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"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRICILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE& DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."

BY

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ABSTRACT

Caring is a fundamental issue in the treatment of a patient with illness. India being a country of traditions and family values, majority of patients stay with their familiesand this informal caregiveris usually a family member. The abstract of this study "Compare The Caregiver Burden Among The Psychiatric Illness And Medical Illness In Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, Tripura West" concisely summarizes the core content. The study aimed to differentiate the burden of caregivers among the psychiatric illness and medical illness. The objectives of the study were to assess the burden of caregivers among psychiatric illness, to assess the burden of caregivers among medical illness, to compare the caregivers burden among the psychiatric illness and medical illness and to determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables. The conceptual framework used for this study was based on **Sister Callista Roy's Adaptation Model (1976).** Quantitative research approach with descriptive comparative research design was adopted by applying purposive sampling technique among 60 caregivers (30 caregivers of the psychiatric illness and 30 caregivers of medical illness) for this study. Care-givers burden were assessed with socio-demographic proforma and standardized Zarit Burden Interview Schedule. The result showed that,60% caregivers of psychiatric illness had moderate burden and57% caregivers

of medical illness had mild burden.The mean score of caregiver burden among the psychiatric illness and medical illnesswas found to be 49.33 and 39.17 respectively. The mean difference was 10.16 and unpaired 't' value was 3.25 which was found to be significant at the level of $P<0.05$. Analysis of variance (ANOVA) showed that there was significant association between caregiver burden among the psychiatric illness with their selected socio-demographic variablesi.e., marital status, cargivers income and patients occupational status. And also there was significant association between caregiver burden among the medical illness with their selected demographic variables i.e., duration of stay with patients and family income per annum. The other variables showed no significance association. So, finally the study findings concluded that, burden experienced by the caregivers of psychiatric illness was mostly of moderate burden whereas the caregivers of medical illness was mild burden.

CHAPTER -I

INTRODUCTION

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INTRODUCTION

BACKGROUND OF THE STUDY

"Caregiving will never be one-size-fits-all".

-Nancy L. Kriseman

Caregiving is a dynamic process which incudes patient & a person who is involved in long term care of the patient. Caregiver is an individual who has the responsibility of meeting the physical and psychological needs of the dependent patient. Psychiatric patients need assistance or supervision in their daily activities and this often places a major burden on their caregivers, thereby placing the caregiver at a great risk of mental and physical health problems.The term "caregiver burden" is used to describe the physical, emotional and financial toll of providing care. As the disease progresses, it carries with it a tremendous increase of burden on the caregiver who does the caregiving.

The burden upon caregivers for a mentally ill patient living at home was first acknowledged by Grad and Sainbury in the early 1960s.

Many authors opine that the level of burden does not correlate with the duration of illness, but has enough variability with age, gender and educational status. [1]

Sinha V., Anwar Z., Mitra S., Yadav N., (2020): Conducted a cross-sectional study to assess and compare the burden on caregivers of elderly medical and psychiatric patients in a medical college of Northern India. A total of 60 elderly patients and their caregivers (30 patients and 30 caregivers in each group) were included in the study. Burden on the caregivers of elderly psychiatric patients was significantly more than that of caregivers of elderly medical patients and worsens with the deterioration of general health and quality of life of elderly patients and with increasing age and duration of care giving. Proper intervention to reduce the burden among the caregivers of elderly patients, particularly psychiatric patients, should be routinely incorporated for the betterment of both the patients and caregiver.[2]

Mathur S., Chadran S., Kishor M., Prakrihi SN., Rao SS. (2018): Conducted a comparative study to compare the caregiver burden in chronic psychiatric illness and

chronic medical illness & to compare the caregiver efficacy in chronic psychiatric illness and chronic medical illness. The study sample included caregivers of inpatients admitted in a tertiary care hospital in South India. A total of 120 caregivers were included in the study with 60 caregivers from psychiatric ward and medicine ward, respectively. The caregivers were then assessed using the Caregiver Burden Scale and the Revised Caregiver Self-efficacy Scale. Results of the study showed that majority of the caregivers were first-degree relatives and women constituted a major part of the caregiver group. Caregiver burden was significantly higher in psychiatric illnesses compared to medical illnesses. Caregiver efficacy was similar in both study groups.[25]

Viana MC., et al. (2012): Conducted a cross-sectional community survey to assess prevalence & correlates of family caregiver burdens associated with mental & physical conditions worldwide. On that surveys asked 43732 adults residing in 19 countries of the WHO World Mental Health Surveys about chronic physical and mental health conditions of first-degree relatives and associated objective (time, financial) and subjective (distress, embarrassment) burdens. The study result showed that, among the 18.9-40.3% of respondents in high, upper-middle, and low/lower-middle income countries with first-degree relatives having serious health problems, 39.0-39.6% reported burden. A higher burden was reported by women than men, and for care of parents, spouses & children than siblings. The uncompensated labor of family caregivers is associated with substantial objective and subjective burden worldwide.[3]

Ampalan P., Gunturu S., Padma V. (2012): Conducted a study to compare the care giver burden in psychiatric illness and chronic medical illness. The study included 2 groups of caregivers, each of 50 members. Group 1 consisted of caregivers of psychiatric patients and group 2 consisted of caregivers of chronic medical illness patients. The Montogomery Borgotta caregiver burden scale was used to assess the burden in terms of objective, subjective and demand burdens. Among the 100 caregivers 44 were males and 56 were females with an age range of 20-60 years. The study concluded that thecaregiver burden scores in the caregivers of psychiatric patients were significantly higher than that of chronic medical illness ($P< 0.0001$). The caregiver burden was found to increase with the duration of illness as well as with the age of caregiver.[1]

Rezende Souza AL., Guimaraes RA., Barbosa MA.,(2014): Conducted a cross-sectional study to identify the factors associated with the burden of caregivers of family members with mental disorders. A non-probability sampling technique was used to collect the sample from the 3 cities in the south-west region of Goias State, Central Brazil. The participants were 281 caregivers who completed a socio-demographic questionnaire and the Zarit Burden Interview.The mean ZBI score was 27.66. The factors independently associated with caregivers' burden were depression, being over 60 years of age, receiving no help with caregiving ,recent patient crisis, contact days and having other family members needing care. The study concluded that the identified factors that deserve the attention of community services and can guide programs, such as family psycoeducation groups which may help to minimize or prevent the effects of burden on family caregivers responsible for patient's home care.[4]

Behere P. et al. (2020): Conducted a cross-sectional study among 100 primary caregivers and patients who regularly accompanied patients for OPD follow ups for a diagnosis of schizophrenia or depression as per ICD-10 criteria were interviewed over a period of 18 months. It was observed that the primary care givers in case of schizophrenia group were mostly parents (39% vs 17%) & in case of depressive disorders caregivers were mostly spouses (60% vs 34%), which was found to be statistically significant. It was observed that all types of burden scores (both subjective & objective) significantly higher in care givers of schizophrenia group as compared to that of depression except scores of burdens due to effect on physical health of caregiver.[16]

ShahSZH., Tabassum AS., Saeed N. (2016-2017): Conducted a cross-sectional comparative study to assess & compare stress, anxiety & depression in long term caregiversof psychiatric & medical patients at OPD of

Medicine & Psychiatry, Combined Military Hospital, Pakistan.102 caregivers were selected by consecutive sampling. Each participants were interviewed through socio-demographic variables & DASS scale. The study concluded that there is a higher level of depression, stress & anxiety in caregivers of psychiatric patients than in caregivers of medical illnesses.[26]

NEED FOR THE STUDY:

According to the World Health Organization (WHO), more than 400 million people worldwide suffering from mental illness. Many people with chronic medical or mental illness depend on family & friends for support & help. Caring for psychiatric or mental disorders requires tireless effort, energy & emotional investment. A caregiver is a family or non-family member who has been living with & closely involved in daily activities, health care & social interaction of the patient for at least a year.[26]Burden of care can be understood by its impact & effects on caregivers. The early conceptualization of burden of care can be divided into 2 distinct components, objectives & subjectives. Objective burden of care deals with effects on finance , health, routine & leisure of the family whereas subjective burden deals with psychological & emotional impact of mental illness on family members. In addition burden of care can be precise in some upsetting notions such as shame, embarrassment, feelings of guilt & self blame.[27]

Over the past few decades, research has shown that certain factors increase a person's risk for caregiver burden, including social isolation, being female, spending a higher number of hours providing care, depression, financial stress and a lack of choice in being a family caregiver.

According to the Caregiving in the U.S. 2020 Report published by The National Alliance for Caregiving (NAC) and AARP, 36% of family caregivers consider their situation to be highly stressful. Furthermore, nearly half of this high-stress group (49%) provides more than 20 hours of care each week.

According to National Alliance for caregiving & AARP. 2015. About 34.2 million Americans have provided unpaid care to an adult age, or older adults. The majority of the caregivers (82%) care for one other adul, while 15% care for 2 adults, & 3 % for 3 or more adults.[5]

A caregiver helps another person with their medical and personal needs. Unlike a paid healthcare worker, a caregiver has a significant personal relationship with the person in need. Usually the person being cared for is a family member or friend who's chronically ill, has a disabling condition, or is an older adult who can't care for themselves. Being a caregiver for someone we know that love can be very rewarding, but it can also be exhausting and frustrating. It's often emotionally, physically, and mentally draining. It tends to limit their social life and can cause financial problems. Sometimes its may cause Caregiver burnout. It occurs when the stress and burden from these negative effects become overwhelming, negatively affecting their life and health. They may feel alone, unsupported, or unappreciated. They often haven't been taking good care of themselves and may be depressed. Eventually, they can lose interest in caring for themselves and the person they look after.Almost every caregiver experiences burnout at some point. If it does happen and it's not addressed, the caregiver

eventually becomes unable to provide good care. For this reason, caregiver burnout can be harmful to the person receiving care as well as to the caregiver.

According to **Journals of Gerontology (2017).** Caregivers who felt that they were under a lot of strain had poorer health outcomes compared to caregivers who felt little or no strain. General warning signs and symptoms for caregiver burnout include: feeling anxious/ depression or exhausted, avoiding people etc. When it happens, caregiver burnout has both physical and emotional signs and symptoms. Physical signs and symptoms include: body aches and pains, fatigue, frequent headaches,increased or decreased appetite etc.

As burnout progresses and depression and anxiety increase, a caregiver may use alcohol or drugs, especially stimulants, to try to relieve the symptoms.This can lead to impairment, which increases the risk of harm to the person receiving care. It can become a very dangerous situation. A caregiver should stop providing care until they're no longer under the influence of drugs or alcohol.[6]

Based on this above findings the student researcher believes that caregiver ofpatients faces lot of burden while giving care to them. That in terms of physical, mental and financial. These burden can cause potential damage to the caregivers. Eventually this worsen the outcome of the patient. Therefore, the student researcher felt that there is a increase need to assess the caregiver burdenamong all this kind of sick patients caregiver. Moreover there was no similar study found in Tripura State. Hence, the student researcher is interested in conducting research on compare the caregiver burden among the psychiatric illness and medical illness.

STATEMENT OF THE PROBLEM:

"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESSIN TRIPURA MEDICAL COLLEGE& DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."

AIM OF THE STUDY:

Differentiate the burden of caregivers among the psychiatric illness and medical illness.

OBJECTIVES OF THE STUDY:

1. To assess the burden of caregivers among psychiatric illness.
2. To assess the burden of caregivers among medical illness.
3. To compare the caregiversburden among the psychiatric illness and medical illness.
4. To determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables.

ASSUMPTION:

Caregivers may prone to develop some burden while giving care to the patients.

HYPOTHESES:

H_1 : There is a significant difference between caregiver burden among the psychiatric illness and medical illness.

H_2 : There is a significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_3 : There is a significant association between caregiver burden among the medical illness with their selected demographic variables.

OPERATIONAL DEFINITIONS:

Care-givers: It refers to the persons who are giving care to the ill family members/ relatives morethan 6 months.

Caregiver Burden: It refers to the negative consequenceswhich is perceived by the caregivers due to the homecare situation of an ill personfor a long timeand it will be measured by using **ZARIT BURDEN INTERVIEW SCALE.**

Psychiatric illness: It refers to thosewho areattending to the psychiatric OPD or ward for treatment purpose.

Medical illness: It refers to those who areattending to the medicine OPD or ward with medical illness apart from cancer, multiple organ disorders, HIV & AIDS patients.

CONCEPTUAL FRAMEWORK:

Conceptualization is a schematic representation. The conceptual framework provides a certain frame of reference for the clinical practice, research & education. It provides a theoretical approach to the study of the problem that are scientifically based and which lay emphasis on the selection, arrangement & clarification of its concept.

According to **Polit & Hungler (1991)** Conceptual framework is a cohesive, supportive linkage of selected interrelated concepts. It is the device for organizing ideas and in turn bringing order to related object observations, events & experiences. It serves as a guide to research & a spring board for the generation of a research hypothesis.

The conceptual model of a study is a general amalgam of all related concepts in the problem area and provides a contracts frame of reference for the researcher. According to **Treece and Treece (1986)** conceptualization is the forming of ideas, designs & plans. It is process of moving from an abstract idea to a concrete proposal.

The conceptual framework of the present study is based on **Sister Callista Roy's Adaptation Model (1976).** This model is a prominent nursing theory aiming to explain or define the provision of nursing science. In her theory, Roy sees the individual as a set of interrelated systems whose strives to maintain a balance between various stimuli.

The following are the paradigms of Calista Roy's adaptation model:

Person:

According to Roy, humans are holistic beings that are in constant interaction with their environment. Humans use a system of adaption, both in it and acquired, to respond to the environmental stimuli they experience. Human systems can be individuals or groups, such as families, organizations and the whole global community.

In this study, person referred to the caregivers of the psychiatric ill & medically ill patients.

Environment:

The environment is defined as conditions, circumstances and influences that affect the development and behavior of humans as an adaptive system. The environment is a stimulus or input that requires a person to adapt. These stimuli can be positive or negative.

Roy categorized these stimuli as **focal, contextual & residual**. **Focal stimuli** are that which confronts the human system and requires the most attention. **Contextual stimuli** are characterized as the rest of the stimuli that present with the focal stimuli and contribute to its effect. **Residual stimuli** are the additional environmental factors present within the situation, but whose effect is unclear. This can include previous experience with certain stimuli.

In this study, **Focal stimuli** referred tolack of family members support, type of family, relationship, diagnosis of the patient and self care ability of the patient..

Contextual stimuli referred to demographic proforma age, gender, religion, residence, educational qualification of care giver, marital status, occupation of the caregiver,family income (per annum), occupation of the patient, and income of the patient.

And **Residual stimuli** referred to lack of knowledge on patient's disease conditions, less responsible & extra burden.

Health:

Health is defined as the state where humans can continually adapt to stimuli. Because illness is a part of life, health is the result of a process where health and illness can coexist. If a human can continue to adapt holistically, they will be able to maintain health to reach completeness and unity within themselves. If they cannot adapt accordingly the integrity of the person can be affected negatively.

In this study health referred to the level of burden among the caregivers of the psychiatric & medically ill patients.

Nursing:

In adaptation model nurses are facilitators of adaptation. They assess the persons behavior for adoption, promote positive adaptation by enhancing environment interactions and helping caregivers react positively to stimuli. Nurses eliminate ineffective coping mechanisms and eventually lead to better outcomes.

In the study, nursing referred to compare the caregivers burden among the psychiatric illness & medical illness with the help of standardized**Zarit Burden Interview Scale.**

Interaction capsulate:

Interaction capsulate is divided into two parts: control processes and effectors.

Control processes:

Regulator: The regulator subsystem is a person's physiological coping mechanism. It is the body's attempt to adapt via regulation of our bodily processes, including neurochemical and endocrine systems.

Cognator: the cognator subsystem is a person's mental coping mechanism. A person uses his brain to cope via self concept, interdependence and role function adaptive modes.

In this study, control process is divided into two parts: development of socio demographic proforma and standardized zarit burden interview scale to assess the caregivers burden among the psychiatric illness& medically illness .

Effectors:

The four adaptive modes of the subsystem are how the regulator and cognator mechanisms are manifested, in other words they are the external expressions of the above and internal processes.

Physiological-physical mode:

Physical and chemical processes involved in the function and activities of living organisms. These are the actual process put in motion by the regulator subsystem.

The basic need of this mode is composed of the needs associated with oxygenation, nutrition, elimination, activity and rest and protection. The complex processes of this mode are associated with the senses, fluid and electrolytes, neurologic function and endocrine function.

In this study, physiological- physical mode referred to,duration of illness, duration of stay with patient & tiredness.

Self- concept group identity mode:

In this mode, the goal of coping is to have a sense of unity, meaning the purposefulness in the universe, as well as a sense of identity, integrity. This includes body image & self ideals.

In this study, self- concept group identity mode referred to family income, less social interaction, affect of personal work and future problem.

Interpersonal relationship mode:

The mode focuses on attaining relational integrity through the giving and receiving of love, respect and value. This is achieved with effective communication and relations.

In this study, this mode referred to, affect of personal relationship &social detachment.

Role function mode:

This mode focuses on the primary, secondary and tertiary roles that a person occupies in society and knowing where he or she stands as a member of society.

In this study, this mode referred to, taking care of the ill person as well as other family members, patient expect more care from caregiver & lost control over their life.

Adaptation or output:

Adaptation is the process and outcome whereby thinking and feeling persons as individuals or in groups use conscious awareness and choice to create human and environmental integration.

In this study, output referred to level of burden response i.e., little or no burden, mild burden, moderate burden and severe burden among caregivers of psychiatric illness & medical illness.

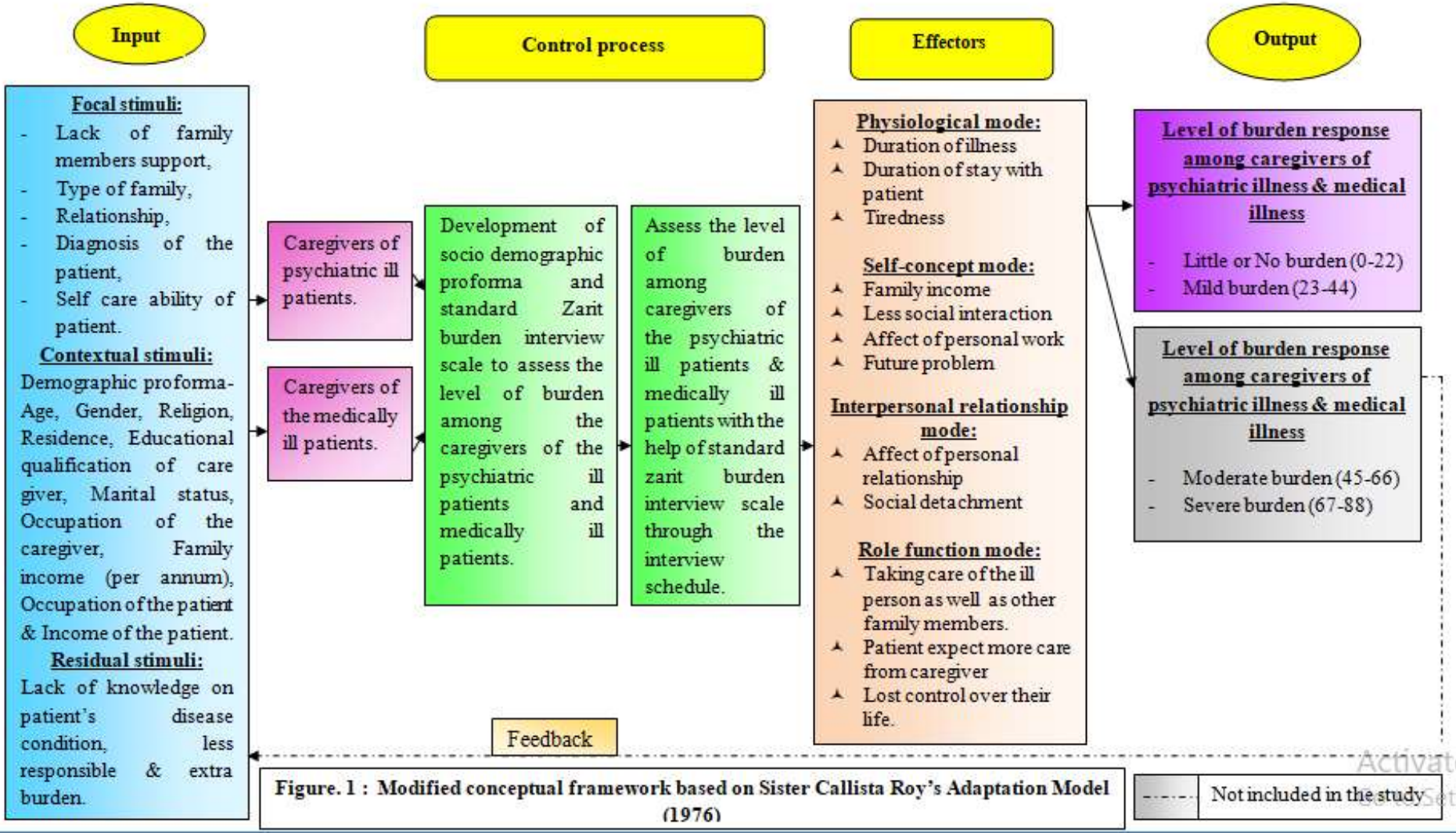


Figure. 1 : Modified conceptual framework based on Sister Callista Roy's Adaptation Model (1976)

DELIMITATION:

The study is delimited to:

The caregivers of the psychiatric ill patients & medically ill patients who visit psychiatric & medicine OPD and admitted in the ward, at Tripura Medical College & Dr. BRAM Teaching Hospital, Hapania, Agartala, Tripura West.

SUMMARY: This chapter dealt with introduction of the study which includes background of the study where discuss about the caregiver burden in India and whole world. it also included need of the study, statement of the study,aims, objectives, variables , operational definition of variables, assumption, hypothesis and delimitation of the study.

CHAPTER -II

REVIEW OF LITERATURE

CHAPTER-II

REVIEW OF LITERATURE

The review of literature is traditionally considered as a systematic critical review of the most important published scholarly literature on a particular topic.

According to **American Nurses Association (ANA), (2000),** "A literature review is a body of text that aims to review the critical points of knowledge on a particular topic of research".

Section A: Studies related to incidence and prevalence of caregiver burden.

Section B: Studies related to level of caregiver burden.

Section C: Studies related to comparison the burden between psychiatric and medical caregivers.

(Section A): Studies related to prevalence of caregiver burden.

