

**THE LEVEL OF PERCEIVED FAMILY BURDEN,  
COPING STRATEGIES AND PSYCHOLOGICAL WELL-  
BEING AMONG THE PRIMARY CAREGIVERS OF  
CHRONIC SCHIZOPHRENIA PATIENTS IN A  
SELECTED HOSPITAL AT MADURAI,TAMILNADU.**

**G.SASIKALA**



**A DISSERTATION SUBMITTED TO THE  
TAMILNADU DR.M.G.R.MEDICAL UNIVERSITY,  
CHENNAI, IN PARTIAL FULFILLMENT OF THE  
REQUIREMENT FOR THE DEGREE OF MASTER OF  
SCIENCE IN NURSING.**

**MARCH – 2010**

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## **ABSTRACT**

A descriptive study to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients in a selected hospital at Madurai, Tamilnadu was conducted in partial fulfillment of the requirement for the award of a degree of Master of Science in Nursing under the TamilNadu Dr. M.G.R.Medical University, Chennai.

### **Objectives of the study were:-**

1. To assess the level of perceived family burden among the primary caregivers of chronic schizophrenia patients.
2. To assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.
3. To assess the level of psychological well-being among the primary caregivers of chronic schizophrenia patients.
4. To find the interrelationship among the level of perceived family burden, coping strategy and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
5. To find out the association between the perceived family burden and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness).
6. To find out the association between coping strategies and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness).

7. To find out the association between psychological well-being and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness of the care receiver).

The study was based on the 'Stress, Coping and Adaptation Model' by Lazarus & Folkman,(1984). Four hypotheses were tested.

1. There will be a interrelationship among the level of perceived family burden, coping strategies and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
2. There will be a significant association between the level of perceived family burden and selected demographic variables.
3. There will be a significant association between the level of coping strategies and selected demographic variables.
4. There will be a significant association between the level of psychological well-being and selected demographic variables.

The aim of the research was to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients. A descriptive research design was used for the study. The study population consisted of 100 primary caregivers of chronic schizophrenia patients who were attending the outpatient department of M.S.Chellamuthu Trust & Research Foundation, Madurai. A purposive sampling technique was used to select the samples. In order to collect the data, the tool comprised of socio-demographic variables, Burden Assessment Schedule of SCARF (BASS,1995), Coping Checklist (CCL, Rao, Subbakrishna and Prabhu 1989) and Psychological Well-Being Questionnaire (Bhogle and

Jaiprakash, 1995) – to assess the level of perceived family burden, coping strategies and psychological well-being.

The pilot study was carried out on 10 primary caregivers of chronic schizophrenia patients who fulfilled the sampling criteria. The data collected during the data collection period were analyzed by means of descriptive and inferential statistics. The findings of the study have been discussed in terms of objectives and hypotheses for the study.

**Major findings of the study were:-**

- ⌘ The result revealed that among the primary caregivers 48% are having mild burden, 36% of them are having moderate burden and 16% of them having severe burden.
- ⌘ The report about the level of coping strategies among the primary caregivers 49% are having moderate level of coping strategies, 42% of them are having inadequate coping strategies and only 9% of them are falling under adequate level of coping strategies.
- ⌘ The study about the level of psychological well being among the primary caregivers majority of them 48% are having inadequate psychological wellbeing, 46% them are having moderate level of wellbeing and only 6% of them are having adequate level of psychological wellbeing.
- ⌘ The relationship among the level of perceived family burden, coping strategies and psychological well being among the primary caregivers reported that the correlation between family burden and coping strategies indicated the moderate, negative(0.43) and significant correlation and it shows that when the burden increases their coping level will decreases. The correlation between the family burden and well being (0.48) showed that the moderate,

negative and significant correlation and it shows that when the burden increases their well being decreases. The correlation between the coping strategies and psychological well being (0.51) indicates the moderate, positive and significant correlation and it shows that when the coping strategies increases their well being also increases.

- ∞ The association between the level of perceived family burden and demographic variables shows that age ( $\chi^2=8.97$ ), duration of illness ( $\chi^2=7.69$ ), and relationship with the patients ( $\chi^2=7.44$ ) are significantly associated with their level of burden. More aged, less income, duration of illness and wife group are having more burden than others.
- ∞ In the midst of the association between the level of coping strategies and demographic variables shows that age ( $\chi^2=8.45$ ), marital status ( $\chi^2=6.45$ ), and health status ( $\chi^2=5.95$ ), are significantly associated with their level of coping. Less aged, married and healthy people are having adequate level of coping strategies.
- ∞ The association between the level of psychological well being and demographic variables shows that duration of illness ( $\chi^2=7.34$ ), and health status ( $\chi^2=6.66$ ), are significantly associated with their level of wellbeing. Less duration of illness and healthy status persons are having adequate level of psychological well being.

**The following recommendations were made based on the findings of the study:-**

- ♣ A similar study can be conducted with large sample for generalization.
- ♣ A comparative study can be done at rural and urban areas.

- ♣ A comparative study can be done among caregivers of chronic schizophrenia and other psychiatric illnesses.
- ♣ A comparative study can be done among caregivers of chronic schizophrenia patients in different hospitals.
- ♣ A similar study can be done to see the effectiveness of structured teaching programme about family burden, coping strategies and psychological wellbeing.
- ♣ An experimental study using pre-test, post-test control group design can be planned to find strategies to provide adaptive coping methods for caregivers of mentally ill patients in Indian setting.

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# CHAPTER I

## INTRODUCTION

Mental wellness is generally viewed as a positive attribute, such that a person can reach enhanced levels of mental health, even if they do not have any diagnosable mental health condition. Mental health highlights emotional well-being, the capacity to live a full and creative life and the flexibility to deal with life's inevitable challenges (Hattie, J.A.2004). The presence of burden indicates a crack in subjective wellbeing of an individual as well as his mental health (**Myers, J.E.2000**).

A severe mental illness like schizophrenia has a devastating impact on the patient as well as his or her family members. This is due to the chronic nature of the illness and the long term disability it often involves. Patients experience problems related to both positive symptoms such as aggressive behavior, delusions, hallucinations and negative symptoms such as poor motivation and inadequate self – care. The capacity for social relationships is often diminished, and employment opportunities are reduced. Modern methods of treatment have helped a large number of patients to recover or to improve significantly, but many continue to display deficits in several areas of functioning. Thus chronic mental illness poses a heavy burden on the patients, the family and the community. (**Schene, Van Wijngaarden & Koeter, 2008**)

Schizophrenia develops gradually that no one realizes that anything is wrong with the person for a long period of time. Sometimes, it may also develop suddenly with dramatic changes in behavior occurring over a periods of few weeks or even a few days (**Kulhara and Wig, 2006**).

Schizophrenia destroys the inner unity of the mind and weakens violation and drive that constitute the essential character .Although there is considerable variability in the effect of illness on different patients, the pathological processes that occur are usually long lasting. The mind loses the intimate connection between thought and emotion and the mental life often repeats with distorted perception, false ideas, lack of clarity and illogically in thought. Aberrant motor and social behavior are manifested **(Carpenter, 2005; (Kraepelin, 2007).).**

The family has always been recognized as an important factor in both the genesis and prognosis of mental illness. Initial studies focused on the possible etiological role of the family in schizophrenia, but the perspective has now changed to incorporate the family as a ‘reactor’ to the mental illness of a member .This has led to an interest in the various problems faced by families that arise from the patient’s illness, such as financial difficulties, or disruption of daily activities. The sum total of these difficulties is referred to as social or family burden. Patient characteristics such as age, gender employment status, duration and severity of illness, as well as caregiver characteristics influence burden.

Caring for a family member with schizophrenia can be viewed as an ongoing stressor. This is due to the continuous nature of the illness, the long term disability and lack of control over the situation. The psychological processes such as coping behaviors that are used by caregivers to deal with the demands of such a stressful are therefore important.

In the west, the engagement of the family as the primary locus of care for a mentally ill relative has been one of the consequences of the deinstitutionalization movement. However, in the Indian setting, families

have traditionally played the role of caregivers for their mentally ill relatives. This is due to the social and cultural milieus as well as the inadequate existing mental health infrastructure .Families in India are involved in most aspects of care for persons with severe mental illness. They are recognized as having a prominent role to play in decisions regarding engagement or disengagement from the treatment process, supervision of medication, providing day to day care and emotional support to the individual **(Shankar, 2002)**.

Coping is defined as the “ongoing cognitive and behavioral efforts to manage specific external and/or internal demands appraised as taxing or exceeding the resources of the person” .There are mainly two types of coping strategies adopted while dealing with stressful situations: problem-focused and emotion focused. The former refers to strategies wherein the environment changes by coping actions, the latter refers to strategies where the individual attempts to change the way he interprets or attends to what is happening. Emotion –focused strategies are aimed at regulating the emotional response to the stressor. The demands of the stressful situation determine the type of coping strategy adopted. In acute stress situations, problem focused coping strategies are likely to be used, whereas in situations of prolonged stress such as caring are likely to be used, whereas in situations of prolonged stress such as caring for a mentally ill relative, emotion-focused coping strategies are more frequently adopted. **(Lazarus, 2003)**

A stress and coping framework is helpful for mental health professionals to understand the range of adaptation responses made by family members to the stress of caring for a mentally ill relative. This perspective views individuals as responding to situations that are perceived as taxing or as exceeding their ability to contend with them .

Caregivers experience considerable amount of distress as a result of the care giving role, and are vulnerable to developing minor psychiatric disorders such as anxiety and depression. **(Vezina, 2000)**

The coping strategies utilized by the caregiver are of importance, as they determine the impact of the stressor on the caregiver's health and adjustment which, in turn, may affect the caregiver's relationship with the ill family member. Coping refers to the person's constantly changing cognitive and behavioral efforts to manage an encounter appraised as stressful ( ). In situations of chronic stress, emotion focused coping strategies are more likely to be adopted **(Provencher et al., 2000; Folkman & Lazarus, 2000, Stanton et al., 2001)**.

A study was conducted in India to identify the family distress and expressed emotions in caregivers of mentally ill. They found that relatives of patients with mental illness suffer from considerable amount of distress and burden. The burden, distress and expressed emotions in the family are significantly related to the outcome of psychiatric patients. Recent studies on psycho education of family members have documented its beneficial effect on outcomes of psychiatric disorders. However, concerted efforts are required to overcome the barriers to the care of psychiatric patients and their relatives in order to fulfill the mental health needs of the population.

As the mental health services have moved away from providing institutional care, to providing community care, family members have increasingly found themselves becoming the primary source of care and social support for their relatives with mental illness. The changing pattern of mental health services has led to the need to develop services that meet the needs of caregivers as well as the service users **(Budd et al, 2008)**.

Caring for a family member who has schizophrenia is an enduring stressor; one which causes considerable burden and distress. Family members have a number of essential needs, such as for information, for skills to cope with the illness and its consequences for the family, and for emotional support for themselves. Intervention programs for family members should therefore, be need based, and strengthen adaptive coping strategies that are culturally relevant.

### **NEED FOR THE STUDY**

A chronic mental illness is a challenging task for caregivers especially in the current era of de-institutionalization. In India, few studies have attempted to directly determine the relationship between coping mechanisms, and burden; in the West, studies have found that improved coping in family members can decrease the perceived burden. **(Seth G.S.2006).**

The demands of caring for a mentally ill relative, which have been defined and quantified by concepts of subjective and objective burden, have both an emotional and practical impact on the caregiver. The fact that the illness leaves a varying degree of disability in the patient and leads to disturbing behavior means that its management is associated with a significant burden of care. However, not all caregivers perceive the same burden of illness because it varies according to their ways of coping.

Coping as a person's constantly changing cognitive and behavioral efforts to manage an encounter appraised as stressful. Birchwood and Cochrane found that relatives of patients with mental illness employed a broad range of coping styles in response to behavioral changes in



patients. Both emotion-focused and problem-focused coping lead to reappraisal of the stressful event, that means patients' illness.

The relationship between coping styles, and perceived burden of care is complex because caregivers subjectively report 'burden'. This subjectivity in turn is a product of the coping styles used by caregivers. In 1994, the consensus reported by Troop states that emotion based coping is associated with an unsatisfactory outcome whereas problem focused coping is associated with a more satisfactory outcome. These findings suggest that the burden of care givers is more dependent on their appraisal of the condition of their patients rather than the actual illness.

In view of the economic and cultural conditions of a developing country being vastly different from those of the western world, the areas of burden and the pattern of accepting from those of the western world, the areas of burden and the pattern of accepting or rejecting patients in India may be entirely different. It's also found that expressed emotion as a concept associated with burden plays a relatively less significant role in families. Not many studies have examined the ways in which relatives cope while caring for a patient with schizophrenia and the relationship of coping styles to burden. Thus, it is more relevant to study the burden of caregivers and their coping styles as shown by various coping strategies employed by caregivers (**Wig et al in 2007**).

The influence of coping styles on burden experienced by caregivers would help us evaluate and plan effective programmes that address their needs and teach them adaptive mechanisms of coping. This would enable them to focus on the positive feelings they experience in association with the care giving role and ways to sustain this positive well-being.

Health professionals, especially mental health nurses have an important role of acknowledge the burden of caregivers. They are in a position to render support and refer them to get further support through social workers and community agencies. Such measure would ensure family well being for families with mentally ill patients. For that, mental health nurse needs to assess the burden and coping of caregivers.

Further reviewing the literature in this area, it was found that limited Indian Nursing Researchers have done some scientific studies regarding the level of perceived family burden, coping strategies and psychological well being. Hence, it was felt that there is a need for scientific study to investigate those factors.

The researcher while working at M.S.Chellamuthu Trust and Research Foundation noticed that a considerable number of caregivers were having some level of family burden, coping strategies and they were in a need of some level of psychological support. All these observation made curiosity and interest in this field, and promoted the researcher to undertake the study related to family burden, coping strategies and psychological well being.

#### **STATEMENT OF THE PROBLEM:-**

A descriptive study to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients in a selected hospital at Madurai, Tamilnadu.

## **OBJECTIVES OF THE STUDY:-**

- To assess the level of perceived family burden among the primary caregivers of chronic schizophrenia patients.
- To assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.
- To assess the level of psychological well-being among the primary caregivers of chronic schizophrenia patients.
- To find the interrelationship among the level of perceived family burden, coping strategy and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
- To find out the association between the perceived family burden and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness).
- To find out the association between coping strategies and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness).
- To find out the association between psychological well-being and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient, and duration of illness of the care receiver).

## **HYPOTHESES:-**

- There will be a interrelationship among the level of perceived family burden, coping strategies and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
- There will be a significant association between the level of perceived family burden and selected demographic variables.
- There will be a significant association between the level of coping strategies and selected demographic variables.
- There will be a significant association between the level of psychological well-being and selected demographic variables.

## **OPERATIONAL DEFINITIONS:-**

### **1. Perceived Family Burden:**

It refers to the feeling of caregivers presence of problems, difficulties or adverse events that affect the lives of caregivers as measured by burden assessment scale of SCARF.

### **2. Coping Strategies:**

Coping strategies refers to the measures which the caregivers take to handle the specific internal or external demands that are appraised as taxing or exceeding the person's resources such as like denial, distraction positive, distraction negative, religion, faith and acceptance as measured by coping checklist.

### **3. Psychological well-being:**

It indicates the degree of happiness, satisfaction or gratification subjectively experienced as measured by psychological well-being scale.

#### **4. Primary caregiver:**

The primary caregiver is a family member who lives in the same household as the index patient, who spends time with him/her, and is directly and actively involved in the care of the patient .

#### **5. Chronic Schizophrenia Patients:**

The chronic schizophrenic patients are characterized in general by disturbances in thought, processes, perception and affect invariably result in a severe deterioration of social and occupational functioning.

#### **ASSUMPTION:-**

1. Care givers of chronic schizophrenia patients will experience an amount of burden.
2. Caregivers of chronic schizophrenia patients will use some kind of coping strategies to manage the burden.
3. Caregivers of chronic schizophrenia patients will experience an amount of distress in their psychological status.

#### **LIMITATION:-**

- Sample size – 100
- Study period – 6 weeks

#### **PROJECTED OUTCOME:-**

1. The study identifies the level of burden among the primary caregivers of chronic schizophrenia patients.
2. The study identifies the level of coping strategies and psychological well-being of the primary caregivers of chronic schizophrenia patients.
3. The findings of the study motivate the health professionals to do more research on similar type of studies in different areas.

## **CONCEPTUAL FRAME WORK**

Conceptual framework refers to interrelated concepts or abstractions assembled together in a rational scheme by virtue of their relevance to a common theme and it provides a perspective regarding interrelated phenomena. The conceptual framework explains the phenomenon of interest and reflects the assumptions and philosophic views, variable under study, hypotheses formulated and the design of the study.

This study is aimed at assessing the caregiver burden, coping strategies and psychological wellbeing among the primary caregivers of chronic schizophrenia patients in selected hospitals at Madurai, Tamilnadu.

The framework for the study is based on the Stress, coping and Adaptation Model (Lazarus and Folkman, 1984). This model has four components; antecedents to the stress, stress, coping and adaptation.

### **ANTECEDENTS TO STRESS:-**

Antecedents to the stress response include the person-environment relationship and the person's cognitive appraisal of the risks and benefits of the situation. The appraisal of the relationship determines the manifestation of stress and the potential for coping. In the present study, antecedents to stress indicates the demographic variables which are the triggering factors for the caregivers to develop the stress.

### **STRESS:-**

Once a person-environment relationship is established and the person appraises it as threatening, harmful, or challenging, an internal stress response occurs. The person has simultaneous physiological and

emotional responses. In the present study, the stress denotes the level of perceived family burden, which will be the reaction towards the antecedents to the stress (level of stress measured by mild, moderate and severe level of family burden).

### **COPING:-**

Coping is the process whereby a person manages the demands and emotions that are generated by the appraisal. In the present study, coping refers to the measures which the caregivers take to handle the specific internal or external demands that are appraised as taxing or exceeding the person's resources such as like denial, distraction positive, distraction negative, religion, faith and acceptance. Coping is measured by the level of adequate, moderate and inadequate.

### **ADAPTATION:-**

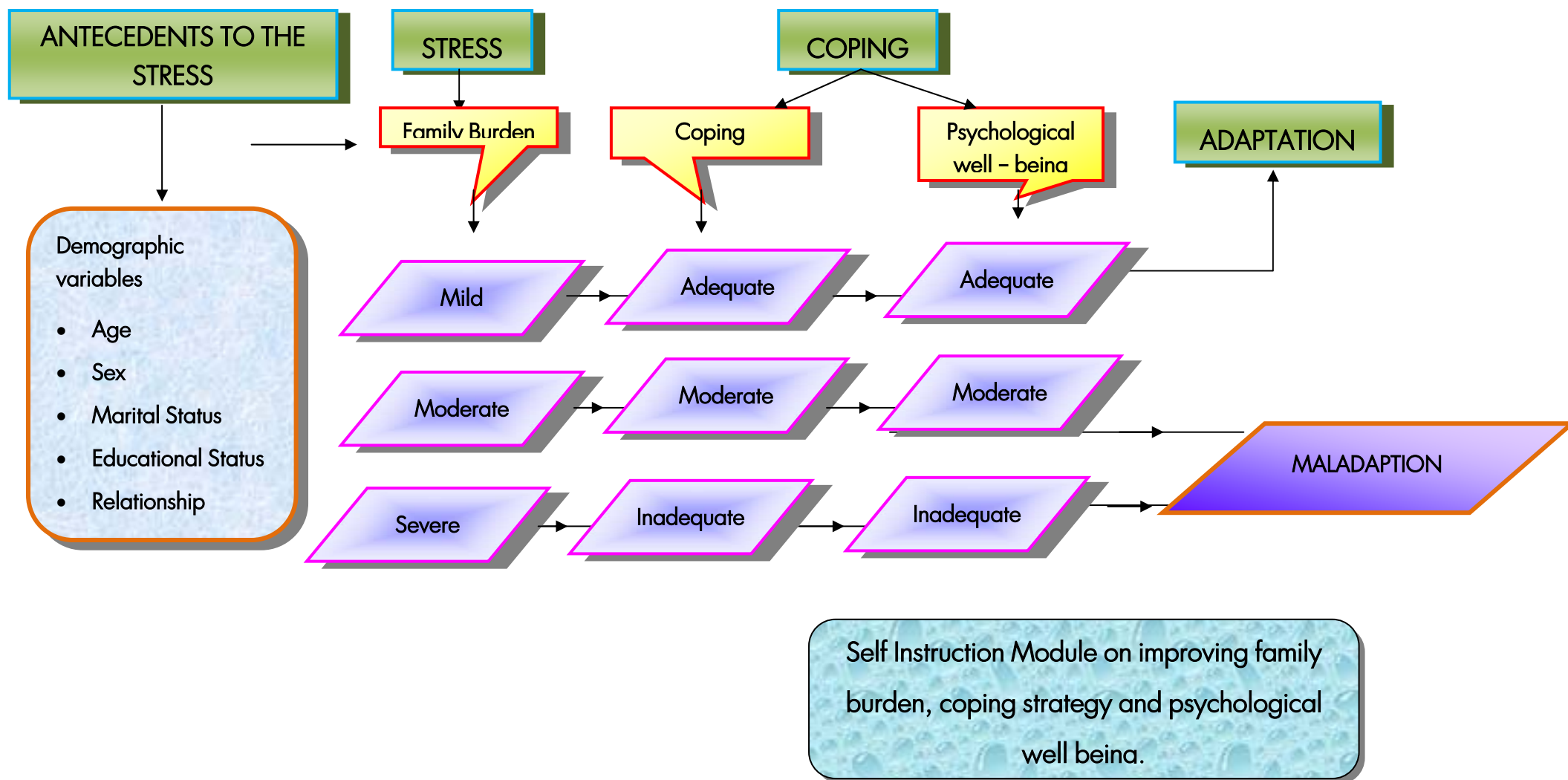
Adaptation can be conceptualized as a person's capacity to survive and flourish. Positive coping leads to adaptation, which is characterized by a balance between health and illness, a sense of well being, and maximum social functioning. When a person does not function positively, maladaptation occur that can shift the balance towards illness, a diminished self-concept, and deterioration in social functioning. In the present study, the adaptation shows that the individual those are having the mild family burden and adequate coping strategy, psychological well being has a balance between health and illness, a sense of well being and a maximum social functioning.

Maladaptation refers to the individual those are having the moderate, severe family burden and moderate, inadequate level of coping strategy and psychological well-being shows that they will have diminished in the well being, social functioning and leads to physical and mental illness.

In the present study caregiver burden include seven areas; emotional burden, caregiver health, family relations, caregiver occupation, finance, patient behavior, and social relations. Coping is cover a wide range of behavioral, cognitive and emotional responses that way be used to handle stress. Further refinement of the tool resulted in seven subscales ; one of problem focused coping (problem solving) five of emotion focused coping (denial, distraction positive, distraction negative, religion, faith and acceptance) and one of social support seeking. Some of these are adaptive and some are maladaptive.

In this study, psychiatric nurse planned the guidelines module focusing pharmacological, psychological, social, family factors and other services to improve the family burden, coping strategies and psychological well being, which in turn would help to prevent maladaptive coping mechanisms.





Modified schematic Representation of “ Stress, coping & Adaptation Model” by Lazarus and Folkman (1984)

## **CHAPTER II**

### **REVIEW OF LITERATURE**

The review of literature entails systematic identification; location and scrutiny of written material that contains relevant information pertinent to the study.

The studies in this review have been organized into the following sections:

**Section I:** International studies on Burden, coping strategies and psychological well being in caregivers of patients with schizophrenia.

**Section II:** Indian studies on burden, coping strategies and psychological well being in caregivers of patients with schizophrenia.

As a part of the **WHO** collaborative study on strategies for extending mental health care, 259 families from developed countries (Columbia, India, Sudan and Philippines) were screened with regard to the social burden caused by mental illness on the families. The result indicated that psychosis caused economic burden more frequently compared to other diagnostic categories. Social acceptance of patients also posed difficulties.

## **SECTION I: Studies on Burden, Coping Strategies and Psychological well being in caregivers of patients with schizophrenia.**

**Ochoa, Susana et al in (2008)** reported that the number of patients needs was correlated with higher levels of family burden in daily life activities, disrupted behavior and impact on caregiver's daily routine. The patient's needs most associated with family burden were daytime activities, drugs, benefits, self-care, alcohol, psychotic symptoms, money and looking after home. In a regression model, a higher number of needs, higher levels of psychopathology and disability, being male and older accounted for higher levels of family burden.

