophrenia.

The research methodology:

A non-experimental descriptive design was used in the study. The study was conducted at Schizophrenia Research Foundation, Chennai. After a formal permission from SCARF and consent from the samples, data was collected. A non-probability purposive sampling technique was used. Tools used were modified perceived stress assessment scale, modified family burden scale and modified COPE scale.

Major findings of the study:

The findings indicate that care givers suffer from mild (86%) to moderate(14%) level of stress and moderate (75%) level of family burden, majority of them have inadequate coping (88%).

A weak negative correlation between stress and coping (r=-0.051) and a weak positive correlation between stress and family burden (r=0.065) and a weak positive correlation between family burden and coping (r=0.088) were found.

The findings also indicated that there was no statistically significant association found between the level of stress, family burden and coping of family care providers with the demographic variables.

The study concluded that care providers suffer from mild to moderate level of stress and moderate level of family burden, majority of them have inadequate coping and none of them had adequate coping.

INTRODUCTION

CHAPTER – 1

INTRODUCTION

"They say when you talk to God, "it's prayer", but when God talks to you, it's schizophrenia."

- Fox Mulder

According to World Health Organization (WHO) report 2001, bipolar affective disorder 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 these patients used to be confined to the walls of the mental hospitals. With the advances in the psychopharmacology and growing emphasis on outpatient treatment in psychiatry, most patients with these disorders are being looked after by their families thus deinstitutionalization became possible.

However, the frequent relapse and remission directed attention to the psychosocial factors that were postulated as influencing the course of illness. The idea that the family interaction and communication pattern influence the development of psychopathology of the psychiatric disorder, so families became the primary agents of the care with deinstitutionalization. Mental disorders have profound effect on health and well-being not only of individuals with the disorder but also of their families and entire community. The impacts are seen having effect associated with personal income, inability to work and productive contribution to the national economy. The most reported burden of the family members are on constraints, social activities, financial difficulties, problems in work place.

Emotional distress affects the ability to cope with stress as well as productivity and thus the impact of the mental illness is enormous. Other negative implications among the family members include alcohol and substance abuse, delinquent behaviour and impaired quality of life. Interest is growing in the field of mental health around the families who care for their mentally ill members. The interest generated has been due to factors such as deinstitutionalization of the mentally ill, increasing professional recognition of the family's burden in caring for the mentally ill members and growing self-help movement of the families of mentally ill.

1.1 BACKGROUND OF THE STUDY

Mental and behavioural disorders account for about 12% of the global burden of disease. The World Health Report 2013 has drawn attention to the fact that of nearly 45 crores people estimated to be suffering from mental and behavioural disorder globally. WHO 2011 report states by 2020, 15% of the Disability Adjusted Life Years (DALYs) lost would be due to mental and behaviour disorders, up from 10% in 2000 to 12% in 2010 and that about 24 million people suffer from schizophrenia and 21 million from depression.

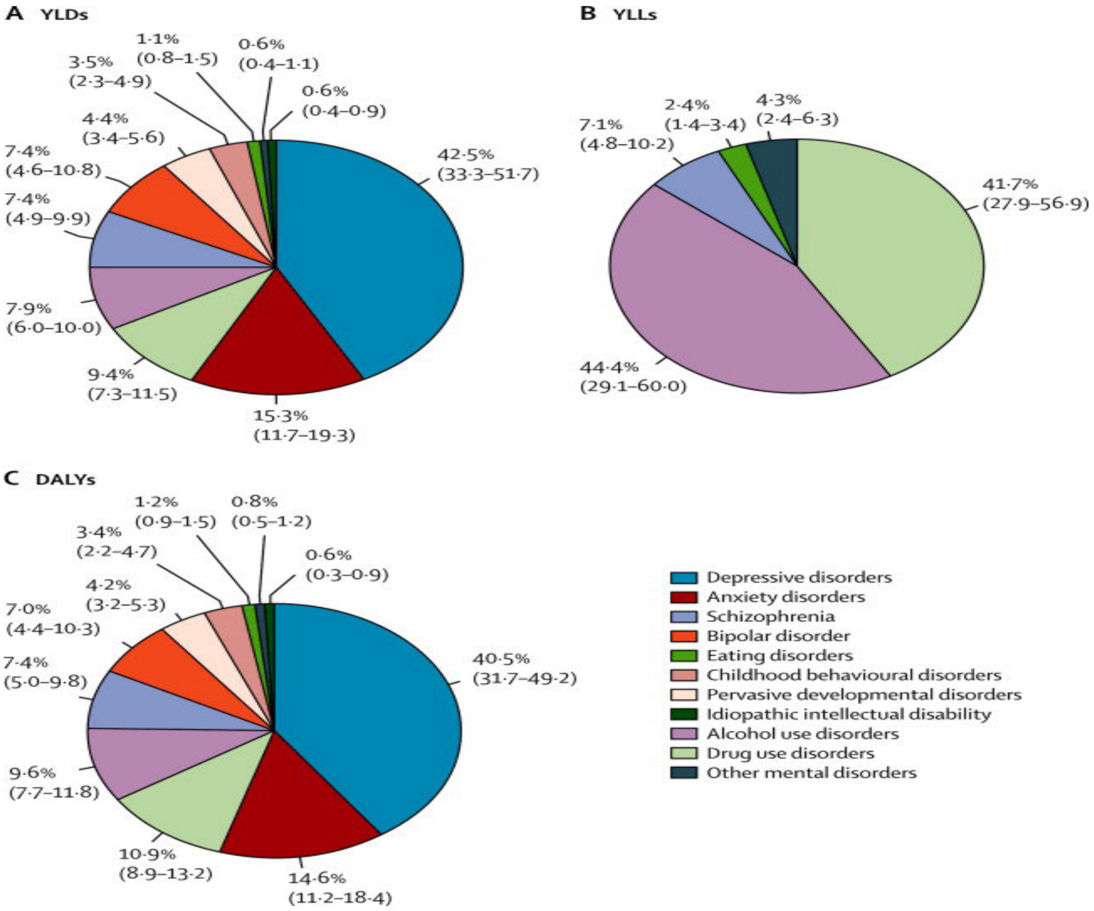

Figure 1.1.1: Global burden of mental health disorders and substance use disorders

Source: Global Burden of Disease, 2010

Global Burden of Diseases, Injuries, and Risk Factors Study (2010) estimated the burden of disease attributable to mental and substance use disorders in terms of disability-adjusted life years (DALYs) accounted 7.4% people with schizophrenia, years of life lost to premature mortality (YLLs) accounted 7.1% people with schizophrenia, and years lived with disability (YLDs) accounted 7.4% people with schizophrenia.

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.

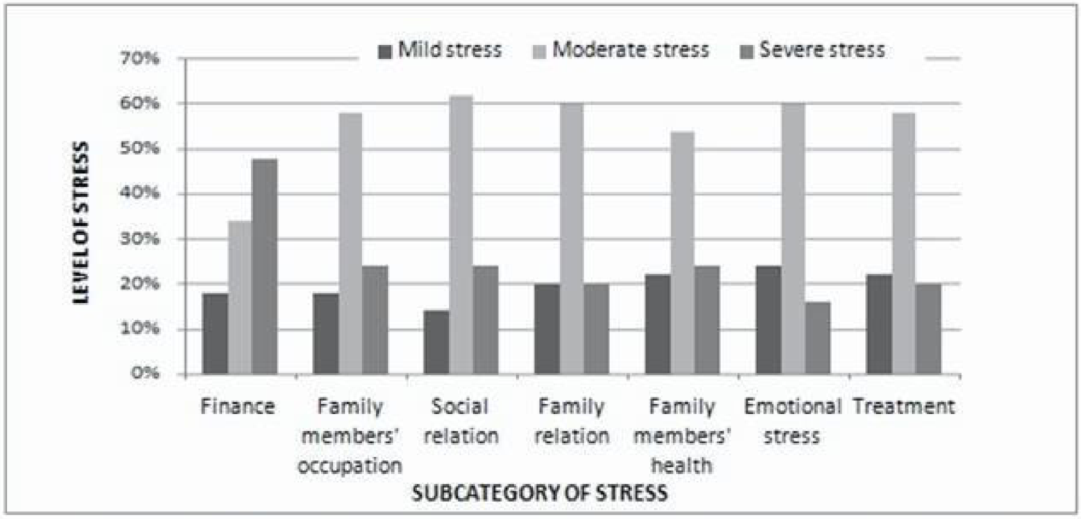

Figure 1.1.2: Distribution of family members by subcategory of stress and level of stress

Source: Indian Journal of Psychiatry

Srinivastav (2005) stated 62% of relatives of schizophrenia with regard to social relation suffer from moderate stress, with regard to family relation 60% suffer from moderate stress with respect to finance 48% suffer from severe stress.

WHO Report (2008) stated that India with a population of more than one billion is home to one sixth of the world's mentally ill. Psychiatrists estimate that about two percent of Indians suffer from mental illnesses i.e. a staggering 20 million people out of a population of one billion. Schizophrenia ranks among the top 10 causes of disability in developed countries worldwide. The prevalence rate for schizophrenia is approximately 1.1% of the population over the age of 18 i.e. 51 million people worldwide suffer from schizophrenia, including 6 to 12 million people in China (a rough estimate based on the population), 4.3 to 8.7 million people in India, 2.2 million people in U.S.A., 285,000 people in Australia, over 280,000 people in Canada and over 250,000 diagnosed cases in Britain. Schizophrenia occurs in all societies regardless of class, colour, religion and culture. However there are some variations in terms of incidence and outcomes for different groups of people.

WHO (2008) stated that the number of people who will be diagnosed as having schizophrenia in a year is about one in 4,000, so about 1.5 million people will be diagnosed with schizophrenia worldwide. About 100,000 people in the United States are diagnosed with schizophrenia. Schizophrenia is a devastating disorder for most people who are afflicted and very costly for families and society. The overall cost of schizophrenia in the U.S.A. in 2012 was estimated to be $62.7 billion, with $22.8 billion excess direct health care cost ($7.0 billion outpatient, $5.0 billion drugs, $2.8 billion inpatient, $8.0 billion long-term care). Schizophrenia is a severe form of mental illness that affects about 7 per 1,000 of the adult population, most of them between the ages of 15 and 35 years.

Fazal et al (2008) stated that coping mechanisms are expending conscious effort to solve personal and interpersonal problem and seeking to master, minimize or tolerate stress and conflict. Care givers used various types of coping strategies to reduce these symptoms, both in problem and emotional focused components. Most coping strategies used by care givers were self-controlling, positive appraisal and escape avoidance. Two most common type of coping mechanism used are psychological coping strategies (cognitive, behavioural and emotional) and social coping strategies (religious, social and professional support) used by caregivers. It is important to understand the coping experience of family and caregivers. It is important to develop effective coping intervention strategies that help careers cope with the stress and strain of caring for a family member with schizophrenia.

Chien et al (2007) stated that numerous physical and psychological health problems ascend such as depression, strain and dissatisfaction with life as well. Extent of burden influences by various factors as age of caregivers, relationship with patient, employment, lack of resources, financial support and education level, and other commitment. Due to long term care of client, caregivers experiences burden that leads to negative consequences. Caregivers of individuals with schizophrenia have received significant attention in the past few years. A couple of decades ago, hospitals and psychiatric institutions were incharge of caring for client with schizophrenia. However this role is shifted and nowadays this role is performed by one or more relatives of the client which has led to profound psychosocial, physical and financial burden on families and patients.

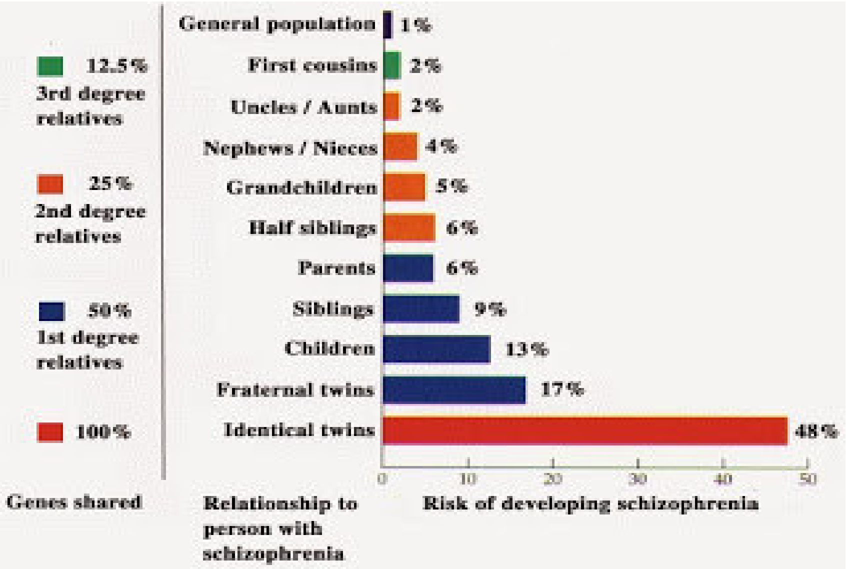

Figure 1.1.3: Statistical Genomics

Source: The dark arts of statistical genomics, Kevin Mitchell, November 7, 2013

As can be seen from the figure above, schizophrenia definitely has a very significant genetic component. Third degree relative with schizophrenia are twice as likely to develop schizophrenia as those in the general population. Second degree relatives have a several-fold higher incidence of schizophrenia than the general population, and first degree relatives have an incidence of schizophrenia in an order of magnitude higher than the general population.

Thara (2005) in a survey report of Schizophrenia Society in Canada revealed that most of the caregivers experienced their life had steadily declined since they started care giving to client having schizophrenia. Caregiver's life is affected because of lack of social support, family routine, family functioning with family and friends. In developing countries, most of the patients with schizophrenia live with their families due to inadequate awareness and health care services. This illness has impact on family in various ways. Among them, the human and economic burdens are significant. Caring of a client with schizophrenia leads to considerable amount of burden among caregivers. Schizophrenia not only affects the patient's life but also constitute a significant burden for their families. When a person develops schizophrenia, parents usually experience feeling of anger, anxiety, sadness, fear and frustration which should be considered in the integral treatment of patients. Most of the caregivers felt care giving had negative impact on their daily living.

According to WHO Report (2003) Schizophrenia is a severe mental disorder and about 26 million people are affected by schizophrenia within the respective age group of 15-35 years. It represents 1.3% of disability life years over all and the fourth leading cause of disability in the developed world and 90% of populations, are untreated in developing countries, it is estimated that about 40-90% of patients with schizophrenia live with their families. In Canada, around one to two thirds of persons with schizophrenia live with their family members. Family caregivers are often the primary caregivers of people with mental disorder. It is estimated that one in four families has atleast one member currently suffering from mental problems.

1.2 NEED FOR THE STUDY

Schizophrenia is a debilitating mental illness that has a significant impact not only in the client but also in the entire family. Caregivers role assumes almost the totality of the clients care. This responsibility exposes caregivers to an intense burden with negative consequences for them and the rest of the family system. Schizophrenia is a serious mental disorder that has a dramatic impact not only in patients suffering from it but in their families as well.

Due to the move from traditional institutional care to community care of psychiatric patients, relatives have become the most important caregivers for adults with major psychiatric disorders. The course of the disorder is also highly associated with the patient's psychosocial factors and home atmosphere. Muela and Godoy (2001) established that there is "something" in family interaction that seems to cause a patient relapse, and it seems to influence the course of the disease rather than the origin of it.

Kumar et al (2008) conducted a study to assess prevalence and pattern of schizophrenia in India. A community based cross- sectional study was done to assess prevalence and pattern of schizophrenia. One thousand subjects were randomly selected from four villages in Karnataka. Disability was assessed by Indian Disability Evaluation and Assessment Scale [IDEAS]. The prevalence of schizophrenia was found to be 2.3%. The prevalence was higher among females (3.1%) than among males (1.5%). The prevalence was higher among elderly (3%) and illiterates (34%). There was a negative association between literacy and prevalence of schizophrenia

Biegel et al (2007) stated that the family experiences chronic grief associated with loss of a relative to never-ending illness and also with the day to day demands of living with the mentally ill person. In consequences to the long term effects of the stress associated with care giving, they developed chronic disorders such as depression, insomnia, hypertension, heart attacks and alcoholism. Families may have to take full responsibility in taking care of the clients or assist in taking care of the clients to a certain extent depending on the available services, resource and support to the persons with schizophrenia and their family caregivers.

Grish et al (2005) stated that schizophrenia is a one of the major mental disorders characterized by abnormalities in the perception or expression of reality. Onset of symptoms typically occurs in young adulthood. Even with available treatments most people with schizophrenia continue to experience symptoms throughout their lives. This will create profound burden in the lives of their family members. Every family undoubtedly faces difficult circumstances and adjustment to new situations. Families with a mentally ill patient face a variety of unique stressors. In U.S.A, about 65% clients with mental illness who are discharged from mental hospitals returned to their own families. In Canada, around one to two thirds of persons with schizophrenia live with their family members. In China, over 90% of persons with schizophrenia live with and are taken care by their family members. In India research over the 10 years has shown that about 80% of patients with schizophrenia responded to drugs. 60% among them and 20% who did not respond require psychosocial intervention and social support.

Kulhara et al (2000) conducted a study in India and stated that antipsychotics are affordable to the family, but the treatment expenditure of co morbidity, side effects and cost of consultation including travel would increase family burden. Families touched by mental illness are often faced with significant financial burdens that arise from healthcare costs and job loss.

At Schizophrenia Research Foundation approximately 500 patients come to OPD every month out of which half of them are diagnosed with schizophrenia. The investigator during her experience in the clinical field of psychiatry came across family members who experienced high levels of emotional exhaustion while caring of a mentally ill patient. However not many studies have examined the coping strategies used by family members in relation to stress and burden. So studying stress, burden of care and coping style of family care providers could be useful way of generating information.

1.3 STATEMENT OF THE PROBLEM

A descriptive study to assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia at a selected setting in Chennai.

1.4 OBJECTIVES OF THE STUDY

1. To assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia
2. To correlate the level of stress, family burden and coping of the family care providers of clients with schizophrenia
3. To associate the level of stress, family burden and coping with the selected demographic variables of the family care providers of clients with schizophrenia

1.5 OPERATIONAL DEFINITION

1.5.1 Stress

Refers to a state of mental or emotional strain, tension or demanding circumstances experienced by family care providers in caring for a client with schizophrenia as measured by Self Administered Modified Perceived Stress Assessment Scale.

1.5.2 Family burden

Refers to strain on care giving which includes physical, psycho social and financial aspects resulting from caring the client with schizophrenia as measured by a Self Administered Modified Family Burden Assessment Scale.

1.5.3 Coping

Refers to the actions and the measures taken by the family care providers in order to deal with the strain produced by caring for the client with schizophrenia as measured by Self Administered Modified COPE Scale.

1.5.4 Family Care providers

A person who belongs to the family and is related to the family, stays with the client and spends a minimum of six hours in a day to provide constant care to a client with schizophrenia.

1.5.5 Client with Schizophrenia

A person clinically diagnosed to have schizophrenia characterized by disturbances in thought, emotion, behavior and insight.

1.6 HYPOTHESES OF THE STUDY

H_1 – There is a significant relationship among the level of stress, family burden and coping of the family care providers of clients with schizophrenia

H_2 – There is a significant association of the level of stress, family burden and coping of the family care providers of clients with schizophrenia with their selected demographic variables

1.7ASSUMPTION

1. The level of stress experienced by family care providers vary from person to person.
2. The client with schizophrenia has an impact on the level of stress, family burden, and coping experienced by the family care providers.
3. The methods of coping used by the family care providers may be adaptive or maladaptive.

1.8 DELIMITATION

1. The data collection period is limited to 4 weeks
2. The study is limited only to family care providers of clients with schizophrenia

1.9 CONCEPTUAL FRAMEWORK

The conceptual framework explains the interrelated concepts or abstractions assembled together in a rational scheme by virtue of their relevance to a common theme. Since the present study was intended to assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia, a well-known model of Lazarus and Folkman's conceptual framework was reviewed, modified and applied.

1.9.1 GENERAL CONCEPTS OF STRESS, FAMILY BURDEN AND COPING

a) Precipitating events:

Lazarus and Folkman's (1984) defined stress as a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being. Precipitating event is a stimulus arising from the internal or external environment and is perceived by the individual in a specific manner.

Predisposing factors are a variety of elements influence how an individual perceives and responds to a stressful event. Predisposing factors includes genetic influences, past experiences and existing conditions such as family history, health status, duration of care, financial and educational resources.

b) Individual's perception of events

Cognitive appraisal is an individual's evaluation of the personal significance of the event or occurrence is based on precipitating events and predisposing factor to which an individual is exposed.