Natalia Henao Piedrahita (2021): Conducted a descriptive cross- sectional observational study to define the caregiver burden syndrome prevalence among formal caregivers of mentally ill dependent patients at Clinica Del Orienta, Colombia. In which 53 caregivers were analysed by a survey with socio-demographic, clinical and work related variables and the Zarit Burden Interview. Among them 20.8% had the syndrome, 17% had mild burden and 3.8% had severe burden. At last the study concluded that the prevalence of caregivers burden syndrome in formal caregivers was lower than found in studies on informal caregivers.[8]

Cham CQ.,et al.,(2022): Conducted a systematic review & meta analysis aimed to investigating the former's caregiver burden and determine its prevalence. An open search, without filters, was conducted. Articles were selected from Medline, Scopus, and PubMed from inception to 30 April 2022 using the PRISMA protocol. Subgroup analyses examined the between-group differences by study setting, measurements used, and disorder type. A total of 5034 caregivers from 23 countries were included in this review. Among the thirty-nine studies, twenty-six were deemed eligible for meta-analysis. The overall pooled prevalence of caregiver burden among caregivers of individuals with mental illness was 31.67%. Pooled prevalence was the highest among care recipients receiving treatment in a hospital setting (36.06%) followed by the community and clinic settings. Caregiver prevalence values were higher for burden measured using the Zarit Burden Interview (38.05%); compared with other instruments, and for carers of care recipients with psychosis (35.88%); compared with those without.[15]

Ranjan LK.,Gupta PR., Kiran M., Singh NK (2022): Conducted a cross- sectional study to assess the relationship between family care burden & psychological distress among caregivers of chronic patients with

schizophrenia at the out-patient department of the Central Institute of Mental Health & Neurosciences, Chhattisgarh, India. A total of 260 samples were selected through a purposive sampling technique. Socio-demographics, burden assessment schedule & depression, anxiety and stress scale were all part of the interview.The study results showed that (70.8%) people perceived high level of care burden , 59.2% reported a severe level of stress, 56.2% reported anxiety & 48.5% reported depressionamong caregivers of chronic patients with schizophrenia. The study concluded the high prevalence of care burden which strongly contributes to psychological distress.[28]

Liu S et al.(2017): Conducted a quantitative cross sectional study to evaluate caregiver burden and factors that influence this burden among caregivers and patients with Alzheimer's disease in China. Sample size-309 caregivers and their patients included in the study. The patient's cognitive, psychological and functional status and their caregivers burden , sleep quality and mental state were evaluated. Descriptive analyses, single factor regression and stepwise factor regression were used to determine the effects of various factors on caregiver burden. The study resulted a lower functional status of the patient was associated with higher care burden. The study concluded that caregiver burden was related to the severity of the patient's dementia and the personal factors of the caregiver.[9]

Rahmani F. et al.(2022): Conducted a cross-sectional study among the 215 caregivers who were recruited from the OPD clinics which was affiliated by a tertiary referral psychiatric hospital in Iran. To select the sample convenient sampling technique was used.And the caregiving burden was measured by the Zarit Burden Interview (ZBI-22) and associations between caregiving burden and potential factors were examined using multiple regression analysis. The STROBE checklist used to report the results.The study resulted that the family caregivers of the patient's with schizophrenia reported a high level of caregiving burden, with 38.2% of caregivers perceiving severe burden relating to their role. And the regression model explained54.4 % of the variance having caregiving burden.[10]

Nenobais A., Jatimi A., Jufriyanto M. (2019): Conducted a systematic review aims to identify and summarize the main focus based on the scientific evidence about family burden as the caregivers of people with mental disorders. The databases used were Scopus, Science Direct and Sage Journal with the keywords 'burden', 'family', 'caregiver', 'mental', 'health', 'illness', 'disorder' and they were limited to 2014 – 2018 from within nursing and health science journals. 104 full text articles were reviewed. The 14 articles that fulfilled the inclusion criteria were analyzed using narrative synthesis followed the Joanna Briggs Methodology model. The results showed that seven main themes were found to be related to family burden as the caregivers of a family member with mental disorders. These were knowledge, emotional burden, physical burden, medication, financial burden, social burden, health services and government support. The findings suggest that the family burden on the caregivers was diverse and that this has an effect on the ability of the family to care for patients with mental disorders. Family burden has become an important indicator for the provision of mental health services.[17]

(Section B): Studies related to level of caregiver burden.

H. Balubiad, et al.(2016): Conducted a cross-sectional study among 150 adult caregivers of patients with chronic illnesses in 3 tertiarymedical centers in Riyadh, to addresses different aspects of burden placed on caregivers of chronicolder patients. In this study, consecutive sampling technique was used and participants wereinterviewed by using an Arabic version of the Montgomery Borgatta Burden Measure Scale. The scale measures theSubjective (SB), Objective (OB) and Stress Burden (StB).The results showed that the SB, OB and StB were found to be mild in the sampled population (7.7±3.7, 14.2±3.4,and 9.05±4.2) respectively, compared to reference values (13.5, 23 and 15) of high burden. The StB was found tobe higher in females than in males (9.86±4.56 vs. 8.44±3.89 respectively, p=0.041). Furthermore, nurses were found to have a greater SB compared to relatives (11.4 ±5.29 vs. 7.58±3.34 respectively, p=0.002). Analysis alsoshowed that the caregivers who were employed elsewhere had lower StB, and OB (p=0.004, and 0.034,respectively). No other associations were found. The study concluded that, caregivers of chronically ill patients experienced a distinct level of burden while providing care. Socio-demographic factors were predictors of the level of burden.[12]

Ajibade B.L., et al. (2016): Conducted a descriptive study to assess the burden of family care givers of patients with mental disorders in Ekiti states. In this study, 138 respondents as sample size using Leshie Kish formula. Apart from the demographic information designed by the researchers, three (3) standardized instruments were used to collect information from the respondents. General Health Questionnaire (GHQ) and Zarit Burden Inventory (ZBI) were used to collect information from the family caregivers. The result revealed 37.0% of the respondents' experienced mild burden while 31.1% experienced moderate burden. High burden was associated with the amount of time spent caring for the relative, finance and trying to meet other responsibilities. The study was concluded that majority of family care-givers experienced a considerable amount of burden and therefore a coping mechanism should be made available by nurses.[18]

Stanley S., Bhuvaneswari GM., & Bhakyalakshmi S.: Conducted a quantitative study used survey methodology to assess caregiving burden in 50 spouses of persons diagnosed with a psychotic illness. Data was collected at a neuro-psychiatric facility in Tiruchirappalli, India. The Depression, Anxiety and Stress Scale and the Burden Assessment Schedule were the instruments administered to assess the mental health status of the spouse and their perceived burden. Findings revealed that the majority of spouses of the respondants were placed were paranoid schizophrenia (38%), chronic schizophrena (26%) and depression (20%), the other categories being BPAD and delusional disorder (8% each).[23]

SC Walke,V. Chandrasekaran and SS Manya (2016): Conducted a cross-sectional study to assess the burden of caregivers of mentally ill individuals and their coping mechanisms, in Udupi, Karnataka. Aconvenient sample of 320 caregivers was taken from 2 private tertiary care centres and 1 public secondary care centre.The study

was conducted by using the Burden Assessment Scale (BAS) and Brief Corps Scale(BCS).In which according to BAS, severe burden accounted for 40.9% and moderate for 59.1%. The highest amount of burden was seen in the areas of physical and mental health, spouse related and in the areas of external support. The BCS showed that the most frequently used coping styles were practicing religion, active coping and planning.In last the study concluded that caregivers of the mentally ill individuals do undergo a lot of burden.[11]

Ignatova D., Kamusheva M., Petrova G., Onchev G.,(2015-16): Conducted a cross-sectional retrospective observational study to examine the burden of informal caregiving for individuals with schizophrenia and affective disorders prior to hospital admission in Bulgaria. The objective and subjective consequences of providing informal care are evaluated with the Burden Assessment Scale (BAS) as a primary outcome measure. The study result showed that 117 individuals with mental disorder and 117 caregivers are evaluated, dichotomized in two groups according to the patient's diagnosis. The mean score on the BAS is 44.7 (SD=11.0) in schizophrenia and 42.0 (SD=12.8) in affective disorder respectively, p=.221. The study concluded that the caregivers of individuals with schizophrenia and affective disorders experience considerable objective and subjective burden.[19]

Dr. Gupta P, Bharti P., Bathla M., Singh AH., Bhusri L. (2020): Conducted a cross-sectional study to assess the socio-demographic profile, the caregiver burden and quality of life of the caregivers of the patients with different psychiatric illness. Also, to compare the burden and quality of life among caregivers of different psychiatric groups. On that study 120 caregivers of patients with psychiatric illnesses were included; divided into four groups (30 each): Anxiety, psychotic, mood and substance use disorders. After the consent, Zarit burden interview, socio demographic profile and quality of life -10 scales were used to assess the objectives. The results revealed that maximum caregivers were males, and spouses in relation with the patient. Most of them were married and educated. Maximum had mild to moderate level of burden (49.1%), followed by moderate to severe level of burden in about 22.5% caregivers. Significant association was seen with the burden level. But no significant association was seen with the quality of life. The study concluded that the caregivers of the psychiatric patients have to suffer a lot and may land up into the psychiatric symptoms themselves.[22]

Dr. Bora K., Dr. Das A. (2017): Conducted a hospital based cross-sectional study in the Department of Psychiatry, Assam MedicaI College and Hospital with a sample size of 30 primary caregivers of equal number of patients of Chronic Schizophrenia and 30 Primary caregivers of equal number of Bipolar Affective Disorder patients. The primary objectives of the study were to assess burden of Caregiver of Chronic Schizophrenia, to assess burden of Caregiver of Bipolar Affective Disorder, make a comparison between these two and to assess the relationship of burden of the caregiver with the global assessment of functioning of patients of Chronic Schizophrenia and Bipolar Affective Disorder.Results showed that the caregivers of Chronic Schizophrenia experienced significantly higher burden than the caregivers of BPAD. The study concluded that the chronic

nature of Schizophrenia puts more burden on the family. A stronger positive correlation between caregiver's burden and level of impairment in functioning is seen in case of Chronic Schizophrenia compared to BPAD.[24]

(Section C):Studies related to comparison the burden between psychiatric and medical caregivers.

H.JB., Rani VN(2016): Conducted a study to compare the caregiver burden in psychiatric illness & chronic medical illness in Aditya multispecialty hospital & GCS hospital & Research Centre at Ahmedabad. The sample size was 100(50 suffering from psychiatric illness, 50 suffering from chronic medical illness) were selected. The research design adopted was non-experimental comparative research design. Caregiver burden was evaluate by using Montegomery Borgatta Burden Scale. The study findings showed that, t- test value was 2.36 (O.B), 3.17 (D.B), 6.65 (S.B). degree of freedom =98 at 0.05 significant level where the table value is 1.9845. the study concluded that caregivers of psychiatric illness were having more burden than chronic medical illness.[28]

Mital AK., Sabnis SG., Kulkarni VV.(2017): Conducted a cross sectional analytical descriptive study among the caregivers of chronically medically and psychiatrically ill patients. Total 100 caregivers of patients (50 each) were taken from the medicine and psychiatry departments of a tertiary municipal medical college. The data was collected by using caregiver's burden scale and were analyzed by SPSS 20 statistical software and pearson correlation coefficient tests. Association was tested by using relative deviate 'Z' of SEDM test at 5% level of significance. The study concluded that caregivers whose patients are psychiatrically ill experience more burden as compared their counterparts from the medicine department.[21]

Kunwar D. et. al., Conducted a analytical cross-sectional study to assess the caregiver burden in families with psychiatric illness and to find association between socio-demographic variables and caregiver burden in families with psychiatric illness. The 96 caregivers of patients visiting outpatient department of two government of Nepal primary health care centers namely, Panchkhal Primary Health Care Center (PHC) Kavre District and Barhabise Health Care Center Sindhupal chowk district. The study result revealed that the majority of the caregivers (56.3 %) were females. Most of the caregivers (54.2%) were aged below 45 years. The large number of participants (74%) were single or separated. The subjective burden was reported in 95%. There were significant differential demographic associations with different domains of caregivers' burden. [20]

SUMMARY: This chapter dealt with the review of literature related to the present study. There are three sections. **Section- A**consists of studies related to prevalence of caregiver burden, **Section- B** consists of studies related to level of caregiver burden and **Section- C**consists of studies related to compare the burden between psychiatric and medical caregivers. The above studies support the researcher for the present study.

CHAPTER -III

RESEARCH METHODOLOGY

CHAPTER-III

RESEARCH METHODOLOGY

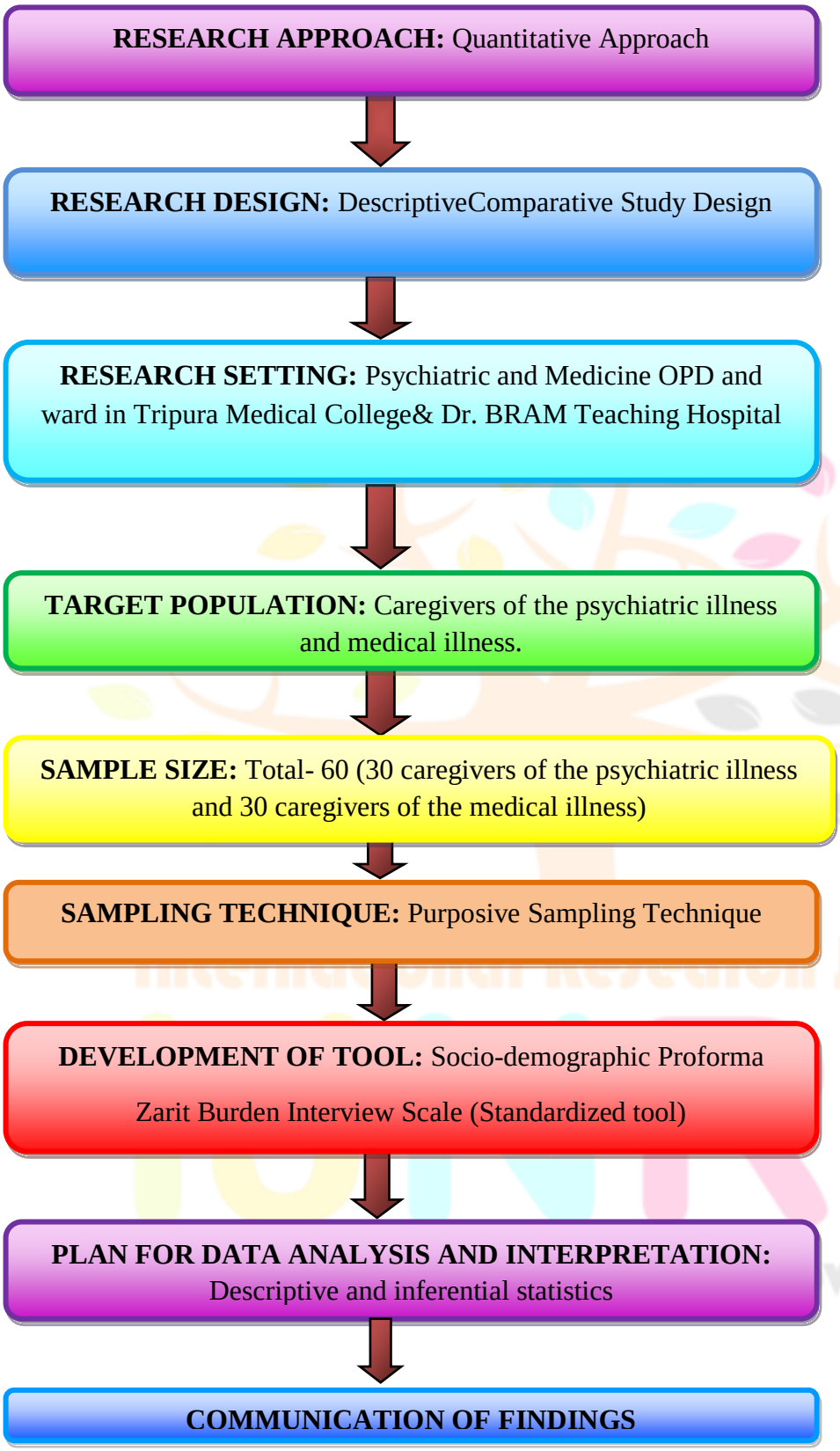


Figure.2 : Schematic representation of research methodology

RESEARCH METHODOLOGY

Research methodology is a way to systematically solve the research problem. It consists of the various steps that are generally adopted by aresearcher in studying the problem along with the logic behind them. The methodology of research indicates the general pattern of organizing the procedure for gathering valid and reliable data for the purpose of the study.[29]It includes the research approach, research design,research variables,research settings, target population, sample and sampling technique, criteria for selection of sample, selection & development of tool, description of tool, validity & reliability of tool, data collection method & plan for data analysis.

RESEARCH APPROACH

The selection of research approach is a basic procedure for collecting data.

According to **Treece & Treece (1996)** Research approach is the umbrella that covers the basic procedure for conducting research. The research approach refers to a general set of orderly disciplined procedure used to acquire dependent anduseful information.[29]

Quantitative research approach was used in this research study.

RESEARCH DESIGN

Research design can be defined as blue print to conduct research study, which involves the description of research approach, study setting, sample size,sampling techniques,tools and methods of data collection and analysis to answer is a specific research question or for testing research hypotheses. [31]

The selection of research design depends on the purpose of the study, research approach and variables under the study.

The Research Design adopted for this study was descriptive comparative study design. A descriptive comparative design was used to compare the caregiver burden among the psychiatric illness & medical illness inTripura Medical College& Dr. BRAM Teaching Hospital, Agartala, Tripura West."

VARIABLES UNDER STUDY

Variable is a content that has measurable changing attributes. Variables are qualities, properties, or characteristics of persons, things, or situation that change or vary. **Chinn and Kramer** stated that variables are concepts at different level of abstraction that are concisely defined to promote their measurement or manipulation within study.[31]

Δ **Research Variables:** In the present study, research variables include caregivers burden among the psychiatric and medical illness.

Δ **Demographic Variables:** In this study, socio-demographic variables refer to baseline data of caregivers such asage, gender, religion, place of the residence, educational qualification of care giver, marital status, occupation of the caregiver, income of the caregiver, type of family, no. of family members, type of relationship with patient, duration of stay with patient, relation of person who bearing the financial responsibility of the patient & his/her income in rupees per annum, age of the patient, diagnosis of the patient, self careability of the patient, duration of illness, occupation of the patient, income of the patient, patient receives any type of financial benefit from other sources : (Yes/No)- If Yes, mention the sources,

RESEARCH SETTING

Research setting refers to the physical location and condition in which the data collection takes place in the study.[31]

The final study was conducted in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, West Tripura.

TARGET POPULATION

According to **Polit & Beck**, Population means the entire aggregation of cases that meet a designed set of criteria.[31]

In the present study, target population were caregivers of the psychiatric illnessand medical illness.

SAMPLE

According to **Polit & Huugler (1999),** "A sample is a small proportion of population of selected for observation & analysis."[32]

In this study sample was caregivers among the psychiatric illness & medical illness in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, Tripura West.

SAMPLING TECHNIQUE

According to **Sharma SK,** "Sampling technique is the process of selecting a representative unit from an entire population of a study."[31]

In present study the sample was drawn by purposive sampling technique.

SAMPLE SIZE

The sample size refers to the population that is selected for the study. In present study sample size was total 60 caregivers (30 caregivers of the psychiatric illness and 30 caregivers of the medical illness).

CRITERIA FOR SAMPLE COLLECTION

- **INCLUSION CRITERIA:**

1. Age of caregivers is more than 18 years of the both sexes.

2. Caregiver staying with the patient more than 6 months in both group.

3. Duration of illness should be more than 6 months in both group.

4. Caregivers of cardiac diseases, respiratory disorders, neurological disorder, musculoskeletal disorders, renal diseases, endocrine diseases & autoimmune disorders.

5. Caregivers who are able to read and understand the English,Bengali& Kokboroklanguage.

- **EXCLUSION CRITERIA:**

1. Not willing to participate.
2. Paid caregivers.
3. Multiple caregivers.
4. Caregivers of cancer, multiple organ disorder, HIV & AIDS patients.

SELECTION & DEVELOPMENT OF TOOLS

Treece EW, Treece JW (1986) stated that the instrument selected in research should be the vehicle that would best obtain the datafor drawing a conclusionpertaining to the study and add to the study of the knowledge in the discipline. An instrument in research refers to the tool or equipment used for collecting data from the population for drawing conclusion pertinent to the study.[33]

A. Selection of the tool:

Socio-demographic data and Zarit Burden interview schedule were selected for the study to collect the data from the caregivers of the psychiatric illness & medical illness and to compare their burden level. It was considered to be the appropriate tool for the present study.

B. Development of the tool:

Tools were prepared on the basis of the objectives of the study. The tool was developed by the investigator based on her personal and professional experience. The related literature was reviewed from books, journals, periodicals, unpublished research studies and mass education media and tool developed was refined and validated by subject experts and guide.

Standardized Zarit Burden Interview Schedule were used to assess the burden among caregivers of the psychiatric illness & medical illness.

The following steps were carried out in preparing the socio-demographic data:

-Reviewof literature

-Preparation of the socio-demographic data

-Based on experts opinion

-Establishment of validity

DESCRIPTION OF THE TOOLS

The data collection tool was partitioned into 2 parts described below:

Part-I (Socio-Demographic Data) The researcher designed the socio-demographic data collection sheet into 2 separate area to collect information from the caregivers & patients respectively. The first area consists of 13 items regarding the demographic information of the caregivers such as: age, gender, religion, place of the residence, educational qualification of caregiver, marital status, occupation of the caregiver, income of the caregiver, type of family, no. of the family members, type of relationship with patient, duration of stay with patient, relationship of person who bearing the financial responsibility of the patient & his/her income in rupees per annum.

The second area consists of 07 items related to the information of the patient such as: age of the patient, diagnosis of the patient, self care ability of the patient, duration of illness, occupation of the patient, income of the patient, patient receives any type of financial benefit from other sources: (yes/no)- If yes, mention the sources.

Part.II: (Zarit Burden Interview Scale): The Zarit Burden Interview (ZBI), by Zarit & Zarit (1987) is a 22-item questionnaire designed to measure the level of burden experienced by caregivers of patients with chronic illnesses. Each item requires a response on a 5-point Likert scale: 'Never'; 'Rarely'; 'Sometimes'; 'Quite frequently' and 'Nearly always'; with a score of 0,1,2,3 and 4 respectively. Total scores range from 0 to 88 and the level of burden are graded as: 0-22 points= no burden, 23-44 points=mild burden,45-66points= moderate burden and 67-88 points=severe burden.[30] [18]

VALIDITY OF TOOLS

Content validity of the tool was established by requesting seven experts from different institutions to go through the developed tool and give their valuable suggestions regarding the relevance, adequacy and appropriateness of items in the tool. The suggestions of expert were incorporated in the tool was further modified and finalized with experts opinionand with consultation of guide.

The prepared tool was established obtaining the suggestions from the experts.

Experts were requested through principal incharge to issue content validity certificate.

The tool was validated with the criteria checklist from the seven experts. The experts include, 4 (four) Mental health nursing specialist, 1 (one)- Psychiatrist, 1(one)-Clinical psychologist, 1 (one)- Psychiatric social worker. The tool was modified as per their recommendation discussing with guide & co-guide.

The tools were modified as follows:

Tool-I: Socio-Demographic data

-Item no.2,11- options were added
-Item no. 7,18 options were modified
-Item no.12 Age of the patient categories were modified to Age of the patients were open ended.
-Item no. 7,13, 19,20 were added.

RELIABILITY OF TOOLS

"Reliability is the degree of consistency and accuracy with which an instrument measures the attribute for which it is designed to measure."

According to the original paper of this ZBI tool the items had a Cronbach's alpha value of 0.93 and a test retest reliability of 0.8924. [30] [18]

ETHICAL PERMISSION, ADMINISTRATIVE PERMISSIONS

The permission was obtained from:

1. The Research Committee of Tripura College of Nursing, Hapania, Agartala, TripuraWest.

2. The Institutional Ethics Committee (IEC), Tripura Medical College and Dr. BRAM Teaching Hospital, Agartala, TripuraWest.

3.The authority of Tripura Medical College and Dr. BRAM Teaching Hospital, Agartala, TripuraWest.

4. And inform consent was taken from each sample before collecting the data.

PILOT STUDY

According to **Sharma SK**, Pilot study is a smaller version of a study carried out before the actual investigation is done.

The pilot study was conducted in the private chambers of General physician Dr. Dipankar Prakash Bhaumik & Psychiatrist Dr. Shantanu Ghosh's clinic with their written prior permission. Total 20 (10+10) caregivers were taken from the both group. Subjects were taken by using purposive sampling technique. The data collection period was from 4th April to 9th April,2023.

THE FINDINGS OF THE PILOT STUDY

- 10% of psychiatric caregivers were having severe burden, maximun i.e., 70% were having moderate level of burden &20% were having mild burden.

Whereas, 20% of medical caregivers were havingmoderate burden,majority i.e,70% were having mild burden, 10% were having little or no burden.

- The mean score of the level of burden among the psychiatric caregivers was 51.5, median 52, SD was 8.20. Incase of the medical caregivers the mean score of the level of burden 37.5, median 34.5 & SD 9.86. The mean difference was 14.

- There was significant difference between caregiver burden among the psychiatric illness and medical illness. Calculated unpaired 't' value=3.45* &tabulated 't' value= 2.10, degree of freedom=18, at 0.05 level of significance. This indicates that null hypothesis (H_{01}) was rejected & research hypothesis was accepted.

- ANOVA was used to determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables.There was no significant association between the burden level of the psychiatric caregivers with their selected socio-demographic variables. Therefore the null hypothesis is accepted (H_{02})&research hypothesis (H_2) is rejected.

- There is a significant association between the burden level of the medical caregivers with occupational status of the caregivers. Calculated f value=6.95 at df=3 (tabulated f value=4.35) at 0.05 level of significance. Therefore theresearch hypothesis is accepted& null hypothesis is rejected.

