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A Comparison of Coping Strategies Among Caregivers of Psychotic and Neurotic Patients

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The present study is conducted to find out if there is any difference in the use of coping strategies among caregivers of patients with psychotic and neurotic disorders. Other hypotheses of the study were that these caregivers would differ in using coping strategies with respect to their gender, family system, age, relationship with the patient and educational level. The sample of the study comprised of 150 caregivers (37 males and 113 females) of patients diagnosed with psychotic and neurotic disorders, purposively selected from five different hospital settings located in Jhelum, Kharian and Gujrat. Coping Strategies Questionnaire (CSQ) (Kausar, 2004) Urdu version was used. Findings of the study indicated on significant difference in coping strategies used by the caregivers of patients with mental illnesses. Significant differences among caregivers existed on active-practical, active-distractive and avoidance-focused coping strategies with respect to their gender. Further, the findings showed significant differences in active-practical and avoidance focused coping strategies among caregivers of patients with respect to their age and family system. In reference to the relationship of caregivers with patients, findings exhibited significant differences on active-distractive and avoidance-focused coping strategies. While keeping in view the educational level, significant differences existed only on religious coping strategies. Implications and the limitations of the research are discussed.

Keywords: coping strategies, caregivers, psychotic, neurotic patients

Introduction

In Pakistani society, domestic caregivers are considered as the mainstay of the healthcare structure. Mostly the principal caregivers are patient's partners, parents or first degree relatives. They are considered liable for providing physical and emotional support for their mentally ill relatives for longer durations (Imran, Bhatti, Haider, Azhar, Omer, & Sattar, 2010). In looking after the patients, they have to face various stressors and to deal with them effectively, they use different coping strategies. Therefore, it is important to identify how they cope with such a life stressor particularly and what type of strategies they mostly use.

According to Richard Lazarus (as cited in Seaward, 2004) coping refers to the process of handling strains that are considered as challenging more than the individual's capabilities. It consisted of both cognitive and action-oriented (behavioral) efforts. These managing process involved several important criteria as for instance,

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an increased awareness of oneself, the situation, and the environment; an emotional regulation process called palliative coping; and behavioral changes, referred to as instrumental coping necessary for the proper handling of the event. Lazarus and Folkman (1984) has explained coping strategies as the behaviors, thoughts, and emotions that caregivers use to regulate the changes that occur in their life as a result of look after services they provide to their loved ones.

Folkman and Moskowitz (2000) stated that coping involved handling challenging situations, employing efforts to solve problems in one's life, and making oneself capable enough to manage and reduce stress. A successful coping included one's sense of control, positive emotions and availability of the personal resources. Further it also depended on the context in which particular coping strategies are used because often people employ various coping behaviors, out of which some are more successful than others.

Lazarus (as cited in Seaward, 2004) explained that every stressor undergoes primary appraisal to determine the level of damage. It is then suppressed in a secondary appraisal. At this point a person has lined up a range of coping responses with that particular stressor to see which the best course of action is. The coping responses are either action-oriented such as time management or assertive behavior, or intrapsychic (acceptance). Therefore, the responses that individuals' mostly used to cope with stress can be derived from two sources that is, inner resource and/or external resource. Inner resources comprised of power, sense of humor, creativity, sense of reason, optimism, faith and self-efficacy. External resources comprised of social support from friends, family, community, money and time. A person uses his/her coping skills to minimize harmful environmental conditions, to make any negative event adjustable, to sustain a positive self-image and emotional stability, and to have satisfactory relationships with others.

According to Aspinwall and Taylor (1997) social support provided by friends and family either present physically or at distance, offer sympathy, reassurance and a second opinion on the events stressful for a person. In addition, the religion served as an extremely important source of social and emotional support for many people. People having strong religious faith are filled with hope and optimism rather than despondency. Religion offered the basic code of conduct in life, provide social support, prevent isolation and promote a safe and secure healthy way of living. Prayers offered psychological and spiritual relaxation to the individuals.

Seaward (2004) reported that coping strategies can either be positive or negative. Positive coping strategies are employed as successful as it proved to be effective and satisfactorily dealt with stress, and ended in a peaceful resolution of the problem. On the other hand, negative coping strategies did not provide enlightened resolution. Instead they perpetuate perception of stress and is considered an ineffective response in a vicious circle that may never be broken or intercepted e.g., to avoid the problem, to exhibit emotional rigidity, hostility, aggression, and self- damaging behaviors.

