International Journal of
Recent Innovations in Medicine and Clinical Research
Open Access, Peer Reviewed, Abstracted and Indexed Journal

ISSN: 2582-1075
https://ijrimcr.com/
Volume-2, Issue-2, 2020: 71-78

Research Article

Determine the Quality of Life among the Caregivers of Mentally ill Patients

Vikrant Nesari[1], Sudha Raddi[2].

Author Affiliations
Mr. Vikrant Nesari, Ph.D. Scholar, JJT University
Dr. Sudha Raddi, Principal, KAHER Institute of Nursing Sciences, Belagavi.

Received: April 28, 2020 **Accepted:** May 28, 2020 **Published:** June 18, 2020

Abstract: Background: Mental disorders are believed to be caused by a complex interplay of biological, psychological, environmental, cultural and economic factors. In countries like India, social determinants of health, such as jobs, education, living standards, the environment, access, equity and others, make a major contribution to both causation and recovery. **Objectives:** (1) To assess the quality of life among the caregivers of mentally ill patients. (2) To find out the association between the quality of life and socio demographic variables. **Methods:** Non-probability, convenient sampling technique was used to select the sample for this study. The sample selection was based on the inclusion and exclusion criteria. **Results:** The study reveals that the 24 (60%) of the subjects are leading high level of quality of life and 16 (40%) of the people were leading low level of quality of life. **Conclusion:** Findings revels that there is no statistically significant association between the quality of life ratings of caregivers of mentally ill patients and selected socio-demographic variables.

Keywords: Quality of life, Caregivers.

Introduction

Health is fundamental to the growth, development and development of society and is vital to lead a productive and healthy life in the world. The concept of health in the World Health Organization encompasses physical, social, moral and mental wellbeing and not just the absence of disease or infirmity[1]. Since ancient times, India has given importance to people's health and highlighted the need for a community that is physically and mentally well balanced. The maxim, 'there is no health without mental health,' underlines the fact that mental wellbeing is an important and necessary part of health. Mental health, often ignored, is now recognised as a vital condition and attracts the attention of policy makers, practitioners and communities in India and around the globe. Throughout history, the existence of mental illness has been the topic of heated debate. In ancient Greece Plato[2,3] advocating a mentalist conception of psychiatric illness, was the first to coin the word "mental health," which was conceived as a justification that helped to balance and to rule over passion. Failure to identify underlying mental health issues also leads to delayed diagnosis and restoration. Mental disorders are believed to be caused by a complex interplay of biological, psychological, environmental, cultural and economic factors[4]. In countries like India, social determinants of health, such as jobs, education, living standards, the environment, access, equity and others, make a major contribution to both causation and recovery. Poverty, inadequate living conditions and related causes are implicated in increased incidents, but they also disrupt the cycle of poverty and impoverishment [5]. Mental illnesses are often considered to be correlated with a broad variety of social and cultural issues where their condition is unrecognised or inadequately handled. Some mental health problems include not only reduced productivity and income opportunities, but also a variety of antisocial behaviours, robberies, homelessness, domestic abuse, alcohol and drug use[6].

Care-giving and receiving can occur at any point in the course of life and is usually associated with chronic illnesses or disabilities, resulting in loss of independence and functioning. There is no standard definition of family care that can be consistently applied from one study to another[7].

Living with and caring for a person with a mental illness seems to be extremely stressful. Family members of psychiatric patients show a wide variety of responses to their conditions. Overall, these family members tolerate a substantially higher degree of psychological distress than the general population. Mental disorder has been an issue in contemporary culture for a long time. The treatment and recovery of mentally ill clients is a tremendous responsibility on the family.

Studies have shown that in taking care of the mentally ill, family members have to face the tension and distress that includes: feelings of unstable grief and worry. Possible damage and violence, stigmatization by families and relatives. psychiatric emergency and relapse. Dependence, Social alienation, Fear of the future[8].