Primary appraisal

Primary cognitive appraisal may be irrelevant, benign-positive or stressful. Stress appraisal includes harm/loss, threat and challenge. Harm/loss appraisal refers to damage or loss already experienced. Appraisals of a threatening nature are perceived as anticipated harm or losses. When an event is appraised as challenging, the family care provider focuses on potential for gain or growth, rather than on risks associated with the event.

Secondary appraisal

It involves the assessment of skills, resources and knowledge that the person possesses to deal with the situation. The individual evaluates by considering the coping strategies available to him/her and the ability to use the coping strategy in an effective manner.

There are two forms of coping:

1) **Problem focused coping** - used when the individual feels they have control over the situation, thus can manage the source of the problem.

2) **Emotion focused coping** - used when the individual feels as if they cannot manage the source of problem.

c) Quality of responses

The availability and effective usage of coping strategies leads to an effective quality of response.

Adaptive - if the quality of response is constructive there is equilibrium regained which resolves the problem.

Maladaptive - if the quality is destructive there is disequilibrium which continues due to which the problem is unresolved.

1.9.2 APPLICATION OF CONCEPTUAL FRAMEWORK BASED ON "LAZARUS AND FOLKMAN'S STRESS ADAPTATION MODEL" IN THE PRESENT STUDY.

a) Precipitating event

The nurse investigator assessed the stimulus which is arising from the internal and external environment of the family care providers such as age, sex, education, occupational status, locality, marital status, type of family, relationship with client, monthly family income, duration of care, which are all the sources of stress.

The client with schizophrenia is considered to be the external environment for the family care providers and also a stimulus of stress and family burden of the care providers so the nurse researcher assessed the demographic variables of the client with schizophrenia to evaluate the personal significance of the event (cognitive appraisal).

b) Individual's perception of events

The stressful event precipitates a response on the part of the individual and the response is influenced by individual's perception of the event. The primary appraisal of stress includes harm/loss which refers to damage or loss experienced by individual. Here the nurse researcher has assessed the stress and family burden of family care providers which is the result of precipitating event and the stress. During the secondary appraisal of the event, the nurse researcher has assessed the coping strategies (problem and emotion focused) of the family care providers.

c) Quality of response

If the family care providers are able to perceive the event realistically and they have the situational supports in environment and if they have adequate coping mechanism that will result in the adaptive behavior where the problem is getting resolved and there is no crisis.

If there is unrealistic perception of event or if there is inadequate coping strategies and lack of situational support it may result in maladaptive behavior and the crisis occurs. The nurse researcher in this study has assessed precipitating events, perception of events and quality of response.

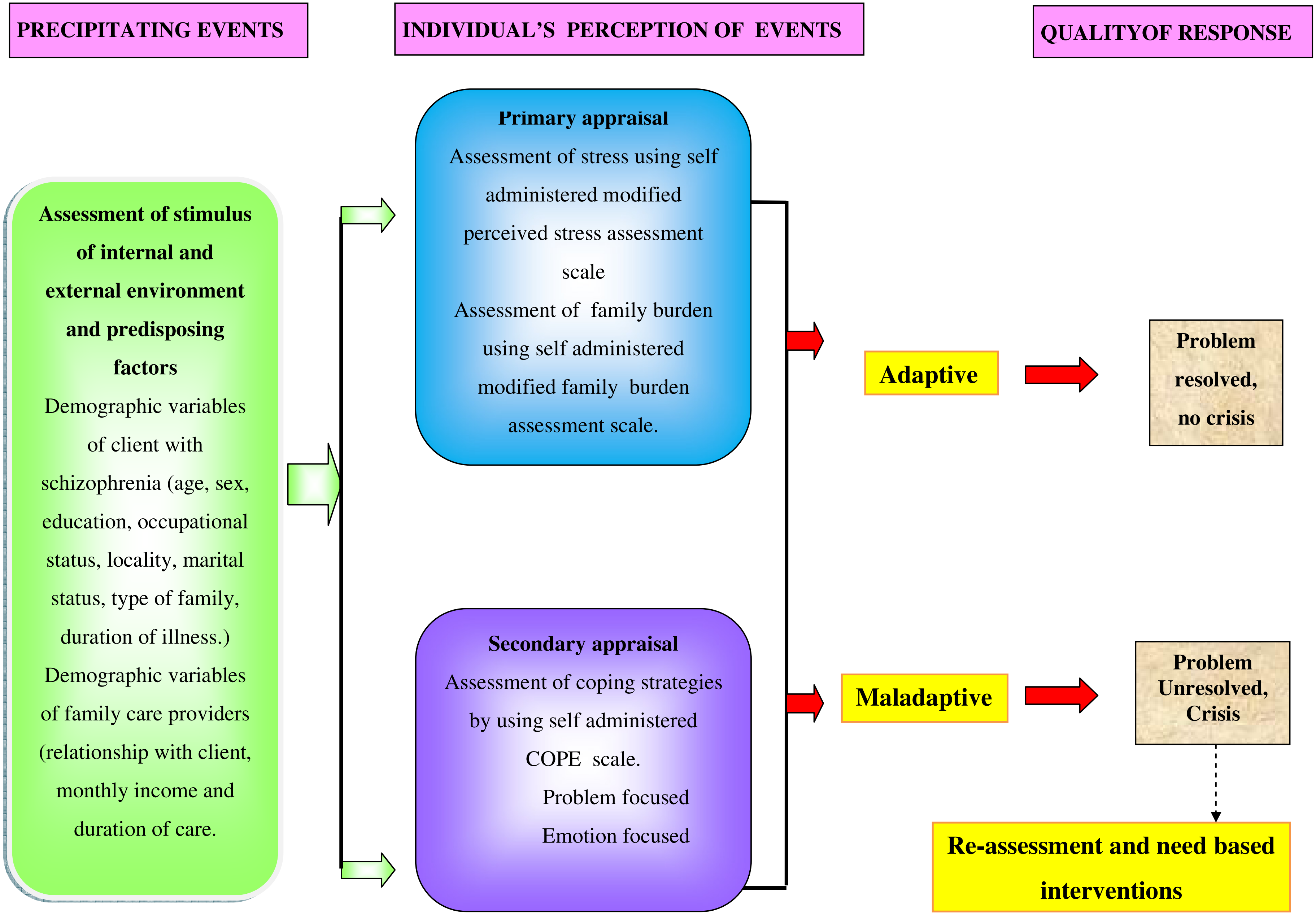

Figure 1.9.1: Modified Lazarus& Folkman's Stress Adaptation Model

Figure 1.9.2: Lazarus& Folkman's stress adaptation Model

REVIEW OF LITERATURE

CHAPTER – 2

REVIEW OF LITERATURE

Review of literature is a systematic search of a published work to gain information about a research topic (Polit & Hungler, 2008). Through the literature review, researcher generates a picture of what is known about particular situation and the knowledge gap that exists between the problem statement and research subject problems and lays a foundation for the research plan.

The literature review is presented in two parts

2.1 General concepts of stress, family burden and coping

2.2 Research reviews of various literatures

2.2.1 Section A : Studies related to prevalence of schizophrenia

2.2.2 Section B : Studies related to stress among family care providers of clients with schizophrenia.

2.2.3 Section C : Studies related to family burden among family care providers of clients with schizophrenia.

2.2.4 Section D : Studies related to coping among family care providers of clients with schizophrenia

2.1 General concepts of stress, family burden and coping

a) Stress

Stress is defined as “The state manifested by a specific syndrome which consists of all the non-specifically-induced changes within a biologic system” (Selye, 1976). This syndrome of symptoms has come to be known as the “fight or flight” syndrome. Dr.Lazarus suggested that there is a difference between eustress, which is a term for positive stress, and distress, which refers to negative stress. In daily life, we often use the term "stress" to describe negative situations. This leads many people to believe that all stress is bad, which is not true. Eustress, or positive stress, has the following characteristics such as motivation, energy building, improve coping abilities, excitement and performance improvement.

Stressors can be internal or external, which triggers the body/a system in body to generate stress. They can be biological, environmental, cognitive or situational in nature.

Types of stressors includes:

Biological stressors: biochemical imbalances, mental or physical illnesses, disabilities, injuries.

Environmental stressors: hurricanes, poverty, pollution, crowding, natural disasters.

Cognitive stressors: inability to solve a problem, pressure to come up with a creative project, working on something a person feels is unethical, have to do with the way the person perceives a problem or what he/she expects from it.

Situational stressors: having a pet or family member die, divorce, trouble among close friends.

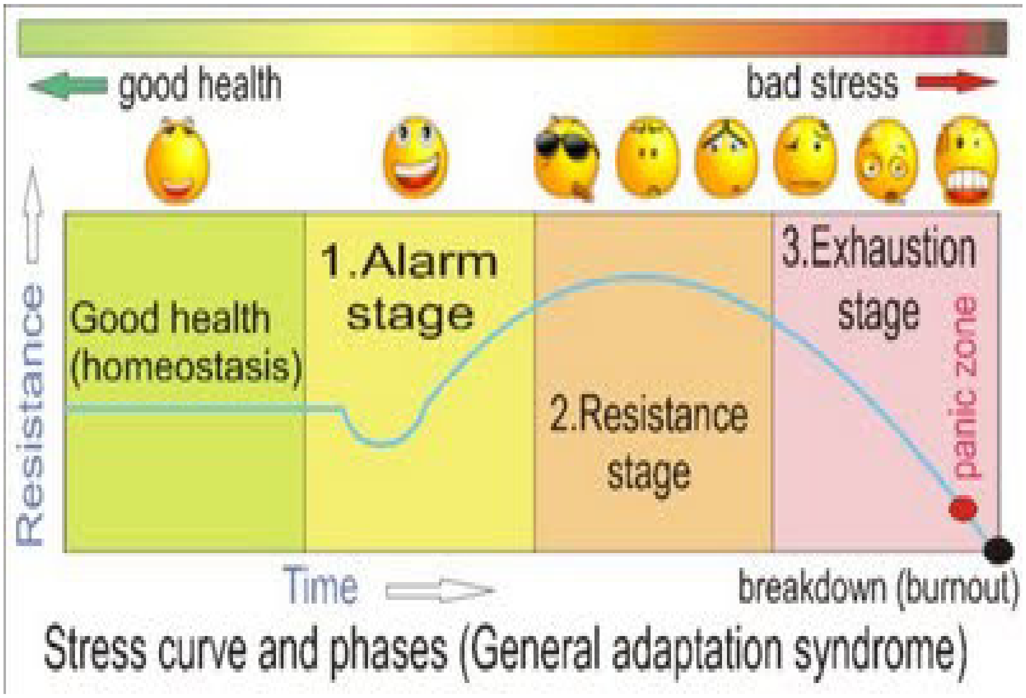

Figure 2.1: Selye's General Adaptation Syndrome

Source: Townsend HC (2002) Psychiatric mental health nursing concepts of care. 4th edition.

Body responds to stress is described by the term “General Adaptation Syndrome” which is the syndrome of symptoms which is known as the “fight or flight” syndrome. Selye called this general reaction of the body to stress as the general adaptation syndrome.

He described the reaction in three distinct stages:

1. **Alarm reaction stage:**

During this stage, the physiological responses of the “fight or flight” syndrome are initiated.

2. **Stage of resistance:**

The individual uses the physiological responses of the first stage as a defence in the attempt to adapt to the stressor. If adaptation occurs, the third stage is prevented or delayed hence the physiological symptoms may disappear.

3. **Stage of exhaustion:**

This stage occurs when there is a prolonged exposure to the stressor to which the body has become adjusted. The adaptive energy is depleted, and the individual can no longer draw from the resources for adaptation described in the first two stages. Disease of adaptation (for example, headaches, mental disorders, coronary artery disease, ulcers, and colitis) may occur. Without intervention for reversal, exhaustion, and in some cases even death may occur (Selye, 1956, 1974).

Health effects of stress:

Short term and long term exposure to stressors in the life can lead to health problems. The four categories of health effects:

1. Physical
2. Emotional
3. Mental
4. Behavioural

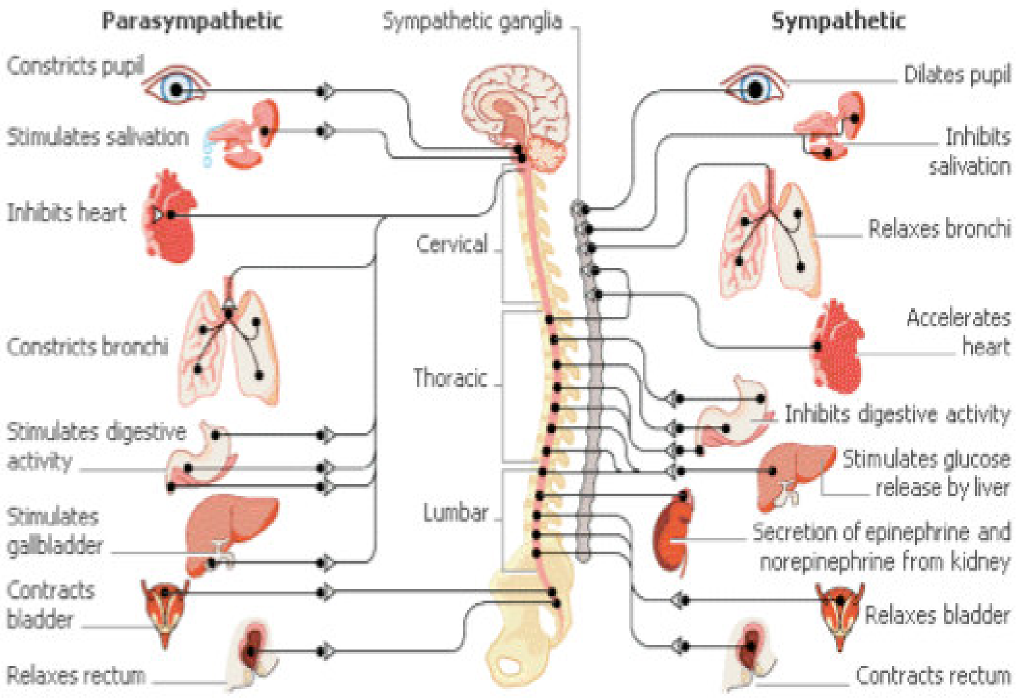

Figure 2.2: Effects of stress

Source: http://www.stress-treatment-21.com/coping-strategies-for-stress

Physical effects of stress:

Headaches, diarrhoea, insomnia, stomach upset, tics/nervous twitches, back pain, and ringing in ears.

Emotional effects of stress:

Frustration, nervousness, boredom, impatience, mood swings, low self-esteem, and loneliness

Mental effects of stress:

Trouble thinking or reading clearly, lack of creativity, constant worry, obsessive thoughts, unable to make decisions, forgetfulness and losing sense of humour.

Behavioural effects of stress includes:

Not eating/overeating, compulsive talking, verbal/physical outbursts, using alcohol, caffeine and other drugs, smoking, gambling, driving too fast/other high-risk behaviours

Managing Stress:

One way of managing stress is identifying the problem which includes: exploring the problem. Identifying the factors which cause stress and eliminating the stressor by changing the way to react to the stressor and to get a new perspective on the stressful situation by learning from the stressor. The other ways of managing stress are:

1) **Engaging in physical activity:** helps to release 'endorphins' which help take mind off the stressor, increase the flow of oxygen in body, feel better, and thereby reduces stress.

2) **Relax and laugh:** a good hearty laugh can reduce stress, lower blood pressure, make an individual feel good.

3) **Re-channelling energy:** handling stress by re-channelling energy such as turn negative energy into positive actions and thoughts, clean the house, walking/exercise. If unable to put physical distance between the person and the stressor then take a mental break, close your eyes and relax and listen to soothing music.

4) **Relaxation techniques:** stress can be handled by relaxation techniques such as, abdominal breathing, yoga, meditation and massage. Talk to individuals trustworthy such as parents, teachers, coaches, siblings, close friends and clergy.

5) **Time management:** these skills are the ways to plan and manage time in an effective, healthful way by setting priorities, goals, tasks or activities that a person feels are more important to do than others, decide which things to do in which order, can help the person organize the day & reduce stress, writing down your priorities, use calendars and day planners to help plan days, weeks and months, set long and short-term goals to help stay on task.

b) Family burden

Care giving is a dynamic process which includes patient, and a person who is involved in long term care of the patient. The deinstitutionalization movement that began more than five decades ago resulted in many families having to care for a relative suffering from mental illness. The early literature existing on families aimed at evaluating the impact of their behaviours on the ill relative. A more recent line of research has explored the reciprocal idea of the impact of functional psychiatric illness on family caregivers. Early study findings indicated that the impact of mental illness was felt across many aspects of family life which includes work, leisure, income, children, family health, relations with extended family, friends and neighbours.

The World Federation of Mental Health (2010) has issued a report supporting that caring for those with a chronic condition requires tireless effort, energy, and empathy and indisputably greatly impacts the daily lives of caregivers. Family caregivers receive little recognition for this valuable work, and policies in most countries do not provide financial support for the care services they provide. As caregivers struggle to balance work, family, and caregiving, their own physical and emotional health is often ignored. In combination with the lack of personal, financial and emotional resources, many caregivers often experience tremendous stress, depression, and/or anxiety in the year after caregiving begins. The adverse consequences of taking care of relatives with severe mental illnesses have been studied since early 1950s, when psychiatric institutions began discharging patients to the community.

c) Coping

Coping is expending conscious effort to solve personal and interpersonal problems, and seeking to master, minimize or tolerate stress or conflict.

Types of coping strategies are:

- **Appraisal-focused:** directed towards challenging one's own assumptions, adaptive cognitive
- **Problem-focused:** directed towards reducing or eliminating a stressor, adaptive behavioural
- **Emotion-focused:** directed towards changing one's own emotional reaction

Appraisal-focused strategies occur when the person modifies the way they think, for example employing, denial, or distancing oneself from the problem. People may alter the way they think about a problem by altering their goals and values, such as by seeing the humour in a situation it is suggested that humour may play a greater role as a stress moderator among women than men.

Problem focused strategies tries to deal with the cause of their problem. They do this by finding out information on the problem and learning new skills to manage the problem. Problem-focused coping is aimed at changing or eliminating the source of the stress. The three problem-focused coping strategies identified by Folkman's and Lazarus are taking control, information seeking, and evaluating the pros and cons.

Emotion focused strategies involve releasing pent-up emotions, distracting oneself, managing hostile feeling, meditating or using systematic relaxation procedures. Emotion-focused coping is oriented toward managing the emotions that accompany the perception of stress. The five emotion-focused coping strategies identified by Folkman's and Lazarus are disclaiming, escape-avoidance, accepting responsibility or blame, exercising self-control, and positive reappraisal. Emotion-focused coping is a mechanism to alleviate distress by minimizing, reducing, or preventing the emotional components of a stressor. This mechanism can be applied through a variety of ways, such as seeking social support, reappraising the stressor in a positive light, accepting responsibility, using avoidance, exercising self-control, and distancing. The focus of this coping mechanism is to change the meaning of the stressor or transfer attention away from it. For example, reappraising tries to find a more positive meaning of the cause of the stress in order to reduce the emotional component of the stressor. Avoidance of the emotional distress will distract from the negative feelings associated with the stressor. Emotion-focused coping is well suited for stressors that seem uncontrollable. For example diagnosis of a terminal illness or loss of a loved one. Some mechanisms of emotion focused coping, such as distancing or avoidance, can have alleviating outcomes for a short period of time, however they can be detrimental when used over an extended period. Positive emotion-focused mechanisms, such as seeking social support, and positive re-appraisal, are associated with beneficial outcomes.

People use a mixture of all three types of coping strategies, and coping. All these methods can prove useful, but some claim that those using problem-focused coping strategies will adjust better to life. Problem-focused coping mechanisms may allow an individual greater perceived control over their problem, whereas emotion-focused coping may sometimes lead to a reduction in perceived control (maladaptive coping).

While adaptive coping methods improve functioning, a maladaptive coping technique will just reduce symptoms while maintaining and strengthening the disorder. Maladaptive techniques are more effective in the short term rather than long term coping process. Examples of maladaptive behaviour strategies includes:

1) **Dissociation** - is the ability of the mind to separate and compartmentalize thoughts, memories, and emotions. This is often associated with post-traumatic stress syndrome.

2) **Sensitization** - is when a person seeks to learn about, rehearse, and/or anticipate fearful events in a protective effort to prevent these events from occurring in the first place.

3) **Safety behaviours** - are demonstrated when individuals with anxiety disorders come to rely on something, or someone, as a means of coping with their excessive anxiety.

4) **Anxious avoidance** - is when a person avoids anxiety provoking situations by all means. This is the most common strategy.

5) **Escape -** is closely related to avoidance. This technique is often demonstrated by people who experience panic attacks or have phobias. These people want to flee the situation at the first sign of anxiety. For example a student not prepared for exams may claim having nausea and take leave the same day.