PROCEDURE FOR DATA COLLECTION

Formal administrative permission was sought from the Research Committee & the Institutional Ethics Committee (IEC). The main study was conducted after obtaining written permission from theMedical Superintendent of Tripura Medical College and Dr. BRAM Teaching Hospital, Agartala, Tripura West. Data

collected from Data collected from 4th May-21st May, 2023 from 9am-4pm.At first choose the sample by purposive sampling technique. After that, the purpose of the study was explained to them and informed consent was obtained from each participant prior to the interview. Face to face interview was conducted by maintaining privacy & confidentiality of each participant throughout the study. .

TABLE-1: DATA COLLECTION TOOLS AND TECHNIQUES

SL NO.	TOOLS	TECHNIQUES
I.	Socio-Demographic data	Interview Schedule method
II.	Standardized Zarit Burden Interview Scale	Interview Schedule method

PLAN FOR DATA ANALYSIS

The collected data was analyzed by using descriptive and inferential statistics.

Descriptive statistics:

★ Collected data was arranged in a master sheet.

★ The description of demographic data was presented in terms of frequency and percentage.

★ Mean, median, standard deviation were used to assess the caregivers burden among psychiatric illness & medical illness.

★ Result was represented in the tables and graphs.

Inferential statistics:

★ Unpaired 't' test was used to compare the caregivers burden among psychiatric illness & medical illness.

★ Anslysis of Variance (ANOVA) was used to determine the association between the caregiver burden with their selected socio-demographic variables.

★ The analyzed data was represented in the graphs.

SUMMARY: The chapter deals with the description of research methodology and different steps, which were undertaken for organizing data for the investigation. It includes description of research approach, research design, variables under study, the setting of the study, target population,sample size and sampling technique, criteria for selection of sample, selection and development of the tool,description of tools, validity, reliability of tool, pilot study, procedure for data collection and plan for data analysis. So it is the mirror of the research, shows how the investigator utilized the research steps and methods to carry out the study.

CHAPTER -IV

ANALYSIS & INTERPRETATION

CHAPTER-IV

"Data is the new science.

Big data holds the answers."

-Pat Gelsinger

Analysis and interpretation of data is the most important phase of the research process, which involves the computation of the certain measures along with searching for patterns of relationship that exists among the data groups. Analysis and interpretation of data includes data compilation, editing, classification an presentation of data.

The chapter deals with the analysis and interpretation of the data collected from the 60 caregivers using demographic variables & zarit burden interview schedule to compare the caregiver burden among psychiatric illness & medical illness in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala , Tripura West.

In order to interpret the data in a logical order both the descriptive and inferential statistics were used. Analysis and interpretation of data was done as per objectives and hypotheses of the study.

The analysis based on the following objectives:

1. To assess the burden of caregivers among psychiatric illness.
2. To assess the burden of caregivers among medical illness.
3. To compare the caregivers burden among the psychiatric illness and medical illness.
4. To determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables.

HYPOTHESES:

The following hypotheses was tested at 0.05 level of significance.

H_1: There is a significant difference between caregiver burden among the psychiatric illness and medical illness.

H_2: There is a significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_3: There is a significant association between caregiver burden among the medical illness with their selected demographic variables.

NULL HYPOTHESES:

H_{01}: There is no significant difference between caregiver burden among the psychiatric illness and medical illness.

H_{02}: There is no significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_{03}: There is no significant association between caregiver burden among the medical illness with their selected demographic variables.

ORGANIZATION AND PRESENTATION OF DATA:

The obtained data were organized in the master sheet for tabulation, statistically analyzed and interpreted by using descriptive and inferential statistics. The data is presented under the following sections:

- **Section-I :**Findings related to analysis of socio-demographic variables among the caregivers of the psychiatric illness & medical illness.
- **Section-II:**Findings related to compare the caregiver burden among the psychiatric illness & medical illness.
- **Section-III :**Findings related to association between caregiver burden among the psychiatric illness & medical illness with their selected socio-demographic variables.

Section-I:Findings related to analysis of socio-demographic variables among the caregivers of the psychiatric illness & medical illness.

The section deals with the socio-demographic data of the caregivers. Frequency and percentage were computed for describing the sample characteristics. Summary of sample characteristics were presented in figures:

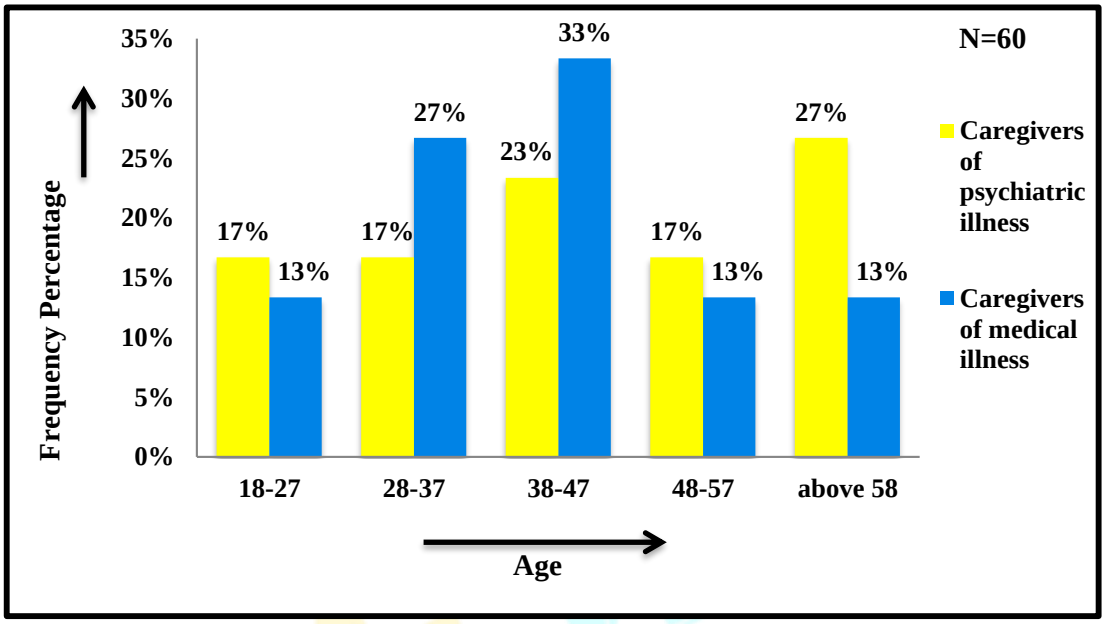


Figure. 3: Bar graph showing age wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph revealed that, among caregivers of psychiatric illness maximum 27% were belongs to above 58 years of age group, 23% were from 38-47 years of age group and 17% were from 18-27 years,28-37 years and 48-57 years in each group. In case of the caregivers of medical illness most of them (33%) werebelongs to 38-47 years, 27% were from 28-37 years and 13% were from18-27 years,48-57 years and above 58 years in each age group.

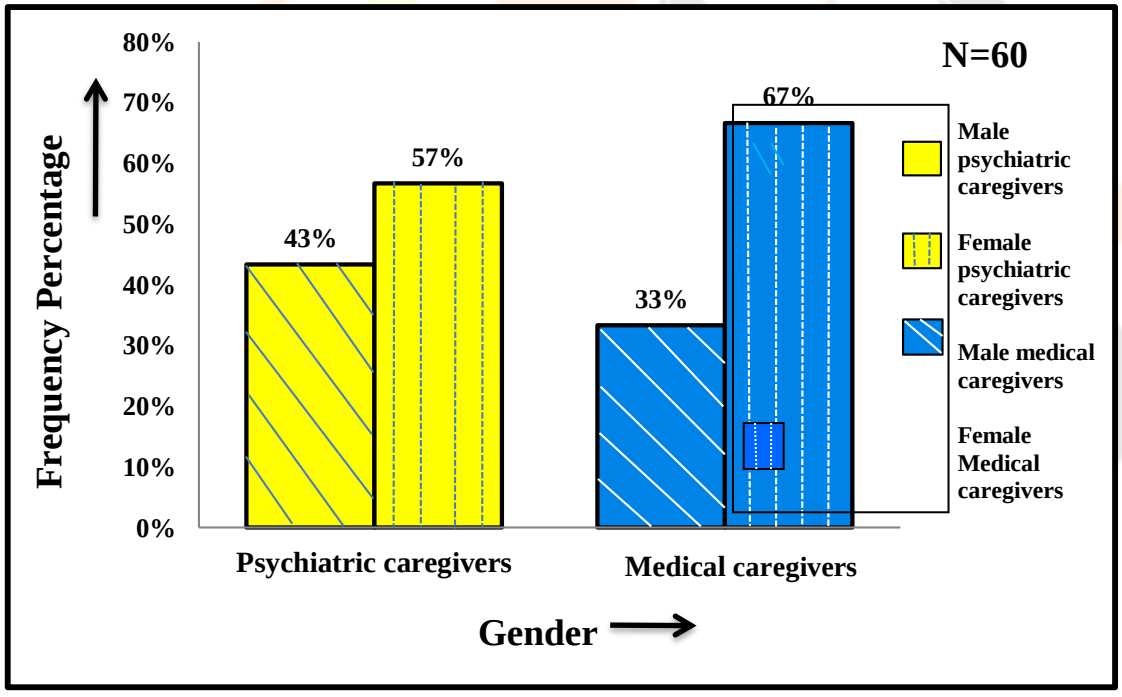


Figure. 4: Bar graph showing gender wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph represented that, in psychiatric illness 57% were female and 43% were male caregivers. Whereas, in medical illness, 67% were female and 33% were male caregivers.

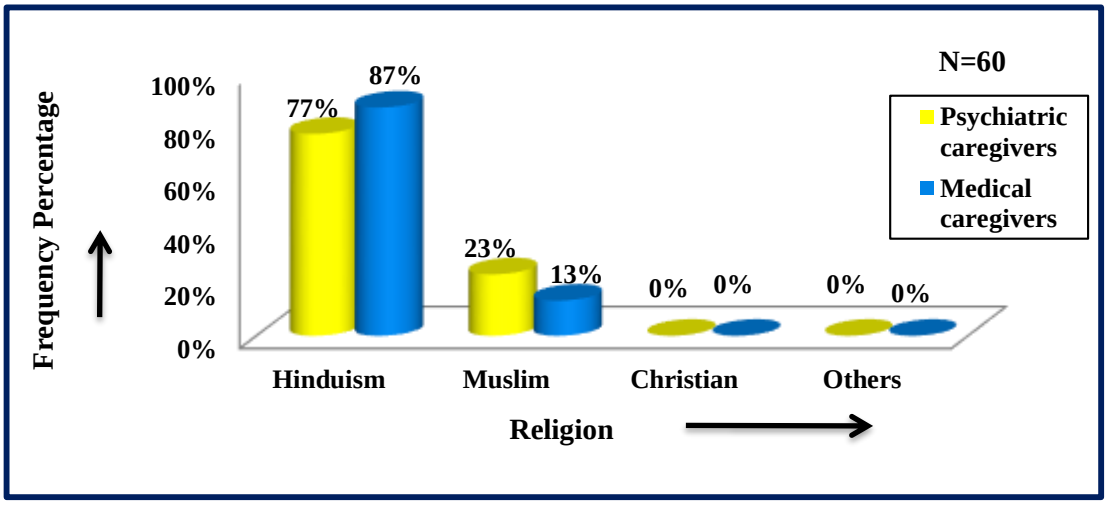


Figure. 5:Cylinder graph showing religion wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph showed that,among the caregivers of psychiatric illness, 77% were belongs to the Hindu community and 23% were belongs to the Muslim community. Whereas in medical illness most of them, 87% were belongs to the Hindu community and 13% were belongs to the Muslim community. There were no one belongs to the both group of other community like Christian and others.

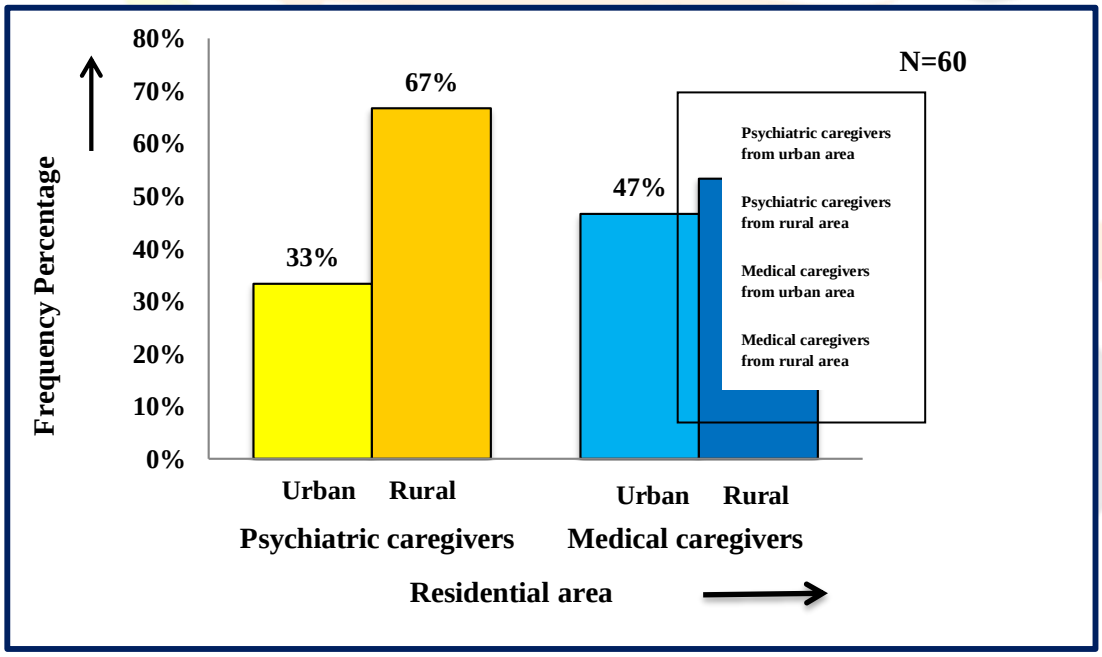


Figure. 6:Bar graph showing residential areawise frequency percentage distribution of caregivers of psychiatric illness &medical illness.

It indicates that, majority of caregiversof psychiatric illness, 67% were fromrural area and 33% were from urban area&incase of caregivers of medical illness,53% were from rural area&47% were from the urban area.

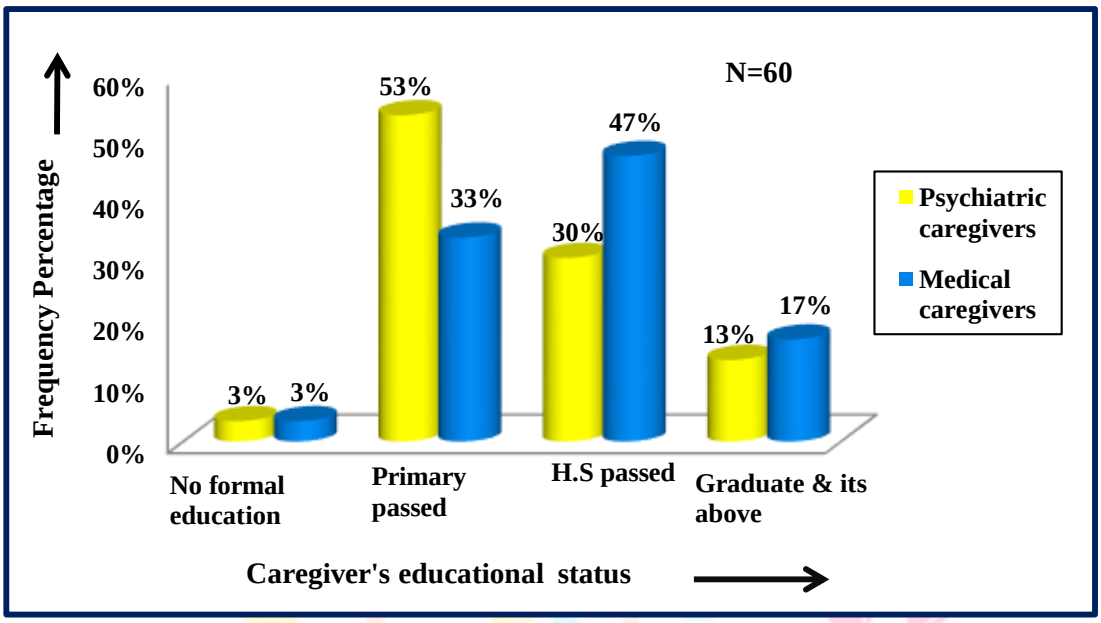


Figure.7: Cylinder graph showing caregiver's educational status wise frequency percentagedistribution of caregivers of psychiatric illness & medical illness.

The graph focusedthat,maximum caregivers of psychiatric illness 53% were primary education passed whereas maximum 47% caregivers of medical illness were HS education passed.And Similar percentage of caregivers (3%)in both group of psychiatric illness& medical illness were not having formal education.

Among the caregivers of psychiatric illness 30% were HS passed & remaining 13% were graduate and above. On the oher hand, 33% caregivers of medical illness were primary education passed and remaining 17% were graduate and above.

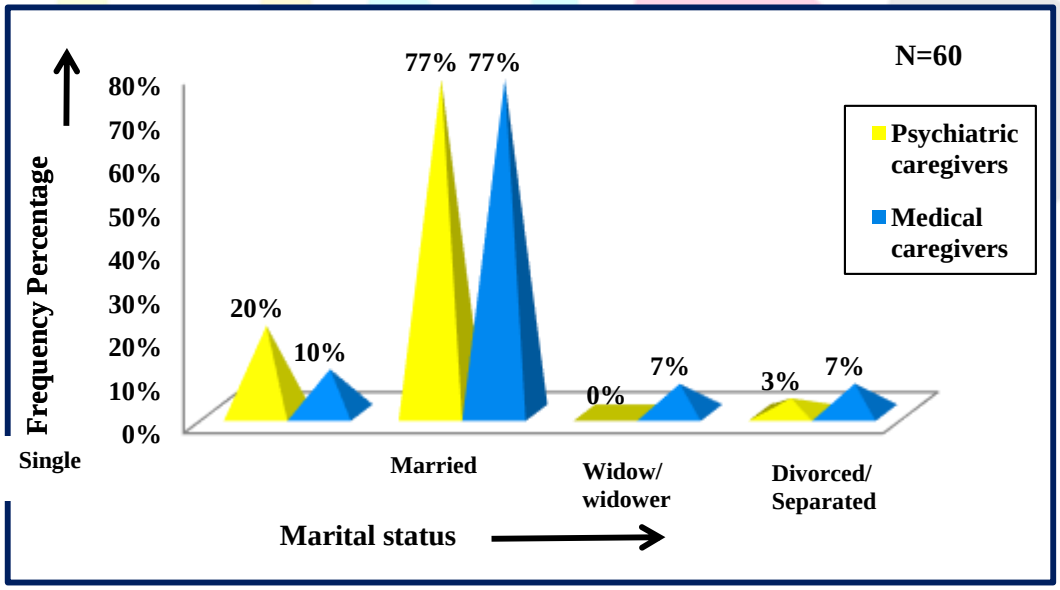


Figure. 8:Pyramidal graph showing marital status wisefrequency percentage distribution of caregivers of psychiatric illness & medical illness.

The above graphindicates that, same percentage of (77%) caregivers from both the group were married in psychiatric illness and medical illness respectively.20% caregivers of psychiatric illness were single whereas, 10% caregivers of medical illness were single. 3% caregivers of psychiatric illness were divorced and & 7% of caregivers of medical illness were divorced/separated. No one from the caregivers of psychiatric illness were widow/widower but remaining 7% caregivers of medical illness were widow/widower.

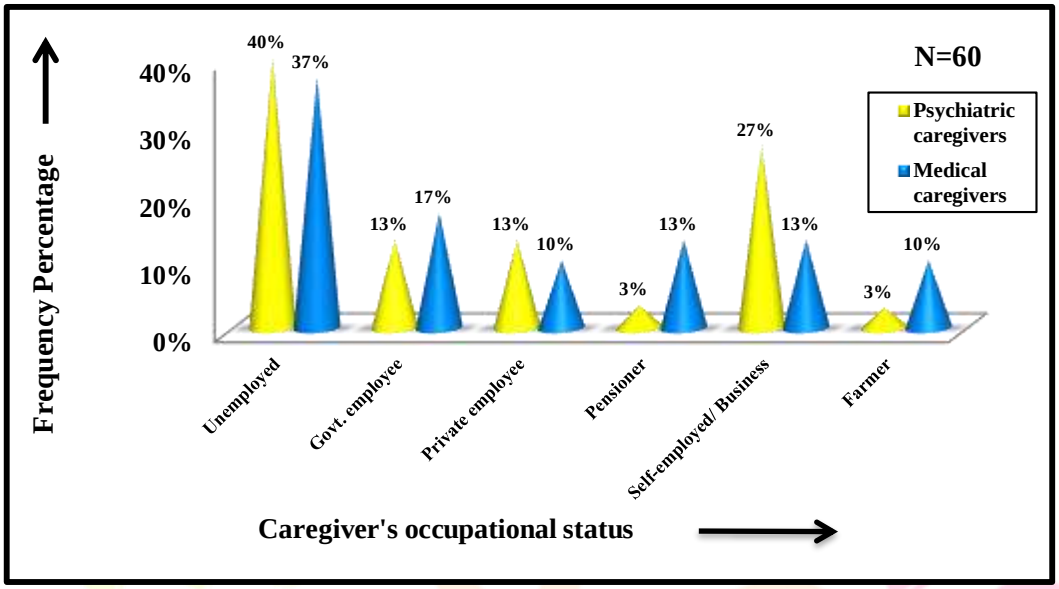


Figure. 9:Cone graph showing caregiver's occupational status wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graphshowed that, occupational status among the caregivers of psychiatric illness and caregivers of medical illnesses were unemployed 40% & 37% respectively. Govt. employee caregivers of psychiatric illnesswere 13% & medical illness were 17%.Private employee caregivers of psychiatric illness were 13%& medical illness were10%.(3%&13%)caregivers of psychiatric illness and medical illness were pensioner respectively. 27% caregivers occupational status of psychiatric illnessand 13% caregivers occupational status of medical illness were self employed/business respectively. And remaining 3% caregivers of psychiatric illness and 10% caregivers of medical illness were farmer.

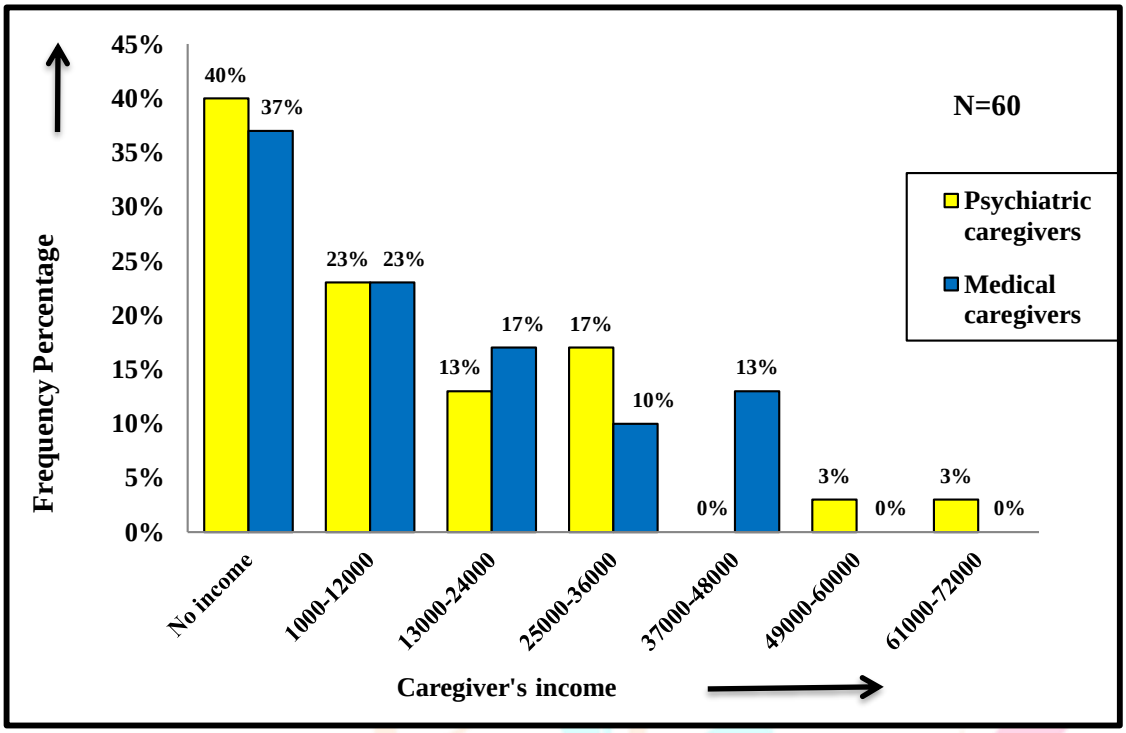


Figure.10:Bar graph showing caregiver's income wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph represented that, 40% of caregivers of psychiatric illness had no income, 23% were earning1000-12000, 13% were earning 13000-24000,17% were earning 25000-36000,3% were earning 49000-60000 & 3% were earning 61000-72000. Most of the caregivers (37%) of medical illnesshad no income, 23% were earning 1000-12000, 17% were earning 13000-24000, 10% were earning 25000-36000 and remaining 13% were earning 37000-48000.