**Grandon P.Jenaco C, Lemos S (2008)** conducted a study on burden and predictor variable among 101 children primary caregivers of schizophrenia outpatients. Results shows low levels of burden were typically found, with the exception of moderate levels on general concerns for the ill relatives. A hierarchical regression analysis with focus blocks showed that clinical characteristics such as higher frequency of relapses, more positive symptoms and lower independence performance, together with lower self-control attributed to the patients, decrease in social interests, and less affective support, predict burden. The results support the relevance of psycho educational interventions where families' needs are addressed.

**Chien et al (2007)** conducted a study to examine the level of perceived burden of the Chinese families caring for a relative with schizophrenia, and to test its associations with their demographic characteristics, social and family functions and health education. Results show the families who perceived a higher level of caregiver burden were those who lived in a family with poorer functioning, poor health status

and minimal social support. The caregiver's burden score was positive correlated with their age: conversely, it was negatively correlated with their monthly household income and number of family members living with patient. Social support was the best predictor of caregiver burden.

**Roick, C, et.al (2007)** compared the differences of family burden in both Germany and Britain. Results revealed family burden was associated with patients' symptoms, male gender, unemployment and marital status, as well as caregivers' coping abilities.

**Motlova L, et.al (2007)** family represents an important supportive social network for most patients with schizophrenia. In order to provide safe and low –stress environment, necessary for the successful long-term treatment of schizophrenia, the family must be helped. Family members suffer both emotionally and financially. Their burden is high and quality of life is low. Relatives change their life values and preferences when and severe mental illness occurs in the family and are ready to cooperate.

**Mazza Carrie, et al in (2007)** reported that relatives' expression of positive emotions (i.e. affective style and expressed emotion) has been found to be a predictor of relapse risk in patients with schizophrenia. Relatives' attribution about the patient has also been found to be related to these negative emotions. However, there is a lack of research regarding the relationship between relatives' attribution about their own role in patient's behaviors and patient relapse.

**Parabiaghi A, et. al in (2007)** conducted a study on predictors of care giving burden included both caregivers' and patient's characteristics and patterns of caregiver-patient interaction. Results revealed higher patient's psycho pathology, higher number of patient related needs,

patient's lower global functioning and patient's poorer quality of life were found to be related to the severity of family burden.

**Roick, C, et al (2006)** conducted longitudinal study about the impact of caregivers' characteristics, patient's conditions and regional differences on family burden in schizophrenia. Results shows interpersonal differences (patient's positive and negative symptom, relation, coping abilities, and patient contact) and intrapersonal changes (relative's coping abilities, patient's negative symptoms and utilization of community care) predicted family burden.

**Perlick et al (2006)** studied components and correlates of care burden in schizophrenia. Hierarchical regression analyses demonstrated differential one sets of burden for each factor, explaining 34 percent of variance each for problem behavior and resource demands and disruption, 21 percent for impairment in activities of daily living, and 38 percent for patient helpfulness. Demographic characteristics and patient symptoms explained the greatest proportion of variance, whereas quality of life and service use explained modest variance and patient neuro-cognition and medication side effects were not significantly associated with burden.

**Ca queo-urizer, et al (2006)** studied the burden of care in families' of patients with schizophrenia in South America. All caregivers show a very high degree of burden, especially mothers who were elderly, with low educational level, without an employment and who are taking care of younger patient's.

**Magliano et al (2006)** studied about family burden and social network in schizophrenia and physical disease at Italy. Study found that in both groups, the consequences of care giving most frequently reported as present were constraints in social activities, negative effects on family

life and a feeling of loss. Objective burden was similar in the 2 groups, while subjective burden was higher in schizophrenia. Social support was lower among relatives of patients with schizophrenia than among those of the other group.

**Rosenfarb, et al (2006)** studied about socio-cultural stress, appraisal and coping model of subjective burden and family attitudes toward patients with schizophrenia. Results indicated that subjective burden of care and patient's odd and unusual thinking during the family discussion each independently predicted relative/attitudes toward patients, suggesting that negative symptoms and perceived burden of care. African American relatives' perceived burden was also predicted by patient's substance abuse. Finally, white family members were significantly more likely than African Americans to feel burdened by and has rejecting attitudes toward their schizophrenia relative suggesting that cultural factors play an important role in determining both perceived burden and relatives' attitudes toward patient's.

**Hasui et al (2002)** studied the predictors of burden in 25 patient-caregiver dyads were examined. Caregivers were assessed on subjective and objective burden, and patients were evaluated on the Global Assessment of Functioning (GAF) Scale and the Positive and Negative Symptoms Scale (PANSS). Subjective burden was negatively correlated with the age of the patient, while objective burden was positively correlated with the duration of illness. The patient's level of functioning, as indicated by the GAF score emerged as the only significant predictor of both objective and as well as subjective burden.

**Veltman, Cameron and Stewart (2002)** documented both the positive and the negative experiences of care giving in a qualitative study on 20 caregivers. Of the 20 interviewed, 17 were women, and 11 were mothers of the index patient. Semi-structured, in-depth interviews were conducted focusing on the caregiver's positive and negative experiences. Caregivers reported negative impacts such as stigma and difficulties in dealing with the health care system. However, they also reported beneficial effects such as feelings of love and caring for the ill relative and also life lessons learned.

**Wolthaus et al (2002)** studied the relationship between patient symptoms, personality traits and caregiver burden was explored. The sample consisted of 103 caregivers, majority of whom were female. The patients were assessed on the Positive and Negative Symptoms Scale (PANSS), Schizotypal Personality Questionnaire (SPQ) and the NEO-Five Factor Inventory (NEO-FFI); while caregivers were assessed on the Involvement Evaluation Questionnaire (IEQ) for burden. Results indicated that disorganization symptoms such as poor attention, disorientation and conceptual disorganization were the most burdensome for caregivers. Personality traits of patients did not modify the relationship between symptoms and caregiver burden.

**Ohaeri and Fido (2001)** documented the burden in families caring for a person with severe mental illness was explored. A sample of 75 relatives of patients with schizophrenia and 20 relatives of people with major affective disorder were compared with relatives of patients with cancer, infertility and sickle cell diseases. Burden, etiological beliefs and attitudes were assessed through a questionnaire. The response patterns of the relatives of the two psychiatric illness groups were similar, with 36% attributing the illness to 'Satan's work', and 11% to 'witchcraft'. More

relatives in the physical illness groups attributed the illness to biological causes. Anger and stigma, to a larger extent, were reported by relatives in the psychiatric illness groups.

**Cuijpers and Stam (2000)** studied the relationship between subjective and objective burden was investigated among 162 caregivers attending psycho education groups. The caregivers were assessed on burden and degree of burnout experienced. Multiple regression analysis was carried out with three elements of subjective burden as the dependent variable and six elements of objective burden, demographic characteristics of the relative and illness variables as predictors. Objective burden together with the other predictors explained 57% of the variance in subjective burden. Two aspects of objective burden; strain on the relationship with the patient and ability to cope with the patient's behavior was related to almost all aspects of subjective burden.

**Hatfield and Lefley (2000)** surveyed 210 caregivers, majority of whom were mothers, to determine the degree to which they had completed future plans for relatives with serious psychiatric disability. They found that only 18% of their respondents had made concrete plans, and that intense anxiety about the future of their relative, lack of knowledge about how to plan and lack of financial resources were the main obstacles to planning. The index patient's refusal to use available resources and resistance to change were also cited as further barriers. These findings underline the problems and concerns faced by elderly caregivers in planning for the future of their ill relative, and the barriers faced.

**Chakrabarti et al, and Vohra et al, Rammohan et al, (2000)** studied the findings of the studies reviewed in this section indicate that



families of mentally ill are burdened considerably by their largely unsupported care giving role. Mental health professionals often give primary emphasis to the Index patient and the relative's needs and concerns are often neglected (Winfield and Havey). Caregivers experience many practical problems in dealing with a chronic illness like schizophrenia. The degree of burden experienced is influenced by patient and caregiver related demographic factors and illness characteristics. Use of unhealthy coping strategies such as denial, avoidance and emotional over involvement add to the burden they experience.

**Sisk (2000)** in a study investigated the relationship between perception of burden and health promoting behaviors of the caregivers. Two hundred primary caregivers were randomly selected. Caregiver burden was measured by objective and subjective burden scales (Zarit et al, 1980). The physical health of the caregivers was measured with the shortened series of illness rating scales (Simon and West, 1985). Caregiver health promotion was measured with the health promoting lifestyle profile (Walker et al, 1987). The study indicated that the feelings involved in care giving such as fear, pain, loss and guilt, may interfere with one's holistic and spiritual well-being and one's ability to keep in contact with medical help and to eat a balanced diet. Caregivers typically lack time and opportunity for exercise and other health promoting behaviors. Those perceived lower subjective burdens practiced more health promoting behaviors than those with higher subjective burden. Interpersonal influences such as the supportive network of friends and family increased the caregiver's promoting behaviors.

**Vohra et al, (2000)** a comparison of burden experienced in families of persons with schizophrenia and depressive illness was studied .The sample comprised of 100 patients each with schizophrenia and

depression. Burden interview schedule (Pai and Kapur, 1981) was administered. Both patient groups experienced higher burden in disruption of family routine, family leisure and interactions. Burden was significantly and positively correlated with duration of illness in both groups.

The studies reviewed in this subsection indicate that empirical work on burden has been carried out for approximately five decades. Despite the diverse methodologies used, it is evident that family members experience considerable amount of burden in their role as caregivers for their relatives with schizophrenia. It is also a role that they largely carry out unsupported, as the mental health infrastructure is often inadequate.

## **SECTION II: INDIAN STUDIES**

Indian studies on burden, coping strategies and psychological well being in caregivers of schizophrenia

### **Indian studies on burden, coping strategies and psychological well being among the caregivers of schizophrenia**

**Thomas et al, (2004)** conducted a study to assess and compare the extent and pattern of psychosocial dysfunction and family burden in schizophrenia and obsessive compulsive disorder. The study was conducted at the outpatient department of central Institute of Psychiatry, Ranchi, Bihar. Sample consists of first day relatives /spouses of 35 schizophrenia and 30 obsessive compulsive disorder patients. Data was collected by using Dysfunction Analysis Questionnaire (Pershad et al, 1985) and family burden Interview schedule (Pai and Kapur, 1981). Caregivers of schizophrenics reported higher burden in disruption of interactions within and outside the family and disruption of family routines as a result of care giving. Association between dysfunction of

schizophrenic patients and disruption of family interactions was significant.

**Chandrasekaran et al,(2002)** studied coping strategy of the relatives of schizophrenia patients at the Department of Psychiatry, JIPMER,Pondicherry. Assessed by using family coping questionnaire (Magliano et al, 1996) and Family Burden Interview Schedule (Pai and Kapur, 1981) for 44 relatives of chronic schizophrenia patients.. 77% of them used resignation an emotion reaction to the situation as a coping strategy. 79% of the relatives failed to maintain social contacts and 60% of them did not seek information about the illness. Only the third of the relatives attempted active social involvement of the patients, coercion and avoidance strategies. Use of resignation had a significant positive correlation with burden. Researcher emphasizes the importance of analyzing the coping strategies of the relatives, before planning clinical interventions to improve their coping skills.

**Rammohan et al, (2002)** conducted a study to assess the burden and coping in caregivers of patients with schizophrenia. The sample comprised of 24 parents and 24 spouses attending the outpatient Department of Psychiatry, NIMHANS, Bangalore. Caregivers were assessed on the Burden Assessment Schedule (Thara et al, 1998) and coping checklist (Rao et al, 1989). The results revealed that parent caregivers use denial as a coping strategy more than spouses. Care giving of older patients resulted in greater burden. The experience of objective burden was similar for both the groups, but they differ in their experience of subjective burden. Spouses reported greater emotional burden. Lower educational level, lower level of functioning, advancing age of the patient and the used of denial by the caregivers added to their experience of burden.

**Vidya (2006)** examined perceived burden and quality of life in sample of 100 caregivers of psychotic patients from the inpatient and outpatient departments of a mental hospital. Burden was significantly higher when severity of symptoms was greater. Caregivers of inpatients experienced greater burden. Total burden and overall quality of life were inversely related, that is greater the burden, poorer the quality of life.

**Chakrabarti et al (2005)** the extent and pattern of family burden in 60 patients with schizophrenia and affective disorder were compared. Both groups were similar with regard to socio demographic variables, duration of illness and dysfunction of the patient. The extent and pattern of burden was similar in both groups. Burden was felt mainly in the areas of family routine, family leisure, family interaction and finances.

**Roychoudhuri et al (2005)** conducted a similar study was carried out by to assess burden and well-being in caregivers of 30 schizophrenic patients and 24 patients with affective disorder. Burden was found to be greater in families of schizophrenic patients. Burden scores were greater when patients were young and male. Despite high subjective burden, majority of careers had subjective well-being scores in the normal range, indicating that they possessed considerable coping resources.

The Indian studies on families of caregivers of patients with schizophrenia have focused on burden, distress and quality of life. The findings across these studies indicate that increased burden is associated with younger age, male sex and greater severity of symptoms. The coping strategies adopted by family members and their relationship with burden and distress, have received comparatively less attention.

## **CHAPTER III**

# **RESEARCH METHODOLOGY**

This chapter includes research design, setting of the study, population, sample, and inclusion and exclusion criteria for selection of sample, development, and description of the tool, content validity, pilot study, data collection procedure and plan for data analysis.

### **RESEARCH APPROACH**

In this study, the researcher used a quantitative approach.

### **RESEARCH DESIGN**

The research design used for this study is a descriptive design.

### **SETTING OF THE STUDY**

The study was conducted at M.S.Chellamuthu Trust and Research Foundation, Madurai which is about 55 km away from Matha College of Nursing, Manamadurai. It is a non-Governmental, non-profit, secular, voluntary organization. It has the services like institution based short and long term care centers and also community based projects to enable the mental disabilities to enhance their quality of life. Around 100 to 120 patients are getting out-patient care per day and nearly 200 patients are receiving inpatient care, 20-30 new cases are receiving treatment per day. Among them there are 5-8 new cases of schizophrenia and minimum of 12-25 old cases of schizophrenia patients are attending the out-patient care per day. It is one of the unique centers where all the facilities are available to treat the patients with psycho-therapy and pharmacotherapy.

## **POPULATION**

The population for this study was the primary caregivers of chronic schizophrenia patients.

## **SAMPLING TECHNIQUE**

The purposive sampling technique was used to select the sample based on the inclusion criteria.

## **SAMPLE SIZE**

A sample of 100 primary caregivers of chronic schizophrenia patients who were receiving treatment and attending outpatient department of M.S.Chellamuthu Trust and Research Foundation, Madurai.

## **CRITERIA FOR SAMPLE SELECTION**

### **Inclusion Criteria:-**

The primary care givers who

- were parent, spouse, sister/brother, children of the index patient.
- were adults above the age of 20 years.
- were available during the study.
- could understand and speak Tamil or English.
- were actively involved in the care of the patients at least 1 year prior to the interview.

## **Exclusion Criteria :-**

The primary caregivers who

- were attending the clinic other than M.S.Chellamuthu Trust & Research Foundation, Madurai.
- were below the age of 20 years.
- were not willing to participate in the study.
- could not understand and speak Tamil or English.

## **RESEARCH TOOL AND TECHNIQUE**

### **Description of the tool:-**

The tool consisted of section I and section II.

### **Section I**

It dealt with the socio demographic data of caregivers such as sex, age, education, marital status, occupation, income, relationship to patient and the duration of care.

### **Section II**

#### **Part I : Burden Assessment schedule of SCARF (BASS 1995)**

This is a 40-item scale, which taps both the subjective and objective components of burden. The scale was developed using the stepwise ethnographic method on caregivers of schizophrenic patients attending the outpatient department at the Government General Hospital, Chennai and at the Schizophrenia Research Foundation (SCARF).

The domains of burden assessed by the tool are:

1. Emotional burden
2. Caregiver health
3. Family relations
4. Caregiver occupation
5. Finance
6. Patient behavior
7. Social relations

The items are rated on a 3-point scale, with 'not at all' marked as 1 and 'very much' marked as 3. Some of the items are reverse coded, depending on the way the questions are framed. Scores range from 40-120, with higher scores indicating higher burden.

**Part II: Coping Checklist (CCL, Rao, Subbakrishna and Prabhu 1989)**

This tool comprises of 70 items, which cover a wide range of behavioral, cognitive and emotional responses that may be used to handle stress. The items are scored dichotomously in a yes/no format. Further refinement of the tool resulted in seven subscales ; one of problem focused coping (problem solving) five of emotion focused coping ( denial, distraction positive, distraction negative, religion, faith and acceptance) and one of social support seeking. Distraction positive comprised of mainly cognitive forms of distraction while distraction negative had predominantly behavioral forms of distraction including high risk behaviors such smoking and taking alcohol.



### **Part III: Psychological Well-Being Questionnaire (Bhogle and Jaiprakash 1995):**

This is a 28-item questionnaire in a forced choice (Yes/No) format to assess psychological well-being. Scores range from 0-28, with higher scores indicating greater well-being.

#### **CONTENT VALIDITY**

The tool was prepared by the investigator based on the standardized inventory and review of literature. The tool was validated by a team of five experts for content validity. The experts included were one consultant specialized in Department of Psychiatry, Psychologist, Psychiatric social worker and 4 nursing experts specialized in Psychiatric Nursing. After obtaining content validity tool was translated into Tamil. The collected data were validated with relatives and care takers and was found correct.

#### **RELIABILITY**

The Burden Assessment Scale has been validated against the family burden schedule of Pai and Kapur (1981) & the correlations ranged from 0.71 to 0.82 for most items. Inter rater reliability for the scale was 0.80(Kappa  $p < 0.01$ ). The reliability for Coping Checklist was 0.82. The Psychological well-being tool was validated against the subjective well-being questionnaire of Nagpal and Sell (1985), correlation coefficient was 0.62.

#### **PILOT STUDY**

After obtaining permission from the concerned authority of M.S.Chellamuthu Trust and Research Foundation, a pilot study was conducted on ten primary caregivers of chronic schizophrenia patients

who fulfilled the inclusion criteria of sample. Pilot study was carried out in the same way as the final study in order to test the feasibility and practicability of the study. The interview was conducted separately. The pilot study showed that the tool was understandable to the caregivers. They showed eagerness to participate in the study. The time taken for data collection for each subject was 30 to 45 minutes. The investigator herself interacted with the subjects and collected the data. Data were analyzed by using descriptive and inferential statistics. Pilot study participants were excluded from main study.

### **DATA COLLECTION PROCEDURE**

The data collection period was for 6 weeks. A formal permission was obtained from the chief Doctor and administration department of M.S.Chellamuthu Trust and Research Foundation, Madurai. Subjects were selected by purposive sampling technique. The researcher collected the details about the primary caregivers of chronic schizophrenia patients from the receptionist of M.S.Chellamuthu Trust and Research Foundation which they will take the prior appointment for seek the medical advice. The medical record of the concern caregivers was gone through prior to their arrival to the outpatient department. The researcher collected data from the primary care givers of chronic schizophrenia patients who fulfill the inclusion criteria. Researcher initially established rapport with the patients and the family members. The purpose of this study was explained to each one of them to obtain verbal consent. Each subject was interviewed separately for 30-40 minutes. Each day 8-12 primary caregivers were interviewed from 9 am to 2 pm in the morning and 4 pm to 8 pm in the evening during the data collection period.

## **PROTECTION OF HUMAN SUBJECTS**

The dissertation committee approved the research proposal prior to the pilot study and main study. Permission was obtained from the Principal and Head of the department of Psychiatric Nursing, Matha College of Nursing, Manamadurai. Formal permission to conduct the study was obtained from the Chief Doctor and Administration Department of M.S.Chellamuthu Trust and Research Foundation, Madurai. Assurance was given to the subjects regarding the confidentiality of the data collected from them.

## **CHAPTER – IV**

### **ANALYSIS AND INTERPRETATION**

This chapter deals with the analysis and interpretation of data collected from 100 samples of primary caregivers of chronic schizophrenia patients to determine the correlation between primary caregiver's perceived family burden, coping strategies and psychological well-being.

The data were analyzed based on the objectives of the study.

#### **PRESENTATION OF DATA**

The collected data were organized, tabulated, analyzed and presented under VIII headings.

#### **SECTION: I**

- Frequency and percentage distribution of demographic variables of primary care givers of chronic schizophrenia patients.

#### **SECTION: II**

- Level of perceived family burden among the primary caregivers of chronic schizophrenia patients.

#### **SECTION: III**

- Level of coping strategies among the primary caregivers of chronic schizophrenia patients.

#### **SECTION: IV**

- Level of psychological well-being among the primary caregivers of chronic schizophrenia patients.

#### **SECTION: V**

- Interrelationship among the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients.

#### **SECTION: VI**

- Association between the perceived family burden and selected demographic variables like age, gender, religion, marital status education, etc.

#### **SECTION: VII**

- Association between coping strategies and selected demographic variables like age, gender, religion, marital status, education, etc.

#### **SECTION: VIII**

- Association between psychological well-being and selected demographic variables like age, gender, religion, marital status, education, etc.

## SECTION – I

**Frequency and percentage distribution of demographic variables of primary caregivers of chronic schizophrenia patients.**

**N= 100**

<b>S.No</b>	<b>Demographic variables</b>		<b>Number</b>	<b>Percentage</b>
1.	Age	20-30 yrs	23	23.0%
		30- 40 yrs	25	25.0%
		40-50 yrs	16	16.0%
		50-60 yrs	23	23.0%
		60-70 yrs	13	13.0%
2.	Gender	Male	60	60.0%
		Female	40	40.0%
3.	Domicile	Rural	64	64.0%
		Urban	36	36.0%
4.	Education status	Illiterate	11	11.0%
		Primary	5	5.0%
		Secondary	19	19.0%
		High secondary	28	28.0%
		Graduate	30	30.0%
		Post Graduate	7	7.0%
5.	Marital status	Married	88	88.0%
		Unmarried	12	12.0%
6.	Type of family	Joint family	42	42.0%
		Nuclear family	58	58.0%
7.	Family size	<5	58	58.0%
		5-8	37	37.0%
		>8	5	5.0%

8.	Occupation	Unemployed	8	8.0%
		Professional	39	39.0%
		Retired	10	10.0%
		Housewife	20	20.0%
		Unskilled worker	9	9.0%
		Business	14	14.0%
9.	Monthly income	<Rs.2000	18	18.0%
		Rs.2001-5000	44	44.0%
		Rs.5001-10000	14	14.0%
		>Rs.10000	24	24.0%
10.	Religion	Hindu	84	84.0%
		Muslim	6	6.0%
		Christian	10	10.0%
11.	Mother Tongue	Tamil	98	98.0%
		Other	2	2.0%
12.	Relationship with patient	Mother	20	20.0%
		Father	11	11.0%
		Brother	8	8.0%
		Sister	11	11.0%
		Husband	27	27.0%
		Wife	11	11.0%
		Daughter	2	2.0%
		Son	10	10.0%
13.	Duration of stay with patient	>10 yrs	53	53.0%
		7-9 yrs	9	9.0%
		4-6 yrs	12	12.0%
		1-3 yrs	26	26.0%
14.	Health status of care giver	Healthy	91	91.0%
		Unhealthy	9	9.0%
15.	Helping people	Family members	98	98.0%
		Neighbours	1	1.0%
		Religious persons	1	1.0%

**Table No.1 shows the demographic information of primary caregivers those who are participated in the study.**

The data in table 1 showed that 25% were 30-40 years, 23% of primary caregivers were in the age of 20-30 years, 23% were 50-60 years, 16% were 40-50 years, and 13% were 60-70 years.

With regard to the gender 60% of primary caregivers were male and 40% of them were female.

64% of the primary caregivers were from rural area and 36% of them were from urban.

According to the education status 30% were graduate, 28% were higher secondary, 19% were secondary, 11% of the primary caregivers were illiterate, 7 % were post graduate and 5% were primary.

With regard to the marital status 88% of the primary caregivers were married and 12% were unmarried.