These coping strategies interfere with the person's ability to unlearn, or break apart, the paired association between the situation and the associated anxiety symptoms. These are maladaptive strategies as they serve to maintain the disorder.

2.2.1 Studies related to prevalence of schizophrenia

Fazal et al (2008) conducted systematic review and meta regression analysis of prevalence of schizophrenia among homeless in the United Kingdom. The study was done by using surveys of the prevalence of schizophrenia among 5,684 homeless individuals from seven countries. A Substantial heterogeneity was observed in prevalence estimates for prevalence of schizophrenia among the studies. The prevalence of schizophrenia ranged from 2.8% to 42.3%.

Kumar et al (2008) conducted a study to assess prevalence and pattern of schizophrenia in India. A community based cross- sectional study was done to assess prevalence and pattern of schizophrenia. One thousand subjects were randomly selected from four villages in Karnataka. Disability was assessed by Indian Disability Evaluation and Assessment Scale [IDEAS]. The prevalence of schizophrenia was found to be 2.3%. The prevalence was higher among females (3.1%) than among males (1.5%). The prevalence was higher among elderly (3%) and illiterates (34%). There was a negative association between literacy and prevalence of schizophrenia.

Saha et al (2005) conducted a meta-analytical study on prevalence of schizophrenia.1,721 prevalence estimated from 46 countries based on an estimated 154,140 potentially prevalent cases. Results show that about seven to eight individuals out of 1,000 were affected by schizophrenia and found point and lifetime prevalence rates of 4.6 and 4 per thousand respectively. Out of 1,000 people 4.6 had the disease at a specific time point and 3.3 had the disease within a surveillance period of one to 12 months. The life time prevalence was 4.0 per 1,000 and the lifetime morbid risk was 7.2 per 1000, which did not differ considerably from previous estimates. The study found that the prevalence of schizophrenia was the same in males and females and in urban and rural sites. When sites were grouped by economic status, prevalence estimates from “least developed” countries were significantly lower than those from both “emerging” and “developed” sites ($p = 0.04$) and was higher in migrant population as compared to native-born individuals.

Welham & Migarth (2005) conducted a systematic review to assess the prevalence of schizophrenia which was conducted in Australia. Studies with original data related to the prevalence of schizophrenia were selected. A total of 1,721 prevalence estimates from 188 studies were identified. These estimates were drawn from 46 countries and were based on an estimated rate of 154, 140 potentially overlapping prevalent cases. Result showed that about seven to eight individuals out of 1,000 were affected by schizophrenia. Out of 1,000 people 4.6 had the disease at a specific time point and 3.3 had the disease within a surveillance period from one to 12 months. The life time prevalence was 4.0 per 1,000 and the lifetime morbid risk was 7.2 per 1,000.The researchers found that the prevalence of schizophrenia was the same in men and women. The prevalence of schizophrenia was lower in poorer countries than in richer countries. The prevalence of schizophrenia in migrants was higher compared to native-born individuals.

Sharma & Meghachandra (2001) conducted a study to estimate the prevalence of schizophrenia.A population based cross-sectional study was conducted in India to estimate the prevalence of schizophrenia by sex, religion, and area, using a Rapid Psychiatric Examination schedule. Stratified random sampling method was used to select 4022 persons (49% males and 51% females) from both urban and rural areas. Prevalence of schizophrenia was 60.2/1000 and was more among males (85.7/1000) than females (35.6/1000) (P<0.001). A predominant mental disorder was schizophrenic psychosis (14.2/1000). Prevalence of schizophrenia was 1.6 times higher among Christians as compared to Hindus. Prevalence rate was similar in both urban and rural areas.

2.2.2 Studies related to stress among family care providers of clients with schizophrenia.

Yusuf & Nuhu (2009) conducted a study to assess the factors associated with emotional distress among caregivers of patients with schizophrenia in Nigeria. Samples of 129 caregivers of patients with schizophrenia were enrolled from the outpatient clinic of Katsina State Psychiatric Hospital. The socio-demographic data collecting sheet and Hospital Anxiety and Depression Scale were analyzed and statistical significance was set at 5% level of probability. The caregivers consisted of 87 (67.4%) females and 42 (32.6%) males. The mean age of the subjects was 45.07 years. Siblings constituted majority of the caregivers. Emotional distress was found in 79.84% of the caregivers. The findings revealed that factors associated with emotional distress in the caregivers were family size, education, financial support, patient’s gender and relationship with the patient.

Sandy (2007) conducted a study to examine psychological distress among Latino family caregivers of adults with schizophrenia in Spain. The caregivers were interviewed by using Zarit Burden Scale (ZBS).120 samples were involved. The results showed that young age of caregiver, low level education of caregivers, and higher levels of the patient’s mental illness symptoms were predictive of higher levels of caregiver’s depressive symptoms. Perceived Burden mediated the relation between patient’s psychiatric symptoms and caregiver’s depression.

Sunil (2005) conducted a cross sectional study to measure the perception of burden and level of stress by caregivers of patients with schizophrenia at Institute of Mental Health and Hospital, Agra. The Burden Assessment Schedule (BAS) was used. The sample comprised of 34 caregivers of patient with schizophrenia. A low positive correlation was found between urban domiciles and support of the patient and the caregiver's routine. It showed that urban people had more stress and was seen high in females compared to males. Married people had more stress. There was a low positive correlation between age less than 30 years and the physical and mental health of the caregiver, and with taking responsibility. Illness severity and patients' disability had a direct positive relationship with perceived family burden. This study suggested to develop local needs based support programme for families of patients with psychiatric disorders in India.

Georgene (2004) conducted a study to investigate the incidence of chronic sorrow in parents of chronically mentally ill adults at Sydney. A purposive sample of 10 parents (four couples and two mothers) of adult children were interviewed using the Burke/ Chronic Sorrow questionnaire (Caregiver Version). Results showed that 8 out of 10 parents experienced chronic sorrow and suggested that healthcare professionals could assist them by providing information about their relative’s illness and by involving them in the treatment process.

Bentsen (2003) conducted a study on the efficacy of psycho educational family intervention by reducing stress levels in families in order to improve outcome, in Norway. Systematic reviews and search in databases were used to find randomized controlled studies. Seven studies of short-term family treatment were found, 15 studies of long-term treatment comparing it to individual therapy, and seven studies comparing family treatment modalities. Long-term family intervention reduces the risk of psychotic relapse to about the half within the first two years. These methods also shorten hospital stays, improve compliance with medication, patients' social functioning and relatives' well-being, and they seem to be cost-effective. Single and group family therapies including patients are equally efficacious. Relatives groups do not seem to improve outcome. The factors such as expressed emotion duration of illness anddrug compliance should be taken into account.

2.2.3 Studies related to family burden among family care providers ofclients with schizophrenia

Chakrabati (2011) conducted a comparative study to assess the extent and pattern of family burden in affective disorders and schizophrenia in India. Data were collected by using Pai and Kapur’s Interview schedule in 78 patients with bipolar disorder and 60 patients with schizophrenia. The extent of objective and subjective burden was significantly more in relatives of schizophrenics and the maximum burden was seen in the routine family activities. When the two groups were compared, it was shown that the schizophrenic group had significantly more financial burden, disruption of family routine and disruption of family leisure.

Prafulla et al (2010) conducted a study to assess family burden and rehabilitation need of beneficiaries of a rural mental health camp in south India. Assessing the rehabilitation needs and the burden of care faced by the families is an important component constituent of planning an effective mental health services. Using the assessment of family burden and rehabilitation needs assessment schedule, 50 care givers were interviewed. The results indicated mild to moderate objective burden experienced by the families. All respondents had some need or the other pertaining to the rehabilitation of the ill family member.

Chang et al (2009) conducted a study to explore the important influence of mental health of family caregivers and burden on their physical health.388 caregivers who were 18 years or older and spent time taking care of family members with schizophrenia were administered the 12-item Chinese Health Questionnaire (CHQ-12),burden was measured using a modified scale for caregiver's burden, health status was assessed using Self-Perceived Health (SPH),illness symptoms and the number of diagnosed chronic diseases. Factors such as age, education level, caring hours per day and emotional, functional and physical support systems used by caregivers were controlled. A high number of hours per day of care giving were associated with low emotional support and SPH, poor mental health and high burden. Higher emotional support was associated with better mental health and fewer illness symptoms. Higher physical support was associated with poorer mental health, higher burden, a greater number of illness symptoms and chronic diseases, and a lower SPH score. Hours per day of care giving and use of emotional, functional, and physical support were associated with mental health and the hours per day of care giving and use of physical support were predictors of burden. Mental health and burden were significantly associated with caregivers' health problems simultaneously.

Fujino and Okamura (2009) conducted a cross sectional study on the factors affecting the sense of burden felt by family members caring for patients with mental illness at home in Japan. A schedule of Family Burden Assessment was used to collect data among 30 family caregivers. A multiple regression analysis with sense of burden as the dependent variable, showed a significant correlation in the univariate analysis as the independent variables. The results of the study revealed that patients' satisfaction with daily life and ability to perform tasks had a strong impact on the sense of burden felt by the caregivers. These results suggested that providing support that enhances the quality of life of the patients with mental illness may indirectly help reduce the sense of burden felt by family members caring for them.

Gloria (2009) had conducted the comparative study on the caregivers of mentally ill relatives to explore the relationship between gender and perceived levels of burden. Ninety-seven caregivers (76 women, 21 men) were interviewed. Women were found to experience a greater sense of burden and frustration than men in caring for their mentally ill relatives. The authors concluded that women encountered a wide range of difficulties centered on family and child rearing. The study explores the influences of selected social and psychological factors that are associated with perceived caregiver stress.

Shibret et al (2009) studied the impact of schizophrenia on family members in Ethiopia. The sample comprised of 301 cases of schizophrenia and their close relatives participated in the study. Results showed that family burden is a common problem of relatives of patients with schizophrenia. Financial difficulty is the most frequently endorsed problem among the family burden domains (74.4%). Relatives of female patients suffered significantly higher social burden. Work and financial burdens affected female relatives more often than males. Disorganized symptoms were the most important factors affecting the family members in all family burden domains. Prayer was found to be the most frequently used coping strategy in work burden (95 %). The scarce existing services in the developing countries should include family interventions and support atleast in the form of educating the family members about the nature of schizophrenia, stigma and family burden.

Hou et al (2008) conducted a study to explore the burden of primary family caregivers of schizophrenia patients in Taiwan. 126 pairs of patients and their primary family caregivers were recruited from the day care and acute wards of two teaching general hospitals. Data was collected on caregivers burden and the caregivers' health condition using demographic sheet BPRS (Brief Psychiatric Rating Scale), Chinese Health Questionnaire. The results revealed that the caregiver burden scores(25.9 +/- 10.7;range, 3-61) indicated a moderate burden level.

Chien et al (2007) in a cross-sectional descriptive study examined the level of perceived burden of 203 Chinese family caregivers of relatives with schizophrenia in the community and tested its associations with their demographic characteristics, social and family factors and health conditions from three regional psychiatric outpatient clinics in Hong Kong. Family Burden Interview Schedule, Family Assessment Device, Six-item Social Support Questionnaire and 36-Item Short Form Health Survey and a socio-demographic data sheet were used. The results indicated that families who perceived a higher level of caregiver burden were those who lived in a family with poorer functioning, worse health status and less satisfaction of social support.

Juvang & Lambert (2007) investigated the relationship between demographic characteristics of caregiver and family caregiver's burden when providing care for a member with schizophrenia in China. A purposive sampling technique was used to recruit 96 subjects from 3 hospitals. Findings showed that the age of caregiver was positively correlated to burden of caregiver. Older caregivers worried more about who would take care of their ill family member in the future. The education level had negative correlation with caregiver's burden. Educational level of the caregivers resulted in more knowledge to deal with stressful events.

Krautgartner et al (2007) investigated the burden of minor relatives of schizophrenia patients and of the need for support for the relatives. The study conducted in Germany with a sample of 135 relatives of patients with schizophrenia or schizoaffective disorders were assessed using the "Involvement Evaluation Questionnaire" and the "Careers' Needs Assessment for Schizophrenia".24.4% of the total sample (N=33) had minor (i.e. below 18 years) siblings (N=18) or children (N=15). If the patient had minor siblings, almost the half of the adult relatives (40) reported moderate or severe problems. However, among those patients who had to take care of minor children, only a fifth reported moderate or severe problems. Offspring under the age of 16years frequently reported behavioural disturbances, reduced appetite and other consequences of the disease. These results indicated that minor relatives frequently reported marked burden.

Kumar and Mohanty (2007) conducted a study on the effects of socio-demographic variables on spousal burden of care in patients with schizophrenia.70 spouses (35 male and 35 female)of chronic schizophrenic patients were drawn from outpatient services. The duration of spousal exposure was determined on the basis of the onset and their stay with the patients. The demographic and clinical characteristics of the patients and spouses were recorded and were individually administered the BAS. Significantly a greater burden was experienced in all areas in female spouses. The patient's unpredictable behaviour and disturbances at home caused marked burden in female spouses, who felt that they had done more than enough to improve the situation and sought temporary separation. The family type significantly affected spousal burden in spouse related, external support and caregivers’ strategy. The joint family system was found to contribute significantly to the burden. Nuclear family system caused more burdens in the areas of external support and caregivers’ strategy.

Lambert and Lambert (2007) conducted a descriptive study on the predictors of family caregivers' burden and quality of life of family members with schizophrenia in the People's Republic of China. The sample size was 205. The study examined: (i) the level of family caregivers burden and Quality of Living (QOL) (ii) its relationships with demographic characteristics of family caregivers and (iii) the best predictors of family caregivers burden and QOL. The findings suggest that family caregivers suffer a high level of burden when caring for a family member with schizophrenia.

Saha & Chant (2007) conducted a study in Madison to examine the relation among mental health, perceived burden and stigma among care givers of patient with schizophrenia. Interview were conducted among 85 Latinos caregivers. Data were collected by using measures such as Depression Scale, the ZBS, and the Greenly Stigma Scale. The findings revealed that 40% of samples were at risk of depression. Younger caregiver age, lower levels of caregiver’s education, and higher levels of the patient’s mental illness symptoms were predictive of higher levels of caregiver’s depressive symptoms. Caregiver’s Perceived burden mediated the relation between patient’s psychiatric symptoms and caregiver’s depression. Caregiver’s perceived stigma was significantly related to caregiver’s depressive symptoms.

Schmid (2006) conducted a study on the burden of siblings of inpatients with schizophrenia, using narrative interviews with 37 siblings of schizophrenia patients, in Germany. The global statements were analyzed using a summarizing content analysis and categories were quantitatively analyzed to assess their relative importance. 492 individual statements of the sibling have revealed 26 global types of statements were assigned to five categories: (1) Burden due to daily contact with the sibling (36.2 %). (2) Burden due to respect of healthy sibling's privacy (26.8 %). (3) Burden due to contact with the family (15.7 %) (4) Burden with respect to the contact with institutions and professionals (14.2 %) and (5) Burden with respect to the siblings own social contacts (friends/public) (7.1 %). Three types of burden were reported by the healthy siblings: Handling the symptoms of illness (100 %), Emotional burden due to the illness of the sibling (100 %) and Uncertainty in judging what amount of stress the schizophrenia patient can cope(81.1%).

Ukpong (2006) conducted a study to examine the demographic factors and clinical correlates of burden and distress in relatives of service users experiencing schizophrenia, in Nigeria. This cross-sectional study used the Carer Burden Index and the 30-item General Health Questionnaire to assess burden and distress in relatives, and the BPRS and the Scale for Assessment of Negative Symptoms to rate the positive and negative symptoms of schizophrenia respectively. High levels of emotional distress and burden were observed in the caregivers and they were significantly associated with some demographic variables. They were also significantly associated with positive and negative symptoms of schizophrenia. Because Nigerian families continue to play a primary care- giving role for their relatives experiencing schizophrenia, there is a need to focus on specific interventions that will reduce their high levels of distress and burden.

Margareta (2005) investigated the different aspects of family burden, need for support and participation in care situations with carers who lived with and apart from their patients. A sample of 162 relatives answered a semi-structured questionnaire concerning their situation as a relative of a severely mentally ill person. Results indicated that there was an increased experience of family burden in several aspects due to the relatives and patient living together. However, relatives who lived with the patient were less likely to believe that the patient would be better off dead, experienced more participation in the patient's treatment and more often viewed the psychiatric services as being of good quality than those relatives who did not live with the patient. The findings of the study are that persons with severe mental illness who are admitted to inpatient units are in need of different aspects of intensive psychiatric care. Some of these needs are supplied by relatives in everyday life, often without any support in providing for the needs of relatives, in relieving their burden, the psychiatric services needs to implement different methods according to whether the relatives live with or apart from the patient.

Wilms et al (2004) conducted a study on the illness related costs for spouses of patients suffering from a mental illness, in Germany using repeated measures.117 spouses of patients suffering from schizophrenia, depression or anxiety disorders, filled in a standardized questionnaire about illness related expenses and financial losses over a period of 12 months. The results revealed that 90% of the spouses reported direct cash expenditures on behalf of the patients' illness. On an average, these costs amounted to yearly expenditures of Euro 1146. Costs did not differ significantly across types of illness and income was not found to be a significant covariate. Spouses reported substantial direct cash expenditures on behalf of the patient's illness. Since expenditures varied to a large extent over the three points of measurement, repeated measurement designs seem to be a prerequisite for a reliable assessment of illness-associated costs. Living with a mentally ill partner is associated with an increased risk of developing a burden for spouses which could lead to double costs and double decreases in income, which needs to be taken into consideration when planning changes in health policy.

Lauber et al (2003) assessed the relationship between caregiver burden and behavioural disturbances of patients with exacerbating schizophrenia in Switzerland. Sixty-four relatives of schizophrenic patients were assessed by a semi-structured interview for measuring the burden on the family. Subscales and total scales of burden were calculated. Predictors were identified by regression analyses. The most important predictor of burden was burden in the relationship between caregiver and the affected representing the changes in the relationship occurring in acute illness. Threats, nuisances, time spent with the affected, and burden due to restricted social life and leisure activities were additional predictors of burden, but not aggression or substance abuse. The findings revealed that two weeks prior to the last hospitalization was considered as being the most burdensome period for relatives.

Sushma et al (2003) studied the association among burden, coping strategies and expressed emotions of 30 relatives of persons with first episode psychosis. The caregivers of patients aged between 18 to 55years, were in daily contact with the patient at least for two years and who were supportive both financially and emotionally. The patients were rated on the BPRS for psychopathology. The caregivers were administered the General Health Questionnaire (GHQ-5) and the BAS, the Attitude Questionnaire and the COPE Scale to find out the effects of patients illness on their health and the burden experienced. Significant differences were found in the expressed emotions, use of emotional coping strategies and psychopathology in the high and low burden groups. The caregivers who were experiencing high burden also had high expressed emotions and made greater use of emotional coping strategies. Family burden was found to increase with psychopathology.

Jungbauer et al (2002) conducted a study to compare the perception of financial burden in parents and spouses of schizophrenic patients, in Germany using a qualitative-interpretative technique. In-depth-interviews with parents and spouses of schizophrenic patients were analyzed. Results revealed that when talking about their living situation, caregivers tend to keep away from the topic of financial charges; played down objective financial disadvantages or didn't assess them as burdensome. However, considerable financial burdens were reported by parents of young patients who were living in their parents' household and by spouses in families with very low income. Financial burdens were usually superimposed by other problems of the caregivers, such as dealing with acute episodes and sorrow about the future. Both material and immaterial costs of caregivers should be considered when taking health policy decisions.

Magliano et al (2002) conducted a study to explore (a) burden related to care giving and support received from professionals and social network in relatives of patients with schizophrenia in Northern, Central and Southern Italy and (b) to test whether a higher level of family burden is associated with a lower level of professional and social network support. Seven hundred and nine patients with schizophrenia and their key-relatives were consecutively recruited in 30 Italian mental health departments. Data were collected on: (a) patients clinical status and levels of disability (b) relative’s burden, social and professional support (c) interventions received by patients and their families. Family burden was found lower in Northern Italy. However, after controlling for psychosocial interventions, differences in family burden among the three geographical areas disappeared. Family burden was associated with patient’s levels of disability and manic/hostility symptoms and with professional and social network support received by the family.

2.2.4: Studies related to coping among family care providers of clients with schizophrenia

Ram (2012) had conducted a descriptive study on burden and coping in caregivers of patients with schizophrenia at National Institute of Health and Neurosciences, Bangalore. The sample comprised of 24 parents and 24 spouses. Patients were assessed on Global Assessment Scale (GAS) and caregivers were assessed on Burden Assessment schedule (BAS) and the Coping Checklist (CCL). Mean total burden experienced by the spouses is greater than by the parents. Spouses reported greater emotional burden. Parents used denial as a coping strategy while spouses used negative distraction strategies. Patient's age, educational level, caregiver's use of denial as a coping strategy emerged as significant predictors of caregiver burden. The study highlighted the fact that family intervention programs need to address the specific concerns of caregivers.

