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Clinical and socio-demographic determinants of psychological health and burden in family caregivers of patients with unipolar depression

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ABSTRACT

Introduction: Depression affects nearly 350 million people worldwide and is currently among the most disabling diagnosis in the world. Caregiver burden can be immense in unipolar depression. The present study seeks to fill the knowledge gap by evaluating sociodemographic factors affecting psychological health and burden in caregivers of patients with unipolar depression.

Method: Eighty outpatients with unipolar depression and their primary caregivers were included in the study. The patients were evaluated using clinical interview, DSM-IV TR criteria for Major Depressive Episode, Hamilton Depression Rating Scale (HDRS), Global Assessment of Functioning Scale (GAF) and Multidimensional Scale for Perceived Social Support (MSPSS). The caregivers were evaluated using HDRS and Zarit Burden Interview (ZBI).

Results: Caregiver burden was significantly higher in female spouse, employed caregivers and spouse caregivers married within the last one year as compared to caregivers other than wife, those unemployed and those married for more than one year. Caregiver burden in moderate as well as severe depressive episode did not show significant difference, although the more prolonged and non-responsive episodes placed a higher degree of burden on the caregivers.

Conclusion: Early psychosocial intervention especially in the vulnerable family caregivers of depressed patients is an unmet need of mental health services which should be addressed by the clinician early to improve outcome and reduce caregiver burden in unipolar depression.

1. Introduction

The World Health Organization (WHO) has categorized depression as among the most disabling clinical diagnosis in the world, estimated to affect nearly 340 million people worldwide and nearly 10 million people in India (WHO, 2008). These statistics underscore the widespread prevalence of depression as a common clinical condition but largely fail to highlight the devastating consequences of this illness. The World Federation of Mental Health has issued a report (WFMH, 2010) supporting that caring for those with a chronic condition like depression requires tireless effort, energy, and empathy and indisputably greatly impacts the daily lives of caregivers. It is now recognized that globally, caregivers will continue to play an important and ever-expanding role, as health and social services systems are resource challenged.

Caregiver burden has often been categorized into objective and subjective burden. Objective burden relates to the patient's symptoms, behavior, and socio demographic characteristics, and factors such as changes in household routine, family or social relations, work, leisure time, and physical health. Subjective burden is the mental health and subjective distress among family members (Ostman and Hansson, 2004). Families of patients with affective disorders experience high levels of caregiver burden (Chakrabarti et al., 1992; Silva et al., 2013).

The clinical diagnosis of almost all mental disorders includes the criterion that "symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning". Although the onset of disorders may not be identified as such by family members, it is still usually the case that relatives and close friends recognize that "something is wrong" with the person affected and they can be influential in decisions to seek

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professional help. The consequences of major depressive disorder extend far beyond the ill individual and are also borne by close family members and friends (Heru and Ryan, 2004; Hinrichsen, 1991; Langa et al., 2004).

In spouses of psychiatric patients suffering from depression, anxiety or schizophrenia, female spouses have prevalence rates for all psychiatric illnesses of 1.8–2.5 times that of male spouses and twice the rate of depressive illnesses (Wittmund et al., 2002). Many caregiver variables have been reported as being significantly related to depression in caregivers, such as the general stress of coping with chronic psychiatric illness (Song et al., 1997) and the grief associated with having a spouse with chronic psychiatric illness (Berg-Weger et al., 2000). The caregiver consequences in affective disorders were found to be strikingly parallel to those in schizophrenia (Grover et al., 2012). Although studies report higher burden in case of schizophrenia, compared to bipolar disorder, major depression and neurotic disorders, it was found that burden was related to specific symptoms and behavior rather than to diagnosis per se. This suggests that psychiatric diagnosis might be of limited value in understanding the relatives experiences (Chakrabarti and Kulhara, 1999; Perlick et al., 1999).

Longitudinal studies of depression and family functioning show that depressed patients with persistent family dysfunction had poorer clinical outcome at 12 months (Keitner et al., 1992). The relationship between poor family functioning and depression is certainly present, but it is unclear if the family dysfunction maintains the depression or if the depression maintains the family dysfunction.