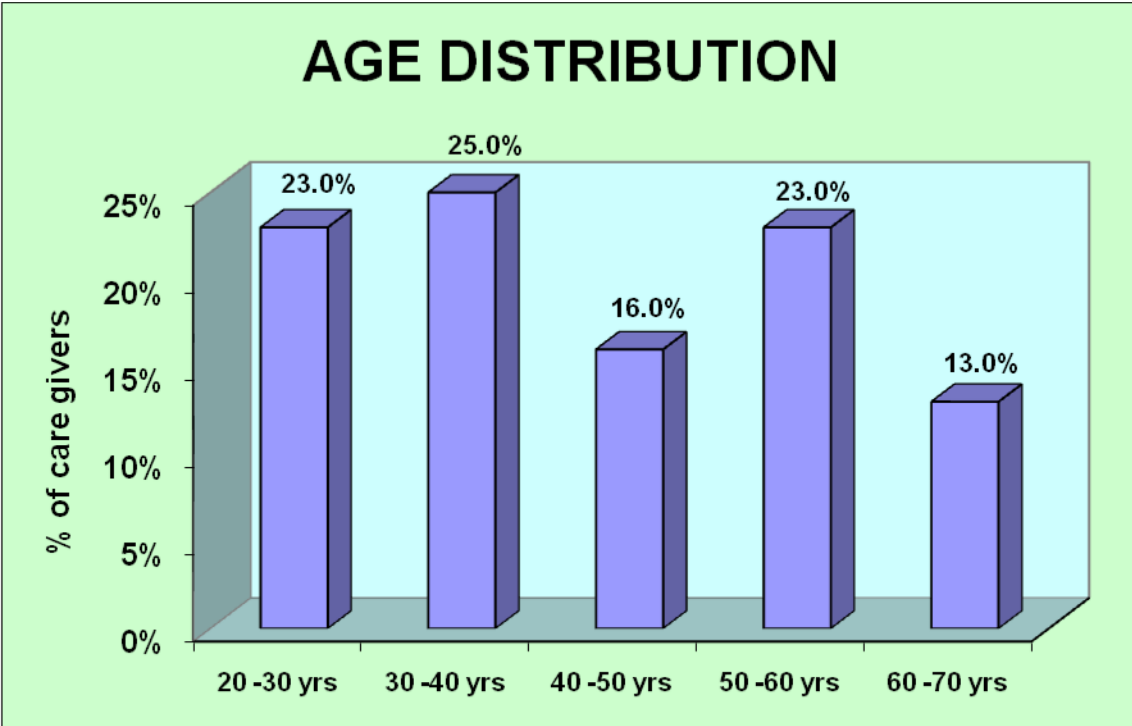
Regarding the type of family 58% were nuclear family and 42% were belongs to joint family.

According to the family size 58% were below 5 members, 37% were 5-8 members and 5% were more than 8 members.

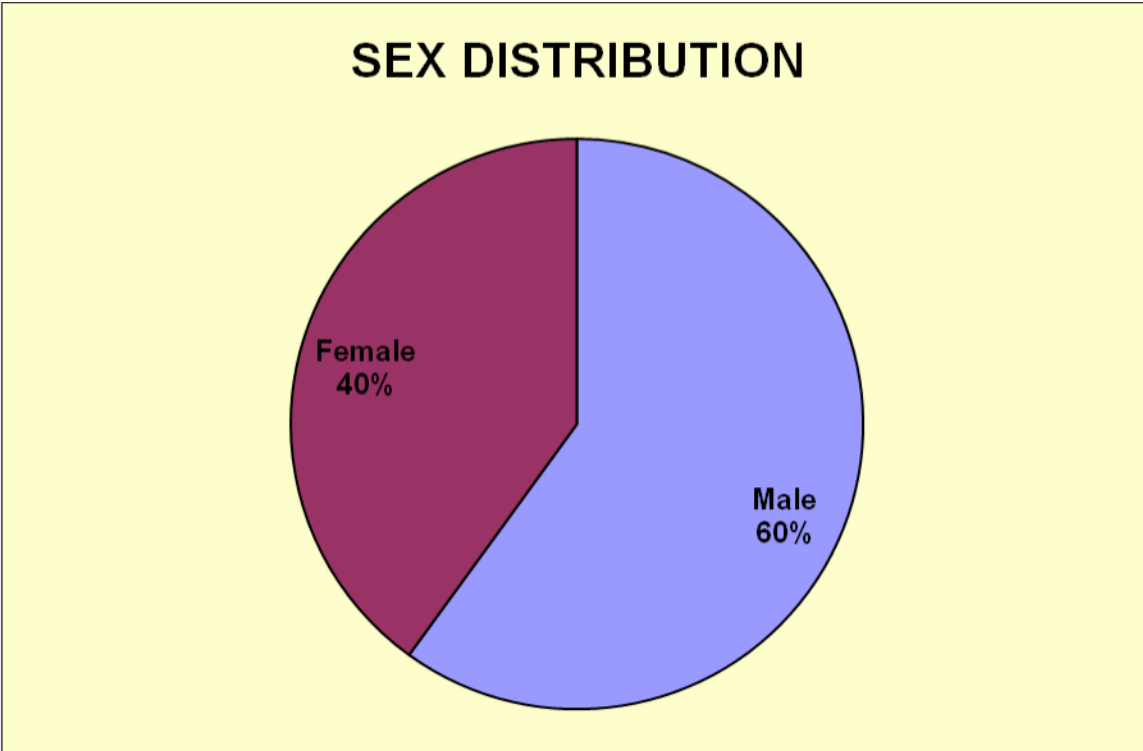
With regard to the occupational status 39% were professional, 20% were housewives, 14% were business, 10% were retired, 9% were unskilled worker and 8% of the primary caregivers were unemployed.

Regarding Monthly income – 44% were earning Rs.2001-5000/month, 24% were above RS.10000, 18% of the primary caregivers were earning less than Rs.2000 and 14% were earning Rs.5001-10000.

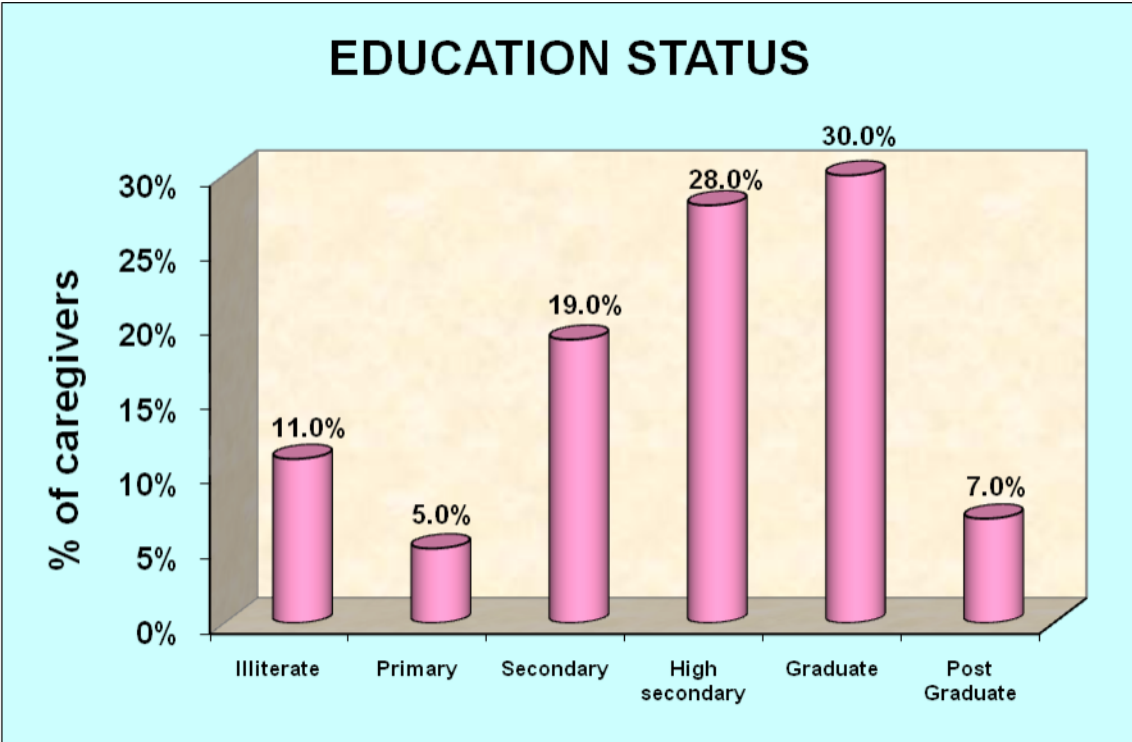




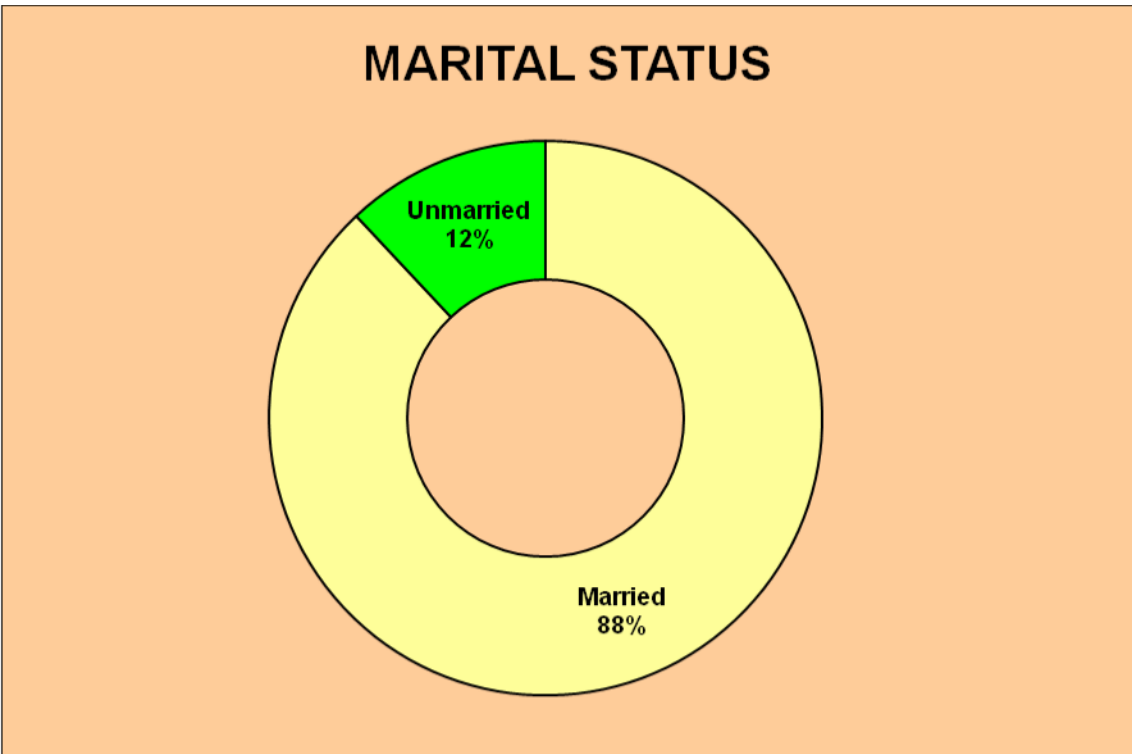
**FIGURE 1: DISTRIBUTION OF SAMPLES IN TERMS OF AGE**



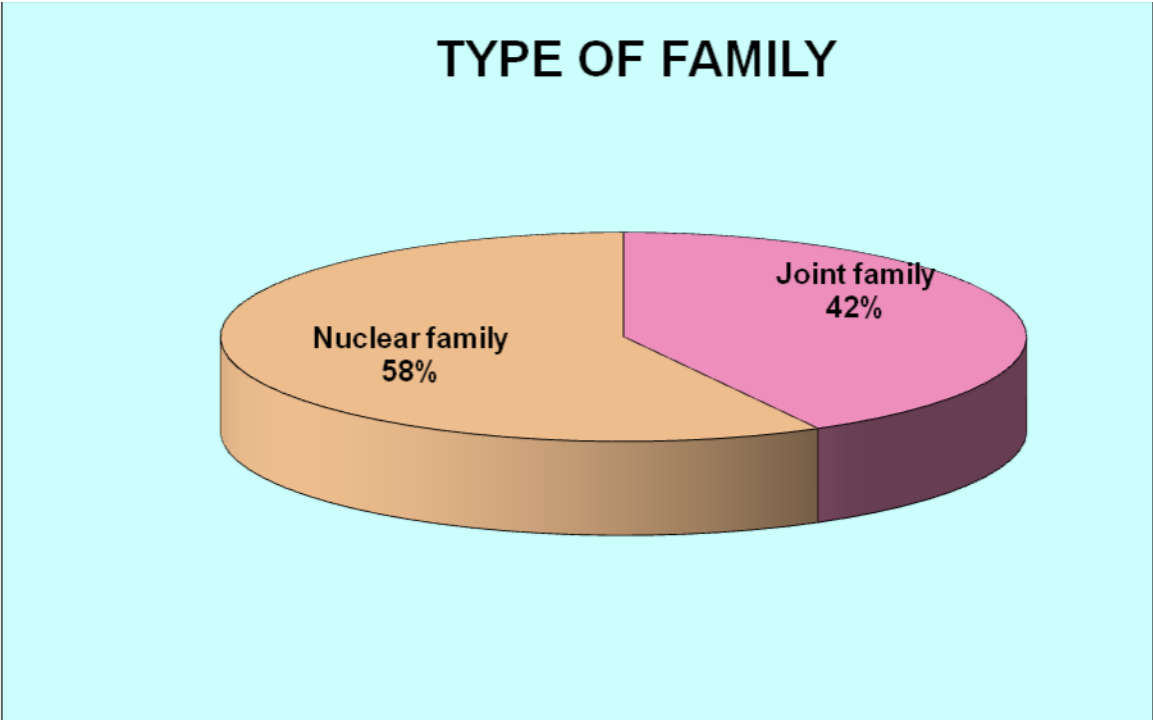
**FIGURE 2: DISTRIBUTION OF SAMPLES IN TERMS OF GENDER**



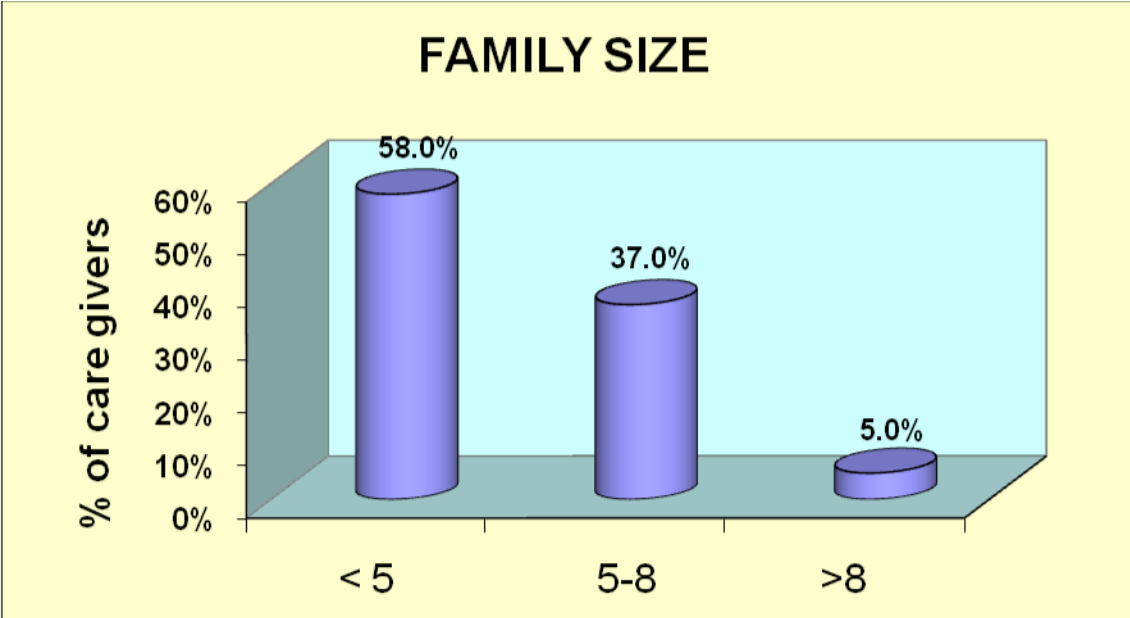
**FIGURE 3: DISTRIBUTION OF SAMPLES IN TERMS OF EDUCATIONAL STATUS**



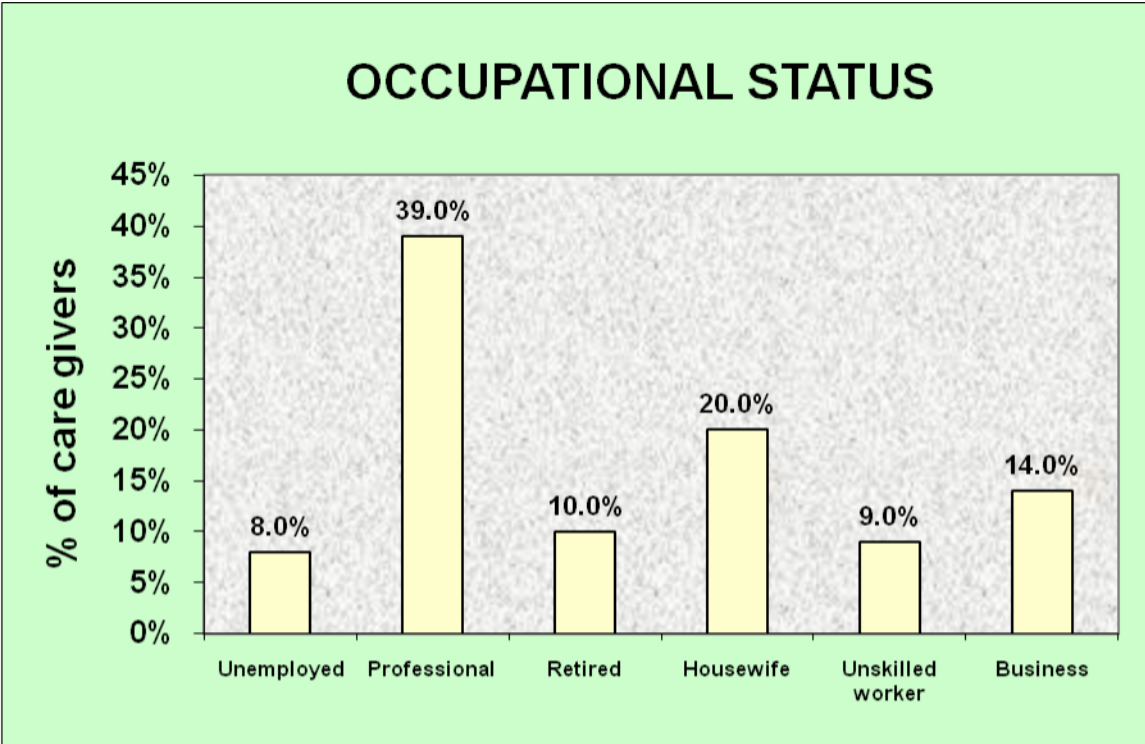
**FIGURE 4: DISTRIBUTION OF SAMPLES IN TERMS OF MARITAL STATUS**



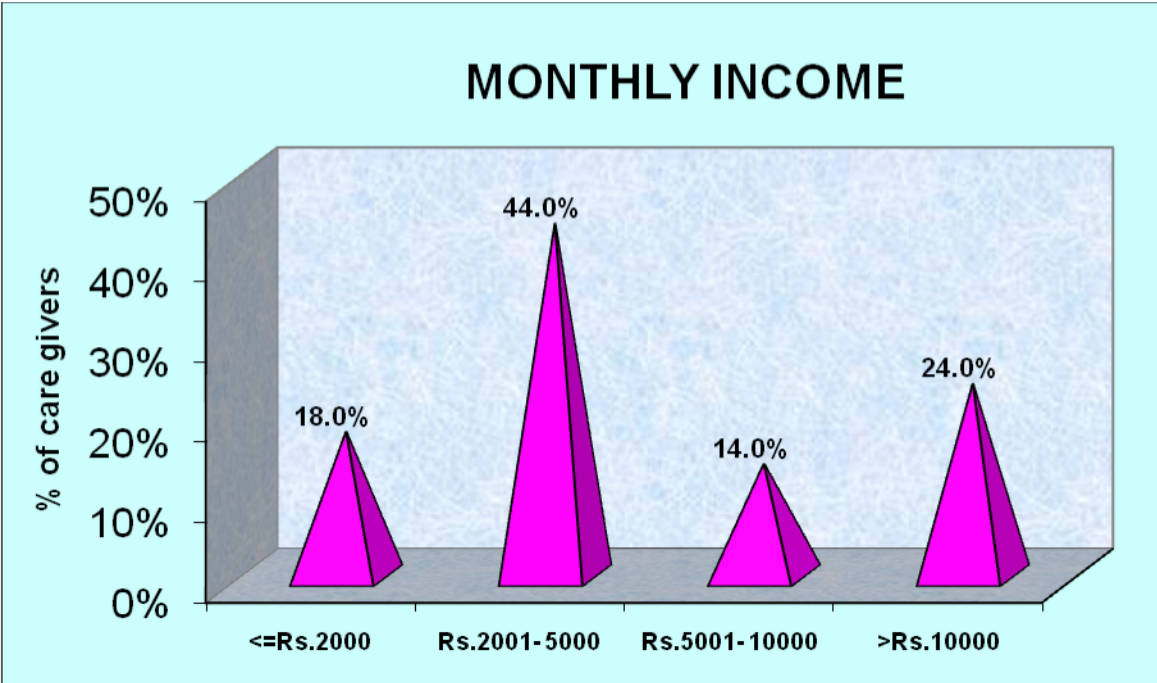
**FIGURE 5: DISTRIBUTION OF SAMPLES IN TERMS OF TYPE OF FAMILY**



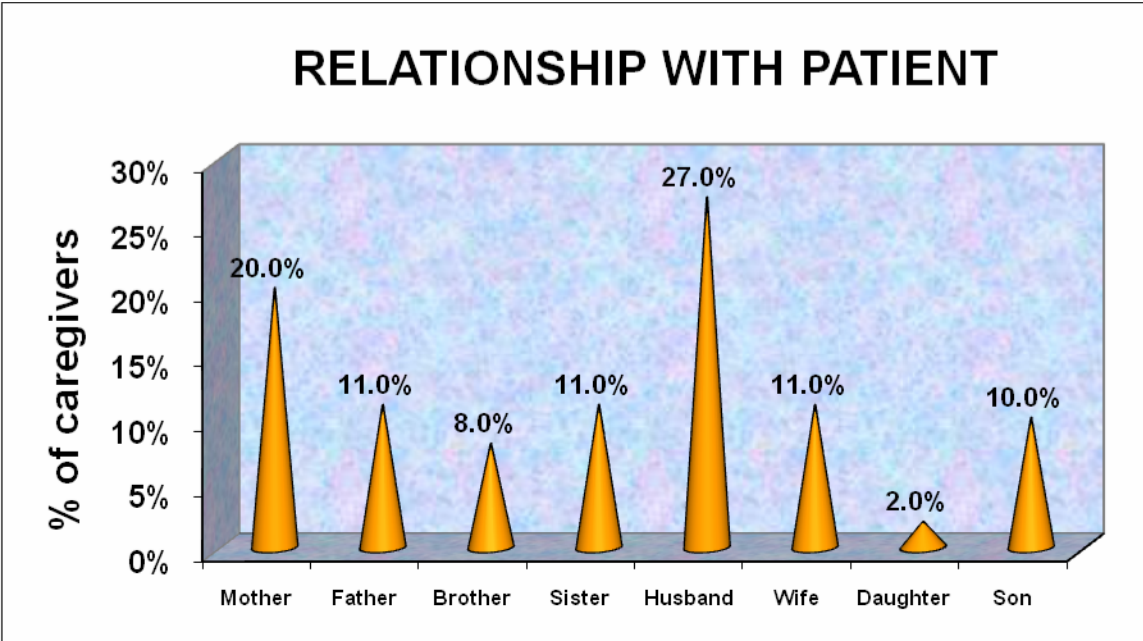
**FIGURE 6: DISTRIBUTION OF SAMPLES IN TERMS OF FAMILY SIZE**