Chandarashekaran (2009) had conducted a descriptive study on coping strategies of the relatives of schizophrenic patients in India. The sample comprised of 44 relatives of patients with schizophrenia. Resignation, an emotional focused strategy, was found to be more commonly employed by the relatives, than other strategies. Majority of the relatives failed to maintain social contacts. Levels of burden and negative symptoms correlated significantly with the resignation strategy. Analysis of the coping strategies of the relatives is essential before planning clinical interventions with families in order to improve the coping skills of the caregivers.

Hanzawa et al (2008) conducted a study on burden and coping strategies in mothers of patients with schizophrenia in Japan. The aim of the study was to identify factors contributing to burden of care in 57 mothers caring for patients with schizophrenia. The scales used were eight-item short version of the Japanese version of the ZBS and general health status (General Health Questionnaire 12 item version). Burden of care was significantly associated with general health status and difficulty in life. The study concluded that on multiple regression 'social interests' and 'resignation', both of which are the subscales of coping strategies, exerted significant and independent effects with respect to burden of care.

Caqueo (2007) conducted a descriptive study on coping strategies in caregivers of patients with schizophrenia at Aymara. Deinstitutionalization has forced families of patients with schizophrenia to take responsibility of informal care, without having the tools to exert their role properly. The aim of this study was to evaluate the coping strategies of caregivers of patients with schizophrenia, belonging to the Aymara ethnic group. The studied sample comprised 45 caregivers of patients with schizophrenia. The finding of the study were that the Family Coping Questionnaire (FCQ) showed that Aymara and non-Aymara caregivers use the same coping strategies except for spiritual help which is more likely to be used by Aymara.

Friedrich et al (2008) surveyed data from a national study of 746 respondents with regard to the importance of mental health services and coping strategies of siblings with schizophrenia. The authors used the Friedrich Lively Inventory Scale, a closed-ended questionnaire that included questions about coping strategies and mental health services. The findings revealed that the siblings identified services for their ill sibling, including symptom control, adequate housing, and long-term planning, as more important than direct services for themselves.

Creado et al (2006) conducted study to evaluate the level of functioning of 100 patients with chronic schizophrenia to the burden and coping of their primary caregivers. The patients attending a psychiatric outpatient department were assessed on the General Assessment of Functioning (GAF) Scale and the caregivers were administered the Burden Assessment Schedule (BAS) and Mechanisms of Coping (MOC) Scale. Fatalism and problem solving were the two most common patterns of coping. It was found that problem focused and expressive action decreased the burden of caregiver while emotion focused coping or fatalism and passivity increased it burden of caregiver.

Geriani et al (2006) conducted a correlational study on burden of care on caregivers of schizophrenia patients. The present study aim to explore the relation between burden of care on the caregivers of schizophrenic patients with various psychological parameters including their coping strategies, personality type, overall quality of life and socio-demographic details. The participants included in the study were 110. They were administered a socio-demographic data sheet and questionnaires to assess their personality type, burden, quality of life, and coping mechanisms of having a schizophrenic in the family. The findings of the study were that a significant correlation was seen between the levels of coping and extrovert type of personality and also with the environmental health of the caregivers. Caregivers belonging to nuclear families coped better than those of joint families.

Scazufca & Kuipers (2005) conducted a study on coping strategies in relatives of people with schizophrenia before and after psychiatric admission. The aim was to use the stress and coping model proposed by Lazarus and Folkman's to examine how relatives coped with patients. Patients with DSM-IV-TR schizophrenia and their relatives were assessed just after hospitalization of the patients and nine months after discharge.50 patients and 50 relatives were assessed at inclusion, and 31 patients and 36 relatives at follow-up. Findings revealed that coping strategies were used more frequently at inclusion than at follow-up. Problem focused coping was the strategy used more often at both assessments and avoidance coping was strongly associated with burden and distress at both assessments.

Jungbauer & Angermeyer (2003) conducted a study on coping strategies in spouses of schizophrenic patients. The objective of the study was to explore the coping behaviour of spouses of schizophrenic patients. 28 in-depth interviews were analyzed with a view to discover the spouses ways of dealing with illness-related burden. Most spouses reported problem-focused coping strategies, such as information seeking and crisis planning. Release-focused coping strategies, such as relaxation activities, time-out and temporal disengagement, are likely to be used when the situation is perceived as unchangeable and spouses feel that they have to look after themselves as well. In the long-term, cognitive-emotional strategies are of great importance, aimed at the re-appraisal of the spouses mental illness and a greater sense of self-efficacy in dealing with acute and everyday burden. Spouses' coping strategies not only have a strong influence on their perception of burden, but also on marital satisfaction and on their commitment to the affected spouse.

Subbakrishna et al (2002) conducted a study on religious coping and psychological wellbeing in carers of relatives with schizophrenia. The objective of the study was to examine the use of religious coping and its relation to psychological wellbeing in carers of relatives with schizophrenia. Sixty carers of patients with an ICD-10 diagnosis of schizophrenia, were assessed on strength of religious belief, perceived burden, religious and other coping strategies and psychological wellbeing. Coping strategies of denial and problem solving, strength of religious belief and perceived burden were significant predictors of wellbeing. Strength of religious belief plays an important role in helping family members to cope with the stress of caring for a mentally ill relative. In addition to psycho-education and problem solving coping, the role of religious coping in enhancing wellbeing of carers needs to be considered in family intervention programme.

Providing care to a family member with a long standing chronic mental illness causes significant disruption in several domains of family life. The above collected reviews had thrown a light on present study to proceed with tools, methodology and analysis.

RESEARCH

METHODOLOGY

CHAPTER – 3

RESEARCH METHODOLOGY

Research methodology is a significant part of any study which enables the researcher to project the research undertaken. Research methodology is the systematic way to carry out an academic study and research in flawless manner. The methodology enables the researcher to project a blue print of the details, data, approach, analysis and finding of research undertaken.

The present study was carried out to assess the level of stress, family burden and coping among family care providers of clients with schizophrenia.

3.1 RESEARCH APPROACH

Research approaches are the plans and the procedures for research that plan the steps from broad assumptions to detailed methods of data collection, analysis and interpretation. In the present study, a quantitative approach was used.

3.2 RESEARCH DESIGN

Research design is the overall plan for obtaining answers to the questions being studied and for handling various challenges to the worth of the study evidence. (Polit and Beck, 2010) A non-experimental descriptive design was used in this study. The researcher observes, describes and documents aspects of event as it naturally occurs and sometimes to serve as a starting point for hypothesis generation or theory development.

3.3 VARIABLES

A variable is any quality of a person, group, or situation that varies or takes on different values typically, numeric values (for example, body temperature, heart rate).(Polit and Beck, 2010)

The variables used for the present study were as follows:-

3.3.1 Study variables: includes stress, family burden and coping of family care providers of clients with schizophrenia.

3.3.2 Demographic variables: includes baseline data of family care providers and clients with schizophrenia.

1) Family care providers details includes sex, locality, marital status, education, occupation, relationship, type of family, family monthly income, duration of care.
2) Client with schizophrenia details includes age, sex, locality, educational status, marital status, duration of illness and type of family.

3.4 RESEARCH SETTING

The present study was conducted at Schizophrenia Research Foundation (SCARF), Chennai. SCARF was started in the year 1960.The SCARF has its collaboration with World Health Organization. It has outpatient and inpatient services including various therapies under its umbrella. There are 40 beds at the inpatient block along with its day care centers. The total numbers of OPD blocks are 10.About 400 – 500 mentally ill patients visit a month and patients diagnosed with schizophrenia are about 50-60 per week.

3.5 POPULATION

A population is an entire aggregation of cases in which a researcher is interested. In the present study, population includes all the family care providers of clients with mental illness.

3.5.1 Target population:

It refers to the elements of people or objects to which the investigator wants to generalize the researcher's findings. In the present study, the target population comprised of all the family care providers of client with schizophrenia in Tamil Nadu.

3.5.2 Accessible population:

Is composed of cases from the target population that are accessible to the researcher as study participants. The accessible populations in the present study comprised of all family care providers of client with schizophrenia attending outpatient department at SCARF, Chennai.

3.6 SAMPLE

The samples for the present study were family care providers of clients with schizophrenia from SCARF, Chennai, in the age group of 18-60 years, who fulfilled the sampling criteria.

3.7 SAMPLE SIZE

The main purpose of the study was to obtain large enough sample to show statistical significance and being economical at the same time. The sample size was 100 family care providers of clients with schizophrenia considering the availability of time, samples and acquaintance of the investigator.

3.8 SAMPLING TECHNIQUE

The purpose of using a sampling technique is to increase representation and to decrease sampling error. In this study, a non-probability purposive sampling technique was used to select the family care providers of clients with schizophrenia who fulfilled the sampling criteria.

3.9 CRITERIA FOR SAMPLE SELECTION

In sampling criteria the researcher specifies the characteristics of the population under the study by detailing the inclusion criteria.

3.9.1 Inclusion criteria

These are the characteristics that each sample elements must possess to be included in the study. In the present study the inclusion criteria were as follows:-

1. Family care providers of clients with schizophrenia
2. Family care providers between the age group of 18 to 60 years
3. Family care providers who were able to communicate in English and Tamil
4. Family care providers who were attending the OPD at SCARF
5. Family care providers who were available at the time of data collection

3.9.2 Exclusion criteria

These are the responses of subjects that require their removal as subjects. In the present study the exclusion criteria were as follows:-

1. Family care providers of clients whose duration of illness was less than six months
2. Family care providers who were illiterate
3. Family care providers who were not the member of client's family or not related to the clients
4. Family care providers who were not willing to participate

3.10 DEVELOPMENT AND DESCRIPTION OF TOOL

In the present study the tool comprised of 4 parts as following:

PART I– Demographic data
PART II- Self-administered Modified Perceived Stress Scale
PART III- Self-administered Modified Family Burden Assessment Scale
PART IV- Self-administered Modified COPE Scale

PART I– Demographic data

1-a) Client demographic details comprised of age, sex, marital status, education, locality, type of family and duration of illness.

1-b) Family care provider demographic details comprised of age, sex, marital status, education, relationship with the client, type of family, occupation, income, locality and duration of care.

PART II – A Self- administered Modified Perceived Stress Scale was used to assess the level of stress of family care providers of clients with schizophrenia. It was adopted from a standardized perceived stress scale which was invented by Mr. William in the year 1995. The modified stress assessment tool contains 20 questions and numbers of positive items were 10 and negative items were 10. Each item in the tool consisted of 4 responses as follows:

RESPONSES	SCORES
Never	0
Rarely	1
Often	2
Always	3

The total score of the tool ranged from 0-60.The higher score indicated high level of stress. The scores were interpreted as follows:

RAW SCORE	PERCENTAGE (%)	LEVEL OF STRESS
<15	25	Mild level
16-35	26-59	Moderate level
36-60	60-100	Severe level

PART III – A Self-Administered Modified Family Burden Assessment Scale was used to assess the level of family burden for the present study. It was invented by SCARF in the year 1987.The Modified Family Burden Assessment Scale contains 25 questions which covers 6 domains as follows:

1. Patient care (4 questions)
2. Personal health (4 questions)
3. Financial burden (4 questions)
4. Family stability (4 questions)
5. Social responsibility (5 questions)
6. Patient behaviour (4 questions)

Each item in the tool consisted of 3 responses as follows

RESPONSES	SCORES
Not at all	0
To some extent	1
Very much	2

The total score of the tool ranged from0-50.The higher the score indicated high level of family burden. The scores were interpreted as follows:

RAW SCORE	PERCENTAGE (%)	LEVEL OF FAMILY BURDEN
<16	32	Low level
17-32	33-64	Moderate level
33-50	66-100	High level

PART IV – A Self-Administered Modified COPE Scale was used for the present study. It was adopted from a standardized COPE scale which was invented by Mr. John Cadre in the year 1995. The modified coping questionnaire consists of 30 questions, 15 questions each under the domains of problem focused and emotion focused coping. Each item in the tool consisted of 4 responses as follows:

RESPONSES	**SCORES**
Never	0
Rarely	1
Often	2
Always	3

The total score of the tool ranged from0-90.The higher the score indicated adequate level of coping. The scores were interpreted as follows:

RAW SCORE	**PERCENTAGE (%)**	**LEVEL OF COPING**
<30	33	Inadequate level
31-60	34-67	Moderate level
61-90	68-100	Adequate level

3.11 VALIDITY OF TOOL

Validity encompasses whether the result obtained meet all of the requirements of the scientific research methods. Content validity of the tool was obtained by submitting the tool to experts including Research experts in the field. In the present, the tool validity was obtained from a psychiatrist, a social worker, a psychologist and two M.Sc. specialized in psychiatric nursing. Six questions were modified as per the suggestions by the experts.

3.12 RELIABILITY OF TOOL

The reliability of the tool was assessed using the split half method. Correlation coefficient was calculated by using the Karl Pearson correlation coefficient.

$$r = \frac{N(\Sigma XY) - (\Sigma X)(\Sigma Y)}{\sqrt{[N\,\Sigma X^2 - (\Sigma X)^2]\,[N\Sigma Y^2 - (\Sigma Y)^2]}}$$

The reliability r' was estimated by using the formula

r'= 2r/1+r

The reliability score for the self-administered modified stress tool was 0.86, reliability score for self-administered modified family burden tool was 0.84 and reliability score for self-administered modified coping tool was 0.99.

3.13 ETHICAL CONSIDERATION

The study was carried out after obtaining an ethical clearance from the ethical committee of Schizophrenia Research Foundation (SCARF). The following ethical principles were followed in course of study.

Ethical Principle	Action Carried out
Principle of beneficence	The study was done to assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia.
Principle of respect for human dignity	Those who were willing to participate were selected as samples for the study and right to withdrawn was ensured before data collection.
Principle of confidentiality	The information regarding the samples and their performance was kept confidential.
Principle of informed consent	Informed consent was obtained from all the samples selected for the study.

3.14 PILOT STUDY

Pilot study is a small scale preliminary study conducted in order to evaluate feasibility, time, cost, adverse events and effectiveness in an attempt to predict an appropriate sample size and improve upon the study design prior to performance of a full scale research project.

In the present study the pilot study was conducted in one week. The pilot study was carried out at SCARF Chennai. Ten family care providers were assessed for the level of stress, family burden and coping. One hour time period was taken by the samples to complete questionnaire. The environment was spacious, calm &well ventilated. After the examination of pilot study, five questions of the tools were reworded for respondents to understand easily.

3.15 DATA COLLECTION PROCEDURE

The permission to carry out the research was obtained from the Director, SCARF. The samples who fulfilled the sample selection criteria were selected by using the non-probability purposive sampling technique. Pilot study samples were excluded from the study. The selected samples were given a brief introduction about the self and the study. Informed consent to participate in the study was obtained. Ethical principles were followed throughout the period of data collection. 3-4 samples were completed each day. Each one took nearly one hour to fill all three questionnaire. The collected data was coded, compiled and tabulated. At the end of the one month period of data collection the investigator collected the data from 100 care providers.

3.16 DATA ANALYSIS PROCEDURE

Data was analyzed using descriptive and inferential statistics.

3.16.1 Descriptive statistics

1. Frequency and percentage distribution was used to assess demographic variables.
2. Mean, SD, frequency and percentage was used to analyze stress, family burden and coping.
3. Correlation coefficient was used to assess the relationship among stress, family burden and coping.

3.16.2 Inferential statistics

1. Chi-square was used to associate stress, family burden and coping of the family caregivers with their selected demographic variables.

DATA ANALYSIS
AND
INTERPRETATION

CHAPTER – 4

DATA ANALYSIS AND INTERPRETATION

Data analysis is the process of systematically applying statistical and logical techniques to condense, describe and illustrate findings of the study. In the present study, the collected data were compiled, analyzed and tabulated under following sections.

ORGANIZATION OF THE DATA

Data collected were organized under the following sections.

SECTION A: Assessment of demographic variables of clients and family care providers of clients with schizophrenia

SECTION B: Assessment of level of Stress, Family Burden and Coping among family care providers of clients with schizophrenia

SECTION C: Assessment of relationship among stress, family burden and coping among family care providers of clients with schizophrenia.

SECTION D: Association of Stress, Family Burden and Coping among family care providers of clients with schizophrenia with their selected demographic variables.

SECTION A: ASSESSMENT OF DEMOGRAPHIC VARIABLES OF CLIENTS AND FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA.

Table 4.1: Frequency and percentage distribution of demographic variables of clients with schizophrenia.

N=100

S. No.	Demographic variables	n	(%)
1	**Age (in years)**		
	18-30	10	10
	31-40	9	9
	41-50	37	37
	51-60	44	44
2	**Sex**		
	Male	35	35
	Female	65	65
3	**Locality**		
	Urban	32	32
	Rural	68	68
4	**Educational status**		
	Illiterate	0	0
	Primary education	36	36
	Secondary education	12	12
	Higher education	19	29
	Graduate	33	33
5	**Marital status**		
	Single	30	30
	Married	60	60
	Separated	10	10
	Widowed	0	0
6	**Duration of illness (in years)**		
	<1	17	17
	1-5	42	42
	6-10	33	33
	>10	8	8
7	**Type of family**		
	Nuclear family	89	89
	Joint family	11	11

The above table 4.1 shows frequency and percentage distribution of demographic variables of clients with schizophrenia.

The findings revealed that with regard to age, 44(44%) are in the age group of 51–60 years and 9 (9%) of them were in the age group of 31-40 years. With respect to sex, 65(65%) of them were females and 35(35%) were males. With regard to locality, most 68(68%) of them belonged to rural area and 32(32%) belonged to urban area.

With regards to educational status, significant 36(36%) of them had primary education. With regard to marital status, majority 60(60%) of them were married. With regard to duration of illness, significant 42(42%) of them had 1-5 years of illness. With regard to relationship with the client, 50(50%) were parents. With respect to type of family, majority 89(89%) of them were from nuclear family.

Most of the clients belong to the age group above 41years. Many of them were female from rural area having primary and graduate education. Majority of them were from nuclear family married and duration of illness was between 1-10 years.