The introduction of the word quality of life in health care can be related back to the denotation of well-being by the World Health Organization in 1948. WHO defines the "Quality of Life" as an acknowledgement of the status of the individual of his or her life in terms of culture and reverence for the environment in which they live and in accordance with their goals, aspirations and standards. Quality of life is comprised of many main determinants, including mental health, career capacity, social ties, social intercommunication, individual well-being, financial status, professional status and physical well-being. Caring the mentally ill patients affects the majority of caregivers and they experience poor psychological well-being, as well as mental illness and a high incidence of depression among caregivers than the general population is recorded. Around 63 per cent higher risk of poor psychological burden than non-caregiver has been registered[9].

Mental conditions lead to tremendous disruptions in the lives of the affected people and their families as well as the caregivers. However, the level of pain and sorrow or unhappiness is a subjective matter that is not observable. One of the ways to assess the effects of mental illness is by the use of quality of life measures.QOL shall evaluate the subjective ratings of persons in different realms for determining the impact of disorder on the lives of individuals, family members and caregivers. Many studies published on QOL among people suffering from mental illness, family members and caregivers, finding that the detrimental effect of mental illness is not only significant but also long-lasting. It has been shown that the quality of life would be poor even after recovery from mental illness due to many social factors such as stigma and prejudice. The result of QOL studies indicates that patients with serious psychiatric illnesses treated in the long term have low quality of life relative to people living in the community[10].

Objectives

1) To assess the quality of life among the caregivers of mentally ill patients.
2) To find out the association between the quality of life and socio demographic variables.

Hypothesis

Hypothesis were formulated for the study based on mentioned objective,

H_1: There will be significant association between the quality of life and socio demographic variables of caregivers of mentally ill patients.

Methods

Variables of the Study

Independent Variables: Caregivers or the family members.
Dependent Variables: Mentally ill patients in the family.
Research Variables: Quality of Life.

Population: In the present survey population includes of caregivers or family members who are taking care of mentally ill patients.

Sample: Sample refers to the subset of population that is selected to represent the entire population in the study.

Sample size: The study comprises of 40 caregivers of mentally ill patients, who fulfilled the sampling criteria.

Criteria for sample selection

The sampling frame structured by the researcher to import the samples for the study included following criteria.

Inclusion criteria

- ✓ Caregivers who are in the age group of 20-60 years.
- ✓ Caregivers who are willing and available during the period of data collection.

Exclusion criteria

- ✓ Caregivers who are having mental or physical impairment.

Sampling technique: Non-probability, convenient sampling technique was used to select the sample for this study. The sample selection was based on the inclusion and exclusion criteria.

Results

Table 1. Distribution of caregivers by their demographic characteristics

Characteristics	No of caregivers	% of caregivers
Gender		
Male	12	30.00
Female	28	70.00
Age groups		
21-30 years	1	2.50
31-40 years	18	45.00
41-50 years	17	42.50
51-60 years	4	10.00
Marital Status		
Married	33	82.50
Divorced	7	17.50
Religions		
Hindu	30	75.00
Muslim	6	15.00
Others	4	10.00
Educations		
Illiterate	2	5.00
Primary	8	20.00
Secondary	17	42.50
Graduate	13	32.50
Occupations		
Employed	15	37.50
Unemployed	25	62.50
Type of family		
Nuclear	16	40.00

Joint	17	42.50
Extended	7	17.50
Family Income (per month)		
<10000	29	72.50
>10000	11	27.50
Place of residence		
Rural	16	40.00
Urban	24	60.00
Total	**40**	**100.00**

Gender: with regard to gender of care givers majority 28(70%) of participants were females and remaining 12(30%) of participants were males.

Age: the findings related to age depicts that, majority 18(45%) of participants were of 31-40 years age batch, 17(42.50%) of participants were belonged to 41-50 years age batch, 4(10%) of participants were belonged to age group to 51-60 years and remaining 1(2.5%) of participant of 21-30 years age crew.

Marital status: concerning to matrimonial status of participants majority 33(82.50%) of participants were married and remaining 7(17.50%) of participants were unmarried.

Religion: data related to religion of participants depict that, majority 30(75%) of participants were belonged to Hindu religion, 6(15%) of participants were belonged to Muslim religion and remaining 4(10%) of participants were belonged to other religion.