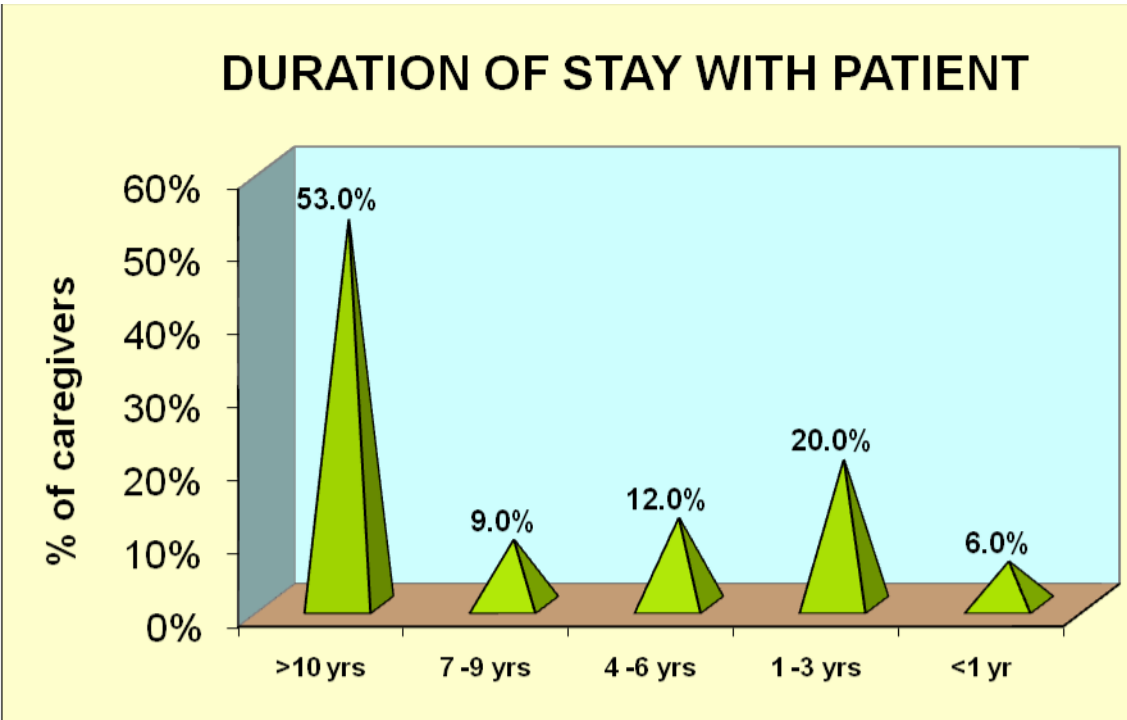
**FIGURE 7: DISTRIBUTION OF SAMPLES IN TERMS OF OCCUPATIONAL STATUS**



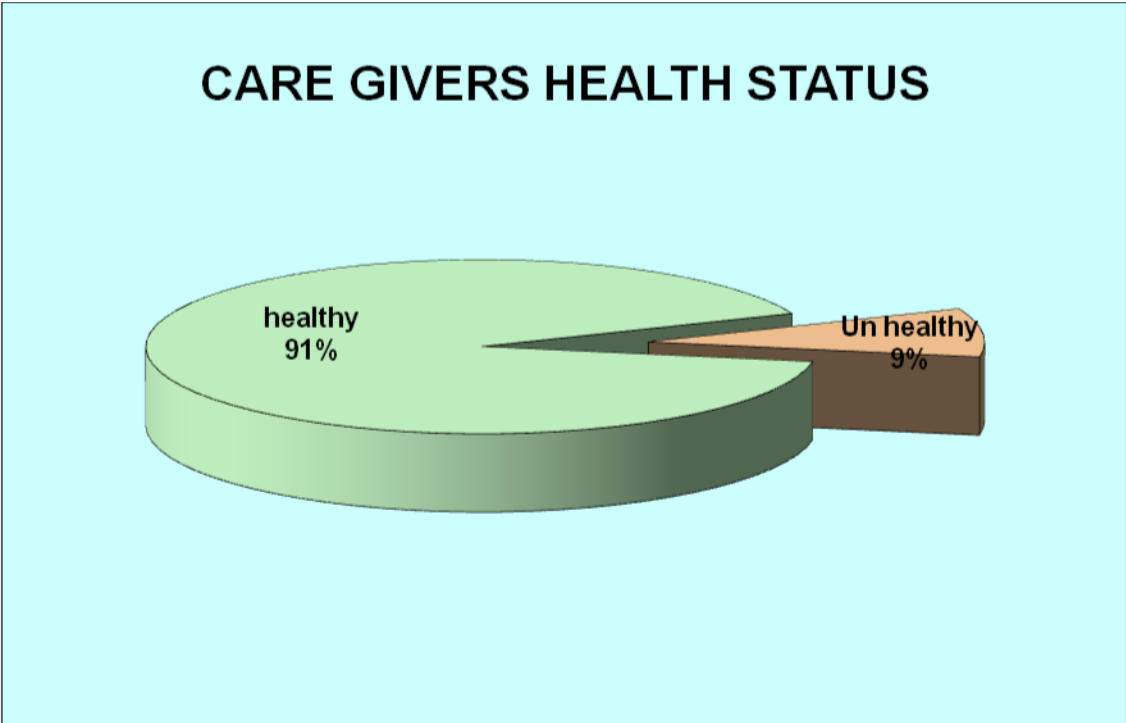
**FIGURE 8: DISTRIBUTION OF SAMPLES IN TERMS OF MONTHLY INCOME**



**FIGURE 9: DISTRIBUTION OF SAMPLES IN TERMS OF RELATIONSHIP WITH PATIENT**



**FIGURE 10: DISTRIBUTION OF SAMPLES IN TERMS OF DURATION OF STAY WITH PATIENT**



**FIGURE 11: DISTRIBUTION OF SAMPLES IN TERMS OF CAREGIVERS  
HEALTH STATUS**

## SECTION - II

**Level of perceived family burden among the primary caregivers of chronic schizophrenia patients.**

**Table No.2 (a): LEVEL OF PERCEIVED FAMILY BURDEN**

**N= 100**

<b>S.No</b>	<b>Level of burden</b>	<b>No. of caregivers</b>	<b>Percentage</b>
1.	Mild	48	48.0%
2.	Moderate	36	36.0%
3.	Severe	16	16.0%
	<b>Total</b>	<b>100</b>	<b>100%</b>

Table 2 (a) showed that the primary caregivers 48% are having mild burden, 36% of them having moderate burden and 16% of them having severe burden.

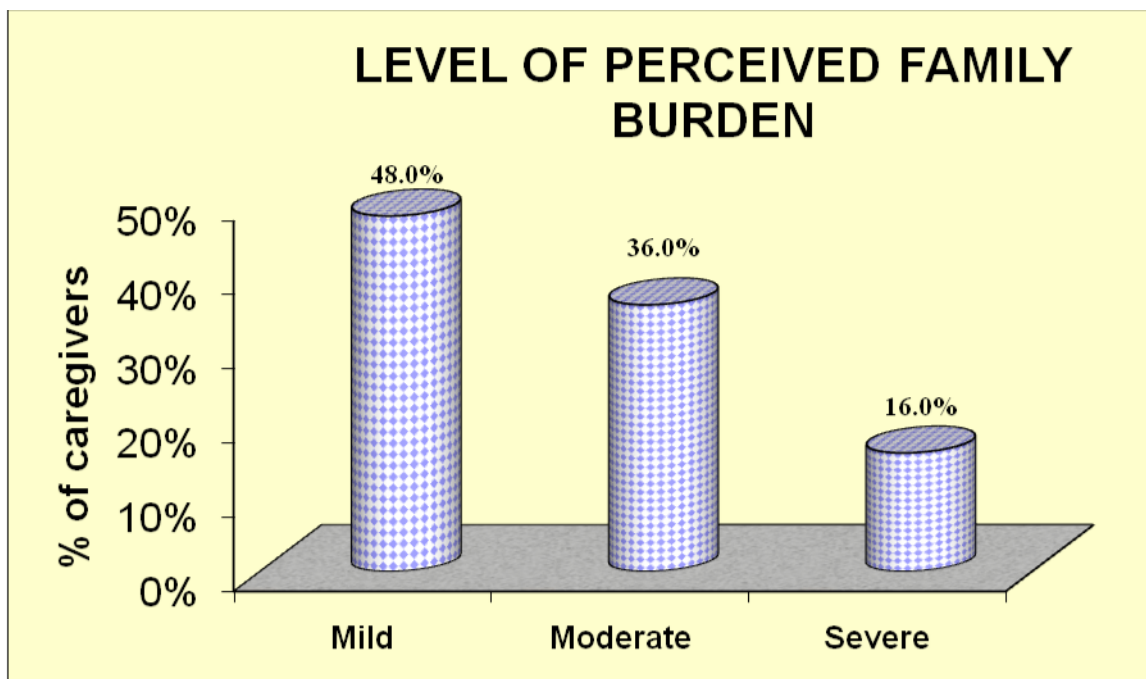
**Table No.2 (b): OVERALL PERCEIVED FAMILY BURDEN SCORE**

**N= 100**

	<b>No. of questions</b>	<b>Min-Max score</b>	<b>Mean <math>\pm</math> SD</b>	<b>Percentage of burden</b>
Burden score	40	40-120	82.87 $\pm$ 14.28	69.1%

Table 2(b) shows the overall perceived family burden among the primary caregivers of chronic schizophrenia patients.

They are scored 82.87 out of 120 score, so on an average 69% they are having perceived family burden.



**FIGURE 12: DISTRIBUTION OF SAMPLES IN TERMS OF LEVEL OF PERCEIVED FAMILY BURDEN**



### SECTION – III

**Level of coping strategies among the primary caregivers of chronic schizophrenia patients.**

**Table 3 (a): LEVEL OF COPING STRATEGIES**

**N= 100**

<b>S.No</b>	<b>Level of coping</b>	<b>No. of caregivers</b>	<b>Percentage</b>
1.	Inadequate	42	42.0%
2.	Moderate	49	49.0%
3.	Adequate	9	9.0%
	<b>Total</b>	<b>100</b>	<b>100%</b>

Table No 3 (a) assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.

Among the primary care givers 49% of them having moderate coping, 42% are having inadequate coping, and 9% of them having adequate coping.

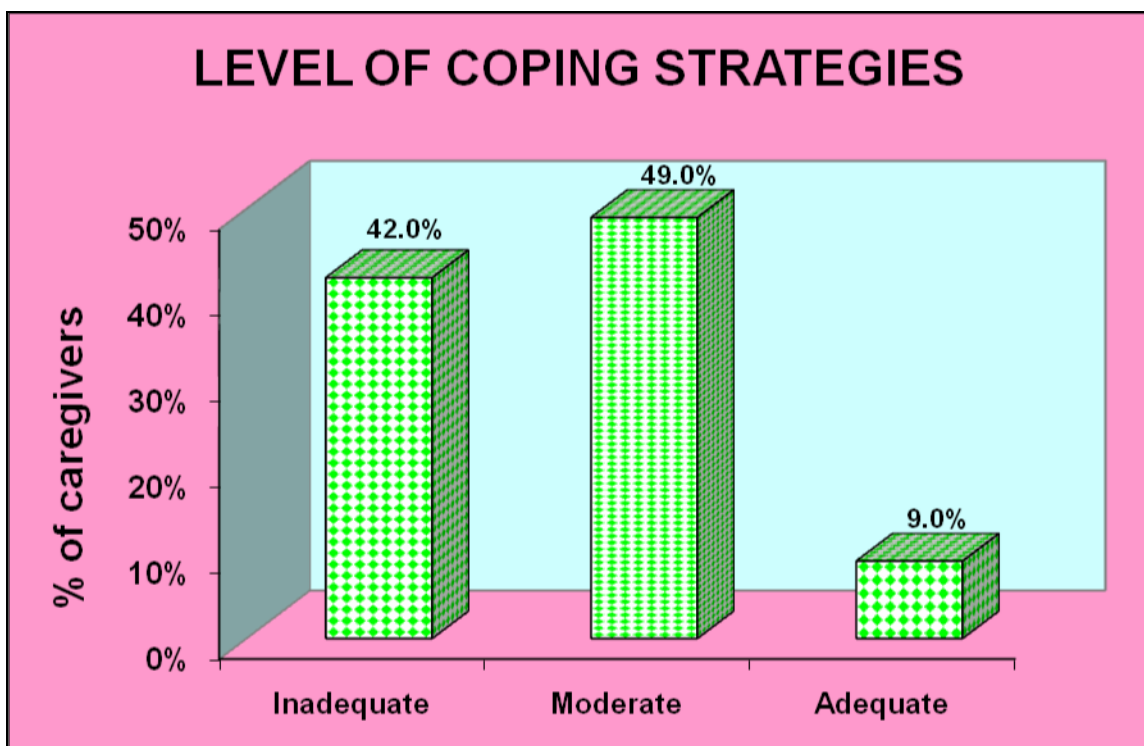
**Table 3 (b): OVERALL COPING STRATEGIES SCORE**

**N= 100**

	<b>No. of questions</b>	<b>Min-Max score</b>	<b>Mean± SD</b>	<b>Percentage</b>
Coping score	70	0-70	39.31± 8.37	56.2%

Table no.3 (b) shows the overall coping strategies among the primary caregivers of chronic schizophrenia patients.

They are scored 39.31 out of 70 score, so on an average 56.2% they are having coping.



**FIGURE 13: DISTRIBUTION OF SAMPLES IN TERMS OF LEVEL OF COPING STRATEGIES**

## SECTION – IV

**Level of psychological well-being among the primary caregivers of chronic schizophrenia patients.**

**Table 4 (a): LEVEL OF PSYCHOLOGICAL WELL-BEING**

**N= 100**

<b>S.No</b>	<b>Level of psychological well-being</b>	<b>No. of caregivers</b>	<b>Percentage</b>
1.	Inadequate	48	48.0%
2.	Moderate	46	46.0%
3.	Adequate	6	6.0%
	<b>Total</b>	<b>100</b>	<b>100%</b>

Table no:5(a) assess the level of psychological well-being among the primary caregivers of chronic schizophrenia patients.

Among the primary care givers 48 % are having inadequate well-being , 46% of them having moderate well-being and 6% of them having adequate well-being.

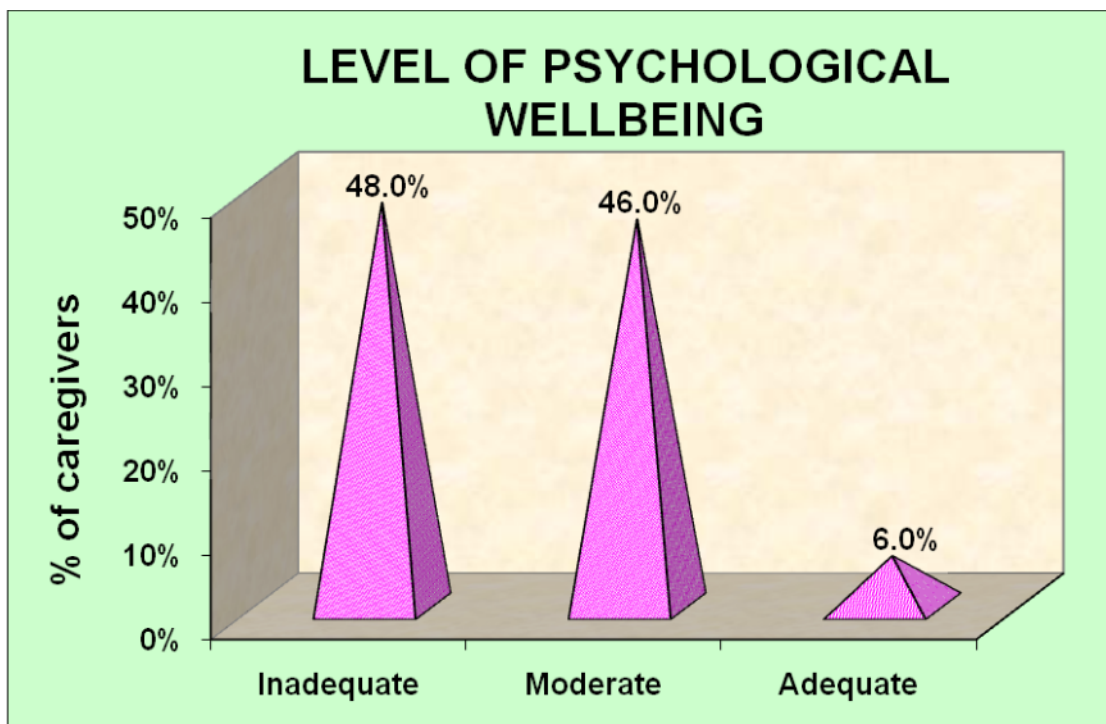
**Table 4 (b): OVERALL PSYCHOLOGICAL  
WELL-BEING SCORE**

**N= 100**

	<b>No. of questions</b>	<b>Level of score</b>	<b>Mean ± SD</b>	<b>Percentage</b>
Psychological well-being	28	0-28	15.07 ± 3.58	53.8%

Table No.5 (b) shows the overall psychological well-being among the primary caregivers of chronic schizophrenia patients.

They are scored 15.07 out of 28 score, so on an average 53.8% they are having psychological well-being.



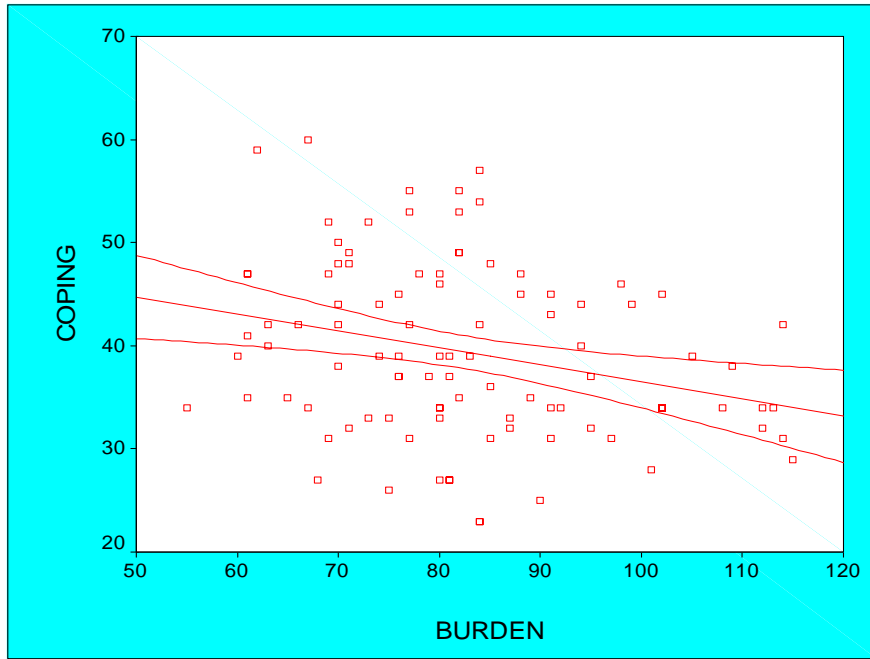
**FIGURE 14: DISTRIBUTION OF SAMPLES IN TERMS OF LEVEL OF  
PSYCHOLOGICAL WELL-BEING**

## SECTION- V

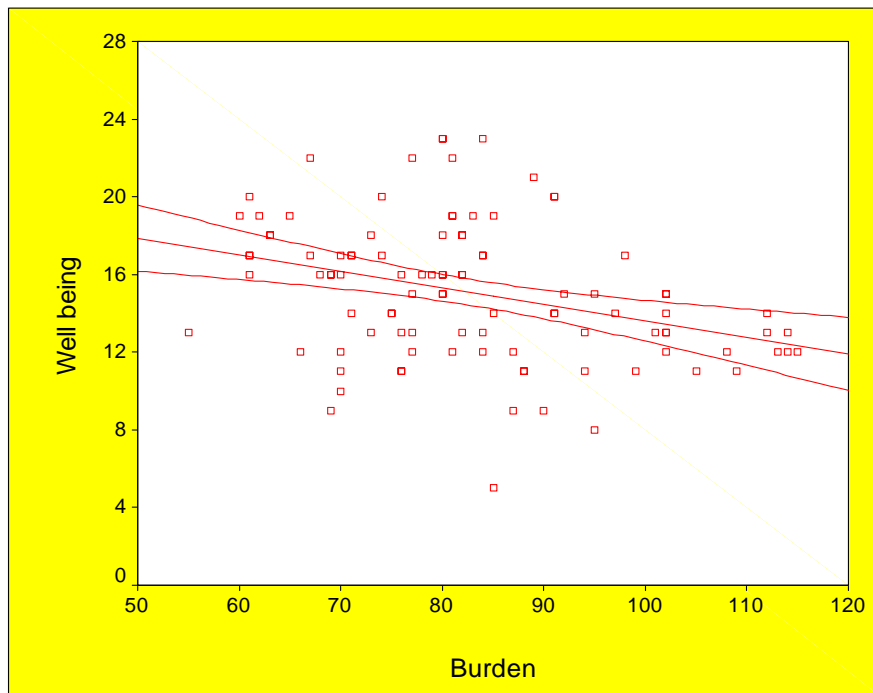
**Interrelationship among the level of perceived family burden, coping strategies and the psychological well-being among the primary caregivers of chronic schizophrenia patients.**

**Table 5: CORRELATION BETWEEN PERCEIVED FAMILY BURDEN, COPING STRATEGIES AND PSYCHOLOGICAL WELL-BEING**

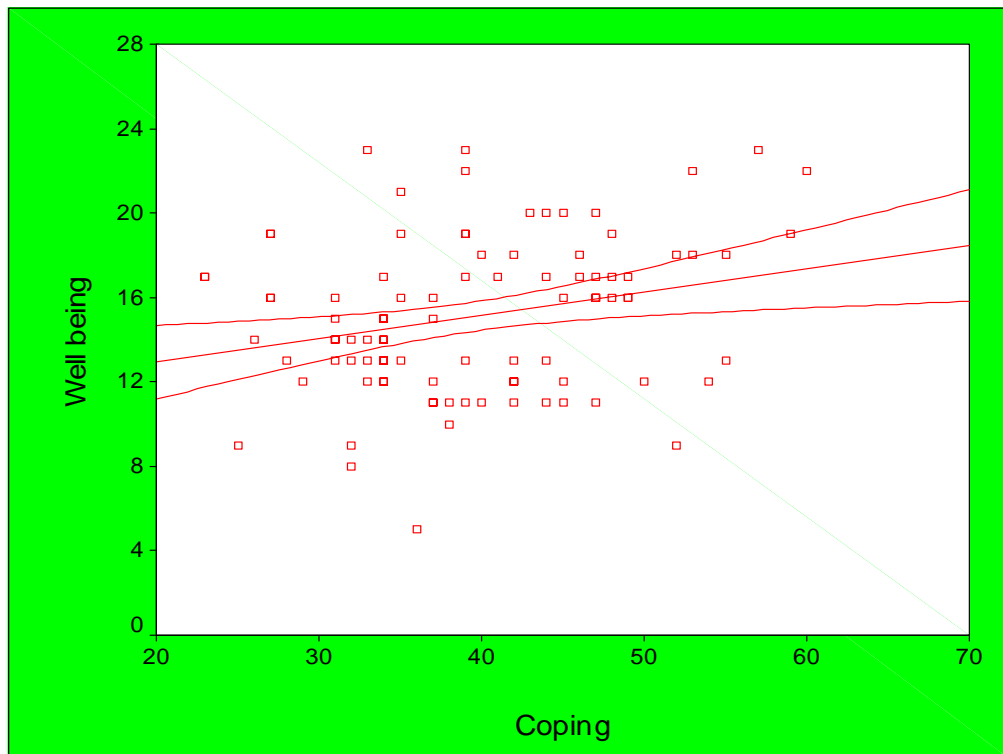
Test	Correlation between	Mean score	Karl Pearson correlation coefficient	Interpretation
		Mean $\pm$ SD		
1.	Family burden	82.87 $\pm$ 14.28	r = 0.43	Moderate, Negative, significant correlation.  It means burden increases their coping decreases.
	Coping	39.31 $\pm$ 8.37		
2.	Family burden	82.87 $\pm$ 14.28	r = 0.48	Moderate, negative, significant correlation.  It means burden increases their well being decreases.
	Well being	15.07 $\pm$ 3.59		
3.	Coping	39.31 $\pm$ 8.37	r = 0.51	Moderate, Positive, significant Correlation.  It means when coping increases their well being also increases.
	Well being	15.07 $\pm$ 3.59		