Other coping styles as reported by the researchers are avoidance versus confrontation (C. J. Holahan, Moos, C. K. Holahan, Brennan, & Schutte, 2005) and combative versus preventive (Matheny, Aycock, Pugh, Curlette, & Cannella, 1986). The first viewpoint has both positive and negative aspects. When avoidance is used to minimize exposure to a stressor, this is considered effective. When avoidance continued the stressor, in that case it not considered effective. The combative style, like confrontation, is considered to be a physical reaction or response, whereas preventive coping, initially, is more cognitive in nature, with the intent to safeguard oneself against the imminent stress.

Eaton, Davis, Hammond, Condon, and McGee (2011) conducted a study to examine the positive and negative coping strategies used by the families of hospitalized psychiatric patients. Findings of the study indicated that caregivers of the psychiatric patients used more emotion-focused coping strategies as compared to problem-focused coping strategies and the emotion-focused coping strategies. Mostly they used avoidance coping behaviors in communication with family members, acceptance of their situation, passive appraisal, and spirituality. Similarly, Stephens, Norris, Kinney and Grotz (1988) conducted a study to examine in which ways the caregivers cope with stressful circumstances. Findings of the study indicated that the caregivers who used more escape avoidance coping strategies experience more stress, depression and conflict in personal relationships as compared to the caregivers who used more positive coping strategies. Majority of the caregivers were women who used escape-avoidance strategies.

Ansari and Qureshi (2013) reported significant differences in the level of coping between the caregivers living in joint and nuclear family system. Kumar and Saini (2012) conducted a study to find out the coping strategies used by the caregivers. Results indicated that the mostly caregivers used positive cognitive coping strategies such as distraction and problem-solving strategies to overcome perceived burden of patient's illness.

Care giving is a strenuous responsibility for the family members of the patients with mental disorders which created social, emotional, behavioral and financial problems for them and as a result restricted their personal life and freedom. These problems eventually caused stress for the caregivers and can affect all domains of their life including work, socializing and relationships, unless or until they used effective ways to cope with that stress. The basic purpose of the current study was to find out if there is any difference in Coping Strategies among caregivers of patients with psychotic disorders and neurotic disorders. It was postulated that

(1) Caregivers of psychotic and neurotic patients will differ in the use of their coping strategies with mentally ill patients;

(2) Caregivers of mentally ill patients will differ in coping strategies with respect to their family system;

(3) Caregivers of mentally ill patients will differ in coping strategies with respect to their gender;

(4) Caregivers of mentally ill patients will differ in coping strategies with respect to their age;

(5) Caregivers of mentally ill patients will differ in coping strategies with respect to their relationship with patient.

Caregivers of mentally ill patients will differ in coping strategies with respect to their education level.

The implications of this study would be beneficial for the clinicians in developing positive and constructive relationship with the caregivers of mentally ill persons and to consider their problems as crucial in delivering care and support to their mentally ill family members. It would be helpful in providing adequate education, advice, information related to the problems of mentally ill family members and provide guideline for counselling to accept the circumstances as they are and to deal actively and positively with the burden of care giving in junction with the other issues of life. It would be helpful in motivating the caregivers to create balance in their roles such as care giving, household, and job etc. and to live a positive life which ensure both physical and mental health. This study would also be helpful for the clinicians in introducing intervention programs which led to the improvement of caregiver and patient relationship and to provide caregivers with adequate information they need to cope better and positively with their stressors as well as their relatives' mental illnesses.

Method

A comparative research design was used to see the differences in the coping styles of caregivers with psychologically disturbed patients.

Sample

The sample was selected by using purposive sampling technique and 150 family caregivers of patients with psychotic and neurotic disorders were selected from the from the following hospital settings such as Combined Military Hospital, Kharian Cantt; Subhan Hospital, Kharian; Aziz Bhatti Hospital, Gujrat; Umar Arshad Hospital, Gujrat and Polyclinic Hospital, Jhelum. The demographic characteristics of the sample are given in Table 1.

Instrument

Coping Strategies Questionnaire (CSQ) (Kausar, 2004) was used to measure coping strategies used by caregivers of mentally ill patients. It comprised of 62 items and was specifically developed for Pakistani population. It is a 4-point scale ranging from "did not use at all" to "use quite a lot" indicating the degree to which a particular strategy issued. It has four subscales namely as active-practical coping, active-distractive coping, avoidance-focused coping and religious-focused coping. The total alpha reliability for CSQ is 0.89.

Procedure

Caregivers were approached at five different psychiatric hospital settings located in Jhelum, Kharian and Gujrat. Data were collected after obtaining written permission from the head of psychiatric departments of hospitals and after obtaining a verbal consent from the caregivers. Caregivers were briefed about the purpose of data collection and for majority of caregivers structured interview technique was used as method of data collection as they were illiterate. It took about 20-30 minutes for each participant and almost three months to complete data collection.