Education: education status of participants depicts that, majority 17(42.50%) of participants were had secondary education, 13(32.50%) of participants were had graduate education, 8(20%) of participants were had primary education and remaining 2(5%) of participants were illiterates.

Occupation: occupation of participants depicts that, majority 25(62.50%) of participants were unemployed and remaining 15(37.50%) of participants were employed.

Type of family: with respect to type of family of respondents majority 17(42.50%) were staying in joint family, 16(40%) were staying in nuclear family and remaining 7(17.50%) were staying in extended family.

Income of family in a month: it describes majority 29(72.50%) of respondents were having more than 10000 income per month and remaining 11(27.50%) of respondents were having less than 10000 income per month.

Residential place: it shows that, majority 24(60%) of respondents were staying in urban areas and remaining 16(40%) of respondents were staying in rural areas.

Table 2. Levels of Quality of Life among the caregivers of mentally ill patients (N=40)

Levels of Quality of Life	Frequency	Percentage
High level	24	60
Low level	16	40
Total	40	100

The study reveals that the 24 (60%) of the subjects are leading high level of quality of life and 16 (40%) of the people were leading low level of quality of life.

Table 3. Association between levels of quality of life of caregivers of mentally ill patients with demographic characteristics

Levels of quality of life								
Characteristics	**Low level**	**%**	**High Level**	**%**	**Total**	**%**	**Chi-square**	**P-value**
Gender								
Male	5	41.67	7	58.33	12	30.00	0.0200	0.8880
Female	11	39.29	17	60.71	28	70.00		
Age groups								
21 - 30 years	1	100.00	0	0.00	1	2.50	2.1800	0.5360
31 - 40 years	8	44.44	10	55.56	18	45.00		
41 - 50 years	6	35.29	11	64.71	17	42.50		
51 - 60 years	1	25.00	3	75.00	4	10.00		
Marital Status								
Married	12	36.36	21	63.64	33	82.50	1.0390	0.3080
Divorced	4	57.14	3	42.86	7	17.50		
Religions								
Hindu	12	40.00	18	60.00	30	75.00	0.2780	0.8700
Muslim	2	33.33	4	66.67	6	15.00		
Others	2	50.00	2	50.00	4	10.00		
Educations								
Illiterate	1	50.00	1	50.00	2	5.00	0.1270	0.9880
Primary	3	37.50	5	62.50	8	20.00		
Secondary	7	41.18	10	58.82	17	42.50		
Graduate	5	38.46	8	61.54	13	32.50		
Occupations								
Employed	7	46.67	8	53.33	15	37.50	0.4440	0.5050
Unemployed	9	36.00	16	64.00	25	62.50		
Type of family								
Nuclear	7	43.75	9	56.25	16	40.00	0.5050	0.0860
Joint	4	23.53	13	76.47	17	42.50		
Extended	5	71.43	2	28.57	7	17.50		
Family Income (per month)								
<10000	13	44.83	16	55.17	29	72.50	1.0240	0.3120
>10000	3	27.27	8	72.73	11	27.50		
Place of residence								
Rural	6	37.50	10	62.50	16	40.00	0.0690	0.7920
Urban	10	41.67	14	58.33	24	60.00		
Total	**16**	**40.00**	**24**	**60.00**	**40**	**100.00**		

The above table depicts the correlation among degree of living standard of concierge and their undertaken personal study elements. It illustrates, no noteworthy consortium was computed among the life standard of caretakers and undertaken personal study variable.

Gender: with respect to males 5 participants were had destitute level of quality of life, 7 participants were had medium level of quality life and 12 participants were had excellent status of life standard. Among the females 11 participants were destitute level of quality life, 17 participants were had passable level of quality life and 28 participants were had excellent status of life standard. The calculated chi square value is 0.0200 with 0.8880 p value is statistically not significant at 0.05 level of significance.