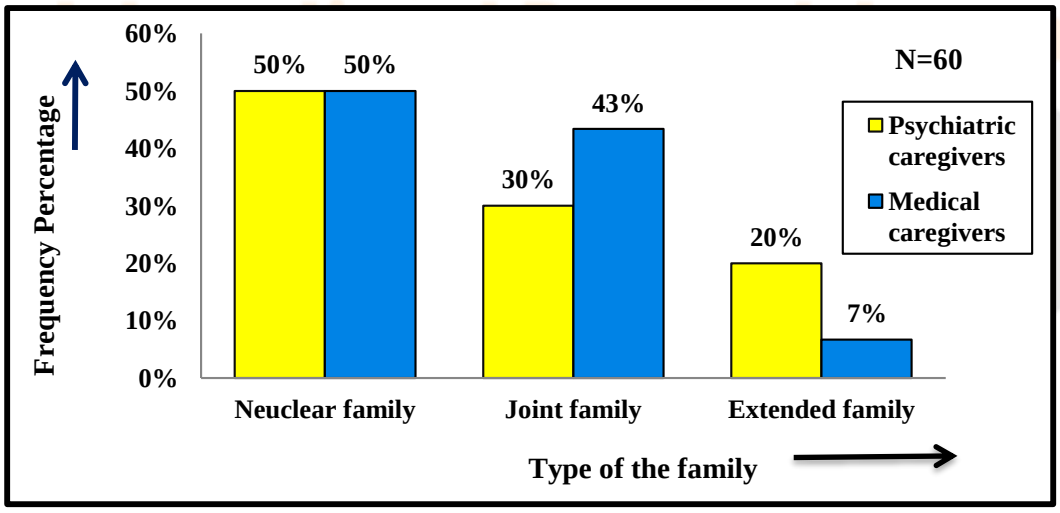


Figure. 11:Bar graph showing type of family wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph indicates that, in both the group same percentage of (50%) caregivers of psychiatric illness and medical illness were from neuclear family. 30% & 43% of caregivers were belongs to joint family in psychiatric

illness and medical illness respectively. 20% caregivers of psychiatric illness and 7% caregivers of medical illness were belongs to the extended family.

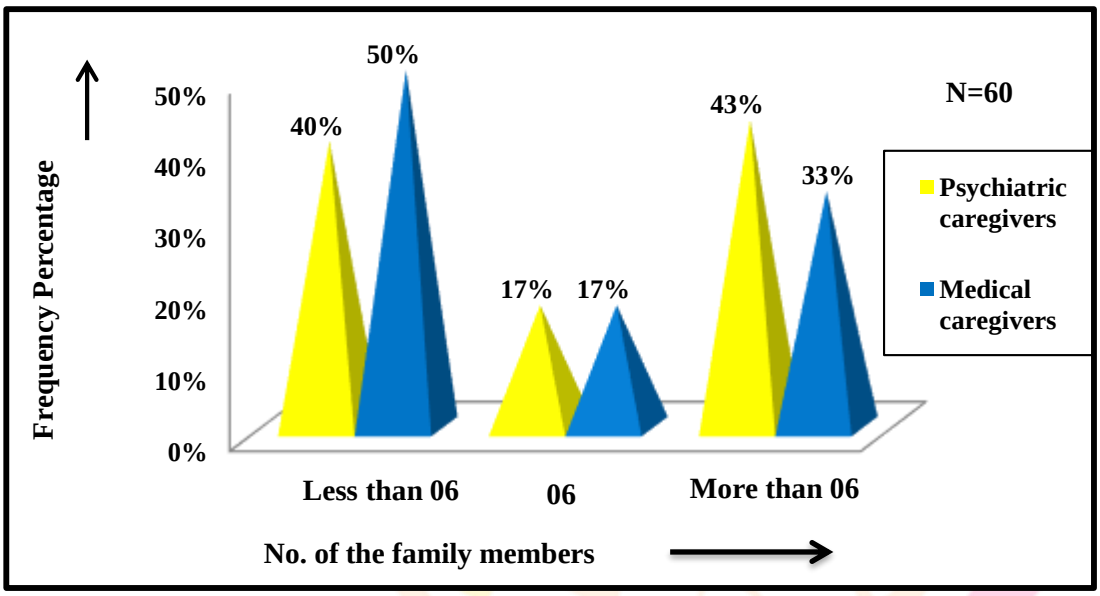


Figure. 12: Pyramidal graph showing no. of family members wise frequency percentage distribution of caregivers of psychiatric illness & medical illness.

The graph explainedthat,40% & 50% caregivers of both groups were having less than 06 numbers of family members in psychiatric illness and medical illness respectively,similar percentage (17%) of caregivers were having 06 numbers of family members in both the group of psychiatric and medical illness respectively.And remaining 43%, 33% caregiversof both the group were having more than 06 numbers of family members in psychiatric illness and medical illness respectively.

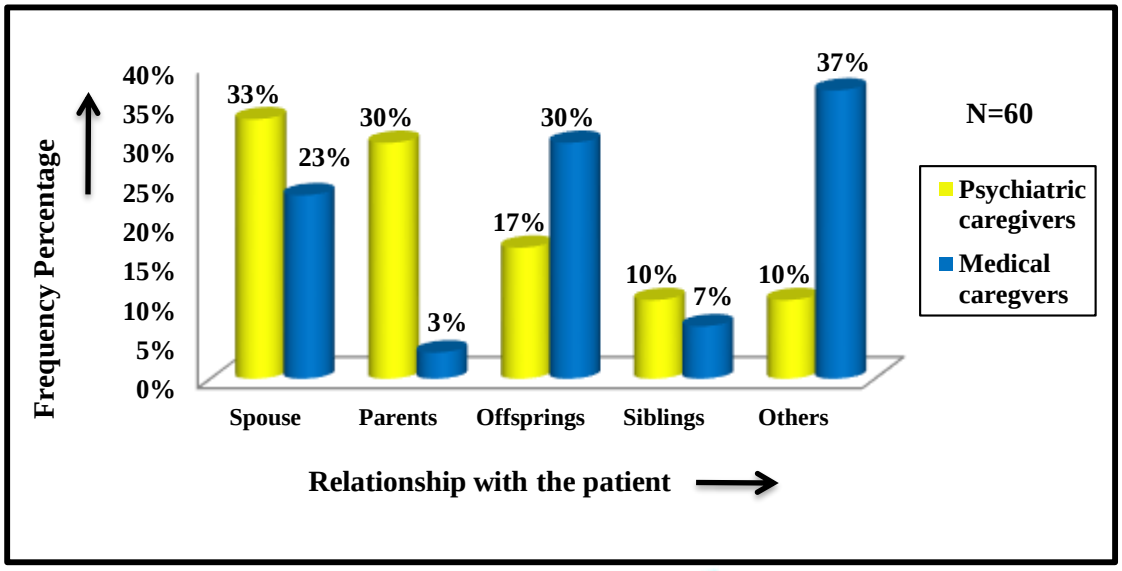


Figure. 13: Cylinder graph showing relation with the patient wise frequency percentage distribution of caregivers among the psychiatric illness & medical illness.

The graph represented that, 33%caregivers were spouse in relation with patient of psychiatric illness whereas 37% caregivers of medical illness were either son-in-law or daughter-in-law in relation with the patient.

30% caregivers of psychiatric illness were parents in relation with the patient,17% were offsprings in relation with the patient, similar percentage (10%) were from siblings in relation with the patient and either son-in-law or daughter- in-law in relation with the patient. On the other hand, 23% caregivers of medical illness were spouse in relation with the patient,3% were parents in relation with the patient, 30% were offsprings in relation with the patient and remaining 7% were siblings in relation with the patient.

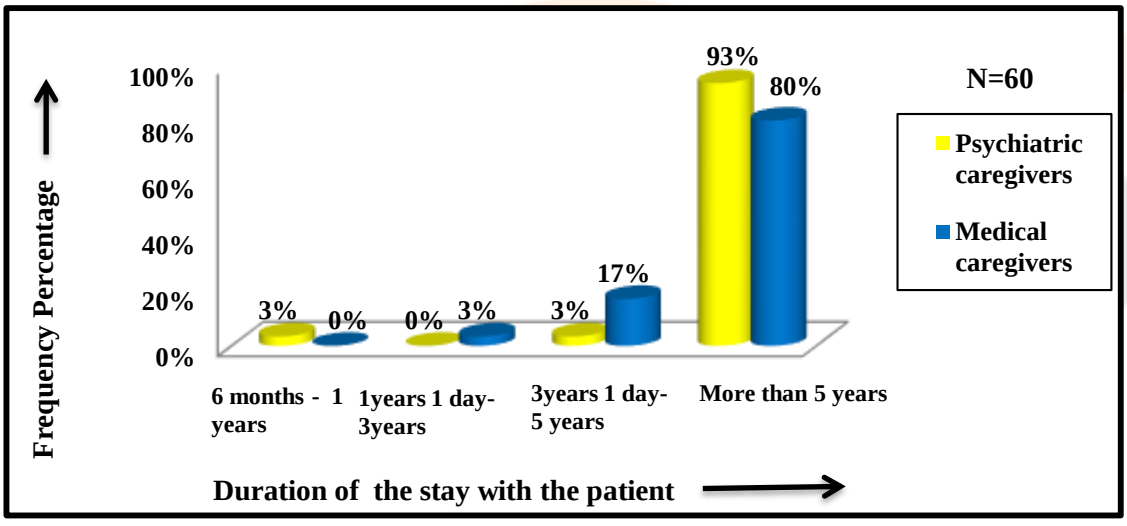


Figure.14:Cylinder graph showing duration of the stay with the patientwise frequency percentage distribution of caregivers among the psychiatric illness & medical illness.

The graph showed that,in most of the caregivers of psychiatric illness(93%) were staying more than 5 years with the patient whereas (80%) caregivers of medical illness were staying more than 5 years with the patient.

Similar percentages (3%) caregivers of psychiatric illness were staying with the patient 6 months- 1year & 3years -5years respectively. Whereas, 17% of caregivers of medical illness were staying with the patient 3 years -5years and remaining 3% were staying with the patient 1 year-3 years.

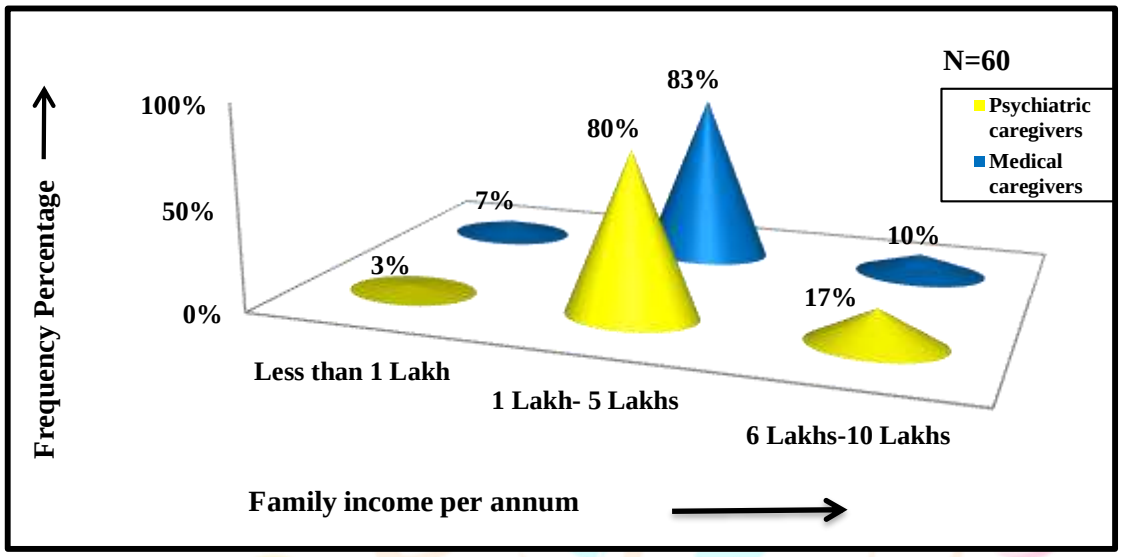


Figure. 15:Cone graph showing family income wise frequency percentage distribution of caregivers of psychiatric illness and medical illness.

The graph revealed that, family income of both group of psychiatric illness and medical illness were 1 lakh-5 lakhs (80% & 83%) respectively. Family income of both group of psychiatric illness and medical illness were (17% , 10%) respectively.Family income of remaining 3% psychiatric illness and 7% medical illness were less than 1 Lakh.

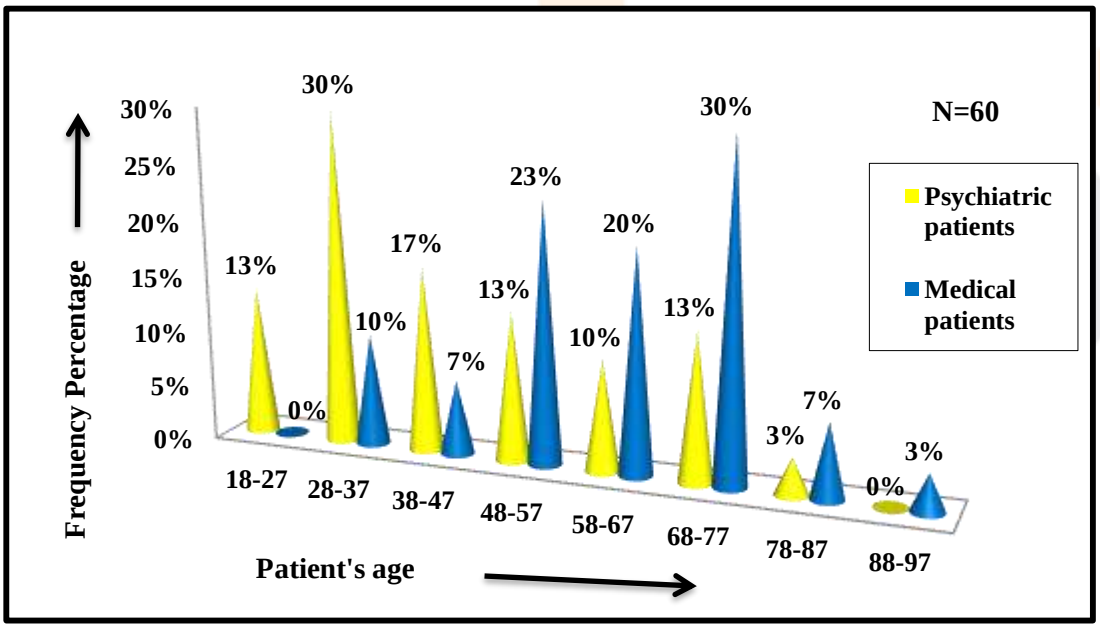


Figure.16: Cone graph showingpatient's age wise frequency percentage distribution of psychiatric caregivers & medical caregivers.

The graph revealed that, in caregivers of psychiatric illness 30% were belongs to the age group of 28-37 years. Whereas in medical illness 30% of caregivers were belongs to the age group of 68-77 years.

According to the age group 18-27 years, 13% patients were psychiatrically ill, no one had medical illness on this group. 10% medically ill patients were from 28-37 years of age group,among the age group of 38-47 years psychiatric patients & medical patientswere (17% & 23%) respectively. Among the 48-57 years 13% patients were from psychiatric illness, 23% patients were from medical illness. In the age group of 58-67 years 10% patients were from psychiatric illness and 20% patients were from medical illness,in the age group of 68-77 years 13 % patients were from psychiatric illness, and the age group of 78-87 3% patients werefrom psychiatric illness and 7% were from medical illness. In the age group of 88-97 years no one had psychiatric illness and 3% patients were frommedical illness.

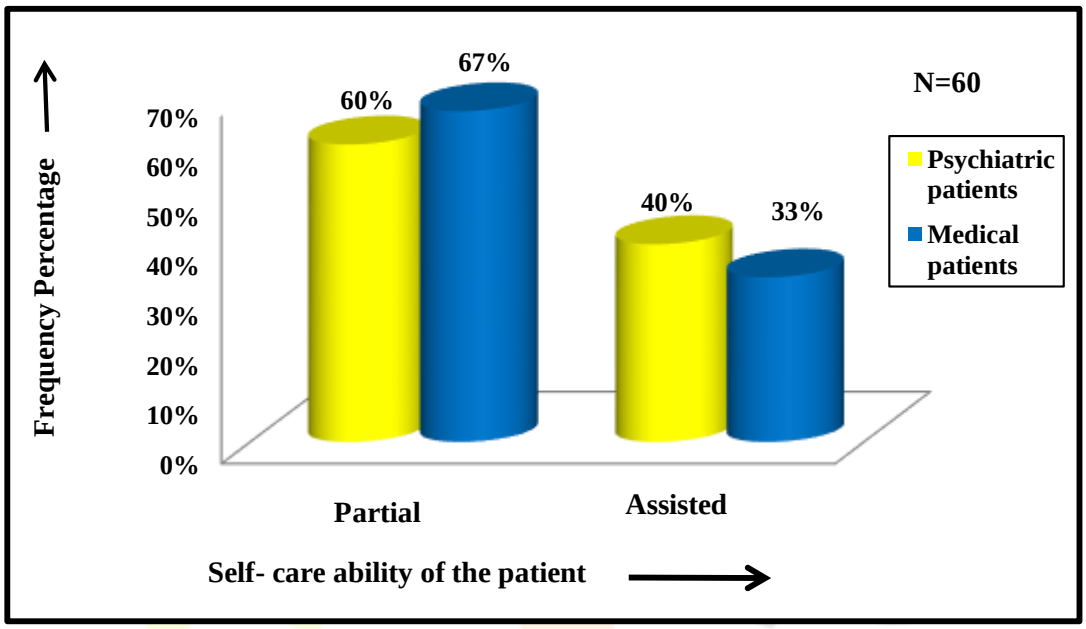


Figure.17: Cylinder graph showing the frequency distribution of self- care ability of the psychiatrically ill & medically ill patients.

The graph indicated that , 60% patients of psychiatric illness&67% patients of medical illness werepartially able to self care.Whereas 40% patients of psychiatric illness and 33% patients of medical illness were needed assistance.

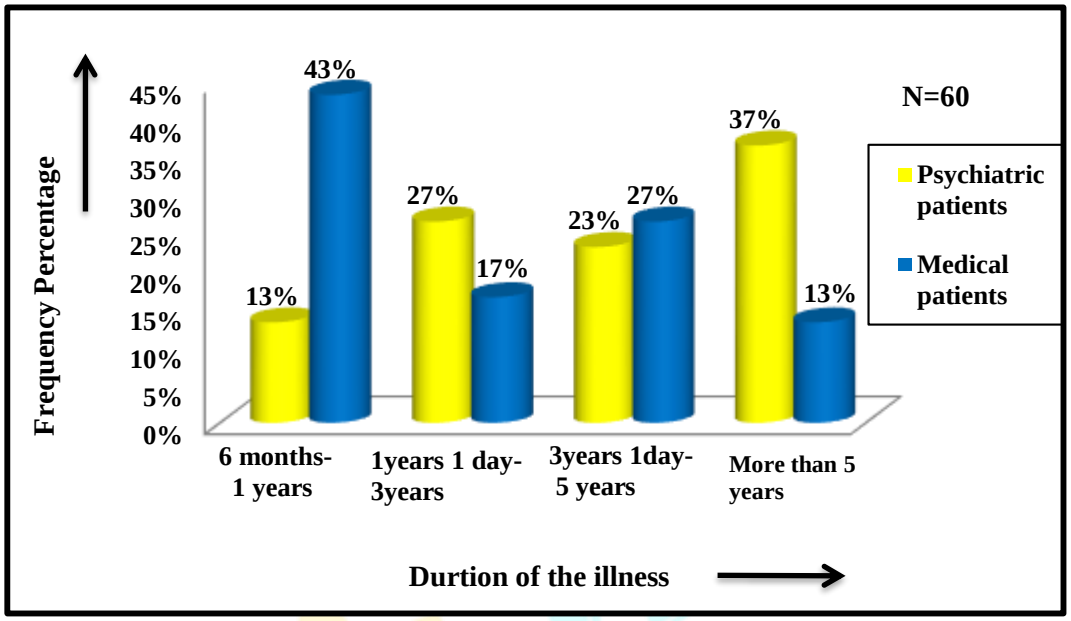


Figure.18: Cylinder graph showing the frequency percentage distribution of duration of illness of the psychiatrically ill & medically ill patients.

The graph represented that,33% psychiatric patients duration of illness were from more than 5 years whereas, 43% medical patients duration of illness were from last 6 months-1years.

13% psychiatric patientswere suffering from last 6 months-1 years, 27% were suffering from 1 year-3 years, 23% were suffering from 3 years-5 years followed by 37 % were suffering from more than 5 years. Incase of patients of medical illness, 17 % were suffering from 1 year-3 years, 27% were suffering from 3 years-5 years and remaining 13% were suffering from more than 5 years.

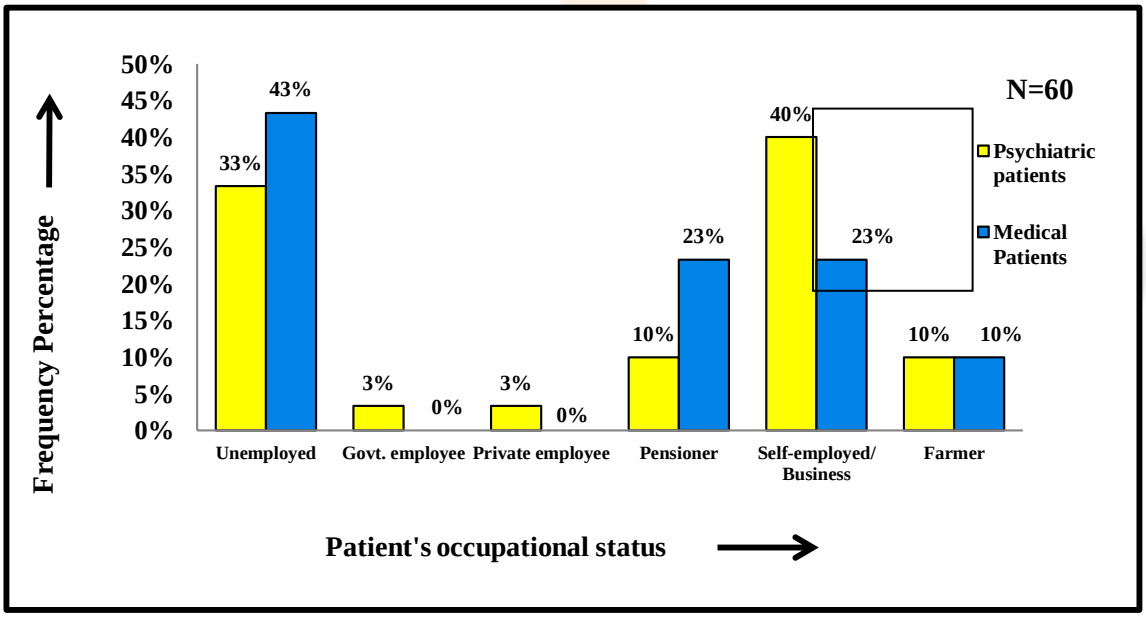


Figure.19: Bar graph showing the frequency percentage distribution of occupational status of the psychiatrically ill & medically ill patients.