Results

Data were analyzed using statistical package version 16.0 the results are given below:

Table 1

Descriptive Statistics of Demographic Variables of the Sample (N = 150)

Demographic Variables	Categories	Frequencies	Percentage
Gender of Caregivers	Male	37	25
	Female	113	75
Age of Caregivers	14-25	20	13.3
	26-49	94	62.7
	50-80	36	24.0
Marital status	Married	127	84.7
	Unmarried	23	15.3
Family system	Joint	80	53
	Nuclear	70	47
Education of Caregiver	Uneducated	53	35.3
	Primary-Middle	38	25.3
	Matric	41	27.3
	F.A-M.A	18	12.0

(Table 1 continued)

Demographic Variables	Categories	Frequencies	Percentage
Relationship with Patient	Parents	61	40.7
	Siblings	32	21.3
	Spouse	25	16.7
	Children	32	21.3
Diagnosis of Patient	Psychotic	70	47
	Neurotic	80	53

Table 1 shows that the majority of the caregivers were females (n = 113) as compared to males (n = 37). Most of them were married (84%). Majority of the caregivers belongs to joint family system (n = 80). Majority of them were parents (n = 61), most of them were uneducated (n = 53) and fall in the age range of 26-49 (n = 94). Majority of them were caregivers of patients with neurotic disorders (53.3%) as compared to the caregivers of patients with psychotic disorders (46.7%).

Table 2

Mean, Standard Deviation and Independent T-test Comparing Caregivers of Psychotic and Neurotic Patients on CSQ (N = 150)

Scale	Variables	Caregivers of					
		Psychotic Patients (n = 70)		Neurotic Patients (n = 80)			
		M	SD	M	SD	t	p
Coping Strategies	Active-Practical	52.3	4.8	53.3	5.4	-1.2	0.231
	Active-Distractive	21.3	2.1	21.9	2.4	-1.54	0.125
	Avoidance-focused	65.7	5.6	65.5	6.8	0.157	0.875
	Religious-focused	42.7	5.00	43.4	5.1	-0.739	0.461

Notes. d.f = 148; $p > 0.05$.

The results showed in Table 2 indicated no significant difference in using any of the four types of coping strategies among caregivers of patients with psychotic disorders and caregivers of patients with neurotic disorders.

Table 3

Differences Between Caregivers on Coping Strategies With Respect to Their Family System

Scale	Variables	Family system					
		Joint (n = 80)		Nuclear (n = 70)			
		M	SD	M	SD	t	p
Coping Strategies	Active-Practical	53.6	5.0	51.9	5.3	2.0	0.046
	Active-Distractive	21.48	2.18	21.9	2.4	-1.01	0.314
	Avoidance-focused	64.17	5.72	67.2	6.5	-3.07	0.002
	Religious-focused	43.25	5.31	42.9	4.8	0.352	0.726

Notes. d.f = 148; $p < 0.05$.

The results presented in Table 3 indicated that there is a difference in using active-practical and avoidance focused coping strategies among caregivers of mentally ill patients with respect to their family system.

Table 4

Independent T-test Comparing Caregivers of Mentally Ill Patients on Coping Strategies With Respect to Their Gender (N = 150)

Scale	Variables	Gender of Caregivers					
		Male (n = 37)		Female (n = 113)			
		M	SD	M	SD	t	p
Coping Strategies	Active-Practical	55.6	6.55	51.99	4.34	3.79	0.000
	Active-Distractive	22.83	2.73	21.31	2.00	3.63	0.000
	Avoidance-focused	62.08	4.90	66.76	6.27	-4.41	0.000
	Religious-focused	43.13	6.05	43.10	4.73	0.030	0.976

Notes. d.f =148; $p < 0.05$.

The results showed in Table 4 indicated significant differences on active-practical, active distractive and avoidance focused coping strategies among caregivers of mentally ill patients with respect to their gender.

Table 5

One Way ANOVA Comparing Caregivers of Mentally Ill Patients on Coping Strategies With Respect to Their Age (N = 150)

	Age of Caregivers (in years)							
	14-25 (n = 20)		26-49 (n = 94)		50-80 (n = 36)			
Coping Strategies	M	SD	M	SD	M	SD	F	p
Active-Practical	50.25	3.59	53.19	5.51	53.50	4.75	3.069	0.049
Active-Distractive	21.50	2.23	21.93	2.26	21.16	2.36	1.558	0.214
Avoidance-focused	69.90	6.99	65.86	6.01	62.58	5.05	9.964	0.000
Religious-focused	41.95	4.63	43.01	5.19	44.02	4.95	1.132	0.325

Notes. d.f = 147; $p < 0.05$.