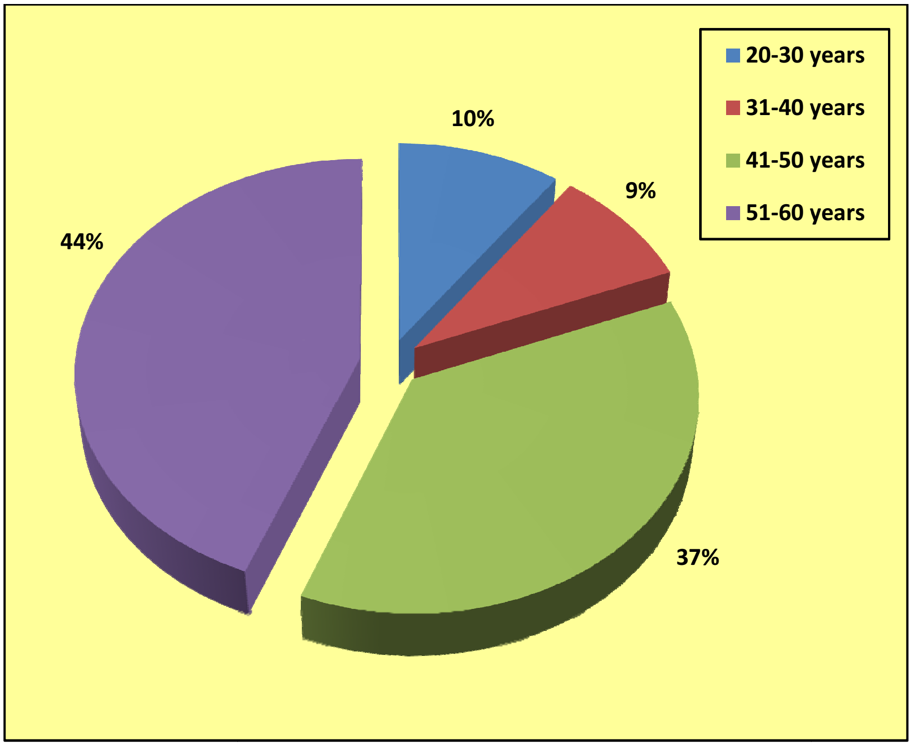

Figure 4.1.1: Percentage distribution of ageof clients with schizophrenia

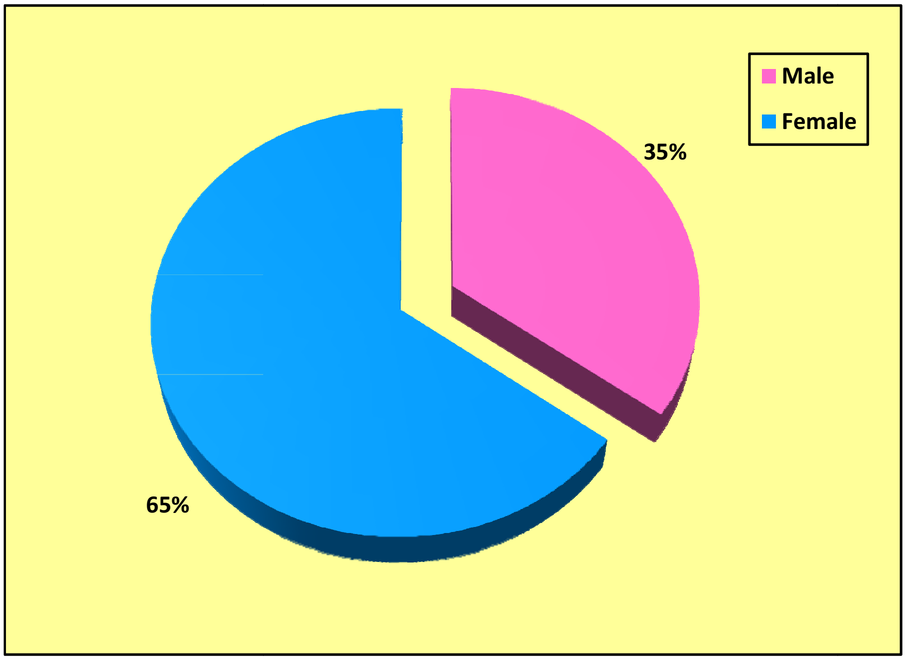

Figure 4.1.2: Percentage distribution of sex of clients with schizophrenia

Table 4.2: Frequency and percentage distribution of demographic variables of family care providers of clients with schizophrenia

N=100

S.No.	Demographic variables	n	(%)
1	**Age (in years)**		
	18-30	14	14
	31-40	10	10
	41-50	36	36
	51-60	40	40
2	**Sex**		
	Male	34	34
	Female	66	66
3	**Locality**		
	Urban	32	32
	Remote	68	68
4	**Educational status**		
	Primary education	36	36
	Secondary education	12	12
	Higher education	19	29
	Graduate	33	33
5	**Marital status**		
	Single	30	30
	Married	60	60
	Separated	10	10
	Widowed	0	0
6	**Work**		
	Job/business	30	30
	House work/farming	60	60
	Others	10	10
7	**Type of family**		
	Nuclear family	79	79
	Joint family	21	21

S.No.	Demographic variables	n	(%)
8	**Monthly Family income(in rupee)**		
	19575	14	14
	9788-19574	17	17
	7323-9787	18	18
	4894-7322	10	10
	2936-4893	27	27
	980-2935	10	10
	<979	14	14
9	**Relationship with client**		
	Parents	36	36
	spouse	47	47
	Sibling’s	14	14
	Others	3	3
10	**Duration of care(in years)**		
	<1	5	5
	1-5	32	32
	6-10	46	46
	>10	17	17

The above table 4.2 shows the frequency and percentage distribution of demographic variables of family care providers of clients with schizophrenia.

The findings revealed that with regard to age, significant 40(40%) were in the age group of 51 –60 years. With respect to sex, majority 66(66%) of them were females and 34(34%) were males. With regard to locality, most 68(68%) of them belonged to rural area and 32(32%) belonged to urban area. With regards to educational status, significant 36(36%) of them had completed primary education.

With regard to marital status, majority 60(60%) of them were married. With respect to work, most 60(60%) of them were doing housework and farming. With respect to type of family, majority 79(79%) of them were from nuclear family. With respect to monthly family income in rupees, 27(27%) receives income ranging between Rs. 2935-4893. With respect to relationship, majority 47(47%) were spouses. With respect to duration of care, majority 46(46%) belonged to 6-10 yrs.

Most of the care givers were female, spouses and parents living in the nuclear family. Many care givers were aged above 41yrs and caring the client for the duration of 1-10 yrs.

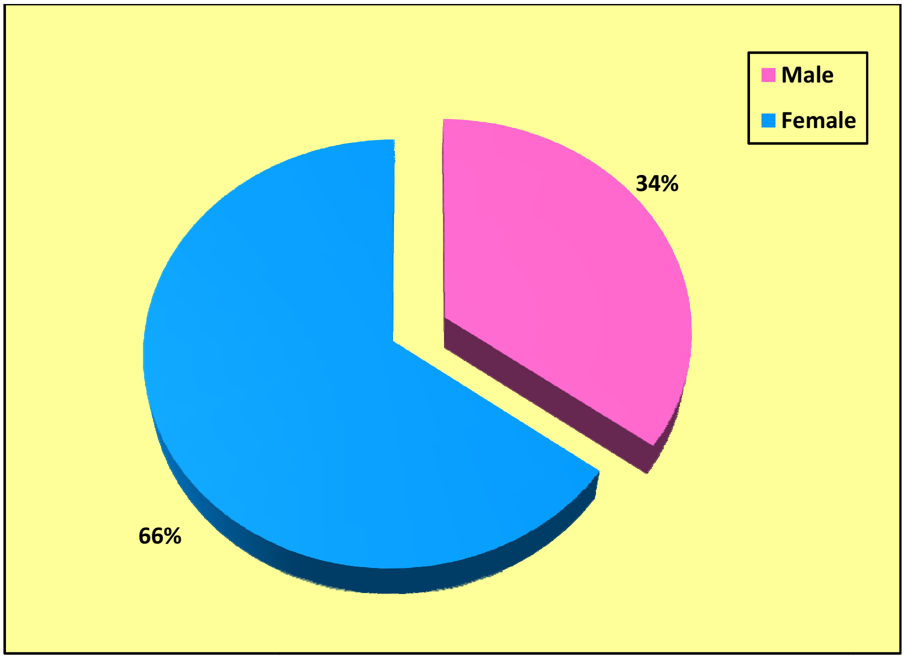

Figure 4.2.1: Percentage distribution of sex of family care providers of clients with schizophrenia

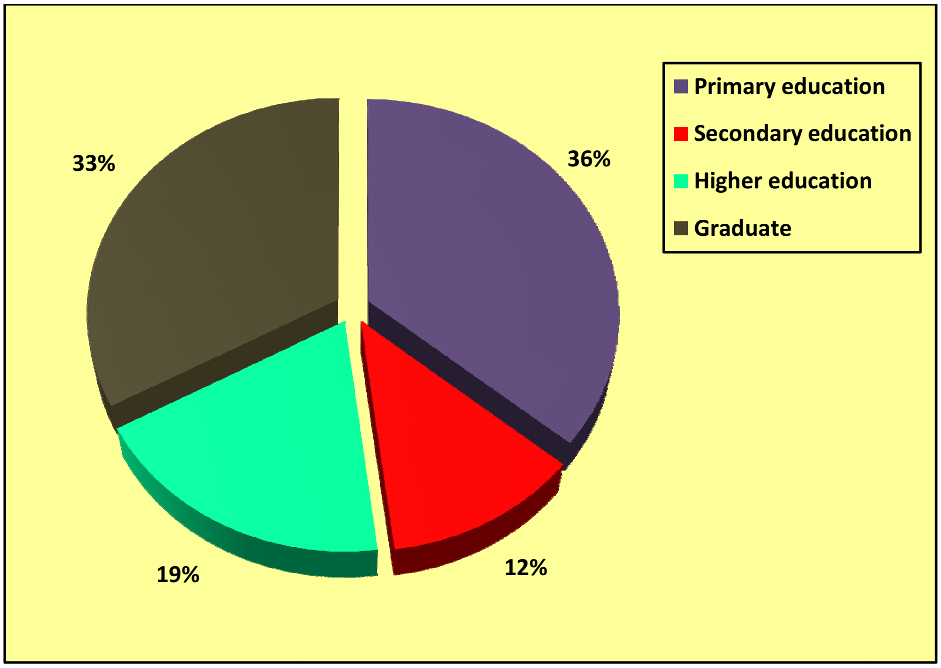

Figure 4.2.2: Percentage distribution of educational status of family care providers of clients with schizophrenia

SECTION B: ASSESSMENT OF LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA.

Table 4.3: Frequency and percentage distribution of level of stress among family care providers of clients with schizophrenia.

N= 100

Variable	**Mild level (≤25%)**		**Moderate level (26 – 59%)**		**Severe level (60 - 100)**	
	n	**%**	**n**	**%**	**n**	**%**
Stress	14	14.0	86	86.0	0	0

The above table 4.3 shows frequency and percentage distribution of level of stress among family care providers of clients with schizophrenia.

The findings revealed that majority of the family care providers 86(86%) had moderate stress and 14(14%) had mild level of stress.

The findings indicate that care givers suffer from mild to moderate level of stress.

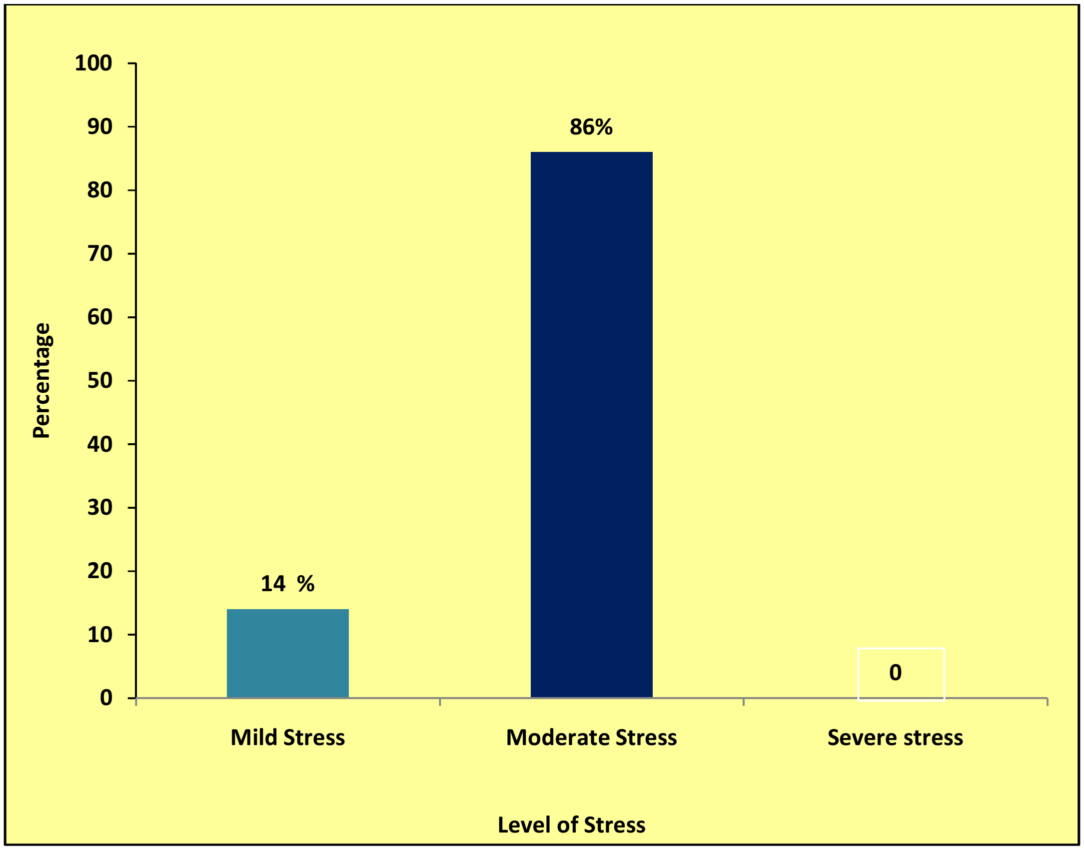

Figure 4.3: Percentage distribution of level of stress among family care providers of clients with schizophrenia

Table 4.4: Frequency and percentage distribution of level of family burden among family care providers of clients with schizophrenia.

N = 100

Family Burden Domains	**Low level (≤32%)**		**Moderate level (33 – 64%)**		**High level (66-100%)**	
	N	**%**	**n**	**%**	**n**	**%**
Patient care	62	62.0	38	38.0	0	0
Personal health	71	71.0	24	24.0	5	5.0
Financial burden	41	41.0	47	47.0	12	12.0
Family stability	52	52.0	38	38.0	10	10.0
Social relationships	83	83.0	17	17.0	0	0
Patient behaviour	36	36.0	52	52.0	12	12.0
Overall	**25**	**25.0**	**75**	**75.0**	**0**	**0**

The above table 4.4 shows frequency and percentage distribution of level of family burden among family care providers of clients with schizophrenia.

Regarding patient care, majority 62(62%) had low level of burden in patient care and 38(38%) had moderate burden in patient care. With respect to personal health, majority 71(71%) had low level of burden, 24(24%) had moderate level of burden and only 5(5%) had high level of burden of personal health. Considering the financial burden, significant of them 47(47%) had moderate level of financial burden, 41(41%) had low level of level of financial burden and 12(12%) had high level of financial burden.

With regard to family stability, significant of them 52(52%) had low burden, 38(38%) had moderate level of burden and 10(10%) had high level of burden of family stability. Regarding social relationships, majority 83(83%) had low level of burden in maintaining social relationships and 17(17%) had moderate level of burden in maintaining social relationships. With respect to patient behaviour, majority 52(52%) had moderate level of burden, 36(36%) had low level of burden and 12(12%) had high level of burden of patient behaviour.

The overall level of family burden revealed that majority 75(75%) had moderate level of family burden and 25(25%) had low level of family burden. The findings revealed that care givers suffer from moderate level of family burden.

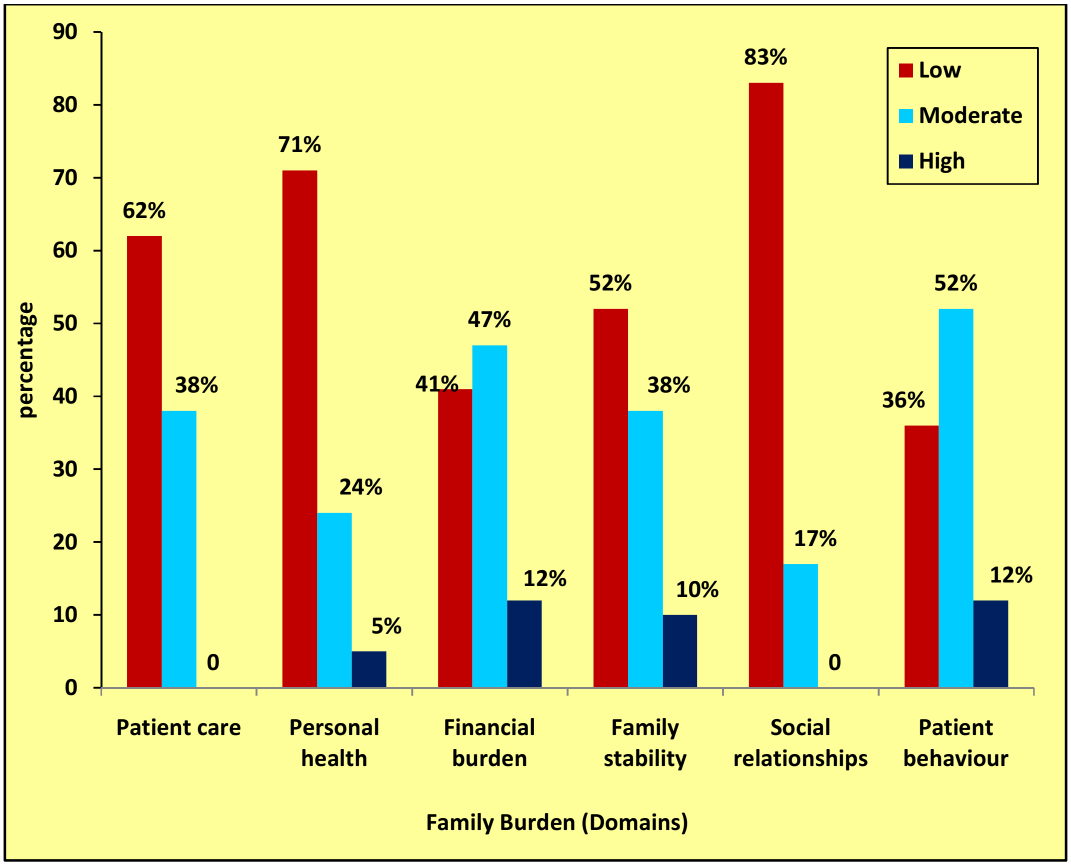

Figure 4.4: Percentage distribution of family burden among family care providers of clients with schizophrenia

Table 4.5: Frequency and percentage distribution of level of coping among family care providers of clients with schizophrenia.

N= 100

Coping Domains	**Inadequate level (≤33%)**		**Moderate level (34 – 67%)**		**Adequate level (68-100%)**	
	N	**%**	**n**	**%**	**N**	**%**
Problem focused	93	93.0	7	7.0	0	0
Emotion focused	74	74.0	26	26.0	0	0
Overall	**88**	**88.0**	**12**	**12.0**	**0**	**0**

The above table 4.5 shows frequency and percentage distribution of level of coping among family care providers of clients with schizophrenia.

Regarding problem focused coping, majority 93(93%) had inadequate level of coping and 7(7%) had moderately adequate level of coping among family care providers of clients with schizophrenia.

With respect to emotion focused coping, majority 74(74%) had inadequate level of coping and 26(26%) had moderate level of coping among family care providers of clients with schizophrenia. The overall level of coping revealed that majority 88(88%) had inadequate level of coping and 12(12%) had moderately adequate level of coping among family care providers of clients with schizophrenia.

The findings indicate that majority of the caregivers had inadequate coping and none of them had adequate coping.

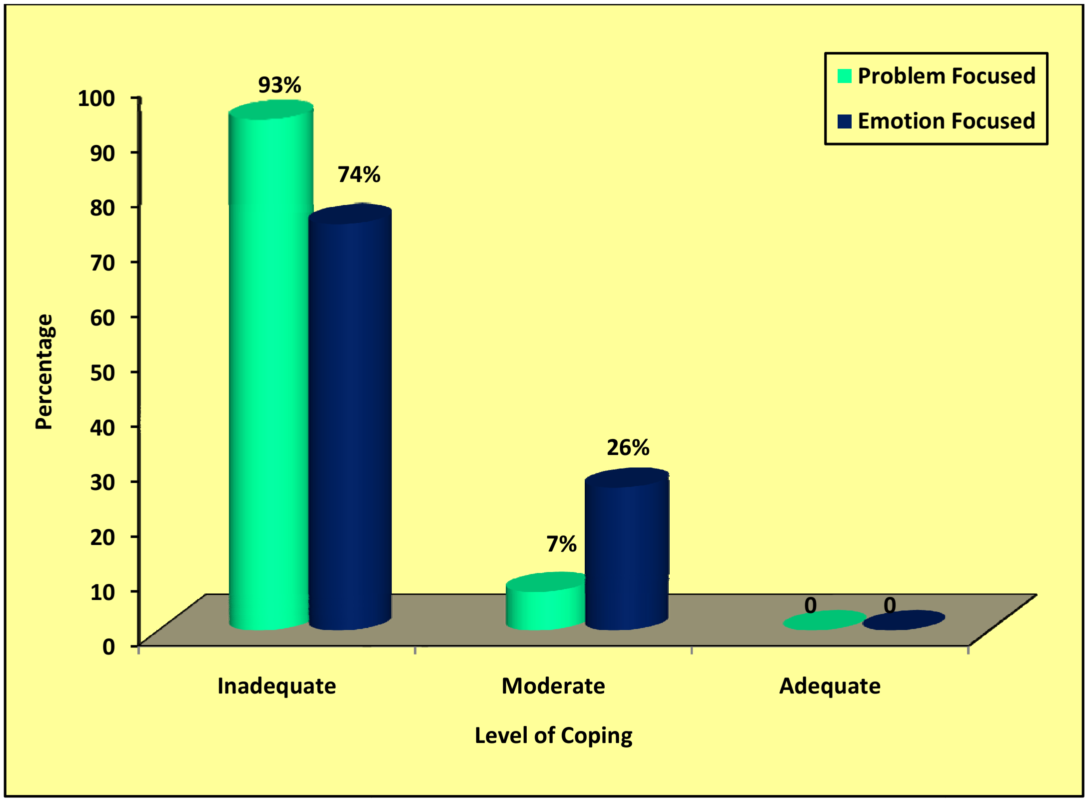

Figure 4.5: Percentage distribution of coping among family care providers of clients with schizophrenia

Table 4.6: Mean and Standard deviation of stress, family burden and coping among family care providers of clients with schizophrenia.

N=100

VARIABLES	MEAN	S.D.
Stress	26.02	4.32
Family burden	27.65	3.92
Coping	38.16	6.56

The above table 4.6 shows mean and standard deviation of stress, family burden and coping among family care providers of clients with schizophrenia.