The graph revealedthat, 33% patients of psychiatric illness were unemployed, followed by 3% were govt.employee, 3% were private employee,10% were pensioner, 40% were self-employed/ businessman and

10% were farmer. Among the patients of medical illness, 43% were unemployed, 23% were pensioner, 23% were self-employed/ businessman and remaining 10 % were farmer.

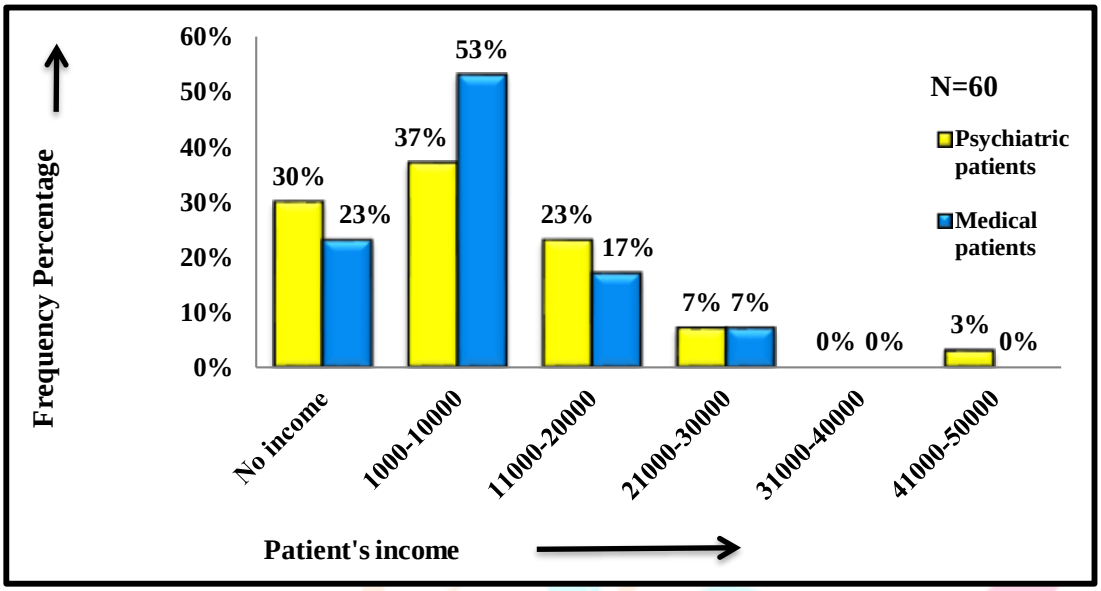


Figure.20: Bar graph showing the frequency percentage distribution of income of psychiatrically ill & medically ill patients.

The graph represented that,37% patients of psychiatric illness & 53% patients of medical illness were earning 1000-10000.

Patients of psychiatric illness & medical illness (30% & 23%) had no income, 23%, patients of psychiatric illness and 17% patients of medical illness were earning 11000-20000,similar percentage (7%) of both group of patients were earning 21000-30000 and remaining only 3% patients of psychiatric illness were earning 41000-50000.

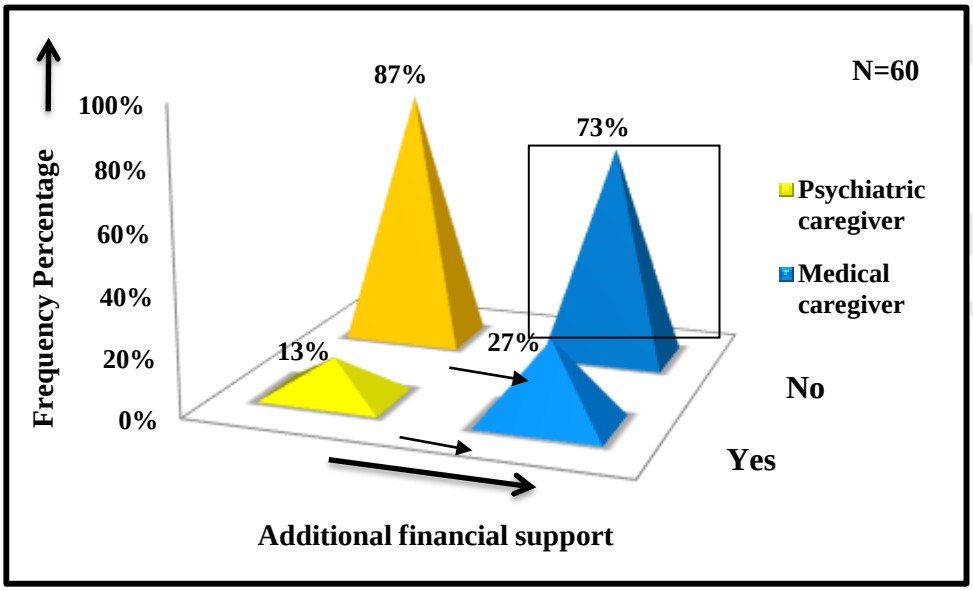


Figure.21:Pyramidal graph showing the frequency percentage distribution of additional financial support of the psychiatrically ill & medically ill patients.

The graph represented that, 87% patients of psychiatric illness &73% patients of medical illnesswere not having any kind of additional financial support. On the other hand, 13%, 27% patients of psychiatric illness and medical illness had additional financial support.

Section-II:

Findings related to compare the caregiver burden among the psychiatric illness & medical illness.

The section deals with the caregivers burden among the psychiatric illness and medical illness. the data was collected by using standardized Zarit Burden Interview Schedule which contained 22 questionnaires. The lowest scoring key for each item was 0 and highest was 4. The collected data was analyzed by using inferential statistics (mean, median, mode, SD , unpaired 't' test and ANOVA)and represented in the form of number and percentage.

H_1: There is a significant difference between caregiver burden among the psychiatric illness and medical illness.

H_{01}: There is no significant difference between caregiver burden among the psychiatric illness and medical illness.

Table-2: Frequency& percentage distribution on level of burden score among the caregivers of the psychiatric illness & medically illness. N=60

Zarit Burden score	Group			
	Psychiatric illness		Medical illness	
	Frequency	Percentage	Frequency	Percentage
Little or No burden (0-22)	01	3.33%	02	6.66%
Mild Burden (23-44)	07	23.33%	17	**56.67%**
Moderate burden (45-66)	18	**60%**	11	36.67%
Severe burden (67-88)	04	13.33%	0	0%

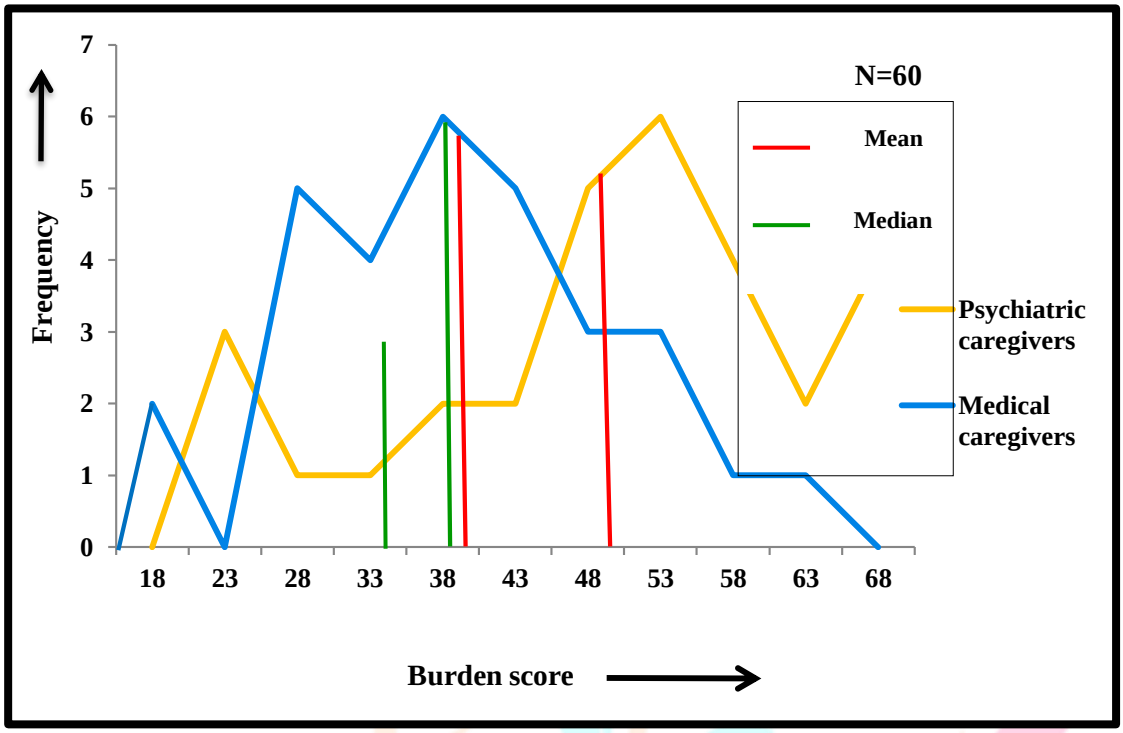
Table-2depicts that 3.33% were having little or no buden followed by 23.33% were having mild burden, 60% were having moderate burden & 13.33% were having severe burden among caregivers of psychiatric illness. 6.66% of medical caregivers were having litte or no burden followed by 56.67% were having mild burden and 36.67% were having moderate burden. The above data revealed that caregivers of psychiatric illness have more burden than caregivers of medical illness.

Table-3:Comparison of mean, median, SD, unpaired 't' value on the caregivers burden among the psychiatric illness & medical illness. N=60

Group	Level of Burden				
	Mean	**Median**	**SD**	**Mean difference**	**Unpaired 't' value**
Caregivers of the psychiatric illness	**49.33**	44.5	13.28	**10.16**	**3.25***
Caregivers of the medical illness	**39.17**	38.83	10.77		

Note * = Significant, at 0.05 level (df=58, tabulated 't' value = 2.00)

Data presented in **Table-3** depicts that the mean burden score among the caregivers of psychiatric illness (49.33) was more than the mean burden score of the caregivers of medical illness (39.17). Median burden score among the caregivers of psychiatric illness (44.5) was also higher than the median burden score of the caregivers of medical illness (38.83).Mean difference between the burden level among the caregivers of psychiatric illness and medical illness was 10.16. SD value of the caregivers of psychiatric illness was 13.28 which was more disperse than the SD value of the caregivers of the medical illness (10.77).Therefore the findings revealed that,the caregivers burdenamong the psychiatric illness were higher than the caregivers burden among the medical illness. Unpaired 't' value was **3.25* (df=58, tabulated 't' value = 2.00)** which was found to be significant at $p<0.05$ level. Hence, null hypothesis (H_{01}) was rejected and research hypothesis (H_1)was accepted, which indicated that there was a significant difference between caregiver burden among the psychiatric illness and medical illness.



The data present in the Figure no. 22 shows that the frequency polygon of compare the caregiver burden among the psychiatric illness and medical illness. The burden score of psychiatric caregivers lie down the right side of medical caregivers, the mean score (49.33) of psychiatric caregivers also lie down on the right side of mean score (39.17) of medical caregivers. So it indicated that the psychiatric caregivers had more burden than the medical caregivers. Also the graph represent the positive skewness in both caregivers of psychiatric illness (1.09) and caregivers of medical illness (0.09), which indicated that the both group of caregivers had burden score but lesser than the average burden score.

Section-III :

Findings related to association between caregiverburden among the psychiatric illness & medical illness with their selected socio-demographic variables.

In order to find out statistical significant association betweencaregiver burden among the psychiatric illness & medical illness with their selected socio-demographic variables.

H_2: There is a significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_3: There is a significant association between caregiver burden among the medical illness with their selected demographic variables.

H_{02}: There is no significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_{03}: There is no significant association between caregiver burden among the medical illness with their selected demographic variables.

ANOVA test used to determine the significant association between caregiver burden among the psychiatric illness & medical illness with their selected socio-demographic variables.

Table-4: ANOVA ('F' value) on association between caregiver burden among psychiatric illness with their selected socio-demogaphic variables. n=30

Sl No.	Demographic Variables	Category	Frequency	DF		Mean sum of square between the group	Mean sum of square within the group	Tabulated F value (0.05)	Calculated F value
				Between group	Within group				
1	**Age of the caregivers**	a. 18-27 years b. 28-37 years c. 38-47 years d. 48-57 years **e.** Above 57 years	05 05 07 05 08	4	25	76.27	199.37	2.76	0.38^{NS}
2	**Caregivers educational qualification**	a. No formal education b. Primary school passed c. Higher school passed d. Graduate & above	01 16 09 04	3	26	324.25	166.02	2.98	1.95^{NS}
3	**Marital status**	a. Single b. Married c. Widow/ Widower d. Divorced/ Separated	06 23 00 01	2	27	1012.46	120.91	3.35	**8.37^{S}**
4	**Caregivers occupational status**	a. Unemployed b. Govt. employee c. Private employee d. Pensioner	12 04 04 01 08	5	24	255.36	167.19	2.62	1.52^{NS}

		e. Self-employed/ business f. Farmer	01						
Sl No.	**Demographic Variables**	**Category**	**Frequency**	**DF**		**Mean sum of square between the group**	**Mean sum of square within the group**	**Tabulated F value (0.05)**	**Calculated F value**
				Between group	**Within group**				
5	**Caregivers income**	a. No income b. 1000-12000 c. 13000-24000 d. 25000-36000 e. 37000-48000 f. 49000-60000 g. 61000-72000	12 07 04 05 00 01 01	6	23	369.14	133.68	2.53	**2.76^{S}**
6	**Type of family**	a. Neuclear family b. Joint family c. Extended family	15 09 06	2	27	232.47	178.69	3.35	1.3^{NS}
7	**No. of family members**	a. Less than 06 b. 06 c. More than 06	12 05 13	2	27	180.36	182.54	3.35	0.98^{NS}
8	**Type of relation with the patient**	a. Spouse b. Parents c. Offsprings d. Sibling e. Others	10 09 05 03 03	4	25	339.85	157.20	2.76	2.16^{NS}

9	**Duration of stay with patients**	a. 6 months-1years b. 1years 1 day- 3 years c. 3years 1 day- 5 years d. More than 5 years	01 00 01 28	2	27	33.41	193.43	3.35	0.17^{NS}
Sl No.	**Demographic Variables**	**Category**	**Frequency**	**DF**		**Mean sum of square between the group**	**Mean sum of square within the group**	**Tabulated F value (0.05)**	**Calculated F value**
				Between group	**Within group**				
10	**Family income per annum:**	a. Less than 1 Lakh b. 1 Lakh-5 Lakhs c. 6 Lakhs-10 Lakhs	01 24 05	2	27	187.5	182.02	3.35	1.03^{NS}
11	**Patient's age**	a. 18-27 years b. 28-37 years c. 38-47 years d. 48-57 years e. 58-67 years f. 68-77 years g. 78-87years h. 88-97 years	04 09 05 04 03 04 01 00	6	23	178	183.54	2.53	0.96^{NS}
12	**Duration of illness**	a. 6 months- 1years b. 1years aday- 3 years c. 3years 1 day- 5 years d. More than 5 years	04 08 07 11	3	26	26.39	200.39	2.98	0.13^{NS}
13	**Patients occupational**	a. Unemployed	10	5	24	395.12	138.07	2.62	**2.86^{S}**

	status	b. Govt. employee c. Private employee d. Pensioner e. Self-employed/ business f. Farmer	01 01 03 12 03						
14	**Patients income:**	a. No income b. 1000-10000 c. 11000-20000 d. 21000-30000 e. 31000-40000 f. 41000-50000	09 11 07 02 00 01	5	24	148.69	189.41	2.62	0.78^{NS}

Note : S = Significant, NS= Not Significant, at 0.05

Data presented in the **Table-4** analysis of variants (ANOVA) result highlights that,there was significant association between caregiver burden among the psychiatric illness with theirselected socio-demographic variables in the aspects of caregivers **'marital status'** among the psychiatric illness at 0.05 level of significance (calculated 'F' value=8.37,tabulated 'F' value=3.35, df between the group=2, df within the group=27),**'caregivers income'**(calculated 'F' value=2.86, tabulated "F" value=2.62, df between the group=5, df within the group=23) and**'Patients occupational status'**(calculated 'F' value=2.86 (tabulated "F" value=2.62 , df between the group=5, df within the group=24).Therefore, the null hypothses**(H_{02})** was rejected & research hypotheses**(H_2)** was accepted. Which indicated that the caregivers burden was dependent on selected socio-demographic variables i.e., marital status, cargivers income and patients occupational status.

Table-5:ANOVA ('F' value) on association between caregiver burden among medical illness with their selected socio-demogaphic variables. n=30

Sl No.	Demographic Variables	Category	Frequency	DF		Mean sum of square between the group	Mean sum of square within the group	Tabulated F value (0.05)	Calculated F value
				Between group	Within group				
1	**Age of the caregivers**	a. 18-27 years b. 28-37 years c. 38-47 years d. 48-57	04 08 10 04 04	4	25	36.98	127.52	2.76	0.28^{NS}

		years e. Above 57 years							
2	**Caregivers educational qualification**	a. No formal education b. Primary school passed c. Higher school passed d. Graduate & above	01 10 14 05	3	26	37.87	123.94	2.98	0.30^{NS}
3	**Marital status**	a. Single b. Married c. Widow/ Widower d. Divorce d/ Separated	03 23 02 02	3	26	6.76	127.53	2.98	0.05^{NS}
4	**Caregivers occupational status**	a. Unemployed b. Govt. employee c. Private employee d. Pensioner e. Self-employed/ Business f. Farmer	11 05 03 04 04 03	5	24	150.41	107.67	2.62	1.39^{NS}
Sl No.	**Demographic Variables**	**Category**	**Frequency**	**DF**		**Mean sum of square between the group**	**Mean sum of square within the group**	**Tabulated F value (0.05)**	**Calculated F value**
				Between group	**Within group**				

5	**Caregivers income**	a. No income b. 1000-12000 c. 13000-24000 d. 25000-36000 e. 37000-48000 f. 49000-60000 g. 61000-72000	11 07 05 03 04 00 00	4	25	43.12	126.54	2.76	0.34^{NS}
6	**Type of family**	a. Neuclear family b. Joint family c. Extended family	15 13 02	2	27	279.75	102.83	3.35	2.72^{NS}
7	**No. of family members**	a. Less than 06 b. 06 c. More than 06	15 051 0	2	27	17.08	122.29	3.35	0.13^{NS}
8	**Type of relation with the patient**	a. Spouse b. Parents c. Offsprings d. Siblings e. Others	07 01 09 02 11	4	25	123.26	113.72	2.76	1.08^{NS}
9	**Duration of stay with patients**	a. 6 months-1years b. 1years 1 day- 3 years c. 3years 1 day- 5 years d. More than 5 years	00 01 05 24	2	27	491.76	87.13	3.35	**5.64^{S}**
10	**Family income per annum:**	a. Less than 1 Lakh b. 1 Lakh-5 Lakhs c. 6 Lakhs-10 Lakhs	02 25 03	2	27	364.60	96.55	3.35	**3.78^{S}**
Sl	**Demographic Variable**	**Category**	**Freq**	**DF**		**Mean sum**	**Mean sum**	**Tablulate**	**Calculate F**

				Between group	Within group				
11	**Patient's age**	a. 18-27 years b. 28-37 years c. 38-47 years d. 48-57 years e. 58-67 years f. 68-77 years g. 78-87years h. 88-97 years	00 03 02 07 06 09 02 01	6	23	73.06	125.99	2.53	0.57^{NS}
12	**Duration of illness**	a. 6 months- 1years b. 1years aday- 3 years c. 3years 1 day- 5 years d. More than 5 years	13 05 08 04	3	26	60.32	121.35	2.98	0.49^{NS}
13	**Patients occupational status**	a.Unemployed b. Govt. employee **c.** Private employee d. Pensioner e. Self-employed/ business f. Farmer	13 00 00 07 07 03	5	24	97.32	118.73	2.62	0.81^{NS}
14	**Patients income:**	a. No income b.1000-10000 c.11000-20000 d.21000-30000 e. 31000-40000 f,41000-50000	07 16 05 02 00 00	3	26	61.57	121.21	2.98	0.50^{NS}

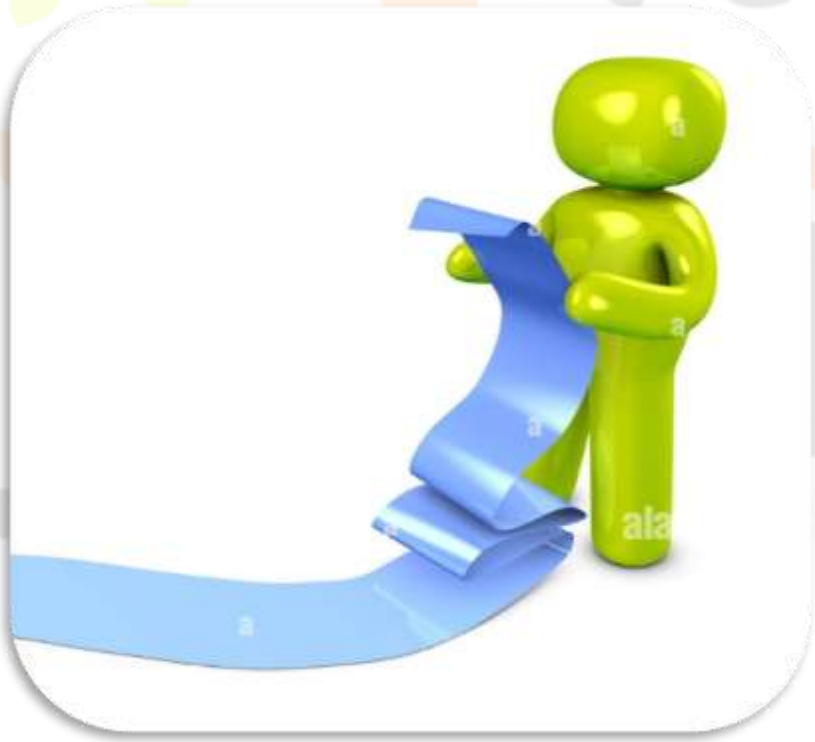
Note: S = Significant, NS= Not Significant, at 0.05

Data presented in **Table-5**ANOVA result showed that, there was significant association between caregiver burden among the medical illness with their selected demographic variables in the aspects of caregivers **'duration of stay with patient'** among the medical illness at 0.05 level of significance (calculated 'F' value= 5.64,tabulated 'F' value=3.35 , df between the group=2, df within the group=27) and **'family income per annum'** (calculated 'F' value=3.78, tabulated "F" value= 3.35 , df between the group=2, df within the group=27).Therefore, the null hypothses **(H_{03})** was rejected & research hypotheses**(H_3)**was accepted. Which indicated that the caregivers burden was dependent on selected socio-demographic variables i.e., duration of stay with patients and family income per annum.

SUMMARY: The chapter has dealt with the analysis and interpretation of the data using descriptive and inferential statistics. Frequency & percentage were used to analyze the sample characteristics. Mean, median, standard deviation, mean difference and unpaired 't' test was used to analyze the data. ANOVA was done to determine the association between caregiver burden among psychiatric illness & medical illness with their selected socio-demogaphic variables.

CHAPTER -V

SUMMARY OF THE STUDY, FINDINGS, DISCUSSION, CONCLUSION, IMPLICATIONS, LIMITATION&



CHAPTER-V

SUMMARY OF THE STUDY:

The chapter deals with summary of the whole study, explanation which was based on the objective, major findings, discussion, conclusion, implication of the study in nursing administration, nursing education, nursing practice and nursing research, limitation of the study and recommendation for the future research in the field.

The study concluded with the following objectives:

1. To assess the burden of caregivers among psychiatric illness.
2. To assess the burden of caregivers among medical illness.
3. To compare the caregivers burden among the psychiatric illness and medical illness.
4. To determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables.

The study was based on following assumptions:

Caregivers may prone to develop some burden while giving care to the patients.

The variables under the study:

Research Variables: In the present study, research variables include caregiver burden among the psychiatric and medical illness.

Demographic Variables: In this study, socio-demographic variables refer to baseline data of caregivers such as: age, gender, religion, place of the residence, educational qualification of caregiver, marital status, occupation of the caregiver, income of the caregiver, type of family, no. of the family members, type of relationship with patient, duration of stay with patient, relationship of person who bearing the financial responsibility of the patient & his/her income in rupees per annum,age of the patient, diagnosis of the patient, self care ability of the patient, duration of illness, occupation of the patient, income of the patient, patient receives any type of financial benefit from other sources: (yes/no)- If yes, mention the sources, presence of alternative caregiver & his/her relationship with the patient & duration.