**FIGURE 15: SCATTER PLOT WITH REGRESSION ESTIMATE SHOWS THE MODERATE NEGATIVE CORRELATION BETWEEN BURDEN SCORE AND COPING SCORE**



**FIGURE 16: SCATTER PLOT WITH REGRESSION ESTIMATE SHOWS THE MODERATE NEGATIVE CORRELATION BETWEEN BURDEN SCORE AND WELL-BEING SCORE**



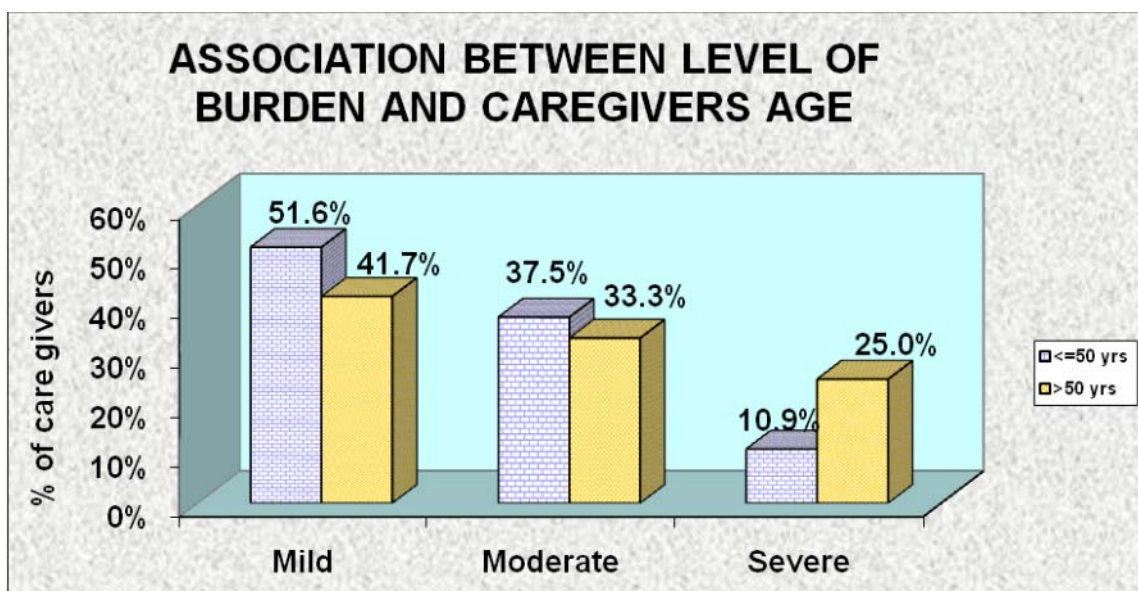
**FIGURE 17: SCATTER PLOT WITH REGRESSION ESTIMATE  
SHOWS THE MODERATE POSITIVE CORRELATION  
BETWEEN COPING SCORE AND WELLBEING SCORE**



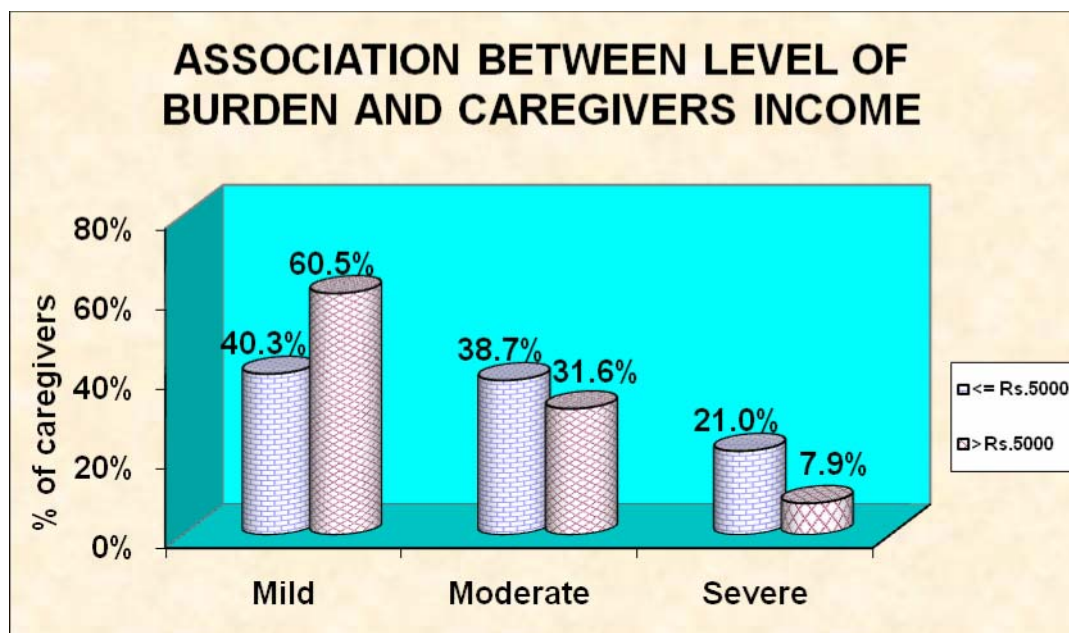


Relationship with patient	Mother/father/sister/brother	30	60.0%	16	32.0%	4	8.0%	50	$\chi^2=7.44$
	Wife/husband/daughter/son	18	36.0%	20	40.0%	12	24.0%	50	
Family size	< 5	29	50.0%	19	32.8%	10	17.2%	58	$\chi^2=0.65$
	=>5	19	45.2%	17	40.5%	6	14.3%	42	
Occupation	Housewife/unemployed/retired	16	42.1%	15	39.5%	7	18.4%	38	$\chi^2=0.87$
	Others	32	51.6%	21	33.9%	9	14.5%	62	
Gender	Male	30	50.0%	24	40.0%	6	10.0%	60	$\chi^2=4.16$
	Female	18	45.0%	12	30.0%	10	25.0%	40	
Marital status	Married	40	45.5%	32	36.4%	16	18.2%	88	$\chi^2=3.19$
	Unmarried	8	66.7%	4	33.3%			12	
Type of Family	Joint family	20	47.6%	17	40.5%	5	11.9%	42	$\chi^2=1.16$
	Nuclear family	28	48.3%	19	32.8%	11	19.0%	58	
Health status	Healthy	46	50.5%	32	35.2%	13	14.3%	91	$\chi^2=3.42$
	Un healthy	2	22.2%	4	44.4%	3	33.3%	9	

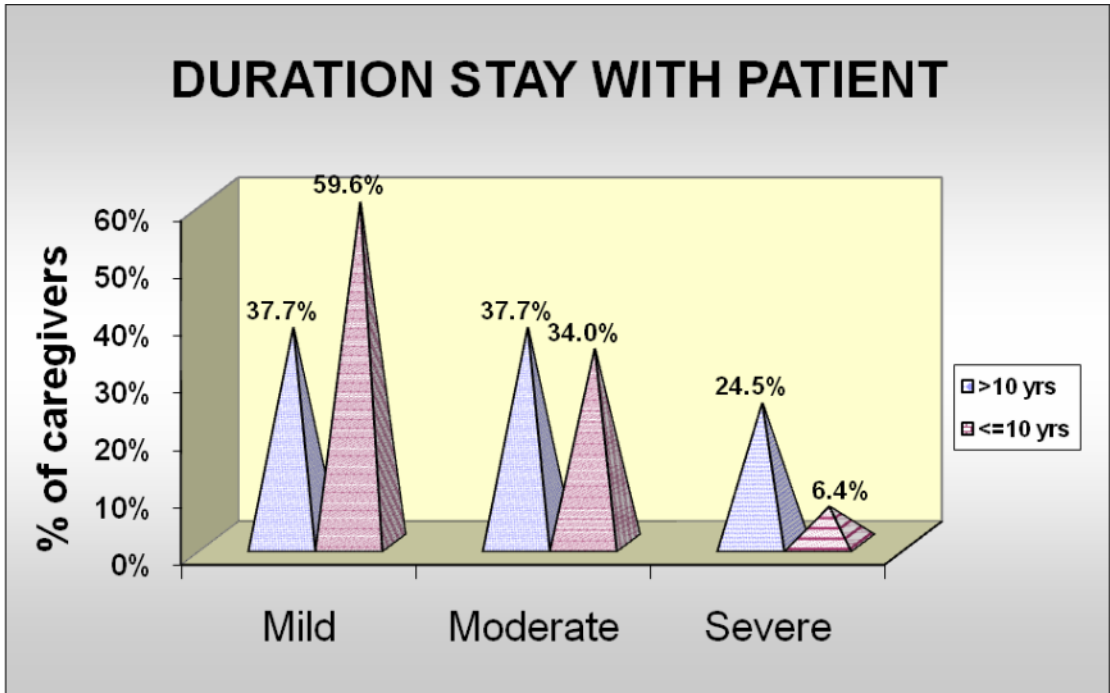
Table no. 7: shows the association between demographic variables and caregivers level of burden. Age, duration of illness and relationship with patients are significantly associated with their level of burden. More aged, less income, long time illness and wife groups are having more burden.



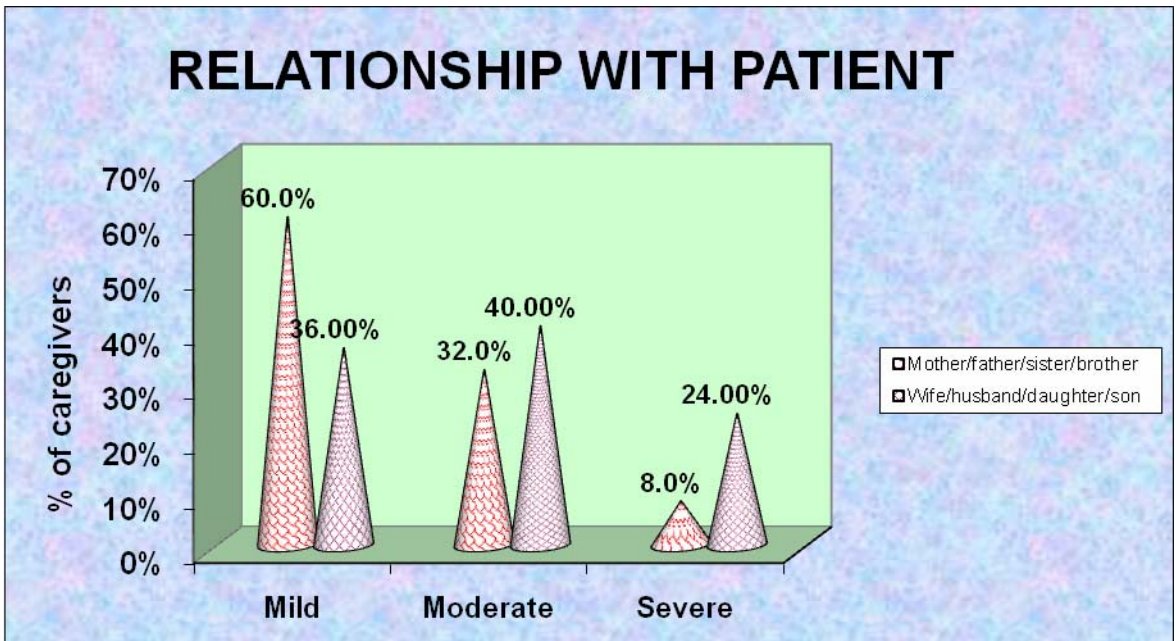
**FIGURE 18: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF BURDEN AND CAREGIVERS AGE**



**FIGURE 19: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF BURDEN AND CAREGIVERS INCOME**



**FIGURE 20: DISTRIBUTION OF SAMPLES IN TERMS OF DURATION OF STAY WITH PATIENT**



**FIGURE 21: DISTRIBUTION OF SAMPLES IN TERMS OF REALTIONSHIP WITH PATIENT**

## SECTION – VII

### Association between coping strategies and selected demographic variables like age, gender, religion, marital status, education, etc.

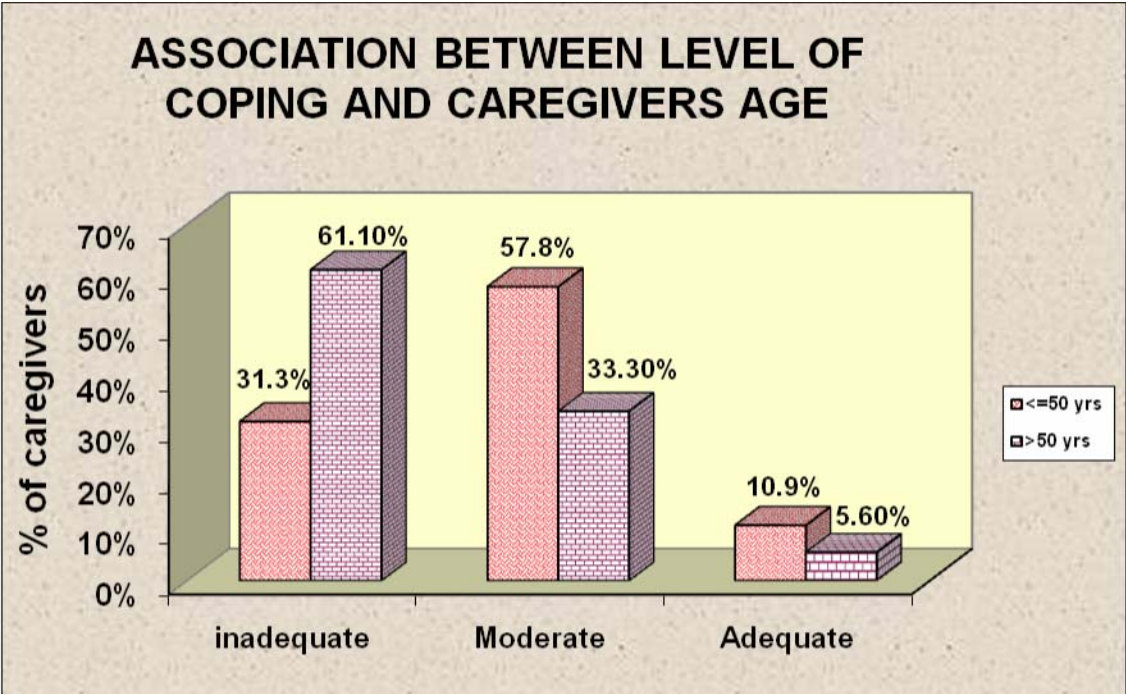
**Table 7: ASSOCIATION BETWEEN LEVEL OF COPING AND DEMOGRAPHIC VARIABLES**

**N= 100**

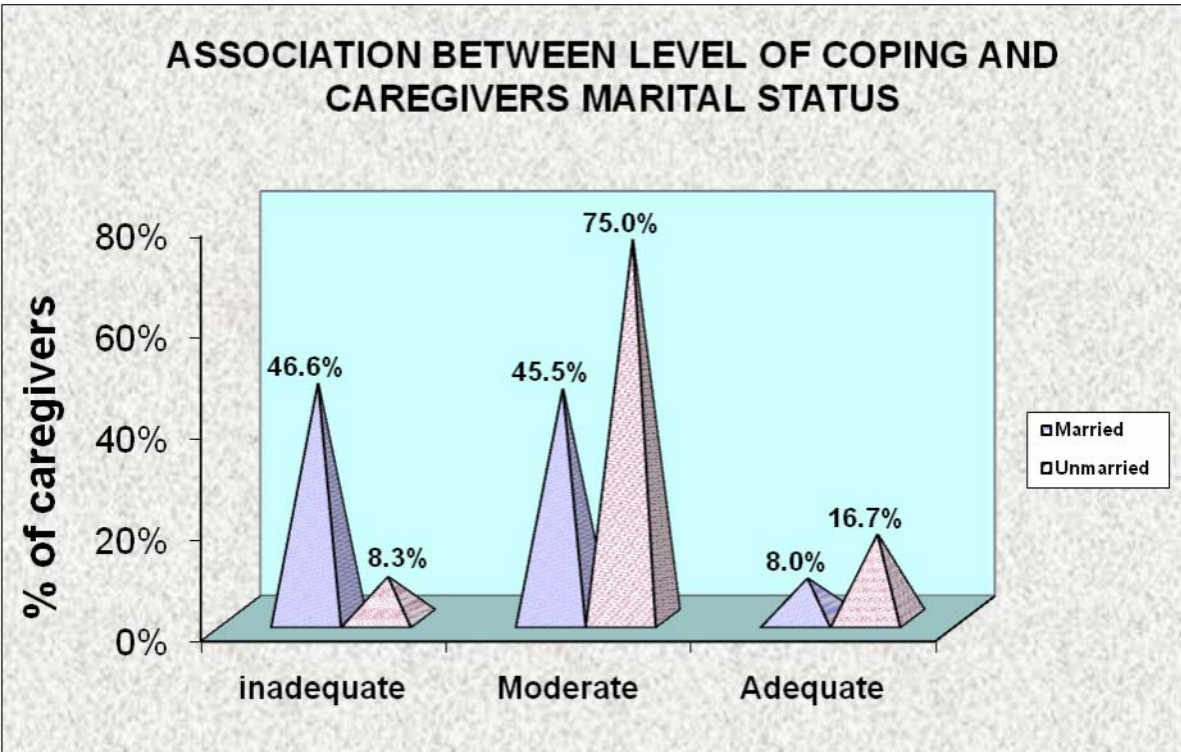
Demographic variables		Level of coping						Total	Chisquare test
		inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age	<=50 yrs	20	31.3%	37	57.8%	7	10.9%	64	$\chi^2=8.45$
	>50 yrs	22	61.1%	12	33.3%	2	5.6%	36	
Education	Illiterate/Primary	5	31.3%	10	62.5%	1	6.3%	16	$\chi^2=1.39$
	Others	37	44.0%	39	46.4%	8	9.5%	84	
Income	<= Rs.5000	25	40.3%	31	50.0%	6	9.7%	62	$\chi^2=0.22$
	>Rs.5000	17	44.7%	18	47.4%	3	7.9%	38	
Duration	>10 yrs	25	47.2%	25	47.2%	3	5.7%	53	$\chi^2=2.19$
	<=10 yrs	17	36.2%	24	51.1%	6	12.8%	47	
Relationship with patient	Mother/father/sister/brother	17	34.0%	27	54.0%	6	12.0%	50	$\chi^2=3.03$
	Wife/husband/daughter/son	25	50.0%	22	44.0%	3	6.0%	50	
Family size	< 5	23	39.7%	30	51.7%	5	8.6%	58	$\chi^2=0.41$
	=>5	19	45.2%	19	45.2%	4	9.5%	42	
Occupation	Housewife/unemployed/retired	21	55.3%	15	39.5%	2	5.3%	38	$\chi^2=4.65$
	Others	21	33.9%	34	54.8%	7	11.3%	62	

Gender	Male	27	45.0%	28	46.7%	5	8.3%	60	$\chi^2=0.56$
	Female	15	37.5%	21	52.5%	4	10.0%	40	
Marital status	Married	41	46.6%	40	45.5%	7	8.0%	88	$\chi^2=6.45$
	Unmarried	1	8.3%	9	75.0%	2	16.7%	12	
Type of Family	Joint family	19	45.2%	19	45.2%	4	9.5%	42	$\chi^2=0.41$
	Nuclear family	23	39.7%	30	51.7%	5	8.6%	58	
Health status	Healthy	35	38.5%	47	51.6%	9	9.9%	91	$\chi^2=5.95$
	Un healthy	7	77.8%	2	22.2%	0	0.0%	9	

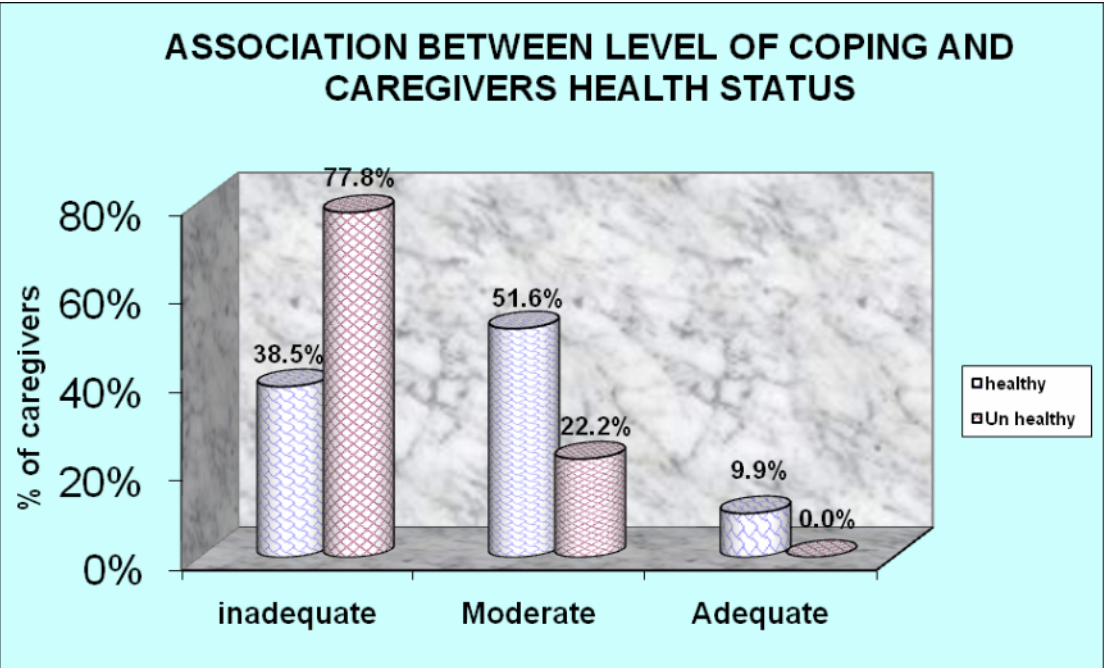
Table No.8 shows the association between demographic variables and caregivers level of coping. Age, marital status and health status are significantly associated with their level of coping. Less aged, Married and healthy are having more coping.