The findings revealed that the mean of stress was 26.02 with S.D. 4.32, mean of family burden was 27.65 with S.D. 3.92 and mean of coping was 38.16 with S.D. 6.56

SECTION C: ASSESSMENT OF RELATIONSHIP AMONG STRESS, FAMILY BURDEN AND COPING AMONG FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA.

Table 4.7: Correlation among stress, family burden and coping of the family care providers of clients with schizophrenia

N=100

Variables	r value
Stress vs. Coping	-0.051 p = 0.614 N.S
Stress vs. Family burden	0.065 p = 0.522 N.S
Family burden vs. Coping	0.088 p = 0.381 N.S

N.S – Not Significant

The above table 4.7 shows correlation among stress, family burden and coping of the family care providers of clients with schizophrenia.

Regarding the relation between stress and coping, the calculated correlation coefficient value was found to be r = -0.051 which showed a weak negative correlation which in turn indicated that when coping increases stress will be decreased.

Regarding the relation between stress and family burden, the calculated correlation coefficient value was found to be r = 0.065 which showed affair positive correlation which in turn indicated that when stress increases family burden will be increased.

Regarding the relation between family burden and coping, the calculated correlation coefficient value was found to be r = 0.088 which showed affair positive correlation which in turn indicated that when family burden increases coping will be increased.

The above findings highlighted that when stress increases family burden increases and when family burden increases also the coping increases and when coping increases the level of stress is reduced.

SECTION D: ASSOCIATION OF LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG FAMILY CARE PROVIDERS OF CLIENTS WITH SCHIZOPHRENIA WITH THEIR SELECTED DEMOGRAPHIC VARIABLES.

Table 4.8: Association of level of stress among family care providers of clients with schizophrenia with their selected demographic variables.

N = 100

S.No.	Demographic Variables	Mild Stress (≤20)		Moderate Stress (21 – 40)		Chi-Square Value CI= 95%
		No.	%	No.	%	
1	**Age**					$\chi^2 = 1.683$ d.f = 3 p = 0.868 N.S
	18 – 30	2	2.0	24	24.0	
	31 – 40	4	4.0	19	19.0	
	41 – 50	2	2.0	16	16.0	
	51 – 60	6	6.0	27	27.0	
2	**Sex**					$\chi^2 = 1.522$ d.f = 1 p = 0.290 N.S
	Male	5	5.0	46	46.0	
	Female	9	9.0	40	40.0	
3	**Locality**					$\chi^2 = 0.246$ d.f = 1 p = 0.926 N.S
	Urban	6	6.0	43	43.0	
	Rural	8	8.0	43	43.0	
4	**Marital Status**					$\chi^2 = 1.024$ d.f = 2 p = 0.701 N.S
	Single	1	1.0	13	13.0	
	Married	13	13.0	71	71.0	
	Widow/Separated	0	0	2	2.0	
5	**Education**					$\chi^2 = 1.170$ d.f = 3 p = 0.497 N.S
	Primary	4	4.0	17	17.0	
	Secondary	4	4.0	23	23.0	
	Higher secondary	3	3.0	16	16.0	
	Graduate	3	3.0	30	30.0	
6	**Occupation**					$\chi^2 = 1.595$ d.f = 2 p = 0.452 N.S
	Job/Business	4	4.0	31	31.0	
	Homemaker	10	10.0	49	49.0	
	Others	0	0	6	6.0	
7	**Relationship**					$\chi^2 = 1.896$ d.f = 3 p = 0.327 N.S
	Parents	4	4.0	18	18.0	
	Spouse	3	3.0	23	23.0	
	Siblings	4	4.0	15	15.0	
	Others	3	3.0	30	30.0	

S.No.	Demographic Variables	Mild Stress (≤20)		Moderate Stress (21 – 40)		Chi-Square Value CI= 95%
		No.	%	No.	%	
8	**Type of Family**					$\chi^2 = 0.832$ d.f=1 p = 0.459 N.S
	Nuclear	5	5.0	42	42.0	
	Joint	9	9.0	44	44.0	
9	**Family Monthly Income (Rupees)**					$\chi^2 = 4.678$ d.f = 6 p = 0.224 N.S
	19575	7	7.0	22	22.0	
	9788 – 1957	0	0	3	3.0	
	7323 – 9787	2	2.0	12	12.0	
	4894 – 7322	2	2.0	13	13.0	
	2936 – 4893	3	3.0	29	29.0	
	980 – 2935	0	0	5	5.0	
	<979	0	0	2	2.0	
10	**Duration of Care (In years)**					$\chi^2 = 1.617$ d.f = 3 p = 0.437 N.S
	<1	4	4.0	18	18.0	
	1-5	3	3.0	23	23.0	
	6-10	4	4.0	16	16.0	
	>10	3	3.0	29	29.0	

N.S – Not Significant

The above table 4.8 shows association of level of stress among family care providers of clients with schizophrenia with their selected demographic variables.

The findings indicates that there was no statistically significant association found between the level of stress and the demographic variables of family care providers like age, sex, locality, marital status, education, occupation, relationship, type of family, family monthly income(rupees) and duration of care(in years).

Table 4.9: Association of level of family burden among family care providers of clients with schizophrenia with their selected demographic variables.

N = 100

S.No.	Demographic Variables	Low (≤50%)		Moderate (51–75%)		Chi-Square Value CI=95%
		N	%	n	%	
1	**Age**					$\chi^2 = 3.129$ d.f = 3 p = 0.879 N.S
	18 – 30	9	9.0	17	17.0	
	31 – 40	7	7.0	16	16.0	
	41 – 50	3	3.0	15	15.0	
	51 – 60	6	6.0	27	27.0	
2	**Sex**					$\chi^2 = 0.654$ d.f = 1 p = 0.226 N.S
	Male	11	11.0	40	40.0	
	Female	14	14.0	35	35.0	
3	**Locality**					$\chi^2 = 0.333$ d.f = 1 p = 0.711 N.S
	Urban	11	11.0	38	38.0	
	Rural	14	14.0	37	37.0	
4	**Marital Status**					$\chi^2 = 1.778$ d.f = 2 p = 0.321 N.S
	Single	2	2.0	12	12.0	
	Married	23	23.0	61	61.0	
	Separated	0	0	2	2.0	
	Widow	0	0	0	0	
5	**Education**					$\chi^2 = 5.356$ d.f = 3 p = 0.287 N.S
	Primary	2	2.0	19	19.0	
	Secondary	9	9.0	18	18.0	
	Higher secondary	7	7.0	12	12.0	
	Graduate	7	7.0	26	26.0	
6	**Occupation**					$\chi^2 = 1.832$ d.f = 2 p = 0.503 N.S
	Job/Business	6	6.0	29	29.0	
	Homemaker	17	17.0	42	42.0	
	Others	2	2.0	4	4.0	
7	**Relationship**					$\chi^2 = 6.649$ d.f = 3 p = 0.430 N.S
	Parents	2	2.0	20	20.0	
	Spouse	8	8.0	18	18.0	
	Siblings	8	8.0	11	11.0	
	Others	7	7.0	26	26.0	
8.	**Type of family**					$\chi^2 = 3.335$ d.f = 1 p = 0.236 N.S
	Nuclear	13	13.0	34	34.0	
	Joint	12	12.0	41	41.0	

S.No.	Demographic Variables	Low (≤50%)		Moderate (51–75%)		Chi-Square Value CI=95%
		N	%	n	%	
9	**Family Monthly Income (Rupees)**					
	19575	10	10.0	19	19.0	χ^2 = 4.119 d.f = 6 p = 0.921 N.S
	9788 – 1957	0	0	3	3.0	
	7323 – 9787	3	3.0	11	11.0	
	4894 – 7322	3	3.0	12	12.0	
	2936 – 4893	7	7.0	25	25.0	
	980 – 2935	2	2.0	3	3.0	
	<979	0	0	2	2.0	
10	**Duration of Care (In years)**					
	<1	2	2.0	20	20.0	χ^2 = 5.998 d.f = 3 0.399 N.S
	1-5	8	8.0	18	18.0	
	6-10	8	8.0	12	12.0	
	>10	7	7.0	25	25.0	

N.S – Not Significant

The above table 4.10 shows the association of level of family burden among family care providers of clients with schizophrenia with their selected demographic variables.

The findings indicated that none of the demographic variables had shown statistically significant association with level of family burden among family care providers of clients with schizophrenia.

Table 4.10: Association of level of coping among family care providers of clients with schizophrenia with their selected demographic variables.

N = 100

S.No.	Demographic Variables	Inadequate (≤50)		Moderate (51 – 75)		Chi-Square Value
		N	%	N	%	
1	**Age**					$\chi^2 = 2.283$ d.f = 3 p = 0.136 N.S
	18 – 30	21	21.0	5	5.0	
	31 – 40	20	20.0	3	3.0	
	41 – 50	17	17.0	1	1.0	
	51 – 60	30	30.0	3	3.0	
2	**Sex**					$\chi^2 = 3.143$ d.f = 1 p = 0.263 N.S
	Male	42	42.0	9	9.0	
	Female	46	46.0	3	3.0	
3	**Locality**					$\chi^2 = 0.475$ d.f = 1 p = 0.170 N.S
	Urban	42	42.0	7	7.0	
	Rural	46	46.0	5	5.0	
4	**Marital Status**					$\chi^2 = 0.681$ d.f = 2 p = 0.703 N.S
	Single	13	13.0	1	1	
	Married	73	73.0	11	11.0	
	Separated	2	2.0	0	0	
	Widow	0	0	0	0	
5	**Education**					$\chi^2 = 2.651$ d.f = 3 p = 0.858 N.S
	Primary	20	20.0	1	1.0	
	Secondary	22	22.0	5	5.0	
	Higher secondary	16	16.0	3	3.0	
	Graduate	30	30.0	3	3.0	
6	**Occupation**					$\chi^2 = 3.453$ d.f = 2 p = 0.119 N.S
	Job/Business	30	30.0	5	5.0	
	Homemaker	54	54.0	5	5.0	
	Others	4	4.0	2	2.0	
7	**Relationship**					$\chi^2 = 2.968$ d.f = 3 p = 0.720 N.S
	Parents	21	21.0	1	1.0	
	Spouse	21	21.0	5	5.0	
	Siblings	16	16.0	3	3.0	
	Others	30	30.0	3	3.0	

S.No.	Demographic Variables	Inadequate (≤50)		Moderate (51 – 75)		Chi-Square Value
		N	%	N	%	
8	**Type of Family**					$\chi^2 = 0.703$ d.f = 1 p = 0.621 N.S
	Nuclear	40	40.0	7	7.0	
	Joint	48	48.0	5	5.0	
9	**Family monthly income (rupees)**					$\chi^2 = 2.650$ d.f = 6 p = 0.311 N.S
	19575	26	26.0	3	3.0	
	9788-1957	3	3.0	0	0	
	7323 – 9787	11	11.0	3	3.0	
	4894 – 7322	13	13.0	2	2.0	
	2936 – 4893	28	28.0	4	4.0	
	980 – 2935	5	5.0	0	0	
	<979	2	2.0	0	0	
10	**Duration of Care (In years)**					$\chi^2 = 2.824$ d.f = 3 p = 0.792 N.S
	<1	21	21.0	1	1.0	
	1-5	21	21.0	5	5.0	
	6-10	17	17.0	3	3.0	
	>10	29	29.0	3	3.0	

N.S – Not Significant

The above table 4.9 shows association of level of coping among family care providers of clients with schizophrenia with their selected demographic variables.

The findings indicates that there was no statistically significant association found between the level of coping and the demographic variables of family care providers like age, sex, locality, marital status, education, occupation, relationship, type of family, family monthly income(rupees) and duration of care(in years).

DISCUSSION

CHAPTER – 5

DISCUSSION

This chapter includes a brief overview of the research process, summary of main findings, implications, suggestions and recommendations for further research. The study was conducted to assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia in a selected psychiatric unit.

Description of demographic variables of clients

The findings revealed that with regard to age, 44(44%) are in the age group of 51 –60 years and 9 (9%) of them were in the age group of 31-40 years. With respect to sex, 65(65%) of them were females and 35(35%) were males. With regard to locality, majority 68(68%) of them belonged to rural area and 32(32%) belonged to urban area.

With regards to educational status, significant 36(36%) of them had primary education. With regard to marital status, majority 60(60%) of them were married. With regard to duration of illness, significant 42(42%) of them had 1-5 yrs of illness. With regard to relationship with the client, 50(50%) were parents. With respect to type of family, majority 89(89%) of them were from nuclear family.

The study findings revealed that most of the clients belong to the age group above 41yrs. Many of them were female from rural area having primary and graduate education. Majority of them were from nuclear family married and duration of illness was between 1-10 years.

Description of demographic variables of family care providers

The findings revealed that with regard to age, significant 40(40%) were in the age group of 51 –60 years. With respect to sex, majority 66(66%) of them were females and 34(34%) were males. With regard to locality, most 68(68%) of them belonged to rural area and 32(32%) belonged to urban area. With regards to educational status, significant 36(36%) of them had completed primary education. With regard to marital status, majority 60(60%) of them were married. With respect to work, most 60(60%) of them were doing housework and farming. With regard to type of family, majority 79(79%) of them were from nuclear family. With respect to monthly family income in rupees, 27(27%) receives income ranging between Rs.2935-4893. With regard to relationship, majority 47 (47%) were spouses. With respect to duration of care, majority46 (46%) belonged to 6-10 yrs.

Most of the care givers were female, spouses and parents living in the nuclear family. Many care givers were aged above 41yrs and caring the client for the duration of 1-10 yrs.

The first objective of the study was to assess the level of stress, family burden and coping among the family care providers of client with schizophrenia.

Regarding the stress majority of the family care providers 86(86%) had moderate stress and 14(14%) had mild level of stress. The mean of stress was 26.02 with S.D. of 4.32.

Regarding the family burden of the family care providers 75(75%) had moderate level of family burden and 25(25%) had low level of family burden. The mean of family burden was 27.65 with S.D. of 3.92.

Regarding the coping of the family care providers 88(88%) had inadequate level of coping and 12(12%) had moderately adequate level of coping. The mean of coping was 38.16 with S.D. of 6.56.

The findings revealed care givers suffer from mild to moderate level of stress, moderate level of family burden, majority of the caregivers had inadequate coping and none of them had adequate coping. The above findings are supported by the following study:

Sunil (2005) conducted a cross sectional study to measure the perception of burden and level of stress by caregivers of patients with schizophrenia at Institute of Mental Health and Hospital, Agra. The BAS was used. The sample comprised of 34 caregivers of patient with schizophrenia. A low positive correlation was found between urban domiciles and support of the patient and the caregiver's routine. It showed that urban people had more stress and was seen high in females compared to males. Married people had more stress. There was a low positive correlation between age less than 30 years and the physical and mental health of the caregiver, and with taking responsibility. Illness severity and patients' disability had a direct positive relationship with perceived family burden. This study suggested to develop local needs based support programme for families of patients with psychiatric disorders in India.

Ram (2012) had conducted a descriptive study on burden and coping in caregivers of patient with schizophrenia at National Institute of Health and Neurosciences, Bangalore. The sample comprised of 24 parents and 24 spouses. Patients were assessed on Global Assessment Scale (GAS) and caregivers were assessed on Burden Assessment schedule (BAS) and the Coping Checklist (CCL). Mean total burden experienced by the spouses is greater than by the parents. Spouses reported greater emotional burden. Parents used more of denial as a coping strategy while spouses used negative distraction strategies. Patient’s age, educational level, caregiver’s use of denial as a coping strategy emerged as significant predictors of caregiver burden. The study highlighted the fact that family intervention programs need to address the specific concerns of caregivers.

The second objective of the study was to correlate the level of stress, family burden and coping among the family care providers of clients with schizophrenia.

Regarding the relation between stress and coping, the calculated correlation coefficient value was found to be r = -0.051 which showed a weak negative correlation which in turn indicated that when coping increases stress will be decreased.

Regarding the relation between stress and family burden, the calculated correlation coefficient value was found to be r = 0.065 which showed affair positive correlation which in turn indicated that when stress increases family burden will be increased.

Regarding the relation between family burden and coping, the calculated correlation coefficient value was found to be r = 0.088 which showed affair positive correlation which in turn indicated that when family burden increases coping will be increased.

The above findings are supported by the following study:

Chandarashekaran (2009) had conducted a descriptive study on coping strategies of the relatives of schizophrenic patients in India. The sample comprised of 44 relatives of patients with schizophrenia. 44 relatives from an outpatient psychiatric clinic were assessed. Resignation is an emotional focused strategy, was found to be more commonly employed by the relatives, than other strategies. Majority of the relatives failed to maintain social contacts. Levels of burden and negative symptoms correlated significantly with the resignation strategy. Analysis of the coping strategies of the relatives is essential before planning clinical interventions with families in order to improve the coping skills of the caregivers.

Hence the hypothesis (H_1) stated earlier that **"there is a significant relationship among the level of stress, family burden and coping of the family care providers of client with schizophrenia"** is accepted.

The third objective of the study was to associate the level of stress, family burden and coping with the selected demographic variables of the family care providers of clients with schizophrenia

The findings indicates that there was no statistically significant association found between the level of stress, family burden and coping of family care providers and the demographic variables like age, sex, locality, marital status, education, occupation, relationship, type of family, family monthly income(rupees) and duration of care(in years).

The above findings are contradicted by the following study:

Ukpong (2006) conducted a study to examine the demographic factors and clinical correlates of burden and distress in relatives of service users experiencing schizophrenia, in Nigeria. This cross-sectional study used the Carer Burden Index and the 30-item General Health Questionnaire to assess burden and distress in relatives, and the Brief Psychiatric Rating Scale and the Scale for Assessment of Negative Symptoms, to rate the positive and negative symptoms of schizophrenia, respectively. High levels of emotional distress and burden were observed in the caregivers and they were significantly associated with some demographic variables. They were also significantly associated with positive and negative symptoms of schizophrenia. Because Nigerian families continue to play a primary care- giving role for their relatives experiencing schizophrenia, there is a need to focus on specific interventions that will reduce their high levels of distress and burden.

Hence the hypothesis (H_2) stated earlier that **"there is a significant association of the level of stress, family burden and coping with the selected demographic variables of the family care providers of client with schizophrenia"** was not accepted.

SUMMARY, CONCLUSION, NURSIN G IMPLICATION, RECOMMENDATION AND LIMITATION

CHAPTER – 6

SUMMARY, CONCLUSION, NURSING IMPLICATION, RECOMMENDATION AND LIMITATION

This chapter includes a brief overview of the research process, summary of main findings, implications, suggestions and recommendations for further research.

6.1 SUMMARY

WHO Report (2008) stated that India with a population of more than one billion is home to one sixth of the world's mentally ill. Psychiatrists estimate that about two percent of Indians suffer from mental illnesses i.e. a staggering 20 million people out of a population of one billion. Families touched by mental illness are often faced with significant financial burdens that arise from healthcare costs and job loss.

The problem statement of the present study was a descriptive study to assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia in a selected psychiatric unit.

The objective of the study were,

1. To assess the level of stress, family burden and coping among the family care providers of clients with schizophrenia
2. To correlate the level of stress, family burden and coping of the family care providers of clients with schizophrenia
3. To associate the level of stress, family burden and coping with the selected demographic variables of the family care providers of clients with schizophrenia.

The hypotheses of the study were,

H_1– There is a significant relationship among the level of stress, family burden and coping of the family care providers of clients with schizophrenia

H_2 – There is a significant association of the level of stress, family burden and coping with the selected demographic variables of the family care providers of clients with schizophrenia

The assumption of the study were,

1. The level of stress experienced by family care providers vary from person to person.
2. The client with schizophrenia has an impact on the level of stress, family burden, and coping experienced by the family care providers.
3. The methods of coping used by the family care providers be adaptive or maladaptive.

Research methodology

A non experimental descriptive design was used in the study. The study was conducted at Schizophrenia Research Foundation, Chennai. The permission to carry out research was obtained from The Director of SCARF, Chennai. Consent from family care providers of clients with schizophrenia was obtained. 100 family care providers those who fulfilled the inclusion criteria were selected by using non probability purposive sampling technique. Tools used were modified perceived stress assessment scale, modified family burden scale and modified COPE scale. The ethical principles were followed accordingly. The data was coded, tabulated and analyzed using both descriptive and inferential statistics.

Major findings of the study

Regarding the stress majority of the family care providers 86(86%) had moderate stress and 14(14%) had mild level of stress. The mean of stress was 26.02 with S.D. of 4.32.

Regarding the family burden of the family care providers 75(75%) had moderate level of family burden and 25(25%) had low level of family burden. The mean of family burden was 27.65 with S.D. of 3.92.

Regarding the coping of the family care providers 88(88%) had inadequate level of coping and 12(12%) had inadequate level of coping. The mean of coping was 38.16 with S.D. of 6.56.

