Screening for Depression, Anxiety and Stress upon Informal Primary Caregivers of Patients Suffering from Common Mental Disorders

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Abstract

WHO defines health as ‘a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity.’ Common mental disorders comprise depression, anxiety, post-traumatic stress, panic attack and obsessive-compulsive disorders.

The study was a hospital-based cross-sectional study. The units of the study were informal primary caregivers coming along with the patients (treatment naïve) for the first time to the psychiatry OPD of Guru Teg Bahadur Hospital, New Delhi. Sample size of the study was 226.

Those caregivers who were themselves suffering from physical or mental illness and those patients who were suffering from mental retardation, schizophrenia, substance abuse and alcohol dependence were not involved. Study tools used were sociodemographic profile of the patient and caregiver and DASS (depression, anxiety and stress scale).

Around 2/3rd of the caregivers were suffering from some levels of depression, with 1/5th in extremely severe depression level. 2/3rd of the caregivers were suffering from some levels of anxiety, with 1/3rd in extremely severe anxiety levels. Less than half of the caregivers were having some levels of stress, with 16% in extremely severe stress levels.

Keywords: Depression, Anxiety, Stress, Caregiver

Introduction

WHO defines health as ‘a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity.’ WHO defines mental illness as ‘all forms of illnesses in which psychological, emotional or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thoughts and by definition it includes wide range of types and severities.’¹

Common mental disorders comprise depression, anxiety, post-traumatic stress, panic attack and obsessive-compulsive disorders.² Global prevalence of common mental disorders was found to be 17.6% with one in five adults experiencing a common mental disorder within the last 12 months and 29.2% across their lifetime.³

Psychiatric patients need help in their daily activities and this becomes a burden on their caregivers, thereby creating greater risk of health problems. The stress of
caregiving has been labelled as caregiver burden in the literature. Most of the caregivers take up the caring role in the absence of any significant knowledge about the illness. The role and demands are incorporated within the family responsibilities. In most of the countries, families have been the mainstay of caregiving for person with mental illness. The family caregivers bear with behavioral disturbances and sometimes are the targets of their abusive and violent behavior.

There is a lot of social stigma associated with mental disorders and the family of the patient suffers the most. They have to curtail on their social and leisure activities and sometimes even take leave from their jobs for caring their relative. Therefore, adherence of human rights standards need to be secured for the patients and their family members, and we must consider the quality of life of the persons and the caregiver with mental disorders and psychosocial disabilities equal to other members of the society. Caregivers play enormous roles in the life of the patients, which often lead to negative impact in their well-being, as well as the patients.

Review of Literature

Basheer et al. studied informal primary caregivers of 50 patients of both genders, 25 males and 25 female patients, to look depression and anxiety in the caregivers of mentally sick patients and saw that the caregivers of young male patients had high level of depression in contrast with older male patients and young female patients, whereas no such significant discoveries were outwardly reported with female caregivers. The duration also demonstrated significant effect on burden, those with more duration, the caregivers felt demoralized and burdened. Caregivers often sacrificed their own physical and emotional necessities. The physical and emotional encounters could strain even the strongest caregiver.

Smith conducted an interview with spouses of the patients suffering from depression, anxiety disorders and schizophrenia. An increased number of spouses were found to be having depressive disorders. It was said that psychiatric patients’ partners were at risk of developing a depressive disorder.

Stanley et al. in his study to assess caregiving burden in fifty spouses of persons diagnosed with a psychotic illness noted that more than 50% caregivers of anxiety and chronic schizophrenia, recognized depression, uneasiness and stress, elevated in the age class 20–25 years. Most of the respondents were in the “severe” and “extremely severe” categories that was around 54% for depression, 60% for anxiety, and 50% for stress. The overall burden for the majority was “high”, and it had an impact on their health, their marital life, their relationship with others, and lack of appreciation for their caring role.

Muscroft and Bowl in their study on the impact of depression on caregivers and other family members a community-based study proved that 18–47% of caregiver’s had acquired depression.

Ogilvie et al. saw in their study that the depression level was high in caregivers of relatives of those suffering with bipolar illness. This study has showed that caregiver burden was associated with depression. Caregiver experience of health services influenced their beliefs on the illness.