**FIGURE 22: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF COPING AND CAREGIVERS AGE**



**FIGURE 23: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF COPING AND CAREGIVERS MARITAL STATUS**



**FIGURE 24: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF COPING AND CAREGIVERS HEALTH STATUS**

## SECTION – VIII

**Association between psychological well-being and selected demographic variables like age, gender, religion, marital status, education, occupation, etc.**

**Table 8: ASSOCIATION BETWEEN LEVEL OF PSYCHOLOGICAL WELLBEING AND DEMOGRAPHIC VARIABLES**

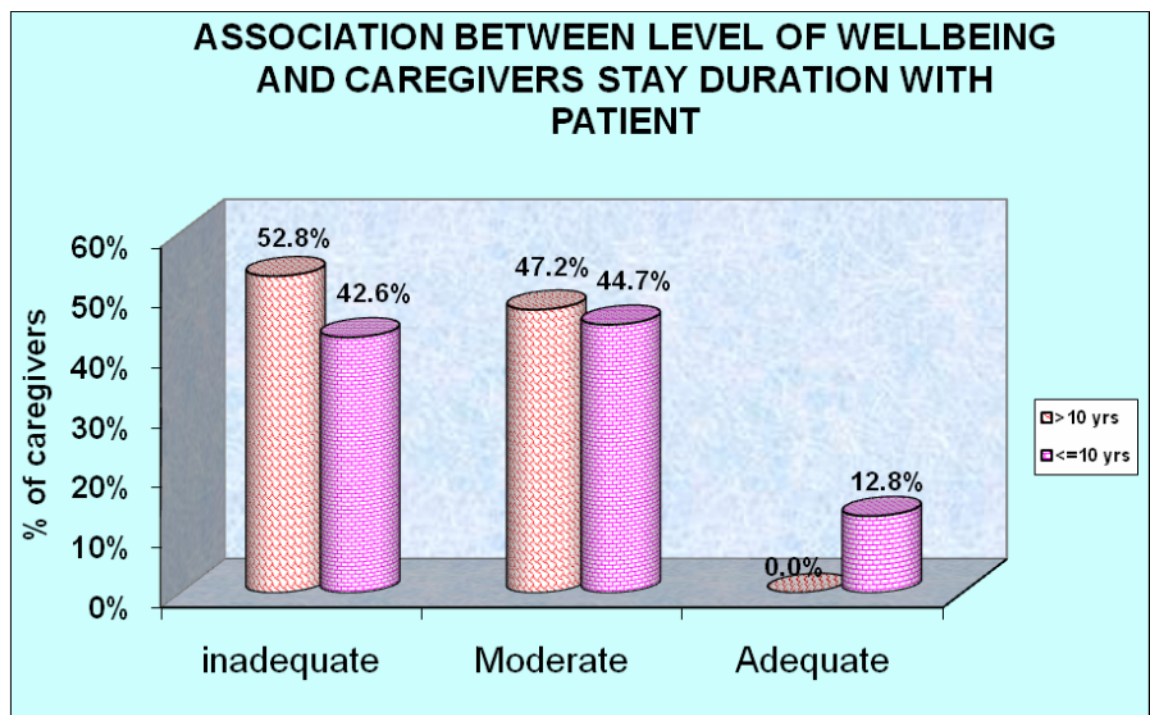
**N = 100**

Demographic variables		Level of wellbeing						Total	Chisquare test
		inadequate		Moderate		Adequate			
		n	%	n	%	N	%		
Age	<=50 yrs	30	46.9%	29	45.3%	5	7.8%	64	$\chi^2=1.03$
	>50 yrs	18	50.0%	17	47.2%	1	2.8%	36	
Education	Illiterate/Primary	8	50.0%	7	43.8%	1	6.3%	16	$\chi^2=0.04$
	Others	40	47.6%	39	46.4%	5	6.0%	84	
income	<= Rs.5000	32	51.6%	27	43.5%	3	4.8%	62	$\chi^2=1.02$
	>Rs.5000	16	42.1%	19	50.0%	3	7.9%	38	
Duration	>10 yrs	28	52.8%	25	47.2%	0	0.0%	53	$\chi^2=7.34$
	<=10 yrs	20	42.6%	21	44.7%	6	12.8%	47	
Relationship with patient	Mother/father/sister/brother	21	42.0%	25	50.0%	4	8.0%	50	$\chi^2=1.76$
	Wife/husband/daughter/son	27	54.0%	21	42.0%	2	4.0%	50	
Family size	< 5	33	56.9%	23	39.7%	2	3.4%	58	$\chi^2=4.98$
	=>5	15	35.7%	23	54.8%	4	9.5%	42	
Occupation	Housewife/unemployed/retired	21	55.3%	16	42.1%	1	2.6%	38	$\chi^2=2.03$
	Others	27	43.5%	30	48.4%	5	8.1%	62	
Gender	Male	27	45.0%	31	51.7%	2	3.3%	60	$\chi^2=3.11$
	Female	21	52.5%	15	37.5%	4	10.0%	40	

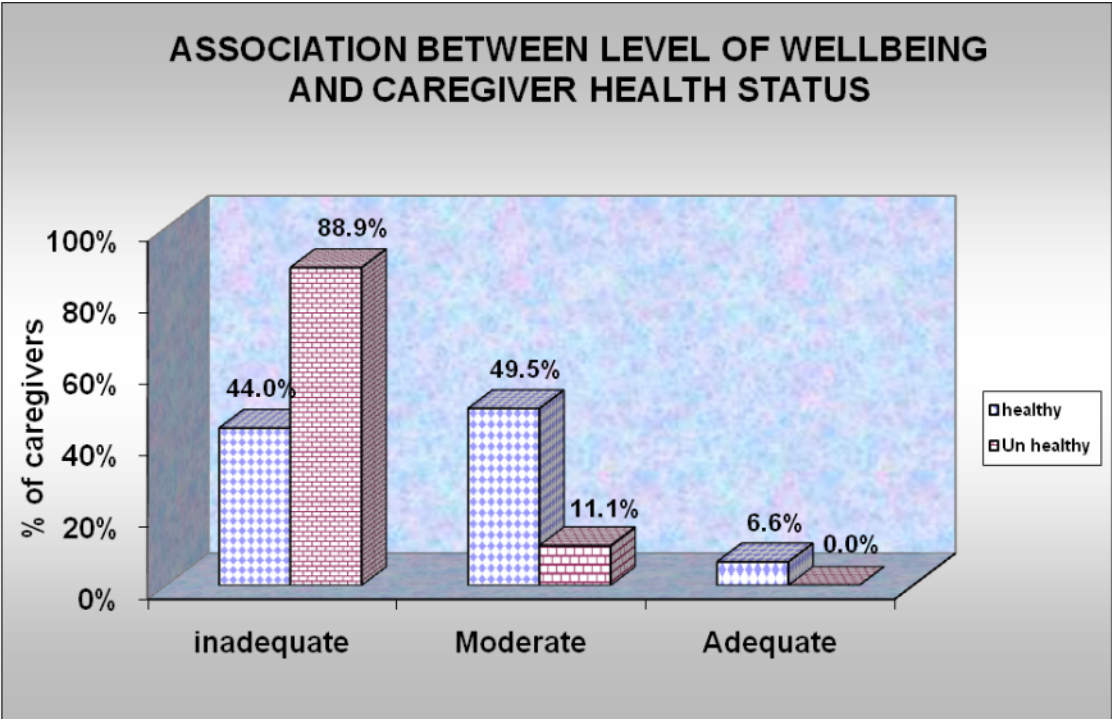


Marital status	Married	41	46.6%	41	46.6%	6	6.8%	88	$\chi^2=1.17$
	Unmarried	7	58.3%	5	41.7%			12	
Type of Family	Joint family	16	38.1%	22	52.4%	4	9.5%	42	$\chi^2=3.62$
	Nuclear family	32	55.2%	24	41.4%	2	3.4%	58	
Health status	Healthy	40	44.0%	45	49.5%	6	6.6%	91	$\chi^2=6.66$
	Un healthy	8	88.9%	1	11.1%	0	0.0%	9	

**Table No.9** shows the association between demographic variables and caregivers level of psychological well-being. Duration of illness and health status are significantly associated with their level of wellbeing. Less year's illness and healthy status persons are having more wellbeing.



**FIGURE 25: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF WELLBEING AND CAREGIVERS STARY DURATION WITH PATIENT**



**FIGURE 26: DISTRIBUTION OF SAMPLES IN TERMS OF ASSOCIATION BETWEEN LEVEL OF WELL-BEING AND CAREGIVER HEALTH STATUS**

## **CHAPTER – V**

### **DISCUSSION**

The aim of the study to assess the level of perceived family burden, coping strategies and psychological well being among the primary caregivers of chronic schizophrenia patients in selected hospital at Madurai. The investigator conducted the study in M.S.Chellamuthu Trust and Research Foundation, Madurai, Tamilnadu.

Hundred patients were selected by using the purposive sampling technique. The samples were selected based on inclusion criteria. The patients were interviewed separately by means of standardized questionnaire to collect the information after getting the validity from experts and pilot study.

The responses were coded, verified and finally processed by using the most commonly used package.

The collected data were classified into two sections. The first section contained the socio-demographic variables of the primary caregivers of chronic schizophrenia patients. The second section included the Burden Assessment Scale, Coping strategy checklist and Psychological well being Questionnaire to assess the level of perceived family burden, coping strategies and psychological well being among the primary caregivers of chronic schizophrenia patients.

The investigator modified the 'stress, coping and Adaptation Model' by Lazarus and Folkman (1984) for this study using the four components of antecedents to the stress, coping and adaptation. Antecedents to the stress response include the person-environment relationship and the person's cognitive appraisal of the risks and benefits of the situation. The appraisal of the relationship determines the manifestation of stress and the potential for coping and psychological well being.

**Objectives of the study:**

1. To assess the level of perceived family burden among the primary caregivers of chronic schizophrenia patients.
2. To assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.
3. To assess the level of psychological well-being among the primary caregivers of chronic schizophrenia patients.
4. To find the interrelationship among the level of perceived family burden, coping strategy and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
5. To find out the association between the perceived family burden and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).
6. To find out the association between coping strategies and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).

7. To find out the association between psychological well-being and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).

**OBJECTIVE I: To assess the level of perceived family burden among the primary caregivers of chronic schizophrenia patients.**

The statistical report of level of perceived family burden (Table 2) revealed that maximum of 48 primary caregivers (48%) were having mild burden, 36 primary caregivers (36%) were having moderate burden and 16 patients (16%) were having severe burden. The disruption in social relationships, particularly feelings of social isolation and impact of illness on the physical and mental health of the caregivers has been documented in several studies carried out in the west (**Fadden, Bebbington and Kuipers 2007, waters and North over (2002)**). Similar findings in the Indian setting have been reported by **Anupama (2002), Gautam and Nijhawan (2004)**, and by **Roychowdhury et al (2000)**. The results obtained are therefore consistent with these findings.

With these findings the investigator concluded that knowledge and awareness about the disease condition and adequate income, family support help the caregivers to adopt with the mild level of family burden and on the other side those who are having the less knowledge and inadequate income, dysfunctional family relationships leads the caregivers to adopt with the moderate and severe level of family burden.

**OBJECTIVE II: To assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.**

The statistical report shows that among the primary care givers 49% of them having moderate coping, 42% are having inadequate coping, and 9% of them having adequate coping. In this group of caregivers, emotion-focused coping strategies such as denial, faith and acceptance are used more often than problem-focused methods. This is consistent with the view that emotion-focused strategies are more likely to be adopted when a chronic stressor, such as the mental illness of a relative, is present. Studies of **Birchwood and Cochrane (2001)**, **Gidron (2004)** and **Magliano (2007)** report the use of strategies such as acceptance, resignation and religion indicating that emotion-focused strategies are more likely to be adopted by relatives.

The investigator concluded that there is an association between the age, marital status and health status, are significantly associated with their level of coping. Less aged, married and healthy people are having adequate level of coping strategies because of less exposure to the problems among the young age, sharing and discussing the issues among the spouses make the individual feel less stress and good health status makes the individual to feel better physically and psychologically

**OBJECTIVE III: To assess the level of psychological well being among the primary caregivers of chronic schizophrenia patients.**

The group on the whole has experienced inadequate well being 48%, moderate 46% and only 6% of them were having adequate psychological well being. This is consistent with the findings of **Oldridge and Hughes (2002)** and in the Indian setting by **Roychowdhury et al (2005)**, who found that caregivers had well-being score below the normal range, despite using adequate coping strategies. The investigator concluded that there is strong relationship between the coping strategies and psychological well beings. When the individual uses the correct coping mechanisms towards the problem or burden, the psychological status of the caregivers is improved. When the coping mechanisms are not used appropriately, the individual exhibits the maladaptive behavior like poor self-esteem, decrease social functioning and relationships among others.

**OBJECTIVE IV: To find the interrelationship among the level of perceived family burden, coping strategy and the psychological well-being among the primary caregivers of chronic schizophrenia patients.**

The correlation between the perceived family burden and coping strategies the correlation coefficient was ( $r = 0.43$ ) shows the moderate, negative, significant correlation. It means when the family burden increases their coping strategies will decrease. The statistical report of the perceived family burden and psychological well being, the correlation coefficient was ( $r=0.48$ ) indicates that the moderate, negative and significant correlation. It means when the burden increases their well being also decreases. The findings between the coping and well being, the

correlation coefficient was ( $r=0.51$ ) showed that moderate, positive, significant correlation. It means when the coping increases their wellbeing also increases.

Older caregivers report lower levels of well being, and greater burden and using less coping strategies particularly in the areas of social relations, caregiver health and family relations (Table 6). The findings of the present study can be explained in terms of older caregivers having more concerns about the future of the patient. It is possible that the social isolation takes place due to the stigma attached to the illness. Another possibility is that families get more nuclear with increasing age. More educated caregivers report increased well-being and less burden and using adequate coping strategies. This could be due to its association with occupational status and income, which leads to greater resources available, more options and empowerment, which in turn could result in lower burden. However **Gopinath and Chaturvedi (2002)** found that younger and more educated caregivers' relatives reported distress more often.

With these findings the investigator concluded that there are strong evidence shows that when there is an increase level of family burden, there will be an inadequate level of coping strategies and psychological well-being. Stress impairs the individual's physical and mental status.

**OBJECTIVE V: To find out the association between the perceived family burden and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).**



Table No.7 showed that age, duration of illness and relationship with patients are significantly associated with their level of burden among socio-demographic variables. More aged, less income, long time illness and wife group are having higher level of burden.

This finding was supported by **Sunil Srivastava (2005)** who conducted a study on, " perception of burden by caregivers of patients with schizophrenia". Interviews were conducted with caregivers of 34 patients with schizophrenia at the OPD of the Institute of Mental Health and Hospital, Agra, using a Burden Assessment Schedule (BAS) by Thara et al. It was generally felt a lesser burden of care giving as compared with caregivers of middle aged patients. A low positive correlation was found between urban domicile and support of the patient: of domicile Agra and effect of other relations; and domicile Agra and effect on the caregiver's routine. 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. The t test for population correlation was significant up to 5% probability level ( $p < 0.05$ ) for correlation between urban domicile and support of the patient; between domicile Agra and effect on other relations; between domicile Agra and the effect on the caregiver's routine; between age less than 30 years and the physical and mental health of the caregivers; and between age less than 30 years their adult children with mental illness had higher rates of chronic health conditions, success high blood pressure, arthritis and eye problems.

**Richard et al, (2008)** conducted a study to describe subjective burden and to identify the predictors of burden in primary caregiver of mentally ill outpatients recruited from eight hospitals in Montreal, Canada. Only 12% of the primary caregivers reported no subjective burden in dealing with one or more sources of difficulties presented by the patient. Behavior related to the depressive state or affect of the patients, symptom related patient behaviors and poor social contact created high levels of caregiver burden. Female primary caregivers perceived greater subjective burden regardless of their age, occupation and relationship to the patient.

**Martyns-Yellowe 2002, Roychowdhury 2005**, which have reported younger age as being associated with greater burden. One of the concerns of the caregivers of chronic psychotic patients, especially parents, is the question of who will look after the patients after their lifetime, and this concern could have been responsible for greater burden being associated with older patients (**Gopinath and Chaturvedi 2002**)

**Grad and Sainsbury 2005**, research findings were longer duration of illness has been associated with greater burden. However duration of illness may need to be seen with reference to severity of psychopathology; better the functioning of the patient, the lesser the burden. Severity of psychopathology is linked to greater overall burden, and burden due to patient's behavior and social relations. Studies have linked symptom severity with greater distress in caregivers. Symptoms such aggression, delusions and hallucinations (**Waters and Northover 2005, Winefield and Harvey 2003**) as well as negative symptoms such as slowness, inactivity and self – care (**Gopinath and Chaturvedi 2002**) caused considerable distress to caregivers. The results of this section suggest that despite the patients being psychiatrically stable, subjective

burden in terms of social isolation, stigma and community problems is still perceived, though objective burden is not felt. This is consistent with the findings of Varghese (2004), where family distress, social isolation and community problems were significantly and positively correlated with objective burden.

With these findings the investigator concluded that there is a relationship between age, duration of illness, and relationship with the patients are significantly associated with their level of burden. More aged, less income, duration of illness and wives are having more burden than others. This is because old age people have fear about patient's future to take care of them after their lives along with less income makes the individual to feel more burden.

**OBJECTIVE VII: To find out the association between coping strategies and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness.**

Table No.8 showed that age, marital status and health status are significantly associated with their level of coping. Less aged, married and healthy are having more coping strategies than other in the demographic variables. It shows that education, income, family size, occupation, gender, type of family are not associated with the level of coping.

**Anupama Rammohan et al (2002)** conducted a study on “Burden and coping in caregivers of persons with schizophrenia”. Interviews were conducted with caregivers of 24 parents and 24 spouses. The findings highlighted that burden was experienced by both parents and spouses in their role as caregivers of patients with mental illness. Spouses reported great emotional burden, while the experience of objective burden was

similar for both parents and spouses but they differed in their experience of subjective burden. The providing care to a family member with a long standing mental illness such as schizophrenia causes significant disruption in several domains of family life. With these findings the investigator concluded that less aged, married and healthy people are having adequate coping strategies to face the problem that is because of the less exposure to the problem in the young people, sharing and discussing the issues with the spouse among the married individuals and good health status makes the individual to feel better physically as well as psychologically.

**OBJECTIVE VIII: To find out the association between psychological well-being and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).**

The result of this study (Table no.9) showed that duration of illness and health status are significantly associated with their level of psychological wellbeing. Less year's illness and healthy status persons are having more psychological wellbeing. It shows that age, education, income, relationship with patient, family size, type of family, gender, marital status are not significantly associated with the psychological well being of the primary caregivers of chronic schizophrenia patients.

This study was supported by **Anupama (2002)** assessed the relationship between religious coping, perceived burden and level of psychological well being. 60 primary caregivers of schizophrenia patients were selected from the outpatient department of Psychiatry, NIMHANS, Bangalore. Data were collected by using Burden Assessment Schedule (Thara et al, 1998). Coping Checklist (Rao et al, 1989) and a semi

structured interview schedule to assess religious beliefs, practice and coping. The group of caregivers experienced moderate levels of burden and moderately high levels of well being. Burden was correlated with patient characteristics. Older and less educated care givers experienced greater burden and psychological wellbeing were inversely correlated.

Gender of the patient is not related to perceived burden and well being of caregivers (Table 9). Research findings on gender and burden are equivocal; greater burden was perceived in caregivers of female patients by **Winefield and Harvey (2003)**. However, studies carried out in developing countries like **Nigeria (Martyns – Yellowe) and India (Gautam and Nijhawan 2004, Roychowdhury et al 2005)** reported that relatives of male schizophrenics experienced greater burden. This is presumably due to the traditional role of breadwinners played by males in these countries.

With these findings the investigator concluded that when there is increase in the duration of the stay with the patient as well as the poor health status of the individual decreases the psychological well-being among the primary caregivers. Less duration and good health status increases the psychological well being because less exposure to the patients signs and symptoms.

## **SUMMARY AND RECOMMENDATION**

This chapter dealt with the summary, major findings, nursing implications, nursing recommendations and conclusion of the study. The demands of caring for a seriously mentally ill relative have both an emotional and a practical impact on the caregiver. The cost that families incur in terms of economic hardships, social isolation and psychological strain is referred to as family burden (Pai and Kapur, 1981; Chakraborti et al, 1995).

The investigator selected the study to assess the level of perceived family burden, coping strategies and psychological well being among the primary caregivers of chronic schizophrenia patients.

### **Objectives of the study:-**

1. To assess the level of perceived family burden among the primary caregivers of chronic schizophrenia patients.
2. To assess the level of coping strategies among the primary caregivers of chronic schizophrenia patients.
3. To assess the level of psychological well-being among the primary caregivers of chronic schizophrenia patients.
4. To find the interrelationship among the level of perceived family burden, coping strategy and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
5. To find out the association between the perceived family burden and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).

6. To find out the association between coping strategies and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).
7. To find out the association between psychological well-being and selected demographic variables (such as age, gender, religion, marital status, education, occupation, income, relationship with the patient and duration of illness).

**Hypotheses:-**

1. There will be a interrelationship among the level of perceived family burden, coping strategies and the psychological well-being among the primary caregivers of chronic schizophrenia patients.
2. There will be a significant association between the level of perceived family burden and selected demographic variables.
3. There will be a significant association between the level of coping strategies and selected demographic variables.
4. There will be a significant association between the level of psychological well-being and selected demographic variables.

A descriptive research method was undertaken to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients. The study was conducted at M.S.Chellamuthu Trust and Research Foundation in Madurai. The data were collected from 100 primary caregivers of chronic schizophrenia patients who fulfill the inclusion criteria by purposive sampling technique.

The research tool consisted of standardized questionnaire (Burden Assessment Scale, Coping Checklist and Psychological wellbeing) and structured interview questionnaire to collect data regarding the demographic profile of the primary care givers.

The review of literature enabled the investigator to develop the conceptual framework. The study was based on the Stress, Coping and Adaptation Model (Lazarus and Folkman, 1984). Antecedents to the stress response include the person-environment relationship and the person's cognitive appraisal of the risks and benefits of the situation. The appraisal of the relationship determines the manifestations of stress and the potential for coping. Descriptive and inferential statistics such as frequency percentage, chi-square were used to interpret the data.

## **MAJOR FINDINGS OF THE STUDY**

- ∞ The result revealed that among the primary caregivers 48% are having mild burden, 36% of them having moderate burden and 16% of them having severe burden.
- ∞ The report about the level of coping strategies among the primary caregivers 49% are having moderate level of coping strategies, 42% of them are having inadequate coping strategies and only 9% of them are falling under adequate level of coping strategies.
- ∞ The study about the level of psychological well being among the primary caregivers majority of them 48% are having inadequate psychological wellbeing, 46% them are having moderate level of wellbeing and only 6% of them are having adequate level of psychological wellbeing.



- ∞ The relationship among the level of perceived family burden, coping strategies and psychological well being among the primary caregivers reported that the correlation between family burden and coping strategies indicated the moderate, negative(0.43) and significant correlation and it shows that when the burden increases their coping level will decreases. The correlation between the family burden and well being (0.48) showed that the moderate, negative and significant correlation and it shows that when the burden increases their well being decreases. The correlation between the coping strategies and psychological well being (0.51) indicates the moderate, positive and significant correlation and it shows that when the coping strategies increases their well being also increases.
- ∞ The association between the level of perceived family burden and demographic variables shows that age ( $\chi^2=8.97$ ), duration of illness ( $\chi^2=7.69$ ), and relationship with the patients ( $\chi^2=7.44$ ) are significantly associated with their level of burden. More aged, less income, duration of illness and wife group are having more burden than others.
- ∞ The association between the level of coping strategies and demographic variables shows that age ( $\chi^2=8.45$ ), marital status ( $\chi^2=6.45$ ), and health status ( $\chi^2=5.95$ ), are significantly associated with their level of coping. Less aged, married and healthy people are having adequate level of coping strategies.
- ∞ The association between the level of psychological well being and demographic variables shows that duration of illness ( $\chi^2=7.34$ ), and health status( $\chi^2=6.66$ ), are significantly associated with their level of wellbeing. Less duration of illness and healthy status persons are having adequate level of psychological well being.

## **IMPLICATION TO NURSING**

The family has always been recognized as an important factor in both the genesis and prognosis of mental illness. Caring for a family member with schizophrenia can be viewed as an ongoing stressor. This is due to the continuous nature of the illness, the long term disability and lack of control over the situation. The psychological processes such as coping behaviors that are used by caregivers to deal with the demands of such a stressful situation are therefore important. This study revealed the level of perceived family burden, coping strategies and psychological well being among the primary caregivers of chronic schizophrenia patients. This study results have implication for nursing practice, nursing education, nursing administration and nursing research.

## **NURSING PRACTICE**

The principle aim of this study is to assess the level of perceived family burden, coping strategies and psychological well being.

Several implications can be drawn from the present study for nursing practice. Age, income, duration of illness and relationship with the patient seems to have influence on the schizophrenic patients and their primary care givers. Hence the nurse practitioner should work with chronic schizophrenic patients and with their families to improve the knowledge of primary caregivers and make the nursing care process of psychiatric patients as comprehensive as possible. This study will help them to identify the burden, coping strategies and psychological well being among the primary caregivers of chronic schizophrenia patients. The psychiatric nurse has a unique role in providing care to the patients with mental illness and their families.

Psychiatric nurses can help the patients and the primary caregivers to cope with their illness and to reduce the burden, which would be a greater contribution to the health of the individual, family, community and nation.

Several education strategies can be applied to disseminate the education to patients and family members through demonstration, printed material, posters, booklets etc. This helps the patients and family members to gain adequate knowledge regarding the need for being compliant with treatment regimen.

## **NURSING EDUCATION**

Nursing education should prepare nurses with the potential for imparting information effectively and assisting the patient and family members to overcome from the burden.

Nursing curriculum should include content areas regarding various hindering problems of schizophrenia. Psycho-education can be shared out by adapting lecture, discussion, demonstration, role play etc., for illiterate people use of colorful visual pictures, posters are effective rather than written material.

Nurse educator should take initiative and make students to prepare the hand books regarding psycho-education on family burden, coping strategies and psychological well being. Nurse educator encourages them to do a project on exploring additional factors and intervention to decipher the problems.