The findings indicate that care givers suffer from mild to moderate level of stress, moderate level of family burden, inadequate coping and none of them had adequate coping.

Regarding the relation between stress and coping, the calculated correlation coefficient value was found to be r = -0.051 which showed a weak negative correlation which in turn indicated that when coping increases stress will be decreased.

Regarding the relation between stress and family burden, the calculated correlation coefficient value was found to be r = 0.065 which showed affair positive correlation which in turn indicated that when stress increases family burden will be increased.

Regarding the relation between family burden and coping, the calculated correlation coefficient value was found to be r = 0.088 which showed affair positive correlation which in turn indicated that when family burden increases coping will be increased.

The findings also indicated that there was no statistically significant association found between the level of stress, family burden and coping of family care providers and the demographic variables like age, sex, locality, marital status, education, occupation, relationship, type of family, family monthly income (rupees) and duration of care (in years) and none of the demographic variables had shown statistically significant association with level of coping among family care providers of clients with schizophrenia.

6.2 CONCLUSION

The study concluded that when stress increases family burden increases which in turn increases level of coping, and when coping increases the level of stress is reduced.

6.3 NURSING IMPLICATION

6.3.1 Nursing Education

1. Nurses should give attention to improve the knowledge of schizophrenia and its treatment and prevention.
2. Inadequate knowledge will lead to high prevalence of stress and family burden among family care providers of clients with schizophrenia.
3. Therefore the family care providers must be aware of the nature of the disease, its treatment and prevention.

6.3.2 Nursing Research

1. The study creates awareness for further studies among family care providers of clients with schizophrenia.
2. Further, researcher can use this study as a valuable reference material. Large scale studies can be conducted.

6.3.3 Nursing Management

Steps should be taken by the higher authorities to organize seminars and workshops for the up gradation of knowledge through skilful training for health professionals.

6.3.4 Nursing Administration

Classes should be provided for family care providers which will help them how to tackle stress, coping and family burden while caring for clients with schizophrenia.

6.4 RECOMMENDATION

1. A similar study can be conducted on a larger sample using random sampling technique for broader generalization.
2. The same study can be replicated in urban, semi urban and rural settings.
3. A longitudinal prospective study can be carried out to rule out the causes of stress, family burden and coping among family care providers of clients with schizophrenia.
4. Interventional studies may be carried out on larger sample.

6.5 LIMITATION

The study was restricted to caregivers of schizophrenic clients in SCARF, Chennai.

6.6 COMMUNICATION OF FINDINGS

The findings of the research will be disseminated through paper presentation both in conferences, workshops at the national and international level and will be published in specialty Journal Indian Society of Psychiatry Nurses (ISPN) or research journals and articles.

6.7 UTILIZATION OF THE RESEARCH FINDINGS

The findings of the research highlighted the fact that family intervention programmes are needed to address the specific concerns of family care providers of clients with schizophrenia.

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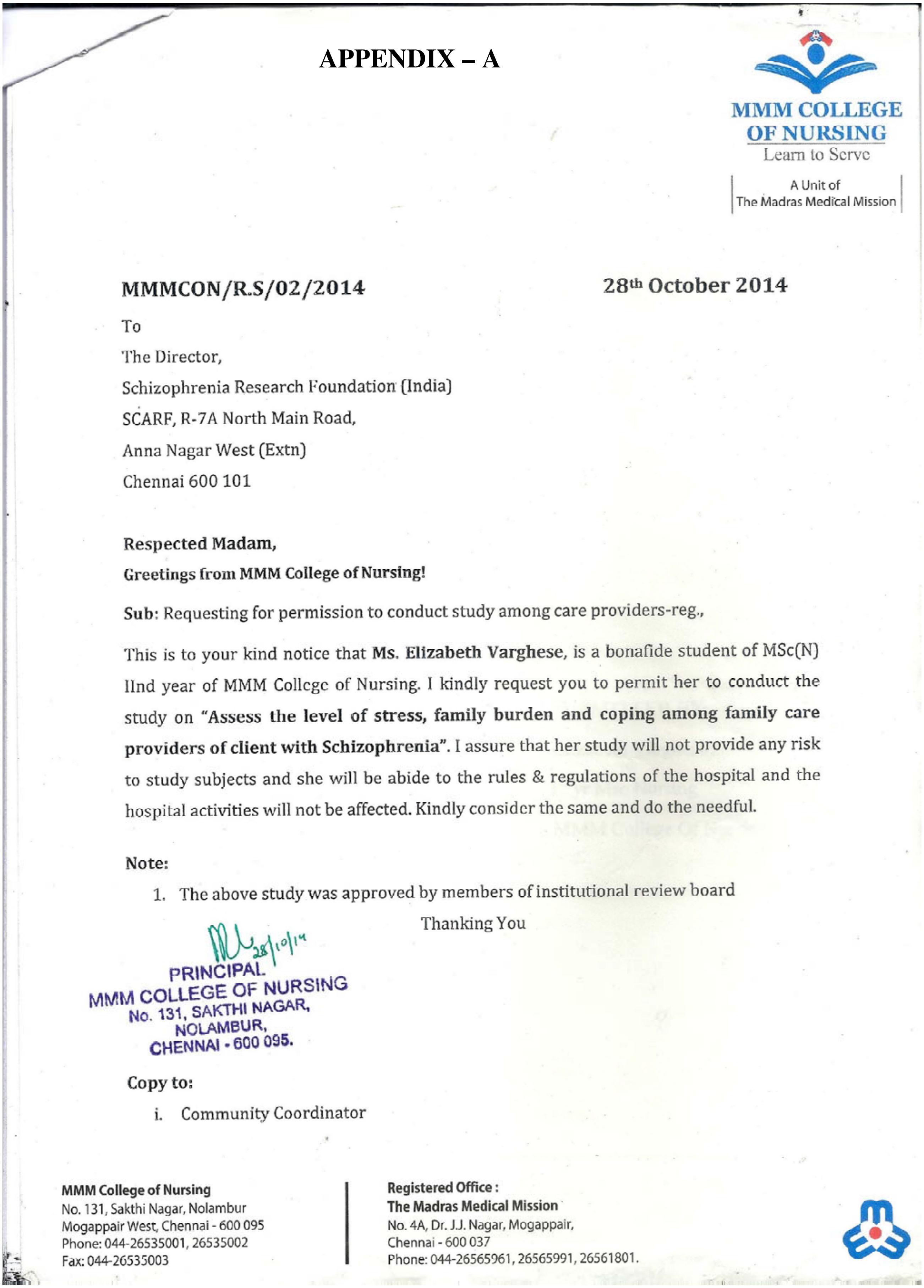
APPENDICES

APPENDIX – A



MMM COLLEGE
OF NURSING
Learn to Serve

A Unit of
The Madras Medical Mission

MMMCON/R.S/02/2014 **28th October 2014**

To
The Director,
Schizophrenia Research Foundation (India)
SCARF, R-7A North Main Road,
Anna Nagar West (Extn)
Chennai 600 101

Respected Madam,

Greetings from MMM College of Nursing!

Sub: Requesting for permission to conduct study among care providers-reg.,

This is to your kind notice that **Ms. Elizabeth Varghese**, is a bonafide student of MSc(N) IInd year of MMM College of Nursing. I kindly request you to permit her to conduct the study on **"Assess the level of stress, family burden and coping among family care providers of client with Schizophrenia"**. I assure that her study will not provide any risk to study subjects and she will be abide to the rules & regulations of the hospital and the hospital activities will not be affected. Kindly consider the same and do the needful.

Note:

1. The above study was approved by members of institutional review board

Thanking You

28/10/14

PRINCIPAL
MMM COLLEGE OF NURSING
No. 131, SAKTHI NAGAR,
NOLAMBUR,
CHENNAI - 600 095.

Copy to:

i. Community Coordinator

MMM College of Nursing
No. 131, Sakthi Nagar, Nolambur
Mogappair West, Chennai - 600 095
Phone: 044-26535001, 26535002
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Registered Office :
The Madras Medical Mission
No. 4A, Dr. J.J. Nagar, Mogappair,
Chennai - 600 037
Phone: 044-26565961, 26565991, 26561801.

SCARF
INDIA

Schizophrenia Research
Foundation

WHO Collaborating Centre for Mental Health Research & Training

Founder Dr M. Sarada Menon • President : Mr R. Seshasayee • Director : Dr R. Thara

29 NOV. 2014

Elizabeth Varghese
1st Year MSc Nursing
MMM College of Nursing
Chennai 600095

Dear Ms. Varghese

We have received your request for permission to collect data at SCARF, for your proposed study "Assess the level of stress, family burden and coping among family care providers of client with schizophrenia".

We are herby granting you approval for the same.

Please note that the necessary administrative fee should be paid and registration process completed with the Student Placement Coordinator at SCARF prior to commencement of the study.

Regards

Dr. R. Thara
Director, SCARF

Mental Health Centre, R/7A.North Main Road, Anna Nagar (West Extn.), Chennai 600 101
Tel.: 044 - 2615 1073,2615 3971 ÷ Fax: 044 - 2615 3971 ÷ E-mail: info@scarfindia.org ÷ www.scarfindia.org
(Registered under Tamil Nadu Societies Registration Act - 1975, Reg.No. 24/84)

APPENDIX – B

INFORMED CONSENT FORM

I confirm that I have been explained and have clearly understood the purpose of the study. I understand that my participation is voluntary and I am free to withdraw from the study.

I understand that trained researcher will administer the questions which will take about an hour and all information will be confidential.

I agree to take part in above study voluntarily.

Participants Sign: **Researcher Sign:**

APPENDIX – C

INTRODUCTION

Good Morning,

I Ms. Elizabeth Varghese, M.Sc. (N) student of MMM CON, Mogappair, Chennai is conducting a study to assess the level of stress, family burden and coping among family care providers of clients with schizophrenia.

I request you to participate in this study, by giving your free and frank opinions being asked, your responses will be kept confidential and used only for the research study.

Further I request you to kindly answer all question to the best of your knowledge.

Thanking you.

TOOL

BASELINE PERFORMA

Instruction: The investigator will explain the purpose of the study to the participants and obtain informed consent. The participant reads the questions and ticks against the relevant answer.

DEMOGRAPHIC TOOL OF CLIENTS

1 **Age (in years)**
a. 18-30 b. 31-40 c. 41-50 d. 51-60

2 **Sex**
a. Male b. Female

3 **Education**
a.Illiterate b. Primary c. Secondary d. Higher e.Graduate

4 **Locality**
a. urban b. rural

5 **Marital status**
a. Single b. Married c. Widowed d. Separated

6 **Type of family**
a. Nuclear b. Joint

7 **Duration of illness (in years)**
a.<1 b.1 to 5 c. 6 to 10 d. >10

DEMOGRAPHIC TOOL OF FAMILY CARE PROVIDERS

1 **Age (in years)**

a. 18-30 b. 31-40 c. 41-50 d. 51-60

2 **Sex**

a. Male b. Female

3 **Education**

a. Primary b. Secondary c. Degree d. Graduate

4 **Work**

a. Job/Business b.House work/farming c.Others

5 **Locality**

a. Urban b. Rural

6 **Marital status**

a. Single b. Married c. Separated d. Widowed

7 **Type of family**

a. Nuclear b. Joint

8 **Relationship with client**

a. Parents b. Spouse c. Sibling's d. Others

9 **Monthly Family income (in rupees)**

a. 19575 b. 9788-19574 c. 7323-9787 d. 4894-7322

e. 2936-4893 f. 980-2935 g. <979

10 **Duration of care (years)**

a.<1 b.1 to 5 c. 6 to 10 d. >10

SELF ADMINISTERED MODIFIED PERCEIVED STRESS ASSESSMENT SCALE

1 I am having little interest or pleasure in doing things

a) Never b) Rarely c) Often d) Always

2 I am feeling down, depressed ,or hopeless

a) Never b) Rarely c) Often d) Always

3 I am having trouble falling asleep

a) Never b) Rarely c) Often d) Always

4 I am sleeping too much

a) Never b) Rarely c) Often d) Always

5 I am feeling tired or having little energy

a) Never b) Rarely c) Often d) Always

6 I am having poor appetite

a) Never b) Rarely c) Often d) Always

7 I am overeating

a) Never b) Rarely c) Often d) Always

8 I am having trouble concentrating on things , such as reading the newspaper or watching television

a) Never b) Rarely c) Often d) Always

9 I am feeling anxious , nervous or on edge

a) Never b) Rarely c) Often d) Always

10 I am not being able to stop or control worrying

a) Never b) Rarely c) Often d) Always

11 I am worrying too much about different things

a) Never b) Rarely c) Often d) Always

12 I am having trouble relaxing

a) Never b) Rarely c) Often d) Always

13 I am being so restless that it is hard to sit still

a) Never b) Rarely c) Often d) Always

14 I am becoming easily annoyed or irritable

a) Never b) Rarely c) Often d) Always

15 I am becoming very emotional

a) Never b) Rarely c) Often d) Always

16 I am having physical pain

a) Never b) Rarely c) Often d) Always

17 I am having nightmares

a) Never b) Rarely c) Often d) Always

18 I am trying hard not to think about it or went out of your way to avoid situation that troubles

a) Never b) Rarely c) Often d) Always

19 I am were constantly on guard , watchful , or easily startled

a) Never b) Rarely c) Often d) Always

20 I am feeling numb or detached from others, activities, or surroundings

a) Never b) Rarely c) Often d) Always

SELF ADMINISTERED MODIFIEDFAMILY BURDEN ASSESSMENT SCALE

PATIENT CARE

1 Are you satisfied with the way the patient looks after himself?

a. Not at all b. To some extent c. Very much

2 Do you feel you have to take the responsibility of ensuring that the patient has everything he needs?

a. Not at all b. To some extent c. Very much

3 Do you think you have to compensate the patient's shortcomings, in general?

a. Not at all b. To some extent c. Very much

4 Does support from your family help in caring for the patient?

a. Not at all b. To some extent c. Very much

PERSONAL HEALTH

5 Does caring for the patient make you feel easily tired and exhausted?

a. Not at all b. To some extent c. Very much

6 Do you think that your health has been affected because of the patient’s illness?

a. Not at all b. To some extent c. Very much

7 Do you find time to look after you health?

a. Not at all b. To some extent c. Very much

8 Are you able to relax for sometime during the day?

a. Not at all b. To some extent c. Very much

FINANCIAL BURDEN

9 Is the current financial position adequate to look after the patient?

a. Not at all b. To some extent c. Very much

10 Are you concerned that you are largely responsible to meet the patient's financial need?

a. Not at all b. To some extent c. Very much

11 Does the patient's future financial situation worry you?

a. Not at all b. To some extent c. Very much

12 Has your family's financial situation worsened since the patient's illness?

a. Not at all b. To some extent c. Very much

FAMILY STABILITY

13 Does the patient cause disturbances in the home?

a. Not at all b. To some extent c. Very much

14 Are you able to care for others in your family?

a. Not at all b. To some extent c. Very much

15 Has your family stability been disrupted by your relative's illness(frequent quarrels, break-up)?

a. Not at all b. To some extent c. Very much

16 Does the patient’s illness prevent you from having satisfying relationship with the rest of your family?

a. Not at all b. To some extent c. Very much

SOCIAL RELATIONSHIPS

17 Does support from friends help in caring for the patient?

a. Not at all b. To some extent c. Very much

18 Does sharing your problems with others make you feel better?

a. Not at all b. To some extent c. Very much

19 Do you feel that your friends appreciate the way you handle the patients?

a. Not at all b. To some extent c. Very much

20 Do you have the feeling that your relative understands and appreciates your effort to help him /her?

a. Not at all b. To some extent c. Very much

21 Are you satisfied with the amount of help that you are getting from health professionals regarding your illness?

a. Not at all b. To some extent c. Very much

PATIENT BEHAVIOUR

22 Does the patient's 'unpredictable behaviour disturbs you?

a. Not at all b. To some extent c. Very much

23 Do you often feel frustrated that the improvement of the patient is slow?

a. Not at all b. To some extent c. Very much

24 Does you relative's illness prevent you from having satisfying relationships with your friends?

a. Not at all b. To some extent c. Very much

25 Have you started to feel lonely and isolated since the patient's illness?

a. Not at all b. To some extent c. Very much

SELF ADMINISTERED MODIFIED COPE SCALE

PROBLEM FOCUSSED

1 I try to grow as a person as a result of the experiences

a) Never b) Rarely c) Often d) Always

2 I turn to work or other substitute activities to take my mind off things

a) Never b) Rarely c) Often d) Always

3 I try to get advice from someone about what to do

a) Never b) Rarely c) Often d) Always

4 I concentrate my efforts on doing something about it

a) Never b) Rarely c) Often d) Always

5 I restrain myself from doing anything too quickly

a) Never b) Rarely c) Often d) Always

6 I take additional action to try to get rid of the problem

a) Never b) Rarely c) Often d) Always

7 I accept the reality of the fact that it happened

a) Never b) Rarely c) Often d) Always

8 I think hard about what steps to take

a) Never b) Rarely c) Often d) Always

9 I learn something from the experience

a) Never b) Rarely c) Often d) Always

10 I ask people who have had similar experiences what they did

a) Never b) Rarely c) Often d) Always

11 I take direct action to get around the problem

a) Never b) Rarely c) Often d) Always

12 I force myself to wait for the right time to do something

a) Never b) Rarely c) Often d) Always

13 I reduce the amount of effort I'm putting into solving the problem

a) Never b) Rarely c) Often d) Always

14 I learn to live with it

a) Never b) Rarely c) Often d) Always

15 I do what has to be done , one step at a time

a) Never b) Rarely c) Often d) Always

EMOTION FOCUSSED

16 I get upset and let my emotions out

a) Never b) Rarely c) Often d) Always

17 I say to myself “this isn’t real”

a) Never b) Rarely c) Often d) Always

18 I put my trust in God

a) Never b) Rarely c) Often d) Always

19 I laugh about the situation

a) Never b) Rarely c) Often d) Always

20 I admit to myself that I can’t deal with it , and quit trying

a) Never b) Rarely c) Often d) Always

21 I discuss my feelings with someone

a) Never b) Rarely c) Often d) Always

22 I use alcohol or drugs to make myself feel better

a) Never b) Rarely c) Often d) Always

23 I talk to someone to find out more about the situation

a) Never b) Rarely c) Often d) Always

24 I accept that this has happened and that it can’t be changed

a) Never b) Rarely c) Often d) Always

25 I try to get emotional support from friends or relatives

a) Never b) Rarely c) Often d) Always

26 I try to see it in a different light, to make it seem more positive

a) Never b) Rarely c) Often d) Always

27 I talk to someone who could do something concrete about the problem

a) Never b) Rarely c) Often d) Always

28 I sleep more than usual

a) Never b) Rarely c) Often d) Always

29 I look for something good in what is happening

a) Never b) Rarely c) Often d) Always

30 I feel a lot of emotional distress and I find myself expressing those feelings a lot

a) Never b) Rarely c) Often d) Always

முன்னுரை

வணக்கம் :

நான் எலிசபெத் வர்கீஸ் இரண்டாம் வருட முதுகலை செவிலியர் பட்டப்படிப்பு முகப்பேறில் உள்ள எம்.எம்.எம். செவிலியர் கல்லூரியில் பயின்று வருகின்றேன். எனது படிப்பில் ஒரு பகுதியாக மூளைக் கோளாறு கொண்ட நோயாளிகளுக்கு குடும்ப பாதுகாப்பு வழங்குநர்கள் மத்தியில் ஏற்படும் மனஅழுத்தம், குடும்ப சுமை மற்றும் குடும்ப சுமையை சமாளிப்பதின் அளவை கண்டறிய ஆய்வு நடத்துகிறேன். இதன் தொடர்பாக நான் தங்களிடம் கொடுக்கும் கேள்வித்தாளை பூர்த்தி செய்து தங்களின் மேலான ஒத்துழைப்பை அளிக்குமாறு வேண்டுகிறேன். தங்களின் கருத்துகள் மிகவும் ரகசியமாக வைக்கப்படும். எனது ஆய்வுக்காக மட்டுமே பயன்படுத்துவேன் என்று உறுதி அளிக்கிறேன்.

நன்றி!

ஆய்வுஒப்புதலில் பங்கேற்பு

நான் போதுமான அளவில், தெளிவாக ஆய்ந்து தகவலைப் புரிந்து கொண்டு தான் உறுதிப்படுத்துகிறேன். நான் என்னுடைய பங்கு தன்னார்வமானது என்பதை நான் இந்த ஆய்வை இலவசமாக செய்கிறேன். பயிற்சியாளர்கள் சுமார் ஒரு மணி நேரம் எடுக்கும் தகவல்களில் நான் இரகசியமாக வைத்திருப்பேன். இதற்கு நானேமுன் வந்து மேலே கொடுக்கப்பட்டுள்ள ஆய்வில் பங்கேற்க ஒப்புக்கொள்கிறேன்.