Objectives of the Study

To screen for depression, anxiety and stress upon informal primary caregivers of patients suffering with common mental disorders.

Materials and Methods

Study Duration

The study period was from November 2015 to April 2017.

Study Design

A hospital-based, cross-sectional study. The units of the study comprised informal primary caregivers coming along with the patients (treatment naïve) for the first time to the psychiatry OPD of Guru Teg Bahadur Hospital, New Delhi.

Study Setting

Study subjects were recruited from psychiatry OPD, Guru Teg Bahadur Hospital, New Delhi.

Study Population

Informal primary caregivers of patients suffering from common mental disorders visiting the psychiatry OPD along with their patients.

Sampling Method

First three consecutive psychiatry OPD attenders, after being diagnosed with common mental disorders by the consultants or the residents of psychiatry OPD of GTB Hospital, New Delhi, were contacted personally. Purpose of the study was explained and written consent was taken. Thereafter interview was carried out.

Sample Size

Taking 17.9% prevalence from previous study at 5% absolute error and 95% confidence interval, the sample size calculated was 226 using Epi info software. The informal primary caregivers were enrolled till the sample size of 226 was achieved.

Criteria for Selection
Informal primary caregivers were those who were taking care of the daily needs of the ill relative, spent most hours on caregiving tasks like feeding, taking them for appointments, washing, etc., and who coordinated the caring process. These included the parents, siblings, spouses, children and other close relations.

**Inclusion Criteria of Primary Caregiver**

Adults of more than 18 years of age and who were staying with and caring for the patient most of the time. Parents, siblings, spouses, children and other close relatives, who consented to participate in the study.

**Exclusion Criteria of Primary Caregiver**

Those who were themselves suffering from physical or mental illness.

**Inclusion Criteria of Patient**

Those who were suffering from common mental illness.

**Exclusion Criteria of Patient**

Those who were suffering from mental retardation, schizophrenia, substance abuse and alcohol dependence.

**Study Tools**

Following tools were used:

**Tool A: Sociodemographic profile of the patient and caregiver.**

A pretested semi-structured, self-administered or interviewer-assisted in cases where the subjects were not able to read or were illiterate. A questionnaire was used to elicit following information:

- Patient’s age, sex, diagnosis, duration of illness.
- Caregiver’s age, sex, relation with the patient, educational qualification, occupation, family income monthly.

**Tool B: DASS (Depression, anxiety and stress scale)**

Depression, anxiety and stress scale (DASS 21) is a 21-item scale with set of three self-reported scales, seven items each to screen depression, anxiety and stress. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-depression, lack of interest/involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious effect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty in relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items. Scores on the DASS-21 are multiplied by 2 to calculate the final score.

The response to each question varies from 0- ‘Did not apply to me at all’, 1- ‘Applies some of the time’, 2- ‘Applied often’, 3- ‘Applied to me very much, or most of the time’ and the scores derived from each category are multiplied by 2 to arrive at the final scores which are interpreted as:

| Category        | Depression | Anxiety | Stress  |
|-----------------|------------|---------|---------|
| Normal          | 0–9        | 0–7     | 0–14    |
| Mild            | 10–13      | 8–9     | 15–18   |
| Moderate        | 14–20      | 10–14   | 19–25   |
| Severe          | 21–27      | 15–19   | 26–33   |
| Extremely severe| 28+        | 20+     | 34+     |

**Data Collection**

Every day on an average, 100–150 patients visit psychiatry OPD of GTB Hospital, New Delhi. Data collection was done three days every week. After 9 a.m., 3 consecutive new patients who had not received any psychiatric treatment earlier, after getting diagnosed by a senior resident for common mental disorder were included in the study. The caregivers selected for the study were contacted personally. The purpose of the study was explained and good rapport was established with the caregivers. Sufficient time was spent with each participant to explain the purpose of the study and doubts, if any, were clarified. A written consent was taken from those caregivers who were willing to participate. The participants were requested to provide correct and complete information. They were assured that the individual information collected would be kept strictly confidential.