Nurse educator should train the student nurses to assess the need of the caregivers, to identify the social support and to provide counseling and education to them. It is essential to instill this concept in under

graduate and postgraduate training to develop mental health nurses as specialist with specific clinical skills to face such situations.

## **NURSING ADMINISTRATION**

Nursing administration should organize in-service education program for staff nurses and encourage them to participate in these activities. She should take an effective role to organize the awareness programme about mental illness and importance of being compliant.

Nurse administrator should be enthusiastic and formulate policies and protocols for short, long term psycho-education. Every patient should receive health information either on inpatient or outpatient basis.

Adequate number of nursing and medical staffs should be posted in psychiatric ward and OPD, as it will increase the quality of care rendered to the patients. In turn it will also help in good interaction between nurses, therapists, patients and family members will enable the compliance among the psychiatric patients.

The nurse administrator has to collaborate with the other health team members like psychiatrists, psychologists, social workers and other therapists to make arrangements for conducting workshops, seminars on family burden, coping strategies and ways to cope with psychological status to help the primary care givers of chronic schizophrenic patients. The nurse administrator is responsible to overview man power, money and materials for the successful implementation of the programme. Nurse administrator should plan and organize for the publication of books, pamphlets about the family burden and ways to cope with the burden.

The nurse administrator should ensure that necessary arrangements are made in terms of sufficient manpower, money and materials are available for conducting of psycho-education programme.

Measures should be taken to involve mass media such as newspaper, radio, television, magazines to convey the message on mental illness to large number of population in simple and regional language.

## **NURSING RESEARCH**

Nursing research should be done on preparation of innovative methods of teaching and effecting teaching materials.

The nurse researcher should have the interest to publish their study result in the conferences, workshop or through other medias. This helps the further researcher have significant role to play conduct studies, in the area of development in affordable, feasible and practicable models of nursing intervention, to improve the quality of life of the patient and family members and strengthen the social support and to maintain conductive family of the mentally ill patients.

## **RECOMMENDATION:**

- ♣ A similar study can be conducted with large sample for better generalization.
- ♣ A comparative study can be done at rural and urban areas.
- ♣ A comparative study can be done among caregivers of chronic schizophrenia and other psychiatric illnesses.
- ♣ A comparative study can be done among caregivers of chronic schizophrenia patients in different hospitals.
- ♣ A similar study can be done to see the effectiveness of structured teaching programme about family burden, coping strategies and psychological wellbeing.
- ♣ An experimental study using pre-test, post-test control group design can be planned to find strategies to provide adaptive coping methods for caregivers of mentally ill patients in Indian setting.

## **CONCLUSION**

The psychiatric nurse being caregiver need to have comprehensive understanding of the patients and their family members' problems in order to plan for appropriate nursing interventions to prevent crisis in patient life and strengthen the family and social support. The nurses should take a key role in educating the patients and family members to understand the need for long term care. It is a high time for the health team members to formulate strategies to improve the health status of the caregivers. It is recommended that further research is needed in this field to know more and understand it better.

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## APPENDIX-(I)

### LETTER SEEKING EXPERTS OPINION FOR CONTENT VALIDITY OF THE TOOL

**FROM:**

Mrs. G.Sasikala  
M.Sc (Nursing) II year,  
Matha College of Nursing,  
Manamadurai.

**TO:**

**Through:** The Principal, Matha College of Nursing, Manamadurai.

**Respected Madam/Sir,**

**Sub:** Requesting opinion and suggestion of experts for content validity of tool.

I am a final year Master Degree Nursing student in Matha College of Nursing, Manamadurai. In partial fulfillment of Master Degree in Nursing, I have selected the topic mentioned below for the research project to be submitted to the Tamilnadu Dr.M.G.R.Medical University, Chennai.

**“A descriptive study to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients in a selected hospital at Madurai, Tamilnadu.”**

I request you to kindly validate the tool and give your opinion for necessary modification and also I would be very grateful, if you could refine the problem statement and the objectives.

**ENCLOSURES:**

- Statement of the problem
- Objectives
- Hypothesis
- Research tool

Thanking you

Place: Manamadurai

Date:

Yours Sincerely

(Mrs.G.Sasikala)

## **APPENDIX-(II)**

### **LETTER SEEKING PERMISSION TO CONDUCT THE STUDY AT M.S.CHELLAMUTHU TRUST AND RESEARCH FOUNDATION IN MADURAI.**

**To**

The Administrative officer,  
M.S.Chellamuthu Trust and Research Foundation,  
Madurai.

**Respected Sir/Madam,**

**Sub:** Project work of M.Sc (Nursing) student at M.S.Chellamuthu Trust and Research Foundation, Madurai.

I am to state that Mrs.G.Sasikala, one of our final year M.Sc (Nursing) students, Matha College of Nursing, Manamadurai, has to conduct a project for the partial fulfillment of university requirements for the degree of Master of Science in Nursing.

The topic of study is **“A descriptive study to assess the level of perceived family burden, coping strategies and psychological well-being among the primary caregivers of chronic schizophrenia patients in a selected hospital at Madurai, Tamilnadu.”**

Kindly permit her to do the research work in your esteemed institution under your valuable guidance and suggestion.

Thanking you

Place: Manamadurai

Date:

Yours Sincerely,

Prof. (Mrs.). Jebamani Augustine, M.Sc (N)  
Principal

## **APPENDIX – (III)**

### **LIST OF EXPERT’S OPINION FOR CONTENT VALIDITY**

Dr. C. Babu, MD in Psychiatry  
Senior Resident  
Department of Psychiatry  
NIMHANS  
Bangalore

Dr. Jamuna  
Assistant Professor  
Department of Mental Health and Social Psychology  
NIMHANS  
Bangalore

Dr. Prakash Rajaram  
Associate Professor  
Department of Psychiatric Social Work  
NIMHANS  
Bangalore

Dr.K. Reddemma,Ph.D.,  
Professor and Head  
Department of Nursing  
NIMHANS  
Bangalore

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## APPENDIX – (iv)

### INTERVIEW GUIDE – ENGLISH

#### PART – 1

#### A.PRIMARY CAREGIVER SOCIO-DEMOGRAPHIC DATA SHEET

1. Name :

2. Age in years :

3. Gender :

Male	Female
1	2

4. Domicile:

Rural	Urban
1	2

5. Educational status:

Illiterate	Primary	Secondary	Higher secondary	Graduate	Post Graduate	Others
1	2	3	4	5	6	7

6. Marital status :

Married	Unmarried	Divorced	Separated	Widowed	Others
1	2	3	4	5	6

7. Type of family:

Single	Joint
1	2

8. Family size : \_\_\_\_\_

9. Occupation :

Unemployed	Professional	Retired	Housewife	Unskilled worker	Business	Cooli
1	2	3	4	5	6	7

10. Monthly Income: Rs. \_\_\_\_\_

11. Religion:

Hindu	Muslim	Christian	Others
1	2	3	4

12. Mother tongue:

Tamil	Hindi	English	Others
1	2	3	4

13. Relationship with the patient :

Mother	Father	Brother	Sister	Husband	Wife	Daughter	Son	Friend	Others
1	2	3	4	5	6	7	8	9	10

14. Duration of stay with the patient :

More than 10 years	7-9 years	4-6 years	1-3 years	Less than 1 years
1	2	3	4	5

15. Health status of the care giver:

Healthy people	Unhealthy people
1	2

16. Helping people:

Family members	Neighbours	Religious people	Others
1	2	3	4

## PART - II

### BURDEN ASSESSMENT SCHEDULE OF SCARF

Please tick the number corresponding to the appropriate answer.

S.No	Please tick the appropriate	Not at all	To some extent	Very much
1.	Is the current financial position adequate to look after the patient?	3	2	1
2.	Are you concerned that you are largely responsible to meet the patient's financial needs?	1	2	3
3.	Does the patient's future financial situation worry you?	1	2	3
4.	Has your family's financial situation worsened since the patient's illness?	1	2	3
5.	Is the patient's illness preventing you from looking for a job?	1	2	3
6.	Do you feel forced into going to work to support the patient?	1	2	3
7.	Does the patient's illness affect your efficiency at work (at home/ at work place)?	1	2	3
8.	Are you satisfied with the way the patient looks after himself?	3	2	1
9.	Do you feel you have to take the responsibility of ensuring that the patient has everything he needs?	1	2	3
10.	Do you think you have to compensate the patient's shortcomings, in general?	3	2	1

11.	Does support from your family help in caring for the patient?	3	2	1
12.	Does the patient cause disturbances in the home?	1	2	3
13.	Are you able to care for others in your family?	3	2	1
14.	Has your family stability been disrupted by your relative's illness (frequent quarrels, break-up)?	1	2	3
15.	Do you think that your family appreciates the way you handle the patient?	3	2	1
16.	Does the patient's illness prevent you from having a satisfying relationship with the rest of your family?	1	2	3
<b>( If the spouse is the ill member in your family please answer the next 4 questions)</b>				
17.	Does your spouse help with family responsibilities?	3	2	1
18.	Is your spouse able to satisfy your sexual needs?	3	2	1
19.	Is your spouse still affectionate towards you?	1	2	3
20.	Has the quality of your marital relationship declined since your spouse's illness?	1	2	3
21.	Does caring for the patient make you feel easily tired and exhausted?	1	2	3
22.	Has your workload increased after the patient's illness?	1	2	3
23.	Do you think that your health has been affected because of the patient's illness?	1	2	3

24.	Do you find time to look after your health?	3	2	1
25.	Are you able to relax for sometime during the day?	3	2	1
26.	Do you sometimes feel depressed and anxious because of the patient?	1	2	3
27.	Do you sometimes feel that there is no solution to your problems?	1	2	3
28.	Do you feel sometimes the need for temporary separation from the patient?	1	2	3
29.	Does reducing the time spent with the patient (work /other activities) help you?	3	2	1
30.	Does the patient's unpredictable behavior disturb you?	1	2	3
31.	Has your sleep been affected since the patient took ill?	1	2	3
32.	Does your relative's illness prevent you from having satisfying relationships with your friends?	1	2	3
33.	Have you started to feel lonely and isolated since the patient's illness?	1	2	3
34.	Does support from friends help in caring for the patient?	3	2	1
35.	Does sharing your problems with others make you feel better?	3	2	1
36.	Does sharing your problems with others make you feel better?	3	2	1
37.	Do you often feel frustrated that the improvement of the patient is slow?	1	2	3

38.	Do you feel that you are more than the patient to improve his/her situation is?	1	2	3
39.	Do you have the feeling that your relative understands and appreciates your effort to help him/her?	3	2	1
40.	Are you satisfied with the amount of help that you are getting from health professionals regarding your relative's illness?	3	2	1

**PART - III**  
**COPING CHECKLIST**

**INSTRUCTIONS:**

The purpose of this checklist is to find out how people deal with or handle difficult situations that they have to face. The list provides some of the commonly used methods of handling stress and reducing distress.

<b>S.No</b>	<b>Handling situations</b>	<b>Yes</b>	<b>No</b>
1.	You go over the problem again and again in your mind, to try to understand it.		
2.	Accept it since nothing can be done.		
3.	Talk to a family member who can do something concrete about the problem.		
4.	Get away from things for a while; take a rest or a vacation.		
5.	Compare yourself with others and feel that you are better off.		
6.	Wish that you could change what has happened.		
7.	Seek reassurance and emotional support from family members.		
8.	Try to make yourself feel better by taking drugs.(mood elevating)		
9.	Visit places of worship, go on a pilgrimage.		
10.	Go on a shopping spree.		
11.	Engage in vigorous physical exercise.		
12.	Anticipate probable outcomes and mentally rehearse them.		

13.	Console yourself that things are not all that bad and could be worse.		
14.	Try your luck at games of chance(Race,Lottery,Cards)		
15.	Seek reassurance and support from friends.		
16.	Retreat to a quiet, favorite spot to think things over.		
17.	Try to make yourself feel better by having a drink or two (alcohol)		
18.	Accept the next best thing to what you wanted.		
19.	Think about fantastic or unreal things to make you feel better.		
20.	Try to look on the bright side of things.		
21.	Attend bhajan groups.		
22.	Go for long walks.		
23.	Blame your fate, sometimes you just have bad luck.		
24.	Make yourself feel better by smoking.		
25.	Wear a lucky charm or amulet.		
26.	Talk to a friend who can do something about the problem.		
27.	Pray to god		
28.	Make light of the situation/refuse to get too serious about it.		
29.	Listen to music for comfort.		
30.	Come up with a couple of different solutions to the problem.		



31.	Try to forget about the whole thing.		
32.	Avoid being with people, seek complete isolation.		
33.	Consult a faith healer.		
34.	Swallow analgesics or minor tranquilizers, not on medical advice.		
35.	Refuse to believe that is happened.		
36.	Attend religious/philosophical discourses and talks.		
37.	Start yoga/meditation; practice yoga/meditation.		
38.	Hope a miracle will happen.		
39.	Consult an astrologer.		
40.	Help others in trouble or distress.		
41.	Feel that time will remedy things; the only thing to do is wait.		
42.	Write letters to significant others.		
43.	Prepare yourself for the worst to come.		
44.	Pace up and down thinking about the problem.		
45.	Turn to work/studies to take your mind off things.		
46.	Seek sexual comfort.		
47.	Find a purpose or meaning in your suffering.		
48.	Spend time in the company of children.		
49.	View the future as bleak and hopeless.		
50.	Write short stories,poetry,etc.		
51.	Blame yourself.		

52.	You know what has to be done so you double your efforts and try harder to make things work.		
53.	Analyze the problem and solve it bit by bit.		
54.	Make a plan of action and follow it.		
55.	Read popular guide books for answers to your problem.		
56.	Draw on your past experience of similar situations.		
57.	Take up or indulge in a hobby (music, art, etc).		
58.	Sleep more than usual to avoid the problem.		
59.	Read novels, magazines, etc. Much more than usual.		
60.	Try to feel better by eating / nibbling.		
61.	Keep your feelings to yourself.		
62.	Make special offerings or perform special pujas.		
63.	Become a member of a group, club or organization, or if already a member attends to group activities.		
64.	See more movies than usual.		
65.	Seek professional help and do as they recommend.		
66.	Raked books on philosophy or religion.		
67.	Compare yourself with others and feel that you are worse off.		
68.	Feel that other people are responsible for what has happened.		
69.	Take a big chance or do something very risky.		
70.	Write to “question-answer” columns n various magazines.		

## PART - IV

### PSYCHOLOGICAL WELL-BEING QUESTIONNAIRE

Given below are a number of questions regarding health, well being, attitudes and interests. We request you to answer them by writing YES if the answer is true or mostly true of you and NO if the answer is false or mostly false. There is no right or wrong answers. All the information given by you will be kept confidential. Please cooperate with us and answer frankly. Thank You.

S.NO	Questionnaire	Answer	
1.	On the whole I would say my health is good	YES	NO
2.	Compared to others of my age and background I am better off.	YES	NO
3.	In the past I have received much support / when I really needed it.	YES	NO
4.	My life often seems empty.	YES	NO
5.	I have recently been getting a feeling of tightness or pressure in my head.	YES	NO
6.	I feel worthless at times	YES	NO
7.	I have felt pleased about having accomplished something	YES	NO
8.	I have recently felt capable of making decisions about things	YES	NO
9.	Life is better now that I had expected it to be.	YES	NO
10.	I have recently thought of the possibility that I may kill myself.	YES	NO
11.	In my case, getting what I want does not depend on luck.	YES	NO

12.	I have recently been getting edgy and bad tempered.	YES	NO
13.	I have recently felt that on the whole I am doing things well.	YES	NO
14.	I have recently been feeling in need of a good tonic.	YES	NO
15.	I feel all alone in the world.	YES	NO
16.	I have recently been getting pains in my head.	YES	NO
17.	I feel I am a person of worth, at least equal to others.	YES	NO
18.	I have felt proud because someone complimented me on some achievement.	YES	NO
19.	I have recently been able to enjoy my normal day to day activities.	YES	NO
20.	These are the best years of my life.	YES	NO
21.	I have recently found that the idea of taking my own life kept coming to my head.	YES	NO
22.	What happens to me depends on me alone.	YES	NO
23.	I am happy. Satisfied with the support I have received.	YES	NO
24.	I have recently felt constantly under strain.	YES	NO
25.	I have recently felt perfectly well and in good health.	YES	NO
26.	I have recently been satisfied with the way I have carried out my task.	YES	NO
27.	(In case married), considering I would say, in marriage, I am satisfied.	YES	NO
28.	On the whole, I would say that my life is satisfactory at present.	YES	NO

## நேர்முக புள்ளி விபரம்

### பிரிவு — I

சமுதாய விளக்க வரைபட பொதுபுள்ளி விபரங்கள்

குடும்பத்தினர் பற்றிய விவரங்கள்

குறிப்பு:-

கீழே உள்ள கேள்விகள் உங்களைப் பற்றி அறிவதற்காக கேட்கப்படும் கேள்விகள். சரியானவற்றை தேர்ந்தெடுத்து குறிப்பிடுக. இந்த பதில்கள் யாரிடமும் காட்டப்படாது.

1. பெயர் :
2. வயது :
3. இனம் :

ஆண்	பெண்
1	2

4. குடியிருக்கும் இடம்:

நகரம்	கிராமம்
1	2

5. கல்வித்தகுதி :

படிக்கவில்லை	1-5ஆம் வகுப்பு வரை	6-10 ஆம் வகுப்பு வரை	10-12ஆம் வகுப்பு வரை	பட்டப் படிப்பு	பட்ட மேற்படிப்பு	மற்றவை
1	2	3	4	5	6	7

6. திருமண விபரம் :

திருமணமானவர்	திருமணம் ஆகாதவர்	பிரிந்து வாழ்பவர்	விவாகரத்துப் பெற்றவர்	தனியாக வாழ்பவர்	மற்றவை
1	2	3	4	5	6

7. குடும்பத்தின் நிலை :

கூட்டுக் குடும்பம்	தனி குடும்பம்
1	2

8. குடும்பத்தில் உள்ள மொத்த நபர்: \_\_\_\_\_

8. தொழில் :

வேலை இல்லாதவர்	சுய வேலை	ஓய்வு பெற்றவர்	வீட்டில் இருப்பவர்	தொழில் செய்ய முடியாதவர்	வியாபாரம் செய்பவர்	கூலி
1	2	3	4	5	6	7

9. மாத வருமானம், ரூபாய் \_\_\_\_\_

10. மதம்

இந்து	முஸ்லீம்	கிறிஸ்தவர்	மற்றவை
1	2	3	4

11. தாய்மொழி :

தமிழ்	ஹிந்தி	ஆங்கிலம்	மற்றவை
1	2	3	4

12. நோயாளியுடனான உறவுமுறை:

அம்மா	அப்பா	சகோதரர்	சகோதரி	கணவர்	மனைவி	மகள்	மகன்	நண்பர்	வேறு யாரேனும்
1	2	3	4	5	6	7	8	9	10

13. நோயாளியுடன் தங்கி இருக்கும் கால வரவு:

10 ஆண்டுக்கு மேல்	7-9 ஆண்டுகள்	4-6 ஆண்டுகள்	1-3 ஆண்டுகள்	ஒரு வருடத்திற்கு குறைவாக
1	2	3	4	5

14. பராமரிப்பு வழங்குபவரின் உடல்நிலை

ஆரோக்கியமுள்ளவர்	ஆரோக்கியமற்றவர்
1	2

15. உதவி செய்பவர்கள்

குடும்பத்தினர்	அயலோர்	மதத்தின் உறுப்பினர்கள்	வேறு ஏதேனும்
1	2	3	4

## குடும்ப மனகஷ்ட அளவீடு

கீழ்க்கண்ட கேள்விகளுக்கு பொருத்தமான விடையளிக்கவும் நீங்கள் குறிப்பிடும் பதில்கள் வேறு யாரிடமும் காட்டப்படமாட்டாது.

1. தற்போதைய பொருளாதார நிலவரம் நோயாளியை கவனிப்பதற்கு போதுமானதாக உள்ளதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
2. நோயாளியின் பொருளாதார தேவைக்கு உங்களுடைய பங்கும் உள்ளது என்று நீங்கள் கருதுகிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
3. நோயாளியின் எதிர்கால பொருளாதாரத் தேவை உங்களை பாதிக்குமா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
4. நோயாளியின் உடல்நிலை பாதிப்பு உங்களுடைய குடும்ப பொருளாதாரத்தை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
5. நோயாளியின் உடல் பாதிப்பு உங்களுக்கு வேலை கிடைப்பதில் இடையூறாக இருக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
6. நோயாளியின் உடல்நிலை பாதிப்பு உங்களை வேலைக்கு செல்ல கட்டாயப்படுத்துவதாக நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
7. நோயாளியின் உடல்நிலை பாதிப்பு உங்களின் வேலைத்திறனை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
8. நோயாளி தன்னைத் தானே கவனித்துக் கொள்ளுதல் மனநிறைவை அளிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
9. நோயாளியின் தேவைகளை நிவர்த்தி செய்வது உங்களுடைய பொறுப்பு என்று நீங்கள் நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
10. நோயாளியின் மருத்துவ செலவுகளை நீங்கள் ஈடுபட்ட முடியுமென நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
11. நீங்கள் நோயாளியை ஆதரிப்பதை உங்கள் குடும்பத்தினர் ஆதரிக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
12. நோயாளி உங்களுக்கு வீட்டில் இடையூறாக இருக்கிறாரா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
13. உங்கள் குடும்பத்தின் மற்ற உறுப்பினர்களை கவனித்துக் கொள்ள உங்களால் முடிகிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்



14. உறவினரின் உடல்நிலை பாதிப்பு உங்கள் குடும்பத்தின் சீரான நிலையை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
15. நோயாளியிடத்தில் உங்களின் அணுகுமுறையை உங்கள் குடும்ப உறுப்பினர் ஆதரிப்பதாக நீங்கள் நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
16. உங்களுக்கும் உங்கள் குடும்ப உறுப்பினருக்கும் இடையே உள்ள உறவை, நோயாளியின் உடல்நிலை பாதிப்பதாக நீங்கள் நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
17. உங்கள் வாழ்க்கைத் துணை குடும்ப பொறுப்பினை ஏற்றுக் கொள்கிறாரா?  
3. எதுவும் இல்லை 2. ஓரளவிற்கு 1. மிகவும்
18. உங்கள் வாழ்க்கைத் துணை உங்கள் உடலுறவுத் தேவையை பூர்த்தி செய்கிறாரா?  
3. எதுவும் இல்லை 2. ஓரளவிற்கு 1. மிகவும்
19. உங்கள் வாழ்க்கைத் துணை உங்களிடம் இன்னும் அன்பு செலுத்துகிறாரா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
20. உங்கள் வாழ்க்கைத் துணையின் உடல்நிலை பாதிப்பு தாம்பத்திய உறவை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
21. நோயாளியை கவனித்துக் கொள்ளும் போது விரைவாக சோர்வும் விரக்தியும் கொள்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
22. நோயாளியின் உடல்நிலை உங்களின் வேலை பளுவை அதிகரிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
23. நோயாளியின் உடல்நிலையால் உங்களின் உடல்நிலை பாதிக்கப்படுவதாக நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
24. உங்களின் ஆரோக்கியத்தை கவனித்துக் கொள்ள உங்களுக்கு நேரம் இருக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
25. சிறிது நேரத்திற்காவது ஓய்வெடுத்துக் கொள்ள உங்களால் முடிகிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
26. நோயாளியின் நிலையில் நீங்கள் சில சமயம் துன்பப்படுவதாக நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
27. சில சமயம் தங்கள் பிரச்சனைகளுக்கு எவ்வித தீர்வும் இல்லையென்று நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
28. நோயாளியிடமிருந்து தற்காலிக பிரிவு தேவை என்று நினைக்கிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்

29. நோயாளிகளுக்கு நீங்கள் செலவிடும் நேரத்தைக் குறைத்துக் கொள்வது உங்களுக்கு உபயோகமாக உள்ளதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
30. நோயாளியின் எதிர்பாராத செயல்கள் உங்களை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
31. உங்கள் உறக்கம் பாதிக்கப்படுகிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
32. உங்கள் உறவினரின் உடல்நிலை பாதிப்பு உங்கள் நண்பர்களுடன் உள்ள நட்புறவை பாதிக்கிறதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
33. நோயாளியின் உடல்நிலை பாதிப்பால் தாங்கள் தனிமைப்படுத்தப்பட்டதாக எண்ணுகிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
34. நண்பர்களின் உதவி நோயாளிகளை கவனித்துக் கொள்வதற்கு உதவிகரமாக உள்ளதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
35. தங்களுடைய பிரச்சனைகளை பிறரிடம் பகிர்ந்து கொள்வதால் மனநிறைவு பெறுகிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
36. தாங்கள் நோயாளியை கையாளும் விதம் கண்டு உங்கள் நண்பர்கள் உங்களை பாராட்டுகிறார்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
37. நோயாளியின் குறைவான உடல்நிலை தேர்வதைக் கண்டு தாங்கள் மனவிரக்தியடைகிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
38. நோயாளி தன்னைத்தானே கவனித்துக் கொள்வதைவிட நீங்கள் கவனித்துக் கொள்வதைத் திருப்தியளிப்பதாக நினைக்கிறார்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
39. தங்களின் சேவை மனப்பான்மை உறவினர்கள் பாராட்டுவதாக எண்ணுகிறீர்களா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்
40. நோயாளிகளுக்கு சுகாதார அலுவலர்கள் அளிக்கும் சிகிச்சை தங்களுக்கு திருப்திகரமாக உள்ளதா?  
1. எதுவும் இல்லை 2. ஓரளவிற்கு 3. மிகவும்

## பகுதி — 3

### பராமரிக்கும் முறையை சரிபார்க்கும் பட்டியல்

சரிபார்க்கும் பட்டியலின் நோக்கம், மனநிலை சரியில்லாதவர்களை பயமான் / சூழ்நிலையில் எப்படி சமாளிப்பதென்பது இதற்கு பதில் ஆம் / இல்லை தயவு செய்து எந்த குறிப்பையும் விட்டுவிடாமல் கடைசியில் கொடுக்கப்பட்டுள்ள இடத்தில் விடைளிக்கவும்.