The study attempted to examine the following hypotheses:

All hypotheses were tested at 0.05 level of significance.

H_1: There is a significant difference between caregiver burden among the psychiatric illness and medical illness.

H_2: There is a significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_3: There is a significant association between caregiver burden among the medical illness with their selected demographic variables.

Conceptual framework of the present study:

The conceptual framework was developed based on **"Sister Callista Roy's Adaptation Model (1976)"**. According to this theory in the present study- input, control processes, effectors and output were included whereas feedback were not included.

Review of Literature:

Review of literature helps the researcher to collect appropriate and relevant information to support the study, design the methodology, conceptual framework, development of tools help to plan the analysis of data. In the present study the review of literature was organized and presented under the following sections:

- ► Section A: Studies related to incidence and prevalence of caregiver burden.
- ► Section B: Studies related to level of caregiver burden.
- ► Section C: Studies related to compare the burden between psychiatric and medical caregivers.

Research Methodology:

- ◊ The study adopted quantitative research approach.
- ◊ The design adopted for the study was descriptive comparative design.
- ◊ The sample was drawn by using purposive sampling technique.
- ◊ The study population comprises caregivers among the psychiatric illness and medical illness.
- ◊ The sample size was 60 caregivers among the psychiatric illness and medical illness.
- ◊ The study was conducted in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, Tripura West.
- ◊ Tools were developed and used for data collection were Socio-demographic data, Standardized Zarit Burden Interview schedule.

MAJOR FINDINGS OF THE STUDY

Major findings of the study were summarized as below:

Findings related to demographic proforma

❖ Maximum of caregivers of psychiatric illness i.e. 27% were belongs to above 57 years of age group & majority of caregivers of medical illness i.e.33% were in the age group of 38-47 years.

❖ Maximum i.e.57% of caregivers ofpsychiatric illness were femaleand majority i.e. 67% of caregivers of medical illness were female.

❖ Maximum of thecaregivers of psychiatric illness i.e.77% and majority of caregivers of medical illnessi.e. 87% were belongs to the Hindu community.

❖ Maximum of caregivers of the psychiatric illness i.e.67% and majority of caregivers of medical illness i.e. 53% were from rural area.

❖ Maximum i.e.53% of caregivers of psychiatric illness were primary passed and 47% of caregivers of medical illness were H.S. passed.

❖ Majority i.e.77% of caregivers of both psychiatric illness and medical illness were married.

❖ Maximum of the caregivers of psychiatric illness i.e. 40% and 37% of caregivers of medical illness were unemployed.

❖ Maximum caregivers of psychiatric illness i.e. 40% and 37% of caregivers of medical illness have no income.

❖ Majority i.e. 50% of caregivers of both psychiatric illness and medical illness were belonged to nuclear family.

❖ Maximum i.e 43% of caregivers of psychiatric illness no. of family members were more than 06 and majority i.e, 50% of caregivers of medical illness no. of family memberswere less than 06 .

❖ Maximum i.e. 33% of caregivers of psychiatric illness in relation with the patients were spouse and majority i.e. 37% of caregivers of medical illness in relation with the patients were either daughter-in-law or son-in-law.

❖ 93% caregiversof psychiatric illness and 80% caregivers of medical illness duration of stay with patients were more than 5 years.

❖ When considering the family income (per annum), 80% of psychiatric patients family and 83% of medical patients family were earning 1lakh -5lakhs.

❖ Maximum i.e. 30% patients of psychiatric illness were belongs to age group 28-37 years and majority i.e. 30%patientsof medical illness were belongs to 68-77 years of age group.

❖ 60% patients of psychiatric illness and67% patients of medical illness were partially able to self care.

❖ Maximum i.e.37% of psychiatric patients duration of illness were more than 5 years and majority i.e. 43% of medical patients duration of illness were 6months-1 year.

❖ Maximum of the patients of psychiatric illness i.e. 40% occupational status were self-employed/business and majority i.e. 43% patients of medical illness were unemployed.

❖ 37% patients of psychiatric illness and 53% patients of medical illness were earning Rs.1000-10000.

❖ 87% patients of psychiatric illness and 73% patients of medical illness wew not getting any kind of additional financial support.

Findings related to compare the caregiver burden among the psychiatric illness & medical illness.

1. 60% caregivers of psychiatric illness were having moderate burden and 57% caregivers of medical illness were having mild burden.
2. The mean score of caregiver burden among the psychiatricillness and medical illness was found to be 49.33 and 39.17 respectively, median 44.5 and 38.83 respectively, and SD was 13.28 and 10.77 respectively. The mean difference was 10.16 and unpaired 't' value was 3.25 which was found to be significant at the level of $P<0.05$. The skewness of the caregivers burden among the psychiatric illness and medical illness was 1.09 and 0.09 respectively.

Findings related to association between burden of the caregivers among the psychiatric illness & medical illness with their selected socio-demographic variables.

1. Analysis of variance (ANOVA) showed that there was significant association between caregiver burden among the psychiatric illness with their selected socio-demographic variables **'marital status'** at 0.05 level of significance (calculated 'F' value=8.37,tabulated 'F' value=3.35 , df between the group=2, df within the group=27), **'caregivers income'** (calculated 'F' value=2.86, tabulated "F" value=2.62 , df between the group=5, df within the group=23) and **'Patients occupational status'(calculated 'F' value=2.86 (tabulated "F" value=2.62 , df between the group=5, df within the group=24).** So, the caregivers burden was dependent on selected socio-demographic variables i.e., marital status, cargivers income and patients occupational status. The other variables showed no significance association.
2. ANOVA result showed that, there was significant association between caregiver burden among the medical illness with their selected demographic variables in the aspects of caregivers **'duration of stay with patient'** among the medical illness at 0.05 level of significance (calculated 'F' value= 5.64, tabulated 'F' value=3.35 , df between the group=2, df within the group=27) and **'family income per annum'** (calculated 'F' value=3.78, tabulated "F" value= 3.35 , df between the group=2, df within the group=27). Which indicated that the caregivers burden was dependent on selected socio-demographic variables i.e., duration of stay with patients and family income per annum. The other variables showed no significance association.

DISCUSSION:

The meaning of research in a simple language is to explore or discover new things and concepts. The findings of the study discussed in the chapter were based on objectives, hypotheses and conceptual framework of the study.

Objective 1 :To assess the burden of caregivers among psychiatric illness.

➢ The findings of the present study revealed that, out of 30 caregivers of psychiatric illness 3% had little or no burden,23% had mild burden, 60% had moderate burden and remaining 13.33% had severe burden.

- The statistical findings of the present study revealed that the mean score of caregiver burden among the psychiatric illness was 49.33, median 44.5, SD was 13.28.

The present study was supported by the findings of the following study:

Dr. Agarwal S., Dr.Naphade N., Dr.Shetty J. (2015): Conducted a cross-sectional study to assessment of caregiver burden among psychiatric illness at Bharati Vidyapeeth Deemed University Medical College and Research Centre; Pune, India on 45 caregivers. The result showed that 56% of caregivers displayed moderate burden, 9% mild burden & 35 % caregivers having severe burden. However females perceived a great level of burdeen compared to men (p=0.322). Longer duration of illnesses were associated with greater burden perceived. parents of patients & spouses experienced greater burden followed by the children & siblings respectively.[7]

Objective 2:To assess the burden of caregivers among medical illness.

- The findings of the present study revealed that, out of 30 caregivers of medical illness 7% had little or no burden, 56.67% had mild burden, 36.67% had moderate burden and 0% had severe burden.

- The statistical findings of the present study revealed that the mean score of the level of burden 39.17, median 38.83 & SD 10.77.

The present study was supported by the findings of the following study:

Dr. Sudhakar V., Dr. Ramamurthy D., Dr. Shetty VB.,(2021): Conducted a cross sectional study to assess the caregiver burden & factors associated amongcaregivers of patients undergoing haemodialysis. 86 caregivers were selected at a Insurance Corporation Hospital, Bangalore.the result showed that mean Zarit Score was found to be 24.36 ± 14.9 with 53.6% of the caregivers having some burden in caregiving . Care giver burden is high among caregivers of haemodialysis patients. This burden is more among patients suffering with more than two co-morbidities.[35]

Objective 3: To compare the caregivers burden among the psychiatric illness and medical illness.

In this present study, the hypotheses and null hypotheses stated as:

H_1: There is a significant difference between caregiver burden among the psychiatric illness and medical illness.

H_{01}:There is no significant difference between caregiver burden among the psychiatric illness and medical illness.

The statistical findings of the present study highlighted that, 60% caregivers of psychiatric illness were having moderate burden and 57% caregivers of medical illness were having mild burden.The mean score of caregiver burden among the psychiatricillness and medical illness was found to be 49.33 and 39.17 respectively, median 44.5 and 38.83 respectively, and SD was 13.28 and 10.77 respectively. The mean difference was 10.16 and unpaired‘t’ value was 3.25 which was found to be significant at the level of $P<0.05$. The skewness of the caregivers burden among the psychiatric illness and medical illness was 1.09 and 0.09 respectively.Hence, null

hypothesis (H_{01}) was rejected and research hypothesis (H_1)was accepted, which indicated that there was a significant difference between caregiver burden among the psychiatric illness and medical illness.

The present study was supported by the findings of the following study:

Vijayalakshmi D., Sunitha D. (2018): Conducted a comparative study to compare the caregiver burden in psychiatric illness (schizophrenia) & chronic medical illness (stroke). The caregivers were classified as group 1 consisting of 60 caregivers of psychiatric patients and group 2 consisting of caregivers of patients suffering from chronic medical illness. The study result showed that majority of patients with schizophrenia are between 31-40 years, and patients with stroke are between the age group of 51-60 years. The caregivers of patients with schizophrenia with mean value of 14.97 whereas, caregivers of patients with stroke with mean value of 11.25 experienced more of objective burden with significant p-value of 0.000. Finally the study concludes that in group 1 caregivers perceived more burden than group 2. [14]

Objective 4: To determine the association between burden of the caregiver among the psychiatric illness and medical illness with their selected socio demographic variables.

In this present study, hypotheses and null hypotheses was stated as:

H_2: There is a significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_3: There is a significant association between caregiver burden among the medical illness with their selected demographic variables.

H_{02}: There is no significant association between caregiver burden among the psychiatric illness with their selected demographic variables.

H_{03} : There is no significant association between caregiver burden among the medical illness with their selected demographic variables.

In the present study, ANOVA 'F' value showed that significant association between caregivers burden of psychiatric illness with their selected demographic variable at 0.05 level of significance, i.e **'marital status'** (calculated 'F' value=8.37,tabulated 'F' value=3.35 , df between the group=2, df within the group=27) , **'caregivers income'**(calculated 'F' value=2.86, tabulated "F" value=2.62 , df between the group=5, df within the group=23) and **'Patients occupational status'**(calculated 'F' value=2.86 (tabulated "F" value=2.62 , df between the group=5, df within the group=24).

So,caregivers burden of the psychiatric illness was dependent on the caregiversmarital status, caregivers income & patient's occupational status.

In another hand, ANOVA 'F' value showed that significant association between caregivers burden of medical illness with their selected demographic variable at 0.05 level of significance, i.e.**'duration of stay with**

patient'(calculated 'F' value=5.64 tabulated 'F' value=3.35, df between the groups=2, within the groups=27) and **'family income per annum'** (calculated 'F' value=3.78 , tabulated 'F' value=3.35, df between the groups=2, within the groups=27).

So, caregivers burden of the medical illness was dependent on their duration of stay with patient & family income per annum.

The present study was supported by the findings of the following study:

Ms. George A et al.(2021): Conducted a descriptive survey to assess the level of burden among the caregivers of patients with mental illness in a selected hospital at Mangaluru. Convenient sampling technique was used to select the sample for the study. The tools used were demographic proforma and Zarit Burden Interview. In the present study, 66% of the subjects reported moderate to severe level of burden, and whereas 21% of the subjects reported with severe level of burden. 12% of them had mild to moderate burden and 1% participants had little or no burden at all. There is significant association found between the level of burden among caregiver of patient with mental illness and selected demographic variables that is age, gender, religion, marital status, educational status, occupational status, monthly income, type of family, duration of care giving and type of relationship with patient. The study findings revealed that selected demographic proforma have significant association with level of burden among care givers of patients with mental illness.[13]

CONCLUSION:

The present study conducted to compare the caregiver burden among the psychiatric illness and medical illness, Agartala, Tripura West. From the findings of the present study it can be concluded that burden experienced by the caregivers of psychiatric illness was mostly of moderate burden whereas the caregivers of medical illness was mild burden. The ANOVA results showed that there was a significant association between caregiver burden of psychiatric illness with their selected demographic variables i.e. caregiver's marital status, caregivers income and occupational status of the patient. On the other hand, the ANOVA result showed that there was a significant association between caregiver burden of medical illness with their selected demographic variables i.e. duration of stay with patient and family income per annum.

IMPLICATION:

The findings of the study could be apply in various areas ofnursinf education, nursing practice, nursing researchand nursing administration.

★ Implications for Nursing Education:

- Education is the key component in the knowledge of an individual. Today's nursing graduates are more multi-talented and diverse than ever and they are going to be tomorrows staff nurses, educators, administrators and supervisors. Hence this study has an implication in nursing education.

- The nurse educator can plan a psychoeducation program or arrange psychodrama about the caregiver burden and its impact on their life and howto improve their coping strategies. In order to achieve this, the nurse as an educator should focus on improvement of coping strategies and strengthen the subjects through nursing curriculum.
- The student nurses and all health professionals should be given the responsibility to teach the caregivers byconducting the educational programme or healthtalk. The teaching should be repeated until they have gained the appropriate coping strategies according to their situation.
- The nurse educator need to be thought as an advocates or facilitator and counselor.

★ **Implications for Nursing Practice:**

- Nurses are committed to work in the hospitals as well as in the community for care and health promotion development. Nurses are the key person of health team that plays a major role in the health promotion and maintenance. They are able to arrange the health education on new techniques to developing their coping strategies. The practice needs to be encouraged in all psychiatric and medicine wards and OPDs.

★ **Implications for Nursing Research:**

- This study will serve as a valuable reference material for the further investigators.
- The findings of the study help the nursing professionals to develop the inquiry by providing a baseline.
- This study helps the nurse researchers to develop the insight among the caregivers regarding the different type of illness, their negative consequences and how to deal with the situations.
- Research suggests that early assessment of caregivers burden can improve the quality of life of the caregivers as well as patients.
- Large scale studies can be conducted in large samples to describe the caregiver burden among the psychiatric illness and medical illness.

★ **Implications for Nursing Adminstration:**

- The nurse administrators should take interest in disseminating the information through instructional materials such as booklets, pamphlets, posters, self- instructional modules etc. that impact helps to the caregivers to dealing with the stressful situation.
- The special implication of nursing administrators that they should pay attention to all caregivers of the psychiatric illness and medical illness.
- The nurse administrators should organize the health educational programme/ awareness programme, workshops, panel discussionsin collaboration with the community health sector.

LIMITATIONS:

1. The study was confined to only small groups.
2. The study was limited to only the caregivers of the psychiatric illness & medical illness.
3. The findings of the study could not be broadly generalized as it was conducted only in one hospital.
4. The samples were selected only those who were caregiving to the patients more than 6 months in both group.
5. The study does not assess the resiliance of the caregiver.

RECOMMENDATIONS:

- Similar study can be replicated on larger sample to generalize the study findings.
- A qualitative study to find out the caregiver burden in different aspects.
- A comparative study to assess the resilience of caregivers of patients with psychiatric & chronic medical illness.
- A comparative community survey to assess prevalence & correlates of family caregiver burdens associated with mental & physical conditions.
- A cross-sectional comparative study to assess & compare the caregivers burden in long term caregivers of chronic psychiatric & chronic medical patients.
- A descriptive study to assess the burden of caregivers of mentally ill individuals and their coping mechanisms.

SUMMARY: This chapter deals with summary, major findings of the study , discussion in relation with the findings of the othe study, conclusions & implications of the study in nursing administration, nursing education, nursing practice & in nursing . The limitations of the study have also been articulated in this section and the investigator has attempted to give an account of recommendation of further study in the field of nursing.

REFERENCES

1. Ampalan P., Gunturu S., Padma V. A comparative study of caregiver burden in psychiatric illness and chronic medical illness.Ind Journ of Psychiatry[Internet].2012 Jul-Sep;54(3):239-243. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3512360

2. Sinha V., Anwar Z., Mitra S., Yadav N. Caregiver burden of elderly psychiatric and medically ill patients: A comparative study. JMSCR [Internet].2019 Feb 02; 07(02): 834-840. Available from: https://www.researchgate.net/publication/331268024_Caregiver_burden_of_elderly_psychiatric_and_medically_ill_patients_A_comparative_study

3. Viana MC., et al. Family burden related to mental & physical disorders in the world: results from the WHO World Mental Health (WMH) Surveys. RBP [Internet]. 2013;35(2):115-125.Available from: https://www.scielo.br/j/rbp/a/jnNh9F89gPSFLJzdXJTz67s/?format=pdf&lang=en

4. Souza ALR., Guimaraes RA., Barbosa MA.et al. Factors associated with the burden of family caregiversof patients with mental disorders: a cross-sectional study. BMC Psychiatry 17,353(2017). Available from:https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-017-1501-1

5. US Government, department of Aging Care [Internet].[Place Unknown]: [Cited-2021 Oct-20]. Available from: https://www.agingcare.com/articles/identifying-caregiver-burden-206799.htm

6. Young C. stated that 'how to care for yourself when you have caregiver burnout", The healthline editorial team.2021 April 26.Available from:https://www.healthline.com/health/health-caregiver-burnout

7. Dr. Agarwal S., Dr.Naphade N., Dr.Shetty J. Assessment of caregiver burden in psychiatric patients. IJSR [Internet].2015 [cited 2017 June);6 (6): 340-43. Available from:https://www.researchgate.net/publication/329118102_Assessment_of_caregiver_burden_in_psychiatric_patients

8. Natalia Henao Piedrahita. Prevalance of caregiver burden syndrome in formal caregivers of institutionalized patients with psychiatric illness. Rev Colomb Psiquiatr (Engl Ed.)2021 Apr-Jun;50(2):101-107. English,Spanish.. Available from: https://pubmed.ncbi.nlm.nih.gov/33735025/

9. Liu S et al. Caregiver burden and prevalence of depression,anxietyand sleep disturbances in Alzheimer's disease caregivers in China. J Clin Nurs.2017 May;26(9-10): 1291-1300. Available from:https://pubmed.ncbi.nlm.nih.gov/27681477/

10. Rahmani F. et al. Caregiver burden and the associated factors in the family caregivers of patients with schizophrenia.WOL.[Internet].2022 March 28. Available from:https://onlinelibrary.wiley.com/doi/full/10.1002/nop2.1205

11. SC Walke,V. Chandrasekaran and SS Manya. Caregiver burden among caregivers of mentally ill individuals and their coping mechanisms. J Neurosci Rural Pract.2018 Apr-Jun;9(2):180-185.Available from:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5912021/

12. H. Balubiad, et al. Caregivers burden of chronic medical illness in older patients. Inter Journ of Aca Sci Research.4;4 2016 Nov-Dec. page- 56-62.Available from:https://www.academia.edu/34347406/Caregivers_Burden_of_Chronic_Medical_Illnesses_in_Older_Patients

13. Ms. George A et al. A study to assess the level of burden among the care givers of patients with mental illness in a selected hospital at Mangaluru. EJBPS.6;4.2021 Nov, PP-219-223. Available from:https://www.researchgate.net/publication/356537295_A_STUDY_TO_ASSESS_THE_LEVEL_OF_BURDEN_AMONG_THE_CARE_GIVERS_OF_PATIENTS_WITH_MENTAL_ILLNESS_IN_A_SELECTED_HOSPITAL_AT_MANGALURU

14. Vijayalakshmi D., Sunitha D. A comparative study of caregivers burden in psychiatric illness and chronic medical illness. IOSR-JDMS [Internet]. 2018[cited 2018 Aug 30]; 17(8): 47-56. Available from: https://www.iosrjournals.org/iosr-jdms/papers/Vol17-issue8/Version-11/J1708114756.pdf

15. Cham CQ.,et al. Caregiver burden among caregivers of patients with mentl illness: A systematic review & meta analysis. MDPI [Internet].2022; 10(12):2423. Available from: https://www.mdpi.com/2227-9032/10/12/2423

16. Behere P. et al. Comparative study of burden in caregivers of patients with schizophrenia and depression. EJMCM.[Internet].2020 July;7(07):1916-1930. Available from: https://ejmcm.com/article_4871_2034d29404814af716b6a6296cec4a40.pdf

17. Nenobais A., Jatimi A., Jufriyanto M. Family burden for the caregivers of people with mental disorders: a systematic review. Jurnal NERS [Internet]. 2019; 14(3):26-34. Available from: https://www.researchgate.net/publication/339847015_Family_Burden_for_the_Caregivers_of_People_with_Mental_Disorders_A_Systematic_Review

18. Ajibade B.L., et al. burden experienced by family caregivers of patients with mental disorders at selected hospitals in Ekiti state, Nigeria. IJHPR [Internet]. 2016 June;4(2):14-41.Available from: http://www.eajournals.org/wp-content/uploads/Burden-Experienced-By-Family-Caregivers-of-Patients-with-Mental-Disorders-at-Selected-Hospitals-in-Ekiti-State-Nigeria..pdf

19. Ignatova D., Kamusheva M., Petrova G., Onchev G. Burden of informal care for individuals with schizophrenia & affective disorders prior to hospital admission. EJPSY [Internet].2015-2016 [cited 2019 Apr-June]; 33(2):54-62. Available from: https://www.elsevier.es/en-revista-european-journal-psychiatry-431-articulo-burden-informal-care-for-individuals-S0213616318300879

20. Kunwar D. et. al. The study of burden of family caregivers of patients living with psychiatric disorders in remote area of Nepal. Kathmandu Univ Med J. Online First [Internet].18(70):40-45. Available from: https://www.nepjol.info/index.php/KUMJ/article/view/33224/26141

21. Mital AK., Sabnis SG., Kulkarni VV. Caregiver burden in medical versus psychiatric patients: A cross-sectional comparative study. IJPM [Internet]. 2017 [cited 2017 Nov- Dec]; 39(6): 777-84. DOI: 10.4103/IJPSYM.IJPSYM_335_17

22. Dr. Gupta P, Bharti P., Bathla M., Singh AH., Bhusri L. A cross-sectional study to assess the caregiver burden and the quality of life of caregivers of the patients suffering with psychiatric illness. IndPsychiatry J[serial online]2022[cited 2023 Jan 7];31(1):151-157. Available from: https://www.industrialpsychiatry.org/article.asp?issn=0972-6748;year=2022;volume=31;issue=1;spage=151;epage=157;aulast=Gupta

23. Stanley S., Bhuvaneswari GM., & Bhakyalakshmi S. Mental health status & perceived burden in caregiving spouses of personswith psychotic illness (A study from India). [Dissertation on the internet].India. Available from: https://core.ac.uk/download/pdf/42606632.pdf

24. Dr. Bora K., Dr. Das A. family burden in caregivers of chronic schizophrenia and bipolar affective disorder- a comparative study. JMSCR [Internet][cited 2017 Nov 11]; 05(11):30237-47. Available from: https://jmscr.igmpublication.org/home/index.php/current-issue/3701-family-burden-in-carevers-of-chronic-schizophrenia-and-bipolr-affective-disorder-a-comparative-study

25. Mathur S., Chadran S., Kishor M., Prakrihi SN., Rao SS. A comparative study of caregiver burden and self- efficacy in chronic psychiatric illness and chronic medical illness: A pilot study. Arch Ment Health [serial online].2018[cited 2023 Jan 3]; 19(2):115-122. Available from: https://www.amhonline.org/article.asp?issn=2589-9171;year=2018;volume=19;issue=2;spage=115;epage=122;aulast=Mathur

26. ShahSZH., Tabassum AS., Saeed N. A comparative study of anxiety, depression & stress in caregivers of psychiatric illness & chronic medical illness in Multan.Pak Armed Forces Med J 2022; 72 (Suppl-2): S191-194. Available from: https://pafmj.org/index.php/PAFMJ/article/download/8843/4095

27. Singh PM, Prajapati A. Burden of schizophrenia on caregivers in Nepal, Nepal Med Coll J.2013; 15(2):140-3. Available from: PMID 24696936

28. H.JB., Rani VN. A study to compare caregiver burden in psychiatric illness & chronic medical illness in selected hospitals at Ahmedabad. Int. J. Adv. Nur. Management. 2017; 5(1): 1-3. Available from: https://ijanm.com/AbstractView.aspx?PID=2017-5-1-1

29. Polit FD, Beck TC. Nursing research : Generating and Assessing Evidence for Nursing Practice. 8th ed. New Delhi: Wolters Kluwer (India) Pvt. Ltd;2008.333-347

30. Inogo C F, Olotu S O, James B O, Nna E O. Burden of Care amongst Caregivers Who are First Degree Relatives of Patients with Schizophrenia. The Pan African Medical Journal 2017; 28: 284 doi:10.11604/panj.2017.28.284.11574 PubMed .