The results showed in Table 5 indicated significant differences on active-practical and avoidance focused coping strategies among caregivers of mentally ill patients with respect to their age.

Table 6

One Way ANOVA Comparing Caregivers of Mentally Ill Patients on Coping Strategies With Respect to Their Relation With Patient (N = 150)

	Relation of Caregiver with Patient									
	Parents (n = 61)		Siblings (n = 32)		Spouse (n = 25)		Children (n = 32)			
Coping Strategies	M	SD	M	SD	M	SD	M	SD	F	p
Active-Practical	52.90	4.33	53.46	5.16	53.44	7.37	51.78	4.76	0.706	0.550
Active-Distractive	21.29	2.12	21.84	1.27	23.24	2.89	21.09	2.41	5.66	0.001

(Table 6 continued)

	Relation of Caregiver with Patient									
	Parents (n = 61)		Siblings (n = 32)		Spouse (n = 25)		Children (n = 32)			
Coping Strategies	M	SD	M	SD	M	SD	M	SD	F	p
Avoidance-focused	64.62	5.73	65.21	5.79	64.12	6.00	69.06	6.99	4.52	0.005
Religious-focused	43.55	5.00	42.56	5.32	42.32	5.96	43.43	4.22	5.24	0.666

Notes. d.f = 146; $p < 0.05$.

The results showed in Table 6indicated significant differences on active-distractive and avoidance focused coping strategies among caregivers of mentally ill patients with respect to their relation with patient.

Table 7

One Way ANOVA Comparing Caregivers of Mentally Ill Patients on Coping Strategies With Respect to Their Education Level (N = 150)

	Education level of Caregivers									
	Uneducated (n = 53)		Primary-Matric (n = 38)		Matric (n = 41)		F.A-M.A (n = 18)			
Coping Strategies	M	SD	M	SD	M	SD	M	SD	F	p
Active-Practical	52.16	4.51	52.52	4.80	53.80	6.41	53.55	4.78	0.921	0.43
Active-Distractive	21.50	2.45	21.31	1.91	22.12	2.39	22.05	2.26	1.08	0.35
Avoidance-focused	64.64	5.28	65.44	6.29	66.00	6.98	67.94	7.16	1.31	0.27
Religious-focused	44.26	4.67	43.36	5.25	41.39	5.23	43.11	4.76	2.60	0.05

Notes. d.f = 146; $p = 0.05$.

The results showed in Table 7 indicated significant difference on religious focused coping strategies among caregivers of mentally ill patients with respect to their education level.

Discussion

The present study was conducted to compare coping strategies used by the caregivers of patients with psychotic and neurotic disorders on each dimension of active-practical, active-distractive, avoidance-focused and religious-focused style. The aim was to find out if there were any differences among caregivers in each of these dimensions of coping strategies with respect to their family system, gender, age, education level and relationship with patients. The results of the study indicated no significant differences in two groups of caregivers on all dimensions of coping strategies. Therefore, the first hypothesis of the study was not accepted on the basis of the results of the present study (see Table 2). However, the findings of insignificant differences in coping style of caregivers are consistent with the research evidence of Magliano et al. (1999) that compared coping styles in caregivers of bipolar patients with those of schizophrenic patients. Findings of the study showed that caregivers used both problem-focused and emotion-focused coping strategies. But there is another study conducted by Chadda, Singh and Ganguly (2007) who reported that caregivers from two groups mostly used problem focused coping and pursued social support type of coping strategies more often than the avoidance strategies. The possible reason for their finding was that majority of the caregivers reported their

monthly income below 30,000 which showed that respondents belonged to lower middle class where financial difficulties are common and they lacked resources to employ different or unique coping styles. The finding is consistent with the view of Seaward (2004) that coping styles may be a direct result of the strength of available resources such as, a prosperous person with many social contacts may rely more on external resources whereas a person without these is going to have to access inner resources to deal with his problems. Nolan, Grant, and Keady (1998) explained that coping also comprised of a combination of financial resources and social support which people usually employ in stressful situations in order to manage those events. But with reference to Pakistani culture, there arose a need to explore and investigate the etiology of null difference between coping styles of caregivers of both major categories of mental disorders.