Age groups: with respect to age group of 21-30 years, 1 participants were had destitute level of quality of life, none of participants were had medium level of quality life and 1 life standard participants were had high level of burden, age group of 31-40 years, 8 participants were had destitute level of quality of life, 10 caregivers were had medium status of quality life and 18 participants were had high status of life standard, of 41-50 years age group, 6 of the participants were had deprived status quality life, 11 care gives were had medium status of life standard and 17 participants were had high status quality life and of 51-60 years age group, one of the participants were had low level of burden, 3 participants were had medium level quality of life and 4 participants were had high status living standard. The calculated chi square value is 2.1800 with p value 0.5360 is statistically significant at 0.05 level of significance.

Marital status: with respect to marital status of participants, 12 participants were had destitute level of quality life, 21 caregivers had medium level of quality life and 33 participants were had high level, quality life and among the divorced participants, 4 of participants were had destitute level of life standard, 3 caregivers were had medium level life standard and 7 participants were had high level of living standard. The calculated chi square value is 1.0390 with p value 0.3080 is statistically not significant at 0.05 level of significance.

Religion: with respect to participants of Hindu religion, 12 participants were had destitute level of life quality, 18 participants were had medium level of quality life and 30 participants were had high level of quality of life, among the participants of Muslim religion, 2 participants were had deprived level of living, 4 caregivers were had medium degree of living standard and 6 participants were had high standard of living and among the participants other religion, 2 participants were had destitute standard of life, 2 caretakers were had average standard of living and 4 participants were had high standard of life. The calculated chi square value is 0.2780 with p value 0.8700 is statistically not significant at 0.05 level of significance.

Education: with respect to illiterate participants, 1 of the participants were had comprised quality of life, 1 caregivers were had average life standard and 2 of caretakers were had high level quality of life, among the participants with primary education, 3 participants were had compromised quality of life, 5 caregivers were had medium standard of living and 8 participants were had high level quality of life, among the participants with secondary education, 7 participants were had deprived quality of life, 10 caregivers were had medium degree life quality and 17 participants were had high level quality of life and among the participants with graduate education, 5 participants were had deprived standard of living, 8 caretakers were had medium degree of life quality and 13 participants were had high level quality life. The calculated chi square value is 0.1270 with p value 0.9880 is statistically not significant at 0.05 level of significance.

Occupation: with respect to employed participants, 7 participants were had miserable level of quality life, 8 participants were had medium average level life quality and 15 participants were had high standard of living and among the unemployed participants, 9 participants were had compromised level living standard, 16 participants were had passable degree of living standard and 25 participants were had prosperous living standard. The calculated chi square value is 0.44 with p value 0.5050 is statistically not significant at 0.05 level of significance.

Type of family: with respect to participants of nuclear family, 7 participants were had compromised living quality, 9 participants were had average level of living quality and 16 participants were had high degree of living quality and among the participants of joint family, 9 participants were had destitute life quality, 15 participants were had average level of living quality and 24 participants were had high degree of life quality.

The calculated chi square value is 0.5050 with p value 0.0860 is statistically significant at 0.05 level of significance.

Family income: with respect to participants with less than 10000 income, 13 participants were had poor life quality, 16 participants were had average life quality and 29 participants were had highly regarded quality of life and among the participants with more than 10000 income, 3 participants were poor degree of living quality, 8 participants were had average life standard and 11 participants were had highly regarded life standard. The calculated chi square value is 1.0240 with p value 0.3120 is statistically significant at 0.05 level of significance.

Place of residence: with respect to participants of rural area, 6 participants were had deprived state living quality, 10 caregivers were had medium status of life quality and 16 participants were had highly regarded life standard and among the participants of urban area, 10 participants were deprived state living quality, 14 participants were had medium status of life quality and 24 participants were had highly regarded life standard. The calculated chi square value is 0.0690 with p value 0.7920 is statistically significant at 0.05 level of significance.