பங்கேற்பாளர் கையொப்பம் : **ஆராய்ச்சியாளர் கையொப்பம் :**

கருவி

அடிப்படையானசெயல்திறன்

வழிமுறை : புலன் விசாரணை பங்கேற்பாளர்கள் ஆய்வின் நோக்கம் மற்றும் விளக்கம் ஆராய்ந்து தகவல் அளிப்பார்கள். பங்கேற்பாளர்கள் கொடுத்திருக்கும் கேள்விக்கு சரியான பதிலை தேர்ந்தெடுக்கவும்.

வாடிக்கையாளர்கள் மக்கள் தொகைகருவி

1. வயது(வருடங்களில்)

அ) 18-30 ஆ) 31-40 இ) 41-50 ஈ) 51-60

2. பால்

அ) ஆண் ஆ) பெண்

3. கல்வி

அ) படிக்கதெரியாத ஆ) முதன்மை இ) இரண்டாம் நிலை

ஈ) உயர் ஈ)பட்டதாரி

4. இருப்பிடம்

அ) நகர்ப்புறம் ஆ) கிராமப்புறம்

5. திருமணத் தகுதி

அ) ஒற்றை ஆ) திருமணம் கேட் இ) துணையிழந்தவர் ஈ) பிரிக்கப்பட்ட

6. குடும்பவகை

அ) அணு ஆ) கூட்டு

7. நோய் காலம் (வருடங்களில்)

அ) <1 ஆ) 1-5 இ) 6-10 ஈ) >10

குடும்ப பராமரிப்பு வழங்குநர்கள் மக்கள் தொகை கருவி

1. வுயது (வருடங்களில்)

   அ) 18-30 ஆ) 31-40 இ) 41-50 ஈ) 51-60

2. பால்

   அ) ஆண் ஆ) பெண்

3. கல்வி

   அ) முதன்மை ஆ) இரண்டாம் நிலை இ) உயர் ஈ)பட்டதாரி

4. இருப்பிடம்

   அ) நகர்ப்புறம் ஆ) கிராமப்புறம்

5. வேலை

   அ) வேலை/தொழில் ஆ) வீட்டிலிருந்தபடிவேலை / விவசாயம் இ) மற்றவர்கள்

6. திருமணத் தகுதி

   அ) ஒற்றை ஆ) திருமணம் கேட் இ)பிரிந்த ஈ) துணையிழந்தவர்

7. குடும்பத்தின்வகை

   அ) அணு ஆ) கூட்டு

8. வாடிக்கையாளர் உறவு

   அ) பெற்றோர் ஆ) கணவன்,மனைவி இ) சகோதரர் ஈ) மற்றவர்கள்

9. முாத குடும்ப வருமானம் (ரூபாயில்)

   அ) 19575 ஆ) 9788-19574 இ) 7323-9787 ஈ) 4894-7322

   உ) 2936-4893 ஊ) 980-2935 எ) <979

10. பாதுகாப்புகாலஅளவு (ஆண்டுகள்)

    அ) <1 ஆ) 1-5 இ) 6-10 ஈ) >10

சுய நிர்வாகத்தில் திருத்தப்பட்ட மன அழுத்த மதிப்பீட்டின் அளவுகோல்

1. சில நேரங்களில் செயல்களை நான் சிறிய விருப்பத்துடனே செய்வேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

2. என்னுடைய உணர்வுகள் குறைவானதாகவும் மன அழுத்தம் நிறைந்ததாகவும் கைவிடப்பட்ட நிலையிலும் உள்ளன.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

3. தூக்கம் வருவதுஎனக்கு கஷ்டமாகஉள்ளதா?
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

4. நான் நிறையநேரம் தூங்குவேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

5. நான் சோர்வாகவும், குறைந்த ஆற்றல் உள்ளவனாகவும் உணர்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

6. பசிஎனக்கு மிகவும் குறைவாக ஏற்படுகிறது.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

7. நான் நிறைய சாப்பிடுகிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

8. நான் காரியங்கள் செய்வதில் கவனக்குறைவாக உள்ளேன். அதாவது செய்தித்தாள் வாசிப்பது, தொலைக்காட்சி பார்ப்பது போன்றவற்றில்
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

9. நான் எப்பொழுதும் பரபரப்புடனும், பதற்றத்துடனும் உணர்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

10. கவலைப்படுவதை என்னால் தடுக்கவோ, கட்டுப்படுத்தவோ முடியவில்லை
    அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

11. நான் வேறு காரியங்களை முன்னிட்டு கவலைப்படுகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

12. நான் ஓய்வெடுப்பதில் சிரமப்படுகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

13. நான் ஓய்வின்றி இருப்பதால் ஓர் இடத்தில் நிலையாக இருப்பது சிரமமாக உள்ளது.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

14. நான் எளிதில் எரிச்சலும், கோபமும் அடைகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

15. நான் எப்போதும் உணர்ச்சிவசப்பட்டு இருக்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

16. எனக்கு உடல் வலி உள்ளது

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

17. நான் கெட்ட கனவுகளை காண்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

18. நான் சிக்கல்களை பற்றி நினையாமல் இருக்க நினைக்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

19. நான் எப்பொழுதும் விழிப்புடனும், எச்சரிக்கையுடனும் உள்ளேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

20. நான் உணர்வற்றவனாகவும், பிறரிடத்திலிருந்து துண்டிக்கப்பட்டவனாகவும் உணர்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

சுய நிர்வாகத்தில் திருத்தப்ட்டகுடும்பசுமையை மதிப்பீட்டின் அளவுகோல்

எண்.	நோயாளியின் பாதுகாப்பு	இல்லை	ஓரளவிற்கு	மிகவும்
1.	நோயாளி தன்னைத்தானே பார்த்து கொள்வது உங்களுக்கு திருப்தியா?			
2.	உங்களுக்கு, நோயாளியின் தேவையெல்லாம் பொறுப்பு ஏற்க வேண்டும் என்று நினைக்கிறீர்களா?			
3.	நோயாளியின் குறுகிய வருகைகளை ஈடு செய்ய வேண்டும் என்று நினைக்கிறீர்களா?			
4.	நோயாளிகளுக்கு, உங்கள் குடும்பத்தின் ஆதரவு பலன் அளிக்குமா?			

எண்.	தனிப்பட்டசுகாதாரம்	இல்லை	ஓரளவிற்கு	மிகவும்
5.	நோயாளியை கவனிப்பதில் நீங்கள் சோர்வு அடைவதாக தோன்றுகிறதா?			
6.	நோயாளியின் நோயினால் உங்களின் ஆரோக்கியம் பாதிப்படைகிறதா?			
7.	உங்களின் சரீர ஆரோக்கியத்தை பார்த்துக் கொள்ள நேரம் இருக்கிறதா?			
8.	உங்களுக்கு ஓய்வெடுக்க நேரம் கிடைக்குமா?			

எண்.	நிதிசுமை	இல்லை	ஓரளவிற்கு	மிகவும்
9.	நோயாளியை கவனிப்பதற்கு உங்கள் நிதி நிலைபோதுமா?			
10.	நீங்கள் நோயாளியின் நிதி தேவையை பூர்த்தி செய்ய பெருமளவில் பொறுப்பேற்க வேண்டும் என்று நினைக்கிறீர்களா?			
11.	நோயாளியின் எதிர்கால நிதி நிலைமையை உங்களுக்கு கவலை தெரிகிறதா?			
12.	உங்கள் குடும்ப நிதி நிலைமை நோயாளியின் நோயினால் முதல் நிலைமைமோசம் அடைந்துள்ளதா?			

எண்.	குடும்பநிலைத்தன்மை	இல்லை	ஓரளவிற்கு	மிகவும்
13.	நோயாளி வீட்டில் உள்ளது தொந்தரவாக உள்ளதா?			
14.	உங்களுக்கு நோயாளி மட்டுமல்லாமல் மற்றவரையும் கவனிக்க முடிகிறதா?			
15.	உங்கள் உறவினர் நோய் மூலம் உங்கள் குடும்பத்தின் ஸ்திரத்தன்னை பாதிக்கப்பட்டுள்ளதா (அதாவது அடிக்கடி சண்டை, தொந்தரவு)			
16.	நோயாளியின் நோய் மூலம் உங்கள் குடும்பத்தில் மற்றவரை திருப்தி படுத்த முடிகிறதா?			

எண்.	சமூகஉறவுகள்	இல்லை	ஓரளவிற்கு	மிகவும்
17.	நண்பரின் ஆதரவு மூலம் உங்களுக்கு நோயாளியை பராமரிக்க உதவுகிறதா?			
18.	உங்கள் பிரச்சனைகளை பகிர்ந்து கொள்வது உங்களுக்கு ஆறுதல் அளிக்கின்றதா?			
19.	நீங்கள் நோயாளியை பராமரிப்பது உங்கள் நண்பர்கள் பாராட்டுவார்கள் என்று நினைக்கிறீர்களா?			
20.	நீங்கள் நோயாளியை கவனிப்பதில் உங்கள் உறவினர்கள் புரிந்து உங்கள் முயற்சியை மதிப்பவராக இருப்பார்கள் என்று நினைக்கிறீர்களா?			
21.	நீங்கள் உங்கள் நோய் தொடர்பான சுகாதார நிபுணர்கள் மூலம் கிடைக்கும் உதவியில் திருப்தியா?			

எண்.	நோயாளியின் நடத்தை	இல்லை	ஓரளவிற்கு	மிகவும்
22.	நோயாளியின் எதிர்பாராத நடத்தை உங்களுக்கு தொல்லையாக உள்ளதா?			
23.	நீங்கள் அடிக்கடி நோயாளியின் முன்னேற்றம் மெதுவாக உள்ளது என்று விரக்தி அடைகிறீர்களா?			
24.	நோயாளியின் நோய் மூலம் நீங்கள் தனிமையாகவும், ஒற்றையாகவும் இருப்பதாக தோன்றுகிறதா?			
25.	நீங்கள் நோயாளியை கவனிப்பதில் உங்கள் உறவினர்கள் புரிந்து உங்கள் முயற்சியை மதிப்பவராக இருப்பார்கள் என்று நினைக்கிறீர்களா?			

சுயமாக சமாளிக்கும் அளவுகோல்

பிரச்சனையில் கவனம் செலுத்துதல்:

1. சுயமாக அனுபவங்களின் விளைவாக நான் வளர்ச்சியுற்ற மனிதனாக வளர முயற்சிக்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

2. நான் வேறு சேவைககளில் ஈடுபடுகிறேன். என் மனதை திசை திருப்பும் பொட்டு.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

3. நான் பிறரிடத்திருந்து ஆலோசனை பெற முயற்சிக்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

4. நான் எனது முயற்சிகளில் மிகுந்த ஈடுபாடு கொண்டுள்ளேன்
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

5. நான் காரியங்களை விரைவாக செய்வதை தவிர்க்கிறேன்
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

6. நான் பிரச்சனையிலிருந்து விடுபடும் பொருட்டு கூடுதலாக முயற்சிகளை மேற்கொள்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

7. நான் இது நடந்தது என்பதை ஒப்புக் கொள்கிறேன்
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

8. எப்படிஅடி எடுப்பது என்பதை ஆழ்ந்து சிந்திக்கின்றேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

9. நான் எனது அனுபவங்களிலிருந்து சிலவற்றை கற்றுக் கொள்கிறேன்.
   அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

10. நான் என் போன்று அனுபங்கள் உள்ளவார்களிடம் பகிர்ந்து கொள்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

11. நான் பிரச்ச்னைகளை மேற்கொள்வதில் சரியான தீர்வு காண்பேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

12. நான் காரியங்களில் செய்வதில் ஏற்ற நேரத்திற்கு காத்திருக்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

13. நான் பிரச்சனைகள் தீரப்பதில் குறைவான முயற்சிகளை போடுகிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

14. நான் எதனோடும் வாழ கற்று கொள்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

15. நான் ஓர் நேரத்தில் ஒரு காரியத்தை செய்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

உணர்ச்சிகவனம் செலுத்துல்:

16. நான் எளிதில் குழப்படைந்து உணர்ச்சி வசப்படுவேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

17. நான் என்னிடம் கூறிக் கொள்வேன். இது நிஜமில்லை என்று.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

18. நான் கடவுள் மீது நம்பிக்கை வைக்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

19. நான் சூழ்நிலைகளை நினைத்து சிரிக்கிறேன்.
அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

20. நான் இது என்னால் மேற்கொள்ள முடியாது என்று நினைத்து கொண்டு முயற்சி செய்வதை விட்டு விடுகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

21. நான் எனது உணர்வுகளை மற்றவர்களிடம் விவாதித்து கொள்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

22. நான் போதை வஸ்துகளையும், மது பானங்களையும் உபயோகின்றேன். என்னை உற்சாகப்படுத்துவதற்கு.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

23. நான் பிறருடன் பேசி,அந்த சூழ்நிலையை பற்றி நிறைய தெரிந்து கொள்வேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

24. நான் நண்பர்களுடனும் உறவுகளுடனும் இருந்து ஆதரவு பெறமுயற்சிப்பேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

25. நான் நண்பர்களுடனும், உறவுகளுடனும் இருந்து ஆதரவு பெற முயற்சிப்பேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

26. நான் வேறு கோணத்தில் பார்க்க முயற்சித்து இது எனக்கு நல்லதாக இருக்கும் என்று எண்ணுவேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

27. நான் பிறரிடம் பேசி பிரச்சனைகளுக்கு தீர்க்கமான தீர்வு காண முயற்சி எடுப்பேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

28. நான் இயல்பைவிட அதிகமாக தூங்குகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

29. நான் நடப்பதில் ஏதாவது நன்மையை காண்கிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

30. நான் நிறைய துயருற்று அதை நிறைய வெளிப்படுத்துகிறேன்.

அ.இல்லை ஆ.எப்போதாவது இ. அடிக்கடி ஈ.எப்பொழுதும்

APPENDIX – D

Letter seeking experts opinion and suggestion for the content validity tool

FROM,

Miss Elizabeth Varghese
1st Year M. Sc. Nursing
MMM College of Nursing
No. 131, Sakthi Nagar, Nolambur,
Mogappair West, Chennai.

TO,

Forwarded Through

Principal,
MMM College of Nursing,
Mogappair West,
Chennai – 60

Respected Sir/Madam,

Sub : Expert opinion for content validation of research tool .

I , Miss Elizabeth Varghese, 1st year Msc nursing student (Psychiatric / Mental health nursing) of MMM College of Nursing , request your good self, if you could kindly accept to validate my research tool on topic "A study to assess the level of stress , family burden and coping among family care providers of clients with schizophrenia" at a selected hospital in Chennai .

I would be obliged if you would kindly affirm your acceptance to the undersigned with your valuable suggestion on this topic. I shall send details of my study along with the research tool.

Thanking you in anticipation.

Yours Sincerely
Miss.Elizabeth Varghese

LIST OF EXPERTS OF CONTENT VALIDITY

1. **Dr. Laxmi Venkataraman,**
   MBBS., MD Psychiatry,
   SCARF,
   Chennai.

2. **Mrs. G. Subhashini,**
   M.Sc. (Psy), M.Phil.,
   Psychologist,
   SCARF.

3. **Ms. Preenu Mathew,**
   MSW
   Social worker,
   SCARF.

4. **Mrs. Hemavathy J.,**
   M.Sc.(N)
   H.O.D. Psychiatry Dept.,
   Omayal Achi College of Nursing

5. **Mrs. Simi J.L.,**
   M.Sc. (N)
   Assistant Professor,
   CSI Kalyani College of Nursing.

CERTIFICATE OF VALIDATION

I hereby certify that I have validated the tool of Miss Elizabeth Varghese, student who is undertaking a study on **"A study to assess the level of stress , family burden and coping among family care providers of patient with schizophrenia"** at a selected hospital in Chennai.

Place:

Signature and seal of expert

Dr. Lakshmi Venkatraman

Date:

Name and designation

Schizophrenia Research
Foundation (India)
R/7A, North Main Road,
Anna Nagar West Extension
Chennai-600 101.
Ph: 26153971, 26151073

CERTIFICATE OF VALIDATION

I hereby certify that I have validated the tool of Miss Elizabeth Varghese, student who is undertaking a study on **"A study to assess the level of stress , family burden and coping among family care providers of patient with schizophrenia"** at a selected hospital in Chennai.

G. Subhashini

Signature and seal of expert

Place: Chennai-101

G. Subhashini

Name and designation

Psychologist.

Date: 30/oct/2014

* Comments added under each scale

Schizophrenia Research
Foundation (India)
R/7A, North Main Road,
Anna Nagar West Extension
Chennai-600 101.
Ph: 26153971, 26151073

CERTIFICATE OF VALIDATION

I hereby certify that I have validated the tool of Miss Elizabeth Varghese, student who is undertaking a study on "**A study to assess the level of stress , family burden and coping among family care providers of patient with schizophrenia**" at a selected hospital in Chennai.

Place: Chennai

Date: 30/10/2014

Signature and seal of expert

PREENU MATHEW

Name and designation

Research Assistant

SCARF.

Schizophrenia Research
Foundation (India)
R/7A, North Main Road,
Anna Nagar West Extension
Chennai-600 101.
Ph: 26153971, 26151073

CERTIFICATE OF VALIDATION

I hereby certify that I have validated the tool of Miss Elizabeth Varghese, student who is undertaking a study on **"A study to assess the level of stress , family burden and coping among family care providers of patient with schizophrenia"** at a selected hospital in Chennai.

Hemavathy

Place: **Signature and seal of expert**

Date: **Name and designation**

HEMAVATHY . J
HOD PSYCHIATRIC DEPT.
PROF & HEAD OF THE DEPARTMENT
PSYCHIATRIC NURSING

OMAYAL ACHI COLLEGE OF NURSING
No.45, Ambattur Road,
PUZHAL,
CHENNAI-600 066

CERTIFICATE OF VALIDATION

I hereby certify that I have validated the tool of Miss Elizabeth Varghese, student who is undertaking a study on **"A study to assess the level of stress , family burden and coping among family care providers of patient with schizophrenia"** at a selected hospital in Chennai.

31/3/15

Place: **Signature and seal of expert**

CSI Kalyani College of Nursing
Chennai-4
Mylapore

Date: **Name and designation**

Simi. J.L
Asst. Professor
CSI Kalyani CON

APPENDIX - E

CERTIFICATE OF ENGLISH EDITING

TO WHOMSOVER IT MAY CONCERN

This is to certify that the dissertation prepared by II Year M.Sc.(N) student of Madras Medical Mission College of Nursing,MogapairWest,Chennai,for this study “A DESCRIPTIVE STUDY TO ASSESS THE LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG THE FAMILY CARE PROVIDERS OF CLIENT WITH SCHIZOPHRENIA IN A SELECTED PSYCHIATRIC UNIT”is edited for English language appropriateness by Dr. ANN THOMAS

Name: DR. ANN THOMAS

Signature: Ann thomas

Dr. ANN THOMAS
ASSISTANT PROFESSOR
DEPARTMENT OF ENGLISH
MADRAS CHRISTIAN COLLEGE,
TAMBARAM, CHENNAI-600 059.

CERTIFICATE OF TAMIL EDITING

TO WHOMSOVER IT MAY CONCERN

This is to certify that the dissertation prepared by II Year M.Sc.(N) student of Madras Medical Mission College of Nursing, Mogappair West, Chennai, for this study "A DESCRIPTIVE STUDY TO ASSESS THE LEVEL OF STRESS, FAMILY BURDEN AND COPING AMONG THE FAMILY CARE PROVIDERS OF CLIENT WITH SCHIZOPHRENIA IN A SELECTED PSYCHIATRIC UNIT"is edited for Tamil language appropriateness by J. Amala

Name: J. Amala

Signature: Amala

ST. JOSEPH'S HR. SEC. SCHOOL
TAMBARAM, CHENNAI - 59.

APPENDIX – F

Plagiarism Detector - Originality Report

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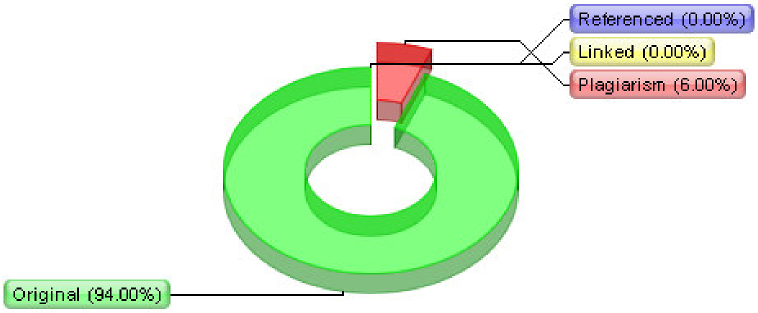

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