Further, the findings of the study indicated that there was a difference on active-practical and avoidance focused dimensions of coping strategies among caregivers of patients with respect to their family system. The caregivers who belonged to joint family system reported more active-practical coping strategies as compared to the caregivers belonging to nuclear family system. The caregivers belonging to the nuclear family system reported more avoidance focused coping strategies as compared to the caregivers who belongs to joint family system as indicated in Table 3 and the second hypothesis of the study was accepted. These findings are consistent with the results of other researches that reported significant differences in the level of coping styles as used by the caregivers of joint and nuclear family system. The possible reason is that in joint family systems the burden of care giving is somewhat less as compared to nuclear family systems as family members provide social and moral support to each other. Joint families are capable enough in providing social, moral, and financial support for their mentally ill member. But in nuclear families, it becomes difficult for the family members to provide constant care for a mentally ill member because of their extremely busy earning routine (Ansari & Qureshi, 2013; Ganguly, Chadda, & Singh, 2009).

The results of the table 4 showed significant differences among caregivers on active-practical, active-distractive and avoidance-focused coping strategies with respect to their gender. However, there was no significant difference in the use of religious coping strategies between male and female caregivers. As depicted in the table 4, male caregivers mostly used active practical and active-distractive coping strategies as compared to female caregivers. The possible reason for this finding might be that the male members of the family have more commitments and socialization as compared to females. These findings of the study are also consistent with the other studies, indicating that male caregivers are more committed and resilient in providing care for mentally ill persons and used more action oriented, persistent and firm approaches. Findings of the study also indicated that female caregivers used more avoidance coping strategies as compared to male caregivers (Mays & Lund, 1999; Stephens, Kinney, Norris, Ritchie, & Grotz, 1988).

The fourth hypothesis of the study was accepted. Findings of one way analysis of variance of the study indicated significant differences in active practical and avoidance focused coping strategies among caregivers with respect to their age (see Table 5). The caregivers who fall in the age range between 26-49 and 50-80 mostly used active-practical coping strategies whereas caregivers who fall in the age range of 14-25 used avoidance coping strategies. These results are consistent with the findings of Stephens et al., (1988) which indicated that younger caregivers used more avoidance strategies.

The Findings of the study indicated that caregivers used more avoidance-focused and active distractive

coping strategies as compared to active-practical and religious focused coping strategies (see Table 6). Hence, the fifth hypothesis of the study was accepted. The present findings are supported by Abbas and Mahmood (2013) who conducted a study to assess difference of coping strategies amongst the partners of psychiatric patients. The study exhibited more use avoidance coping style. However, it showed insignificant difference in use of religion as a coping strategy which is also consistent with the findings of the study conducted by Pun, He and Wang (2014) who examined the coping strategies incorporated by family caregivers living with psychiatric patients. The results of the study indicated that religion, acceptance, positive reframing and self-distraction were used frequently to handle the stress of looking after the patients with neurotic and psychotic tendencies. Other researches (Rammohan, Rao, & Subbakrishna, 2002; Snyder et al., 2014) indicated that spouses used more negative distraction as coping strategies while children used more avoidance coping strategies. Adult child caregivers often considered providing care as a problem which led to increased and stable use of avoidance coping strategy. The possible reason for this finding is that in Pakistani society children are not independent and they mostly live in joint family system where parents or senior family members are responsible for decision makings and looking after the matters of daily living. Therefore, in case of any stressful event in the family children are most likely to use avoidance coping strategies rather than active-practical coping strategies.

The findings (see Table 7) of one way analysis of variance indicated significant difference in religious coping strategies with respect to their education level, therefore, sixth hypothesis of the study has been accepted. Uneducated caregivers used more religious coping. These findings are not consistent with the previous studies which indicated that caregivers having higher educational qualification mostly adopt positive coping styles as compared to caregivers with less education (Abbas & Mahmood, 2013; Kellis, 2007). The possible reason for this finding might be that in Pakistan regardless of formal education, it is compulsion for the people to get religious education informally at home. Children observe parents using religious practices and prayers as a coping tool for dealing with difficult situations in their lives.

Conclusions

The present study concluded that caregivers who belonged to joint family system used more positive coping strategies followed by active-practical whereas caregivers belonging to the nuclear family system used more negative coping strategies such as avoidance. Male caregivers mostly used active-practical and active distractive coping strategies whereas female caregivers used more avoidance coping strategies. Among caregivers spouses used more active-distractive coping strategies whereas children used more avoidance coping strategies. Uneducated caregivers used more religious focused coping strategies. Younger caregivers used more avoidance coping strategies as compared to elders.

Limitations and Suggestions

The sample size for this study was small as it was not sufficient for the generalization of results. It is suggested that in future studies a large sample size should be selected in order to ensure the generalization of results. Another limitation of the study was that majority of the respondents were females. It is suggested that in future research design sample must be comprised of equal proportion of male and female respondents.

Moreover, a comparison must be made between patients and caregivers in order to determine the differences in using coping strategies with the mental disorders.

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