Discussion

The present study was undertaken to evaluate the quality of life among the caregivers of mentally ill patients. To achieve the formulated objectives, a non-experimental descriptive design adopted and non-probability convenient sampling technique is used to select the samples, study reveals major finding as follows,

Study results with respect to demographic data of caregivers of mentally ill patients, 70 per cent of caregivers are female, 30 per cent of whom are male, 87 per cent of whom are 31-60 years of age, and 10 per cent of whom are 51-60 years of age 82.50 per cent were married, 17.50 per cent were divorced. In consideration of religion 75% are Hindu, 15% are Muslims & 10% are belongs to other religion respectively. As far as schooling is concerned, 42.50 per cent are completed secondary education, 32.50 per cent are graduated, 20 per cent are elementary and 5 per cent are illiterate. 62.50% are working in the profession and the remaining caregivers are unemployed. 42.50 per cent belong to the joint family, 40 per cent belong to the nuclear family and the remaining 17.50 per cent belong to the extended family. In terms of receiving 72.50 per cent less than ten thousand rupees and 27.50 per cent more than ten thousand rupees per month. The majority of caregivers, i.e. 60 per cent, live in urban areas while 40 per cent live in rural areas.

The data was collected by the samples by using WHO Quality of Life assessment scale having 27 questionnaire are comprised of physical, psychological, social and environment domains. The tool was administered to 40 respondents.

The respondents depicted that the 24 (60%) of the subjects are leading high level of quality of life and 16 (40%) of the people were leading low level of quality of life.

In order to find out the association between the quality of life and socio demographic variables of caregivers of mentally ill patients by using the Chi-square test. Findings revels that there is no statistically significant association between the quality of life ratings of caregivers of mentally ill patients and selected socio-demographic variables of subjects such as gender, marital status, religion, education, occupations, and age, type of family, family income, place of residence of the respondents is significant association as values are greater than that of table value of confidence.

Conclusion

Mental health issues have a long-term effect. This effect lasts a prolonged time, which eventually leads to a poor quality of life on these individuals and their families. From a cultural point of view, mental disorder in Indian society is associated with a greater amount of stigma, contributing to neglect and marginalisation. Because of prevalent attitudes, media portrayals, social inequality and the lack of resources, these individuals and their families face various difficulties in daily life, both in terms of handling the situation and making it effective. The family is a significant support system for the continuing care of mentally ill persons. While many families show tremendous strength in caring for an ill parent, we cannot ignore their share of physical and emotional distress. It is most important to identify and resolve the health needs of the caregiver of mentally ill patients, and the well-being of caregivers also has a direct effect on the proper treatment of the patient. Health professionals will need to help families improve their quality of life through healthy education and training to improve their own health and well-being.

Conflict of Interest

The authors have no conflicts of interest to declare.

References

1. WHO as adopted by the International Health Conference, New York, 19 June-22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948
2. Grube GM. Greek medicine and the Greek genius.Phoenix. 1954;8(4):123-35.
3. Kenny A. The anatomy of the soul: historical essays in the philosophy of mind. Oxford: Blackwell; 1973.
4. World Health Organisation. The world health report 2001-Mental health: new understanding, new hope. World Health Organisation, Geneva, 2001.
5. Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA, Swartz L, Patel V. Poverty and common mental disorders in low and middle income countries: A systematic review. Soc Sci Med. 2010;71(3):517-28.
6. Keyes CL. The nexus of cardiovascular disease and depression revisited: The complete mental health perspective and the moderating role of age and gender. Agi Men Heal. 2004;8(3):266-74.
7. Ricard N. A career devoted to caregivers and to people, suffering from mental disorders, Mammothmag. 10;2011.
8. Reinhard SC, Given B, Petlick NH, Bemis A. Supporting family caregivers in providing care. In Patient safety and quality: An evidence-based handbook for nurses 2008 Apr. Agency for Healthcare Research and Quality (US).
9. Post M. Definitions of Quality of Life: What Has Happened and How to Move On. Top Spi Cord Inj Rehabil. 2014;20(3):167-180.
10. Brundtland GH. Mental Health: New Understanding New Hope. Geneva: World Health Organisation;2002.

Citation: Nesari V, Raddi S. Determine the Quality of Life among the Caregivers of Mentally ill Patients. Int J Rec Innov Med Clin Res. 2020;2(2):71-78.