31. Sharma SK. Nursing Research & Statistics .2nd ed. New Delhi: Elsevier India Pvt. Ltd; 2015. 40, 71,138, 286, 288, 291.

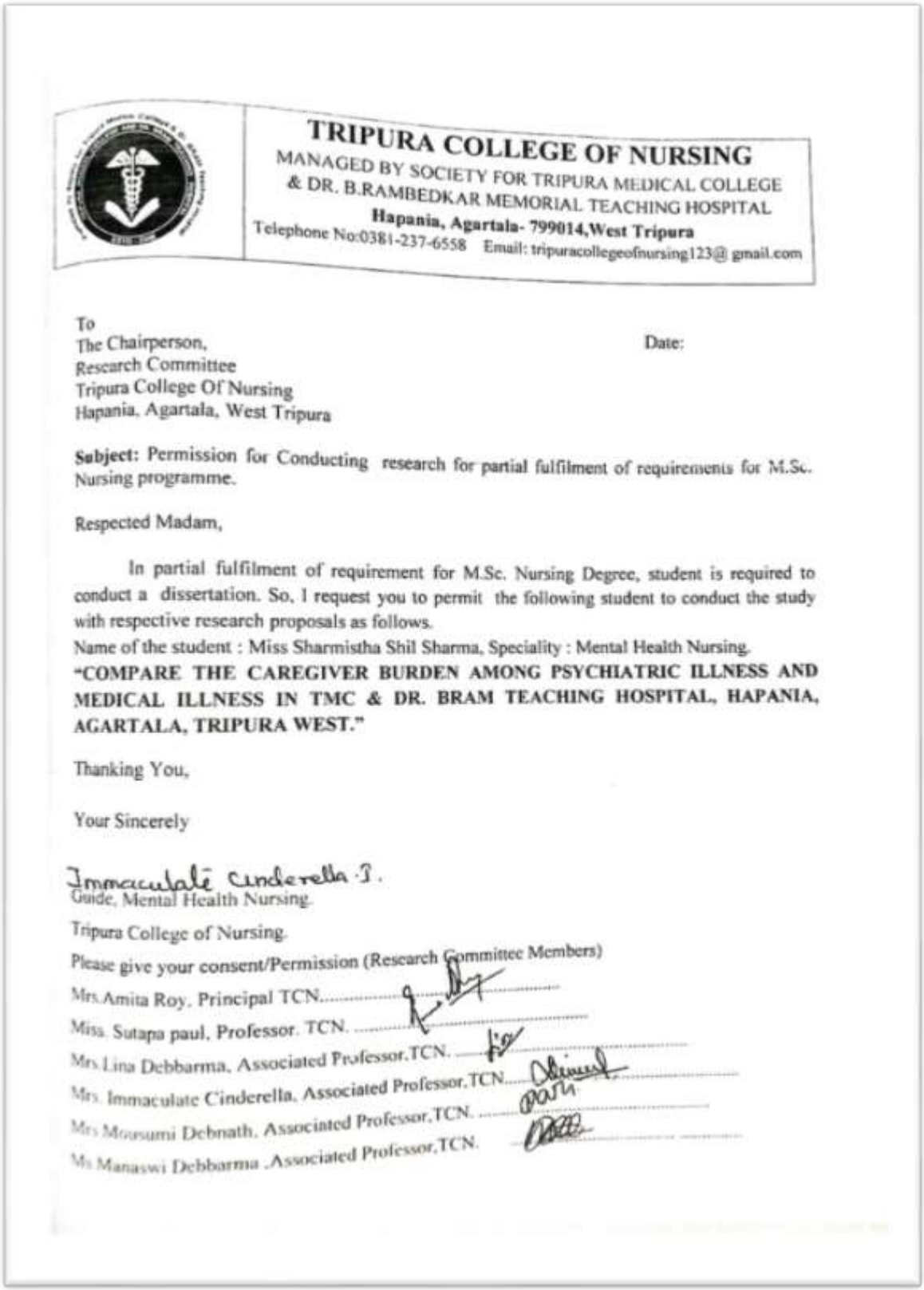
32. Polit FD, Hungler BP. Nursing Research:Principles and Methods. 8th ed. Philadelphia: Wolters Kluwer Publications; 2008.

33. Treece EW, Treece JW. Elements of research in nursing. 2nd ed.St. Louis Missouri: Mosby Publication; 1977[[Added date 2012-03-07]. Available from: https://archive.org/details/elementsofresear00tree.

34. Dr. Sudhakar V., Dr. Ramamurthy D., Dr. Shetty VB. The assessment of caregiver burden in caregiversof insured haemodialysis patients at a tertiary hospital in Bangalore. NIJ [Internet].2018[cited 2021 Feb]; 2(1):1-6. Available from:https://www.researchgate.net/publication/350399091_The_assessment_of_caregiver_burden_in_caregivers_of_insured_haemodialysis_patients_at_a_tertiary_hospital_in_Bangalore

ANNEXURE-I

LETTER SEEKING PERMISSION FROM RESEARCH COMMITTEE TO CONDUCT THE STUDY



TRIPURA COLLEGE OF NURSING
MANAGED BY SOCIETY FOR TRIPURA MEDICAL COLLEGE
& DR. B.RAMBEDKAR MEMORIAL TEACHING HOSPITAL
Hapania, Agartala- 799014,West Tripura
Telephone No:0381-237-6558 Email: tripuracollegeofnursing123@ gmail.com

To
The Chairperson,
Research Committee
Tripura College Of Nursing
Hapania, Agartala, West Tripura

Date:

Subject: Permission for Conducting research for partial fulfilment of requirements for M.Sc. Nursing programme.

Respected Madam,

In partial fulfilment of requirement for M.Sc. Nursing Degree, student is required to conduct a dissertation. So, I request you to permit the following student to conduct the study with respective research proposals as follows.

Name of the student : Miss Sharmistha Shil Sharma, Speciality : Mental Health Nursing.

"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TMC & DR. BRAM TEACHING HOSPITAL, HAPANIA, AGARTALA, TRIPURA WEST."

Thanking You,

Your Sincerely

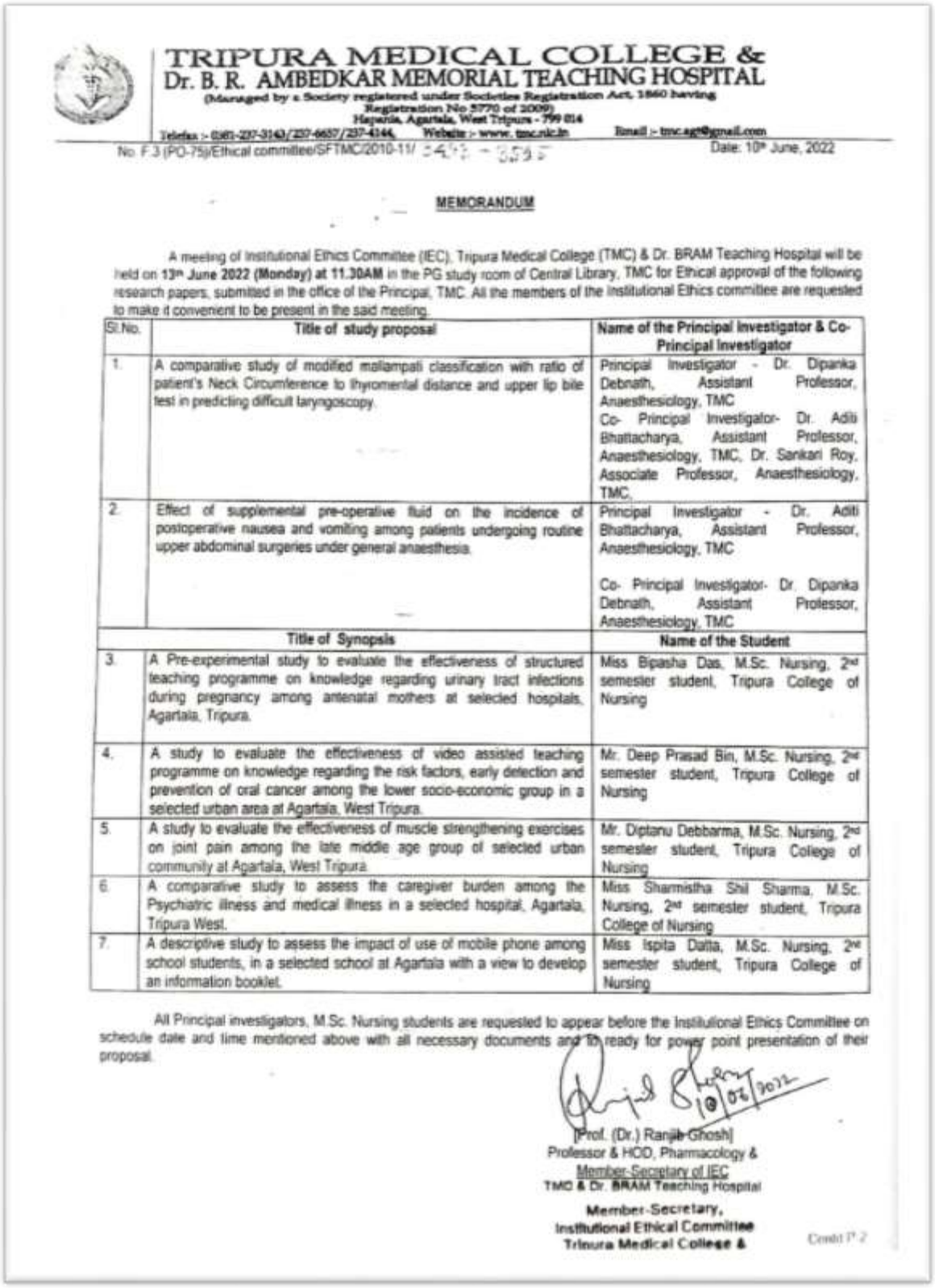
Immaculate Cinderella .I.
Guide, Mental Health Nursing.
Tripura College of Nursing.

Please give your consent/Permission (Research Committee Members)

Mrs.Amita Roy, Principal TCN.....
Miss. Sutapa paul, Professor. TCN. .....
Mrs.Lina Debbarma, Associated Professor,TCN. .....
Mrs. Immaculate Cinderella, Associated Professor,TCN.....
Mrs Mousumi Debnath, Associated Professor,TCN. .....
Ms Manaswi Debbarma ,Associated Professor,TCN.

ANNEXURE-II

LETTER SEEKING PERMISSION FROM INSTITUTIONAL ETHICS COMMITTEE TO CONDUCT THE STUDY



TRIPURA MEDICAL COLLEGE &
Dr. B. R. AMBEDKAR MEMORIAL TEACHING HOSPITAL
(Managed by a Society registered under Societies Registration Act, 1860 having
Registration No 5770 of 2009)
Hapania, Agartala, West Tripura - 799 014
Telefax :- 0381-237-3143/237-6657/237-4144, Website :- www.tmc.nic.in Email :- tmc.agt@gmail.com

No. F.3 (PO-75)/Ethical committee/SFTMC/2010-11/ 3412 - 3595 Date: 10th June, 2022

MEMORANDUM

A meeting of Institutional Ethics Committee (IEC), Tripura Medical College (TMC) & Dr. BRAM Teaching Hospital will be held on **13th June 2022 (Monday) at 11.30AM** in the PG study room of Central Library, TMC for Ethical approval of the following research papers, submitted in the office of the Principal, TMC. All the members of the Institutional Ethics committee are requested to make it convenient to be present in the said meeting.

Sl.No.	Title of study proposal	Name of the Principal Investigator & Co-Principal Investigator
1.	A comparative study of modified mallampati classification with ratio of patient's Neck Circumference to thyromental distance and upper lip bite test in predicting difficult laryngoscopy.	Principal Investigator - Dr. Dipanka Debnath, Assistant Professor, Anaesthesiology, TMC Co- Principal Investigator- Dr. Aditi Bhattacharya, Assistant Professor, Anaesthesiology, TMC, Dr. Sankari Roy, Associate Professor, Anaesthesiology, TMC,
2.	Effect of supplemental pre-operative fluid on the incidence of postoperative nausea and vomiting among patients undergoing routine upper abdominal surgeries under general anaesthesia.	Principal Investigator - Dr. Aditi Bhattacharya, Assistant Professor, Anaesthesiology, TMC Co- Principal Investigator- Dr. Dipanka Debnath, Assistant Professor, Anaesthesiology, TMC
	Title of Synopsis	**Name of the Student**
3.	A Pre-experimental study to evaluate the effectiveness of structured teaching programme on knowledge regarding urinary tract infections during pregnancy among antenatal mothers at selected hospitals, Agartala, Tripura.	Miss Bipasha Das, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
4.	A study to evaluate the effectiveness of video assisted teaching programme on knowledge regarding the risk factors, early detection and prevention of oral cancer among the lower socio-economic group in a selected urban area at Agartala, West Tripura.	Mr. Deep Prasad Bin, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
5.	A study to evaluate the effectiveness of muscle strengthening exercises on joint pain among the late middle age group of selected urban community at Agartala, West Tripura.	Mr. Diptanu Debbarma, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
6.	A comparative study to assess the caregiver burden among the Psychiatric illness and medical illness in a selected hospital, Agartala, Tripura West.	Miss Sharmistha Shil Sharma, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
7.	A descriptive study to assess the impact of use of mobile phone among school students, in a selected school at Agartala with a view to develop an information booklet.	Miss Ispita Datta, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing

All Principal investigators, M.Sc. Nursing students are requested to appear before the Institutional Ethics Committee on schedule date and time mentioned above with all necessary documents and to ready for power point presentation of their proposal.

10/06/2022

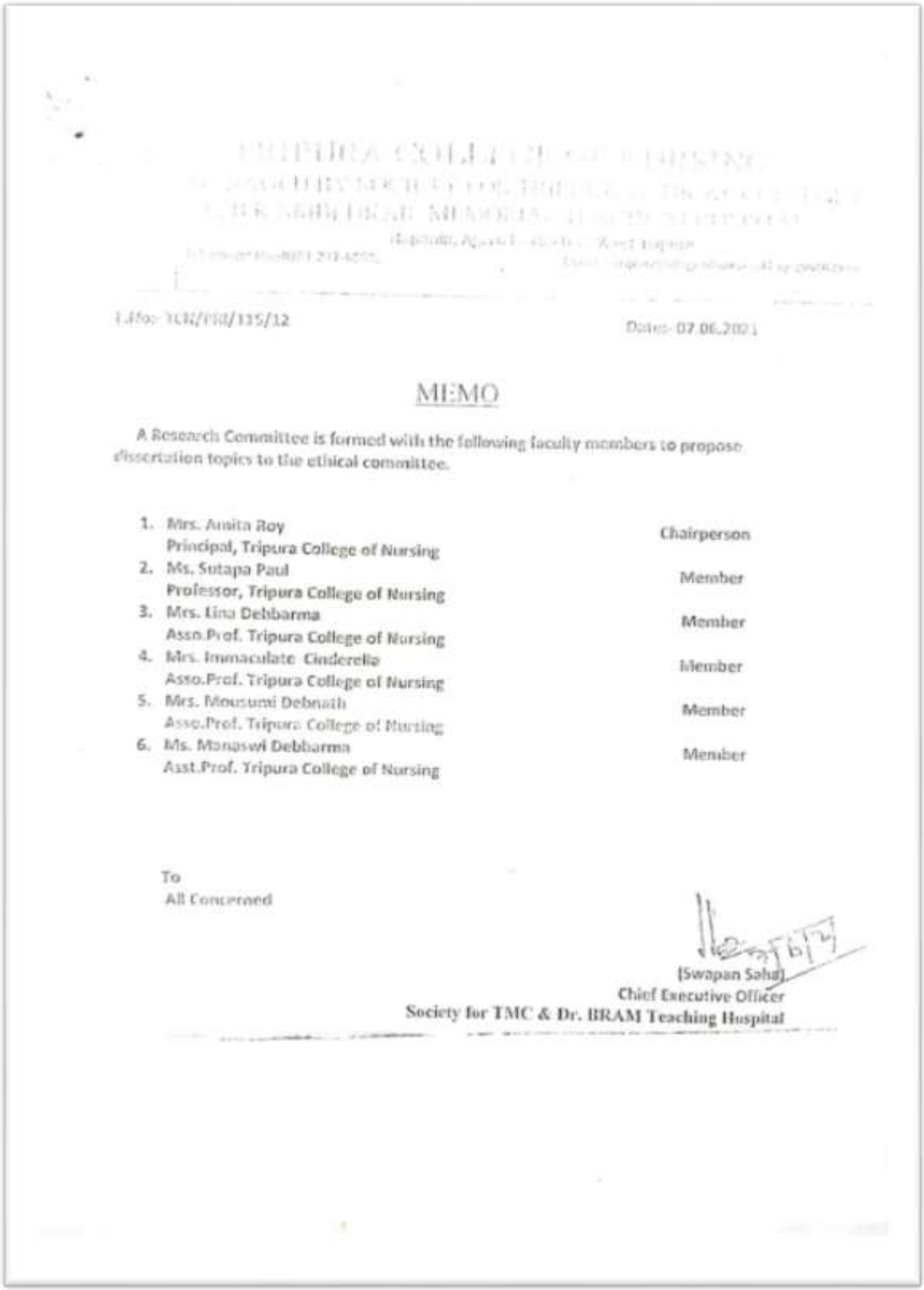
[Prof. (Dr.) Ranjit Ghosh]
Professor & HOD, Pharmacology &
Member-Secretary of IEC
TMC & Dr. BRAM Teaching Hospital

Member-Secretary,
Institutional Ethical Committee
Tripura Medical College &

Contd P/2

ANNEXURE-III

LIST OF MEMBERS OF RESEARCH COMMITTEE



Ref No: TCH/RSH/135/12 Dated: 07.06.2021

MEMO

A Research Committee is formed with the following faculty members to propose dissertation topics to the ethical committee.

1. Mrs. Anita Roy — Chairperson
   Principal, Tripura College of Nursing
2. Ms. Sutapa Paul — Member
   Professor, Tripura College of Nursing
3. Mrs. Lina Debbarma — Member
   Asso.Prof. Tripura College of Nursing
4. Mrs. Immaculate Cinderella — Member
   Asso.Prof. Tripura College of Nursing
5. Mrs. Mousumi Debnath — Member
   Asso.Prof. Tripura College of Nursing
6. Ms. Manaswi Debbarma — Member
   Asst.Prof. Tripura College of Nursing

To
All Concerned

[Swapan Saha]
Chief Executive Officer
Society for TMC & Dr. BRAM Teaching Hospital

ANNEXURE-IV

LIST OF MEMBERS OF INSTITUTIONAL ETHICS COMMITTEE

TRIPURA MEDICAL COLLEGE &
Dr. B. R. AMBEDKAR MEMORIAL TEACHING HOSPITAL
(Managed by a Society registered under Societies Registration Act, 1860 having
Registration No 5770 of 2009)
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Telefax :- 0381-237-0141/237-6457/237-4144, Website :- www.tmc.nic.in Email :- tmc.agt@gmail.com

P-2

No. F.3 (PO-75)/Ethical committee/SFTMC/2010-11/2899-2918 Date: 19th May, 2022

To

1. Dr. Jaharlal Saha, Chairperson, IEC.
2. Prof. Ranjib Ghosh, HOD Pharmacology, Member-Secretary, IEC.
3. Prof. Dibakar Dey, HOD Physiology, Member IEC.
4. Prof. D.P. Chakrabarti, HOD of General Medicine, Member IEC.
5. Prof. Abhijit Sarkar, HOD of Orthopaedics, Member IEC.
6. Dr. Lakshman Das, Associate Professor, Pharmacology, Member IEC.
7. Dr. Nirmalya Saha, Associate Professor, Anatomy, Member IEC.
8. Ms. Sutapa Paul, Professor, TCN, Member IEC
9. Mr. Arindam Roy, Advocate, Member IEC.
10. Mr. Abhijit Mallick, Member IEC.
11. Smt. Kajal Debnath, Member IEC.

Copy to:

1. Dr. Dipanka Debnath, Assistant Professor, Anaesthesiology, TMC
2. Dr. Aditi Bhattacharya, Assistant Professor, Anaesthesiology, TMC
3. Miss Bipasha Das, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
4. Mr. Deep Prasad Bin, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
5. Mr. Diptanu Debbarma, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
6. Miss Sharmistha Shil Sharma, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing
7. Miss Ispita Datta, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing

Copy for kind information to:

1. The Chief Executive Officer, SFTMC
2. The Principal, TMC
3. The Principal, TCN
4. The GM (HR), SFTMC
5. Mrs. Payel Banerjee, Librarian, Central Library is requested to arrange the PG study room accordingly for conduction of the meeting.

10/05/2022

[Prof. (Dr.) Ranjib Ghosh]
Professor & HOD, Pharmacology &
Member-Secretary of IEC
TMC & Dr. BRAM Teaching Hospital
Member-Secretary,
Institutional Ethical Committee
Tripura Medical College &
Dr. BRAM Teaching Hospital

ANNEXURE-V

LETTER SEEKING PERMISSION TO CONDUCT PILOT STUDY

To
The Principal,
Tripura College Of Nursing
Hapania, Agartala, West Tripura

Subject: Permission letter for your student to conduct the pilot study in my clinic.

Respected Madam,

This is give consent to your student Miss Sharmistha Shil Sharma, to conduct the research study on **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."** And I hope during her study the patients will not get any harm & she will complete her work by following the ethical principles.

Therefore, she can conduct her research study in due time.

Best wishes for student.

Thanking You.

Sincerely,

22.6.21

The Medical Officer of Department of Psychiatry
Agartala, West Tripura

Date:

Place:

ANNEXURE-V

LETTER SEEKING PERMISSION TO CONDUCT PILOT STUDY

To
The Principal,
Tripura College Of Nursing
Hapania, Agartala, West Tripura

Subject: Permission letter for your student to conduct the pilot study in my clinic.

Respected Madam,

This is give consent to your student Miss Sharmistha Shil Sharma, to conduct the research study on **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."** And I hope during her study the patients will not get any harm & she will complete her work by following the ethical principles.

Therefore, she can conduct her research study in due time.

Best wishes for student.

Thanking You.

Sincerely.