**Ethical Considerations**

Ethical clearance was obtained from the Institutional Ethics Committee of UCMS and the Institutional Ethics Committee of Guru Teg Bahadur Hospital, New Delhi. Informed written consent was taken from the study subjects prior to conducting the study.

**Results**

The present study was conducted in psychiatry out-patient department, Guru Teg Bahadur Hospital, New Delhi. A total of 226 informal primary caregivers of common mental disorders were interviewed and the results are presented below:

The age of patients ranged from 10–81 years. The majority of the patients 50.4% (114) were in the age group of 20–39
years. The mean±SD age of the study participants was 35±15 years. About 12% (27) of the patients belonged to the geriatric age group.

Nearly 65.9% of the patients were female.

The majority of the patients 49.1% (111) were suffering from depression, followed by anxiety 41.2% (93). Remaining patients were diagnosed with posttraumatic stress disorder 3.5% (8), obsessive compulsive disorder 3.5% (8) and panic attack 2.7% (6).

The majority (88.1%) of the patients were suffering from disease for less than 1 year.

The range of caregivers’ age was 18–75 years. Majority of the patients 55.7% (126) were in the age group of 20–39 years. The mean±SD age of the study participants was 37±12 years. About 3/4th of the caregivers were in the age group of 20–49 years. About 7.1% (16) of the caregivers belonged to geriatric age group.

Around 54.9% (124) of the caregivers were male.

The blood relation included relatives like father, mother, sister, brother, daughter, son and grandson. The relations by marriage were husband, wife, mother-in-law, sister-in-law and brother-in-law. The other category was for the relatives like aunt, uncle, niece and nephew.

Majority around 44.2% had attained middle school, followed by graduate/post-graduation (19.9%) and high school (19.6%).

Roughly 1/3rd of the caregivers were housewives and students followed by skilled worker (16.8%), and clerks/shop owners/farmers (13.3%).

Around half of the study population had total family income of <Rs. 10,372/month, while 1/6th of the study subjects were living on meagre income of <Rs. 6223/ month.

Almost 60.6% of the caregivers were screened to be having some levels of depression ranging from mild to moderate, to severe to extremely severe, out of which 20.4% were screened to have extremely severe depression. Around 30.5% of the caregivers were screened with extremely severe anxiety.

Approaching 30.6% caregivers were screened as having moderate to severe to extremely severe stress.

Discussion

The caregiver starts developing anxiety in the course of giving care. The emotional impact of any psychiatric disorder on caregiver varies from frustration, anger, anxiety, guilt, depression to grief. Anxiety in caregivers can lead to adverse outcomes. Studies have shown that spouses, siblings and parents experience considerable levels of burden and feeling of fear, anxiety, worry and isolation for their ailing relative. The social dysfunction and anxiety were reported as the most common aspects of psychiatric morbidity. There were reports where the caregivers admitted that they felt anxious when they thought of the future, thoughts like ‘no one to look after them once I am gone’ kept them anxious most of the time. This was similar to our study as we could see that anxiety was significant for the caregivers.

It was also found in a study that more anxious nature of the caregivers had an impact on their utilization of the health services. The more anxious the caregiver were the more they sought for professional help as they wanted to help their relative the best way.

Stress contributed to the caregiver burden rather than being merely a manifestation of burden. Caregiver burden is a response to the perceived stress resulting in taking care of an ill relative. Burden was associated with stress-related variables known as stressors; these could be the financial stress, own disorder of caregiver, job strain, family conflicts, caring for small children, etc. Daily care-related stressors are important facets of stress that is experienced by the caregiver.

Stress was found to have great impact. It was observed how long-term stress affected the health of the caregiver indirectly through alteration in health behavior such as increase in smoking and alcohol consumption as well as decreasing the immunity leading to illness and morbidity. It was also noted in some studies that the stress had influenced the coping abilities of the caregiver.

It was observed that illness of more than 18 months had higher depression as compared to the illness of less than 18 months.

The demanding nature of caregiving required by the relative may take physical, emotional and social toll on the caregiver. The caregivers find it hard to keep up with many responsibilities, which have come upon them since the relative fell ill. The expectations of the relative and the society from the caregivers can cause a sense of burden on the caregiver. Inability to meet up the expectations can lead to higher burden.

Conflict of Interest: None

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