Social support and particularly the emotional support from a close relationship is one important protective factor for mental health problems. Often, but not always, this close relationship is with a spouse/partner or parent. People lacking such a close supportive relationship are at greater risk of anxiety and depression, and while this demonstrates one of the special strengths of family support, it also identifies a possible weakness. When life events or other disadvantages affect several family members simultaneously, this can sometimes undermine the capacity of individuals to support one another. Some families may "pull together" in the face of mutual difficulties while others lose their collective strength (Robinson et al., 2008). Family separation is a special example where support systems that have been in place for a long time, may no longer be sustained or cease to be effective for a family. In these circumstances, family members (including children) may need to seek support from elsewhere.

Depression produces a particular strain on relationships between spouses, children and parents. Studies have shown that 98.3% of the patients of depression live with their families in India compared to 50% in the western countries (Dani and Thienhaus, 1996; Sharma et al., 1998). No doubt, family is a major source of support for psychiatric patients and Indian families show a lot of resilience in caring for their depressed patients but they also do feel significant said or unsaid emotional, financial and physical stress and burden. There is greater co-operation and involvement of family members in treatment decision, career choice and marriage of Indian patients (Heitzman and Worden, 1995).

Research on involvement of care-givers is mostly talked about in chronic schizophrenia (Reine et al., 2003), dementia disorders (Papastavrou et al., 2011) and other older mental patients (Sakuria, 1999) but less in relatively common conditions like depression and obsessive compulsive disorder (Vikas et al., 2009).

2. Aims

This study aims to determine the family caregiver burden associated with unipolar depression. The authors also aim to study the clinical and socio-demographic factors influencing the level of caregiver burden as well as the perceived support by the patient.

3. Materials and methods

This study tested the hypothesis that caregiver burden is significant in unipolar depression and clinical and sociodemographic factors largely determine the family caregiver burden level.

The study was conducted at the Department of Psychiatry in a multispecialty tertiary care government hospital in New Delhi, India between the period of 1st January 2012 and 31st December 2012. After taking approval from the institutional ethical committee, eighty consecutive eligible subjects fulfilling the DSM-IV TR criteria (APA, 2000) for a depressive episode were recruited. Family caregivers included in the study were defined as first degree relatives only.

Exclusion criteria for subjects: (1) any major co-morbid physical illness, (2) substance use disorder (not occasional use), (3) bipolar mood disorder, (4) below 14 or above 60 year old subjects and (5) if the patient was admitted to the inpatient departments during the past 6 months.

Exclusion criteria for care-givers: (1) if the caregiver is less than 18 years old, (2) if the caregiver is not living with the patient for at least 12 months, (3) if the caregiver is suffering from a psychotic disorder.

Informed consent in writing was taken from both the subject and the family caregiver. Clinical history and examination were obtained from the patient and the caregiver. Sociodemographic information like age, sex, education, employment status, income levels, age at marriage and duration of marriage was also documented. Depressed patients in the study were assessed by Hamilton Rating Scale for Depression (HDRS-21) (Hamilton, 1960) at the presentation. They were also assessed by Global Assessment of Functioning Scale (GAF) (Hall, 1995) and Multi-dimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988). MSPSS, which consists of 12 items, was developed to identify the social support factors perceived by the individuals. Each item is rated using a 7 range scale varying between "definitely no" and "definitely yes". The lowest overall scale score is 12, and the highest is 84.

The caregiver burden was assessed using Zarit Burden Interview (ZBI) (Zarit et al., 1980). The Zarit Burden Interview was developed to measure subjective burden among caregivers of adults with dementia. Items were generated based on clinical experience with caregivers and prior studies resulting in a 22-item self-report inventory that examines burden associated with functional/behavioral impairments and the home care situation. The items are worded subjectively, focusing on the affective response of the caregiver. Each question is scored on a 5 point Likert scale ranging from never to nearly always present. Total scores range from 0 (low burden) to 88 (high burden).

Final analysis was done using statistical tests including Chi-Square test, Fischer's exact test, Student's *t*-test, Pearson's correlation coefficient, univariate and multiple regression analysis. *p*-Value <0.05 was considered to denote statistical significance. Non-parametric data was analyzed using Mann–Whitney test. Binomial test was done for test of proportion.

4. Results

The mean ages of the patient and caregiver group were 39.2 years and 49 years respectively (Table 1). Male sex dominated in the patient group ($n = 50$,62.5%) while the caregivers were predominantly females ($n = 46$,57.5%). The caregivers were mostly wives (40%) and husbands (26%) (Tables 1 and 2). 63.6% of the family caregivers had education of more than 10 years and 56% were not working. The ZBI score in the lower middle class was higher (39.4) than the other two classes studied i.e. upper middle class (32.3) and lower class (37). The caregiver burden as measured across the

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