தங்கள் ஒத்துழைப்பிற்கு நன்றி

வ.எண்	பராமரிக்கும் முறை	ஆம் / இல்லை
1	பிரச்சனையை புரிந்து கொள்வதற்காக அதைப் பற்றி நீங்கள் மீண்டும் மீண்டும் யோசிக்கிறீர்கள்.	ஆம் / இல்லை
2	வேறொன்றும் செய்யமுடியாதென்பதால் அதை ஏற்றுக் கொள்கிறீர்கள்.	ஆம் / இல்லை
3	குடும்ப அங்கத்தினர் யார் அந்த பிரச்சனைக்கு ஏதாவது தீர்க்கமாக செய்ய முடியுமோ அவர்களோடு பேசுகின்றீர்கள்.	ஆம் / இல்லை
4	உங்கள் வேலையிலிருந்து கொஞ்சம் ஒதுங்குகிறீர்கள், ஒய்வெடுக்கிறீர்கள் அல்லது விடுமுறையில் செல்கிறீர்கள்.	ஆம் / இல்லை
5	மற்றவர்களோடு ஒப்பிடும் போது, நீங்கள் உற்சாகமாக இருக்கிறீர்கள்.	ஆம் / இல்லை
6	நடந்ததை உங்களால் மாற்றமுடியும் என்று நினைக்கிறீர்கள்.	ஆம் / இல்லை
7	குடும்ப அங்கத்தினர்களிடமிருந்து மீண்டும் உறுதிபடுத்துதலையும், உணர்வுபூர்வமான ஒத்துழைப்பையும் எதிர்பார்க்கிறீர்கள்.	ஆம் / இல்லை
8	மருந்து உட்கொண்டு உற்சாகமாக இருக்க முயற்சிக்கிறீர்கள்.	ஆம் / இல்லை
9	வழிபாட்டு தலங்களுக்கும், திரு யாத்திரை ஸ்தலங்களுக்கும் செல்கிறீர்கள்.	ஆம் / இல்லை

10	தொடர்ந்து கடைகளுக்குச் செல்கிறீர்கள் மகிழ்ச்சியாய் இருக்கிறீர்கள்.	ஆம் / இல்லை
11	மிகவும் கடினமான உடற்பயிசிகளில் ஈடுபடுத்திக் கொள்கிறீர்கள்.	ஆம் / இல்லை
12	சாத்தியமான முடிவுகளை முன் கூட்டியே உத்தேசித்து, அதை மனதுக்குள்ளே ஒத்திகை பார்த்துக் கொள்கிறீர்கள்.	ஆம் / இல்லை
13	நடந்தவை மிக மோசமானதாக இல்லாமல், நீங்கள் ஏற்றுக் கொள்ள கூடிய அளவுக்குத் தான் மோசமாக இருந்தது என்று உங்களையே நீங்கள் தேற்றிக் கொள்கிறீர்கள்.	ஆம் / இல்லை
14	மாற்று விளையாட்டுகளில் உங்களை ஈடுபடுத்திக் கொண்டு உங்கள் அதிர்ஷ்டத்தை சோதிக்கிறீர்கள்.	ஆம் / இல்லை
15	நண்பர்களிடமிருந்து மீண்டும் உறுதிபடுத்துதலையும், உணர்வுபூர்வமான ஒத்துழைப்பையும் எதிர்பார்க்கிறீர்கள்.	ஆம் / இல்லை
16	அமைதியான மற்றும் நீங்கள் நடப்புகளைப் பற்றிச் சிந்திக்கச் சாதகமான சூழலை தேடுகிறீர்கள்.	ஆம் / இல்லை
17	மது அருந்துவதன் மூலம் மன அமைதி தேடுகிறீர்கள்.	ஆம் / இல்லை
18	நீங்கள் எதிர்பார்த்து ஏங்கியதற்கு அடுத்தபடியான நல்லவற்றையும் ஏற்றுக் கொள்கிறீர்கள்.	ஆம் / இல்லை
19	இதமான கனவுகளாலும், அத்த கற்பனைகளாலும் நீங்கள் உற்சாகமாக உணருகிறீர்கள்.	ஆம் / இல்லை
20	நடப்பவற்றில் நல்ல விஷயங்களை மட்டுமே பார்க்க முயற்சிக்கிறீர்கள்.	ஆம் / இல்லை
21	பஜனைக் குழுக்களோடு பங்கேற்கிறீர்கள்.	ஆம் / இல்லை
22	நீண்டதூர நடைபயணம் மேற்கொள்கிறீர்கள்.	ஆம் / இல்லை
23	விதியை வெறுக்கிறீர்கள், சில சமயம் துரதிர்ஷ்டம் என்று தேற்றிக் கொள்கிறீர்கள்.	ஆம் / இல்லை
24	பீர் போன்ற பானங்களை குடித்து, நீங்கள் உற்சாகமாக உணர முயலுகிறீர்கள்.	ஆம் / இல்லை
25	தாயத்து மற்றும் அதிர்ஷ்ட பொருட்களை அணிந்து கொள்கிறீர்கள்.	ஆம் / இல்லை

26	பிரச்சனைகளை தீர்க்க ஏதாவது செய்யமுடியும் என்று நீங்கள் நினைக்கும் நண்பர்களோடு பேசுகிறீர்கள்.	ஆம் / இல்லை
27	கடவுளிடம் வேண்டுகிறீர்கள்.	ஆம் / இல்லை
28	பிரச்சனையை மிக எளிதாக நினைக்கிறீர்கள் / மிக கடினமாக ஒன்று என்று ஏற்றுக் கொள்ள மறுக்கிறீர்கள்.	ஆம் / இல்லை
29	உங்களைத் தேற்றிக் கொள்வதற்காக இசையைக் கேட்கிறீர்கள்.	ஆம் / இல்லை
30	பிரச்சனைகளுக்கு பல தீர்வுகளைக் காண்கிறீர்கள்.	ஆம் / இல்லை
31	எல்லாவற்றையும் மறக்க முயற்சிக்கிறீர்கள்.	ஆம் / இல்லை
32	மக்களிடமிருந்து ஒதுங்கி தனிமையை தேடுகிறீர்கள்.	ஆம் / இல்லை
33	குணமாக்குபவரிடம் நம்பிக்கையோடு ஆலோசித்தல்.	ஆம் / இல்லை
34	வலி நிவராணிகளையோ அல்லது சிறிதளவிலுள்ள தூக்க மாத்திரைகளையோ தானாக உட்கொள்ளுகிறீர்கள்.	ஆம் / இல்லை
35	ஒருவேளை அது நடந்தால் ஏற்றுக் கொள்ள மறுக்கிறீர்கள்.	ஆம் / இல்லை
36	மதம் தத்துவ போதனைகளையும், சொற்பொழிவுகளையும் கேட்பதற்கு உங்கள் நேரத்தை செலவழிக்கிறீர்கள்.	ஆம் / இல்லை
37	யோகா மற்றும் தியான முறைகளை தொடங்குகிறீர்கள் அல்லது பயிற்சி பெறுகிறீர்கள்.	ஆம் / இல்லை
38	புதுமை நடக்க வேண்டும் என்று நம்புகிறீர்கள்.	ஆம் / இல்லை
39	ஜோதிடரையோ, கைரேகை நிபுணரையோ கலந்தாலோசிக்கிறீர்கள்.	ஆம் / இல்லை
40	கஷ்டப்படுவோருக்கு அல்லது துன்புறுவோருக்கு உதவுகிறீர்கள்.	ஆம் / இல்லை
41	காலம் நிலைமையை மாற்றும் என்று நம்புகிறீர்கள், ஆனால் நீங்கள் காத்திருக்க வேண்டும்.	ஆம் / இல்லை
42	முக்கியமானவர்களுக்கு கடிதங்கள் எழுதுகிறீர்கள்.	ஆம் / இல்லை
43	மோசமானவை நடந்தாலும் அதை ஏற்றுக் கொள்ள தயார்படுத்திக் கொள்கிறீர்கள்.	ஆம் / இல்லை

44	பிரச்சனைகளை நினைத்துக் கொண்டே மேலும் கீழும் நடக்கிறீர்கள்.	ஆம் / இல்லை
45	பாதியிலேயே நிறுத்திவிட்டு வேலைக்கோ, படிக்கிற்கோ செல்கிறீர்கள்.	ஆம் / இல்லை
46	பாலுணர்வு சுகத்தை நாடுகிறீர்கள்.	ஆம் / இல்லை
47	துன்புறத்தலின் காரணியை, பொருளை அறிந்து கொள்ள முயற்சிக்கிறீர்கள்.	ஆம் / இல்லை
48	குழந்தைகளோடு உங்களுடைய நேரத்தை செலவழிக்கிறீர்கள்.	ஆம் / இல்லை
49	எதிர்காலம் வெறுமையாக நம்பிக்கையற்ற ஒன்றாகக் கற்பனை செய்து கொள்கிறீர்கள்.	ஆம் / இல்லை
50	சிறுகதைகள், கவிதைகள் போன்று எழுத முயற்சிக்கிறீர்கள்.	ஆம் / இல்லை
51	உங்களையே குறை கூறி கொள்கிறீர்கள்.	ஆம் / இல்லை
52	உங்களுக்குத் தெரிந்த வகையில் உங்கள் முயற்சியை இரட்டிப்பாக்கி கடினமாக உழைத்து எல்லாவற்றையும் சரிசெய்வீர்கள்.	ஆம் / இல்லை
53	பிரச்சனையை ஆராய்ந்து படிப்படியாக தீர்வு காண்கிறீர்கள்.	ஆம் / இல்லை
54	செயல்திட்டம் வகுத்து அதை பின்பற்றுகிறீர்கள்.	ஆம் / இல்லை
55	பிரச்சனைகளுக்குத் தீர்வு காண பிரயோகமான வழிகாட்டிகளின் உதவியை நாடுகிறீர்கள்.	ஆம் / இல்லை
56	இதுபோன்று நடந்து முடிந்த நிகழ்வுகளை நினைக்கிறீர்கள்.	ஆம் / இல்லை
57	இசை, ஓவியம் போன்ற பொழுதுபோக்கு அம்சங்களில் ஈடுபாடு காட்டுகிறீர்கள்.	ஆம் / இல்லை
58	பிரச்சனைத் தவிர்ப்பதற்காக அளவுக்கு அதிகமாக தூங்குகிறீர்கள்.	ஆம் / இல்லை

59	நாவல் (புதினம்) இன்னும் பிற பத்திரிக்கைகள் வாசிக்க கூடுதல் நேரம் செலவழிக்கிறீர்கள்.	ஆம் / இல்லை
60	புகையிலை போன்ற லாகிரி வஸ்துக்களை உபயோகித்து உற்சாகமாக உணர முயலுகிறீர்கள்.	ஆம் / இல்லை
61	உங்களுடைய உணர்வுகளை மனதுக்குள்ளே போட்டு மறைத்து விடுகிறீர்கள்.	ஆம் / இல்லை
62	தனிப்பட்ட விதமான காணிக்கைகளையும், தனிப்பட்ட விதமான பூஜைகளும் நடத்துகிறீர்கள்.	ஆம் / இல்லை
63	ஒரு குழுவில் சங்கத்தில் நிறுவனகத்தில் உறுப்பினராக இருந்தால் அந்த இயக்க நடவடிக்கைகளில் ஈடுபடுகிறீர்கள்.	ஆம் / இல்லை
64	வழக்கத்தை விட அதிகமாக திரைப்படம் பார்க்கிறீர்கள்.	ஆம் / இல்லை
65	அந்த துறையில் தனித்துவம் பெற்றவரின் உதவியை நாடி அவரின் ஆலோசனைகளை பின்பற்றுகிறீர்கள்.	ஆம் / இல்லை
66	தத்துவம் அல்லது மதம் பற்றி புத்தகங்கள் வாசிக்கிறீர்கள்.	ஆம் / இல்லை
67	மற்றவர்களோடு உங்களை ஒப்பிட்டு நீங்கள் மிக மோசமானவர் என்று கருதுகிறீர்கள்.	ஆம் / இல்லை
68	நடந்த எல்லாவற்றிற்கும் மற்றவர்கள் தான் விதி / பொறுப்பென்று எண்ணுகிறீர்கள்.	ஆம் / இல்லை
69	பெரியதொரு வாய்ப்பினையோ அல்லது ஆபத்தான தொன்றையோ ஏற்றுக் கொள்கிறீர்கள்.	ஆம் / இல்லை
70	உங்களுக்குப் பிரியமான பத்திரிக்கைகளுக்கு கேள்வி பதில் எழுதுவதில் ஈடுபடுத்திக் கொள்கிறீர்கள்.	ஆம் / இல்லை

மனநல வினா நிரல்

கீழ்க்கண்ட கேள்விகளுக்கு விடையளிக்கவும் நீங்கள் குறிப்பிடும் பதில்கள் வேறு யாரிடமும் காட்டப்படமாட்டாது. தயவு செய்து ஒத்துழைக்கும்படி வேண்டிக் கொள்கிறேன். நன்றி.

வரிசை எண்	வினா நிரல்	பதில்	
1	முழுவதுமாகக் கூறினால் நான் ஆரோக்கியமாக உள்ளேன்.	ஆம்	இல்லை
2	எனக்குச் சமமான வயதுடையவர்களுடன் ஒப்பிடும்போது நான் நலமாக உள்ளேன்.	ஆம்	இல்லை
3	கடந்த காலத்தில், எனக்கு தேவையான நேரத்தில் போதுமான அளவு ஒத்துழைப்பைப் பெற்றேன்.	ஆம்	இல்லை
4	என் வாழ்க்கை எப்போதும் வெற்றிடமாக உள்ளது.	ஆம்	இல்லை
5	நான் சமீபகாலமாக எனது தலைப்பகுதியில் ஒரு விதமான இறுக்கத்தையும் அழுத்ததையும் உணர்கிறேன்.	ஆம்	இல்லை
6	அந்த நேரங்களில் பயனற்றவராக உணருகிறேன்.	ஆம்	இல்லை
7	சில காலமாக என்னுடைய தேவைக்காக அடுத்தவரைத் தாழ்மையான முறையில் வேண்டிக் கொள்வதாக நான் உணருகிறேன்.	ஆம்	இல்லை
8	சமீபகாலமாக தீர்வு எடுக்கும் திறனுடையவராக என்னை உணர்கின்றேன்.	ஆம்	இல்லை
9	நான் எதிர்பார்த்ததை விட வாழ்க்கை இப்போது நன்றாக உள்ளது	ஆம்	இல்லை
10	சமீபகாலமாக என்னையே நான் அழித்துக் கொள்ளும் சூழல் உடையவனாக எண்ணுகின்றேன்.	ஆம்	இல்லை
11	என்னை பொருத்தவரை, என்னுடைய தேவையானவை அதிர்ஷ்டத்தை சார்ந்திருப்பதாக இல்லை.	ஆம்	இல்லை
12	நான் சமீபகாலமாக ஒதுக்கப்படுவது போலவும் மற்றும் மோசமாக ஆத்திரம் அடைவதாகவும் எண்ணுகின்றேன்.	ஆம்	இல்லை
13	சமீபகாலமாக நான் செய்யும் வேலைகள் நல்ல விதமாகச் செல்வதைப் போல் உணர்கின்றேன்.	ஆம்	இல்லை



14	சமீபகாலமாக ஊக்கமளிப்பது எனக்குத் தேவையென உணர்கின்றேன்.	ஆம்	இல்லை
15	நான் இந்த உலகத்தில் தனிமையில் இருப்பதாக உணர்கின்றேன்.	ஆம்	இல்லை
16	நான் சமீபகாலமாக எனது தலைப்பகுதியில் வலியை உணர்கின்றேன்.	ஆம்	இல்லை
17	நான் என்னைப் பயனுள்ள மனிதனாகவும் அடுத்தவர்களுக்கு நிகராக இருப்பதையும் உணர்கின்றேன்.	ஆம்	இல்லை

18	நான் அடையும் சில வெற்றிகளைப் பற்றி அடுத்தவர்கள் கூறுகையில் நான் பெருமைப்படுவதாக உணருகிறேன்.	ஆம்	இல்லை
19	சமீபகாலமாகச் செய்யும் எனது அன்றாட வேலைகளில் மகிழ்ச்சி அடைகிறேன்.	ஆம்	இல்லை
20	இவ் ஆண்டுகளை எனது வாழ்வில் சிறந்ததாக உணர்கின்றேன்.	ஆம்	இல்லை
21	நான் சமீபகாலமாக எனது வாழ்க்கையை முடித்துக் கொள்வதைப் போன்ற சிந்தனைகள் எனக்குத் தோன்றுகின்றது.	ஆம்	இல்லை
22	எனக்கு என்ன நடக்கிறது என்பது என்னை மட்டுமே சார்ந்தது,	ஆம்	இல்லை
23	நான் மகிழ்ச்சியாக உள்ளேன் எனக்குக் கிடைத்த ஒத்துழைப்பை நினைத்து ஆறுதல் அடைகிறேன்.	ஆம்	இல்லை
24	நான் சமீபகாலமாகத் தொடர்ந்து வேதனையான நிலையில் இருப்பதாக உணர்கின்றேன்.	ஆம்	இல்லை
25	நான் சமீபகாலமாக முறையான நல்ல உடல் நலத்துடன் இருப்பதை உணர்கின்றேன்.	ஆம்	இல்லை
26	நான் சமீபகாலமாக எனது வேலைகளை மிகவும் திருப்தியான முறையில் செய்ததாக உணர்கின்றேன்.	ஆம்	இல்லை
27	(ஒருவேளை திருமணமானவராக இருந்தால்) நான் எனது திருமண வாழ்க்கையில் திருப்தியை உணர்கின்றேன்.	ஆம்	இல்லை
28	ஒட்டுமொத்தமாகக் கூறுவதானால், நான் தற்போதைய வாழ்க்கையில் திருப்தியை உணர்கின்றேன்.	ஆம்	இல்லை

# **SELF INSTRUCTION MODULE ON REDUCTION OF FAMILY BURDEN, INCREASE THE COPING STRATEGIES AND PSYCHOLOGICAL WELL-BEING AMONG THE PRIMARY CAREGIVERS OF CHRONIC SCHIZOPHRENIA**

*“When a patient becomes ill, it is someone else’s responsibility to set the things right”*

- LEON KASS

## **INTRODUCTION:-**

A schizophrenia disorder has been recognized for centuries and was even marked upon by Hippocrates. It is a serious problem, and has many serious effects on the overall treatment and prognosis of the illness. Caregivers providing care to chronically ill family members at home are potentially at risk for caregiver burden and decline the physical and psychological well being. The caregiver role can be stressful and identifying these patients can help the family members to cope with the challenges of the caregiver role.

## **AIM:-**

The family members who equip themselves with the content of this guideline will be able

- ✓ To identify the vulnerable characteristics of chronic schizophrenia.
- ✓ To diagnose the factors influencing schizophrenia.
- ✓ To focus on a core problems which are manifested in schizophrenia.
- ✓ To eradicate underlying causes of schizophrenia.
- ✓ To evaluate periodically the effectiveness of strategies of schizophrenia.

## **OBJECTIVES:-**

By analyzing all the guidelines, the family members will be able to gain knowledge regarding the family burden, coping strategies and psychological well-being and able to practice effectively this strategies in their settings.

## **GROUP:-**

The group is the family members who take care of chronic schizophrenia patients.

## **STEPS TO IMPROVE THE FAMILY BURDEN, COPING STRATEGIES AND PSYCHOLOGICAL WELL-BEING:-**

### **❖ Awareness of mental illness**

- Mental illness is not an incurable one; it is curable disease
- Regular hospitalization and treatment is necessary.
- Knowledge about the disease symptoms and the diagnostic criteria and its management strategy, to reduce the symptoms and have a good confidence about the illness.
- By taking regular medication, helps to reduce the symptoms and improve the mental health.
- Proper follow-up lead the person in a happy and quality of life.
- Mental illness is a curable, but the duration of mental illness is too long. So by taking regular medication without missing of medications will help to prevent relapse symptoms.
- Until the doctors advice the person should not discontinue the treatment plan.

### **❖ Time Management and Planning**

- By managing the time and prioritizing task, you can have personal time to relax and to socialize.
- Make list of the things you need to be working on (for the short and long term) so you can use your time effectively.
- Divide the time, schedule and allot the work for mainly medication giving, teaching some exercises, providing foods, supervising the simple house hold activities, monitoring self care needs and teaching some occupational therapy according to the person ability and interest.
- Divide the time schedule for relaxation and the recreation for the clients as well as time for taking rest and relax yourself.
- Not allow the patient to sit simply and allow the person to be alone.
- Always engage them with some of the occupational and recreational activities according to their ability and interest.

### ❖ **Eat right and exercise**

- Good nutrition and exercise can help to reduce tension. Be sure to eat nutritious meals or snacks which are rich in protein, carbohydrate and vitamins. It leads to have a good strength to take care of the patient more effectively and reduce the stress also.
- Getting adequate physical activity by doing regular and continuous exercise prevents further disorders.

### ❖ **Sleep**

- Sleep allows your body to re-energize. Lack of sleep can make a person become irritable and moody.
- Getting enough sleep can help you to become active and it can reduce your burden.

### ❖ **Develop a support system**

- Talk about things with your other family members, friends and your relatives. Talking about some of your stressful situations may help you gain insight.
- To supplement traditional support groups by providing informal recreational and social activities with a peer group of caregivers who are experiencing similar situations.

### ❖ **Spiritual support**

- Go for worshipping the god according to their region, it helps to reduce burden gives strength to them.

### ❖ **Pets**

- Having pet animal in home can reduce stress and burden. It gives the animal an intuitive sense of being care for and at the same time gives the individual the calming feeling of warmth, affection and interdependence with a reliable trusting feeling.

### ❖ **Music**

- It is true that music can “soothe the savage beast”. Creating and listening to music stimulate motivation, enjoyment and relaxation. Music can reduce burden and bring about measurable changes in mood and general activity.

❖ **Extracurricular activities**

- Participating such activities like games both indoor and outdoor
- Cultivating seeds (making gardening) through this the person may ventilate his thoughts to one another.
- By going out like small tour, camp, field visit can improve good mental health by seeing differently the person may express their ideas in differently.
- Hobbies like drawing, painting, hearing music, dancing, watching movies, reading books can reduce stress and burden.

❖ **Day care centre offering rehabilitation services**

- Rehabilitation helps to improve the client's ego strengths. So that he can be made mentally fit and ready to work. Through this the person capabilities and competencies will improved
- Though this caregiver burden will be reduced.