01/04/2023

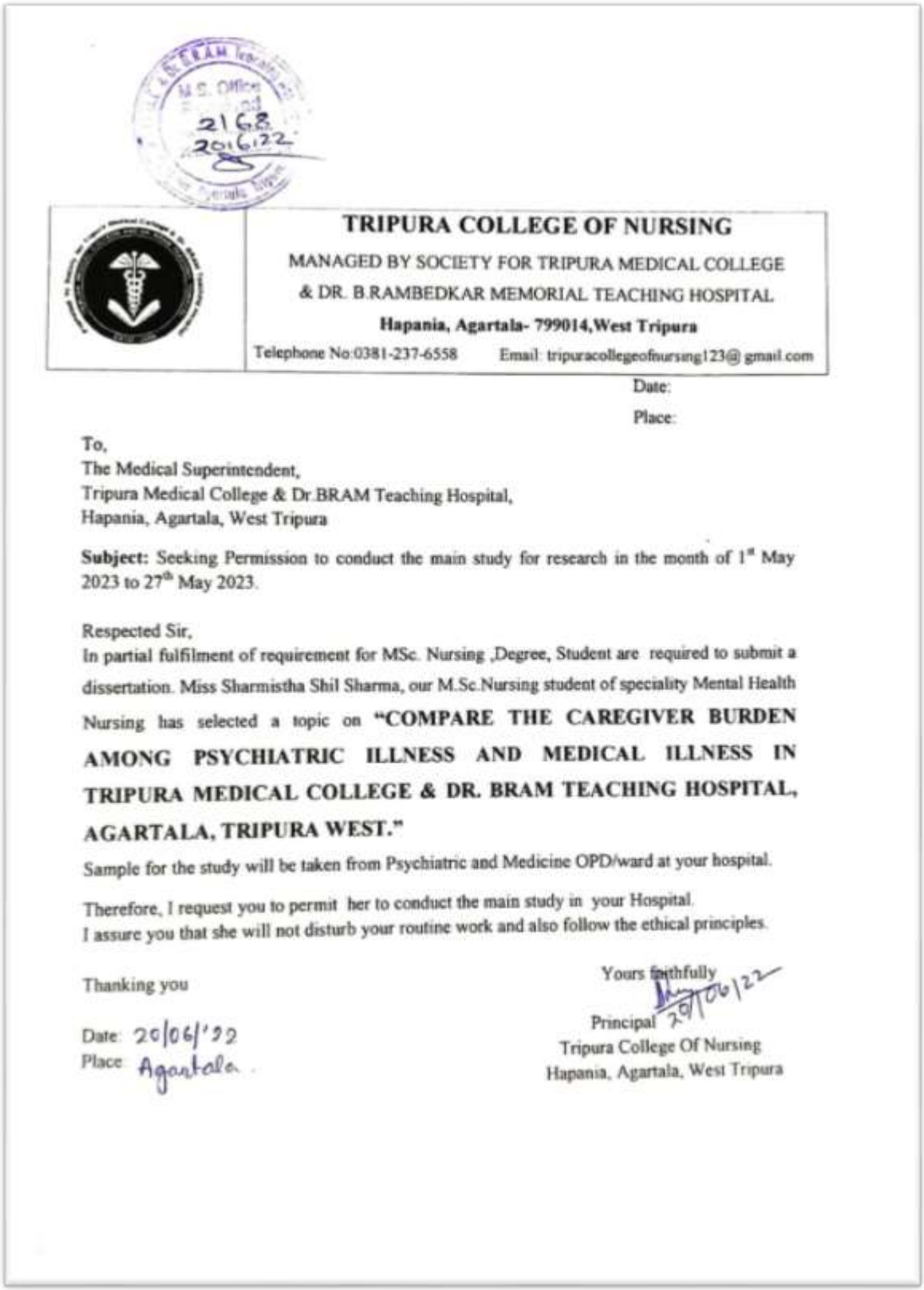
Dr. Dipankar Prakas Bhaumik
MD(Medicine),DFID, FIACM, FICP
Assoc. Professor, Dept. of Medicine
Tripura Med. al College
& Dr. BRAM Hospital
Agartala, Tripura

The Medical Officer of Department of Medicine
Agartala, West Tripura

Date: 01/04/2023
Place: Agartala, Tripura

ANNEXURE-VI

LETTER SEEKING PERMISSION TO CONDUCT MAIN STUDY



M.S. Office
2168
20/6/22

TRIPURA COLLEGE OF NURSING

MANAGED BY SOCIETY FOR TRIPURA MEDICAL COLLEGE
& DR. B.RAMBEDKAR MEMORIAL TEACHING HOSPITAL
Hapania, Agartala- 799014,West Tripura
Telephone No:0381-237-6558 Email: tripuracollegeofnursing123@ gmail.com

Date:
Place:

To,
The Medical Superintendent,
Tripura Medical College & Dr.BRAM Teaching Hospital,
Hapania, Agartala, West Tripura

Subject: Seeking Permission to conduct the main study for research in the month of 1st May 2023 to 27th May 2023.

Respected Sir,
In partial fulfilment of requirement for MSc. Nursing ,Degree, Student are required to submit a dissertation. Miss Sharmistha Shil Sharma, our M.Sc.Nursing student of speciality Mental Health Nursing has selected a topic on **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

Sample for the study will be taken from Psychiatric and Medicine OPD/ward at your hospital.

Therefore, I request you to permit her to conduct the main study in your Hospital.
I assure you that she will not disturb your routine work and also follow the ethical principles.

Thanking you

Yours faithfully
20/06/22
Principal
Tripura College Of Nursing
Hapania, Agartala, West Tripura

Date: 20/06/'22
Place: Agartala

ANNEXURE-VI

LETTER SEEKING PERMISSION TO CONDUCT MAIN STUDY

To
The Principal,
Tripura College Of Nursing
Hapania, Agartala, West Tripura

Subject: Permission letter for your student to conduct main research study in our hospital, in the duration of 1st May, 2023 to 28th May,2023.

Respected Madam,

This is give consent to your student Miss Sharmistha Shil Sharma, to conduct the research study on **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."** And I hope during her study the patients will not get any harm & she will complete her work by following the ethical principles.
Therefore, she can conduct her research study in due time.

Best wishes for student.
Thanking You.
Sincerely,

The Medical Superintendent of
Tripura Medical College & Dr. BRAM Teaching Hospital
Hapania, Agartala, West Tripura.

PROF. (DR.) [illegible]TA KUMAR PODDAR
MEDICAL SUPERINTENDENT
TMC & Dr. BRAM Teaching Hospital

ANNEXURE-VII

ETHICAL CLEARANCE CERTIFICATE TO CONDUCT THE STUDY

TRIPURA MEDICAL COLLEGE &
Dr. B. R. AMBEDKAR MEMORIAL TEACHING HOSPITAL
(Managed by a Society registered under Societies Registration Act, 1860 having
Registration No 5770 of 2009)
Hapania, Agartala, West Tripura - 799 014
Telefax :- 0381-237-3143/237-6657/237-4144, Website :- www. tmc.nic.in Email :- tmc.agt@gmail.com

No. F.3 (PO-75)/Inst. Ethical Com./SFTMC/09 (Sub-1)/4230 Date: 2nd July, 2022

ETHICAL CLEARANCE CERTIFICATE

The Institutional Ethics Committee, Tripura Medical College (TMC) & Dr. BRAM Teaching Hospital has approved to conduct the following study from the ethical point of view.

Ref. Sl.	Title of Synopsis	Name of the Principal Investigator (PI)
IEC/SFTMC/2022/3/006	Compare the caregiver burden among Psychiatric illness and medical illness in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, Tripura West.	Miss Sharmistha Shil Sharma, M.Sc. Nursing, 2nd semester student, Tripura College of Nursing

02/07/2022
(Dr. Jaharlal Saha)
Chairperson,
Institutional Ethics Committee
Tripura Medical College &
Dr. BRAM Teaching Hospital
Chairperson,
Institutional Ethical Committee
Tripura Medical College &
Dr. BRAM Teaching Hospital

To
Miss Sharmistha Shil Sharma,
M.Sc. Nursing, 2nd semester student,
Tripura College of Nursing

ANNEXURE-VIII

LETTER SEEKING EXPERT'S OPINION AND SUGGESTIONS FOR CONTENT VALIDITY OF THE TOOL

From
Miss. Sharmistha Shil Sharma
M.Sc Nursing 3rd semester
Tripura College of Nursing
Hapania, Agartala, Tripura West

To , ……..

Forwarded through
Mrs. Amita Roy
Principal
Tripura College of Nursing, Hapania, Agartala, Tripura West.

Subject: Expert opinion for content validity of the research tool.

Respected Sir/Madam,

I , Miss. Sharmistha Shil Sharma, M.Sc Nursing 3rd semester student in the specialty of Mental Health Nursing in Tripura College of Nursing request your good self, if you could kindly accept to validate my research tool on topic **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

I would be obliged if you kindly affirm your acceptance to the undersigned with your valuable suggestions on this topic.

Thanking you in anticipation.

Date: Yours sincerely,

Place: Sharmistha Shil Sharma

PRINCIPAL TRIPURA COLLEGE OF NURSING HAPANIA, AGARTALA

Enclousure: Sharmistha Shil Sharma.

1] Problem statement, objectives of the study

2]Research methodology

3] Tool I-Socio-Demographic data

4] Tool II- Standard Zarit Burden Interview Scale

5] Scoring key and answer key

6] Evaluation criteria checklist for Tool I

7] Content validity certificate

ANNEXURE-IX

LIST OF EXPERTS FOR CONTENT VALIDITY OF THE TOOLS

SL NO.	Name of the validators	Designation	Signature
1.	Dr. Mridula Saikia	Principal, ILS College Of Nursing, Agartala, Tripura	[Prof. (Dr) Mridula Saikia K] Principal ILS Nursing Institute Agartala, Tripura (W)
2.	Dr. Subhra Sarkar	Nursing tutor, Department of Psychiatric Nursing, LGBRIMH, Tezpur	
3.	Mrs. Madhushri Manna	Professor cum Vice Principal, College of Nursing, Asia Heart Foundation, Kolkata	
4.	Dr. Ganajit Debbarma	Professor & HOD Dept. of Psychiatry, TMC & Dr. BRAM Teaching Hospital	
5.	Mrs. Poulami Dutta	Nursing Superintendant Cum Principal (Nursing Training) Antara Psychiatry Hospital, Kolkata	Poulami Dutta Nursing Superintendent Cum Principal (Nursing Training) ANTARA
6.	Mr. Nitai Chad Mukherjee	Psychiatric Social Worker, Antara Psychiatry Hospital, Kolkata	N. C. Mukherjee B.Sc., P.G.B.T., M.Sc., M.S.W Dip. in PSW, M.Phil in PSW Regd. No. B/C – 7958
	Ms. Indrani Chakraborty	Chief Clinical Psychologist, Antara Psychiatric Hospital, Kolkata	Indrani Charkaborty Chief Clinical Psychologist Antara Psychiatric Hospital Kolkata- 700 145

ANNEXURE-X

EVALUATION CRITERIA CHECKLIST FOR VALIDATION OF TOOLS

Respected evaluator,

Kindly go through the evaluation criteria checklist for validation of the tool. There are two columns given for your responses and a column for remarks. Kindly place a tick in appropriate column and gives your remarks.

SL.NO	CONTENT	YES	NO	REMARKS
1.	Socio- Demographic Data: All characteristics necessary for the study are included.			
2.	Standerdized Zarit Burden Interview Schedule to assess the level of burden among the caregivers of the psychiatric ill or medically ill patients.			

ANY OTHER COMMENTS :

DESIGNATION:

NAME OF THE EVALUATOR:

SIGNATURE:

ANNEXURE-XI

VALIDATOR'S OPINION REGARDING SOCIO-DEMOGRAPHIC DATA

Respected Madam,

Kindly go through the content and place tick mark against the question in following columns ranging from relevant to not relevant, when found needs notification, kindly give your opinion in the remarks column.

SL NO.	ITEMS	RELEVANT	NEEDS MODIFICATION	NOT RELEVANT	REMARKS
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					

Date: Signature of Expert with Seal

Place: Name & Designation

ANNEXURE-XII

CONTENT VALIDITY CERTIFICATE

I hereby certify that I have validated the tool of Ms. Sharmistha Shil Sharma, M.Sc Nursing Student, who is undertaking a study **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

Date:

Place: Signature and seal of the expert

Name & Designation

ANNEXURE-XIII

LETTER SEEKING CONSENT OF THE SUBJECTS FOR PARTICIPATION IN THE STUDY

Participant ID…….

PART-I (Participants information sheet)

Title:"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESSIN TRIPURA MEDICAL COLLEGE& DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."

Principal Investigator (PI) : Miss. Sharmistha Shil Sharma

Introduction : I am Sharmistha Shil Sharma, working on a study at Tripura College of Nursing, Hapania, West Tripura and I am collecting the data for study called "COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESSIN TRIPURA MEDICAL COLLEGE& DR. BRAM TEACHING HOSPITAL,AGARTALA, TRIPURA WEST."

You are being requested for participation by chance and not for any other reasons. This consent form gives information about the study. If you are willing to participate , it is necessary for you to sign this consent form on today's date. If you are not willing to participate or do not wish to sign than a witness will sign it for you.

Purpose of study:

The study is done to throw some light on compare the burden of the caregivers among the psychiatric illness and medical illness in TMC & Dr. BRAM Teaching hospital, Hapania, Agartala, Tripura West.

Procedure of the study: Permission will be granted from the selected hospital before data collection. 1st day I will go to selected hospital and choose the sample by the sampling technique. After that I will explain about the study and the purpose and nature of the study and the procedure of data collection. Consent form will be provide to the willing participants and then consent taken from the participants. The data will be collected by the Socio-demographic proforma & The Zarit Burden Interview. By this way I will collect the data from the Psychiatric OPD also .

Study population:60 nos. caregivers.

Risks & Benefits of participating in the study:

Risks: You may decline to answer any or all questions and you may terminate your involvement at any time if you choose.

Benefits: Partcipating in this study will help you to know the reason of the burden which is felt by you during giving the care.

If you decide not to participate in the study: Your participation in this study is entirely voluntary. It is your choice whether to participate or not. If you choose not to sign, you will not be disturbed again, you may also choose to your mind later and stop participating, even if you agreed earlier.

Confidentiality: The information that I collect from you for the purpose of this research study will be kept confidential and no one but the researchers will be able to see it.

Problems about the study: If you have any questions about this study or in case of research related enquiries you should contact Miss. Sharmistha Shil Sharma, Tripura College of Nursing, Agartala, Tripura West. My contact number is +91-9612363676.

PART-II (CONSENT FORM)

VOLUNTARY CONSENT BY THE PARTICIPANT

Participation in this study is completely voluntary and your consent is required before you participate in this study.

I have read this consent form completely (or it has been read to me) and I fully understand the contents of this document and voluntarily consent to participate in the study. I understand that I can withdraw my participation any time, if I feel o. I have received and understood the information about my rights and have been promised that my personal information shall be kept confidential. All of my questions concerning this study have been answered. All my doubts have been cleared.

I want to participate in this study myself by my own free will.

I have been offered a copy of my consent form and I want a copy of my consent form/I don't want a copy of my consent form. I understand that any time I can contact the investigators in case of any doubt. If I have any questions in the future about this study they will be answered by the investigators listed below. I have been promised to be provided of any new development/ information which has a bearing to this study. I understand that this consent ends at the conclusion of this study.

Contact Address with Phone number:

Prnciple investigator Name and contact no.	**Address for communication**
Miss. Sharmistha Shil Sharma Contact No. (M) :+ 91-9612363676 (for 24 x7 communication)	Department of Mental Health Nursing Tripura College of Nursing

Place: Agartala, West Tripura Name:

Date: Participant's full signature with date:

Thumb impression of participant:

Witness name and relation:

Witness full signature with date:

Address of the witness:

সম্মতি পত্র

অংশ -১ (অংশগ্রহনকারীর তথ্যপত্র)

শিরোনামঃ "কম্পেয়ার দ্য কেয়ারগিভার বার্ডেন এমং সাইকিয়াট্রিক ইলনেস অ্যান্ড মেডিকেল ইলনেস ইন ত্রিপুরা মেডিকাল কলেজ অ্যান্ড ডঃ ব্রাম টিচিং হসপিটাল, হাঁপানিয়া, আগরতলা, ত্রিপুরা ওয়েস্ট।"

প্রধান তদন্তকারীঃ- মিস শর্মিষ্ঠা শীল শর্মা।

ভূমিকাঃ- আমি শর্মিষ্ঠা শীল শর্মা ত্রিপুরা মেডিকেল কলেজ অ্যান্ড ডঃ ব্রাম টিচিং হসপিটাল, আগরতলা, ওয়েস্ট ত্রিপুরাতে একটি গবেষণার ওপর কাজ করছি এবং এই গবেষণার জন্য তথ্য সংগ্রহ করছি যার নাম "কম্পেয়ার দ্য কেয়ারগিভার বার্ডেন এমং সাইকিয়াট্রিক ইলনেস অ্যান্ড মেডিকেল ইলনেস ইন টিএমসি অ্যান্ড ডঃ ব্রাম টিচিং হসপিটাল, হাঁপানিয়া, আগরতলা, ত্রিপুরা ওয়েস্ট ।"

আপনাকে সুযোগক্রমে এই গবেষণায় অংশগ্রহনের জন্য অনুরোধ করা হচ্ছে , অন্য কোনো কারনে নয়। এই ফর্মটি গবেষণা সম্পর্কে সমস্ত তথ্য দেয়। আপনি যদি এই গবেষণায় অংশগ্রহনে ইচ্ছুক হন, তাহলে আজকের তারিখে আপনাকে এই সম্মতি ফর্মে সাক্ষর করতে হবে। যদি আপনি অংশগ্রহনে ইচ্ছুক হন, এবং আপনি সাক্ষর করতে না পারেন বা করতে না চান, তাহলে একজন স্বাক্ষী আপনার জন্য এইটি স্বাক্ষর করে দেবেন।

গবেষণার উদ্দেশ্যঃ-এই গবেষণাতে মূলত আলোকপাত করা হয়েছে - আগরতলা, ওয়েস্ট ত্রিপুরার সিলেক্টেড হসপিটালের সাইকিয়াট্রিক ইলনেস এবং মেডিকেল ইলনেস নিয়ে আসা রোগীদের কেয়ারগিভারদের বার্ডেন-এর মধ্যে।

গবেষণার পদ্ধতিঃ-তথ্য সংগ্রহের পূর্বে নির্বাচিত হাসপাতাল থেকে আমি অনুমতি নেব। তথ্য সংগ্রহের প্রথম দিন আমি হাসপাতালে যাব এবং উদ্দেশ্যমূলক নমুনা কৌশল দ্বারা অংশগ্রহণকারীদের নির্বাচন করব। তারপর আমি অংশগ্রহণকারীদের গবেষণার উদ্দেশ্য, প্রকৃতি ও তথ্য সংগ্রহ পদ্ধতি ব্যাখ্যা করব। তারপর তাদের মধ্যে থেকে স্বেচ্ছায় অংশগ্রহণকারীদেরকে সম্মতি ফর্ম প্রদান করব, এতে তাদের স্বাক্ষর নেওয়ার পর সোসিও-ডেমোগ্রাফিক প্রফোর্মা এবং মডিফাইড জারিত বার্ডেন ইন্টারভিউ এর মাধ্যমে তাদের থেকে তথ্য সংগ্রহ করব। এই পদ্ধতিতেই আমি উভয় বিভাগ থেকে তথ্য সংগ্রহ করব।

গবেষণারজনসংখ্যা ঃ- ৬০ জন কেয়ারগিভার ।

গবেষণায় অংশগ্রহনের ঝুঁকি ও সুবিধাঃ-

ঝুঁকিঃ- গবেষণায় অংশ নিয়ে আপনারা যে কোনোওপ্রশ্নের বা সমস্ত প্রশ্নের উত্তর দিতে পারেন অথবা যে কোনো সময় এই গবেষণা থেকে আপনার অংশগ্রহন প্রত্যাহার করতে পারেন।

সুবিধাঃ- এই গবেষণায় অংশগ্রহন করে আপনারা জানতে পারবেন যে ঠিক কি কারণে আপনারা অসুস্থদের শুশ্রূষা করতে গিয়ে চাপ অনুভব করেন ।

যদি আপনি গবেষণায় অংশগ্রহন না করার সিদ্ধান্ত নেনঃ- এই গবেষণায় আপনার অংশগ্রহণ সম্পূর্ণ স্বেছামূলক। অংশগ্রহণ করা বা না করা সম্পূর্ণ আপনার ব্যাপার। যদি আপনি স্বাক্ষর না করার সিদ্ধান্ত নেন তবে আপনাকে আর বিরক্ত করা হবে না। আপনি গবেষণায় অংশগ্রহণ করার পর যদি নিজস্ব অংশগ্রহণ প্রত্যাহার করতে চান তবে তা ও সম্ভব।

গোপনীয়তাঃ- আমি এইগবেষণার জন্য যা তথ্য আপনার থেকে সংগ্রহ করব তা সম্পূর্ণরূপে গোপন রাখা হবে। রিসার্চার ব্যতীত এই তথ্য আর কেউ দেখতে পারবে না।

গবেষণা সম্পর্কে সমস্যা ঃ- এই গবেষণা সম্পর্কে অনুসন্ধানের ক্ষেত্রে আপনার যদি কোনো প্রশ্ন থাকে তবে আপনারা আগরতলা, পশ্চিম ত্রিপুরায় অবস্থিত ত্রিপুরা কলেজ অফ নার্সিং-এর মেন্টাল হেল্‌থ নার্সিং বিভাগের মিস শর্মিষ্ঠা শীল শর্মা এর সাথে যোগাযোগ করতে পারেন। যোগাযোগ নং (মোঃ)- +৯১-৯৬১২৩৬৩৬৭৬

অংশ -২ (সম্মতি পত্র)

(অংশগ্রহনকারীর সেচ্ছাসম্মতি)

এই গবেষণায়আপনার অংশগ্রহন সম্পূর্ণ স্বেচ্ছামূলক এবং এই গবেষণায় অংশগ্রহণের পূর্বে আপনার সম্মতি প্রয়োজন।

আমি এই সম্মতি ফর্মটি সম্পূর্ণরূপে পড়েছি (বা আমায় পড়ে শোনানো হয়েছে) । আমি এই নথির বিষয়বস্তু সম্পূর্ণরূপে বুঝতে পেরেছি এবং এই গবেষণায় অংশগ্রহনের সম্মতি দিচ্ছি। আমি বুঝতে পারি যে, ভবিষ্যতে আমি যে কোনো সময় এই গবেষণা থেকে আমার অংশগ্রহন প্রত্যাহার করতে পারি। আমায় এই গবেষণা সম্পর্কিত সমস্ত তথ্য দেওয়া হয়েছে এবং আমাকে প্রতিশ্রুতি দেওয়া হয়েছে যে আমার সমস্ত ব্যক্তিগত তথ্য গোপন রাখা হবে। আমি আমার স্ব-ইচ্ছায় এই গবেষণায় যোগদান করতে চাই। আমাকে আমার সম্মতি ফর্ম-এর একটি কপি দেওয়া হয়েছে। ভবিষ্যতে এই গবেষণাসম্পর্কিত যদি আমার কোন প্রশ্ন থাকে তবে সেগুলি নিম্নলিখিত তদন্তকারীদের দ্বারা বিশদে আলোচনা করা হবে এবং আমি বুঝতে পেরেছি যে, এই সম্মতি পত্রটির বৈধতা গবেষণার সমাপ্তি অব্দি রয়েছে।

ফোন নম্বর সহ পরিচিতি ঠিকানা ঃ-

মূল তদন্তকারীর নাম এবং যোগাযোগ নং	যোগাযোগের ঠিকানা
মিস শর্মিষ্ঠা শীল শর্মা। যোগাযোগ নং (মোঃ)- +৯১-৯৬১২৩৬৩৬৭৬ (২৪ x ৭ যোগাযোগের জন্য প্রস্তুত)	মেন্টাল হেল্‌থ নার্সিং ত্রিপুরা কলেজ অফ নার্সিং পোঃ- ও এন জি সি কলোনি , আগরতলা, ওয়েস্ট ত্রিপুরা। পিনঃ- ৭৯৯০১৪

স্থানঃ আগরতলা, পশ্চিম ত্রিপুরা। নামঃ

তারিখঃ

তারিখ সহ অংশগ্রহণকারীর সম্পূর্ণ স্বাক্ষরঃ

অংশগ্রহণকারীর আঙ্গুলের ছাপঃ

স্বাক্ষীর নাম এবং সম্পর্কঃ

তারিখ সহ স্বাক্ষীর সম্পূর্ণ স্বাক্ষরঃ

স্বাক্ষীর ঠিকানাঃ

অবহিত সম্মতির শংসাপত্রঃ

আমি শংসাপত্র দিচ্ছি যে, আমি শ্রী/শ্রীমতী ..... কে "কম্পেয়ার দ্য কেয়ারগিভার বার্ডেন এমং সাইকিয়াট্রিক ইলনেস অ্যান্ড মেডিকেল ইলনেস ইন ত্রিপুরা মেডিকাল কলেজ অ্যান্ড ডঃ ব্রাম টিচিং হসপিটাল, হাঁপানিয়া, আগরতলা, ত্রিপুরা ওয়েস্ট"- নামক এই গবেষণার প্রকৃতি এবং উদ্দেশ্য সম্পর্কে ব্যাখ্যা করেছি এবং আমি এই গবেষণায় অংশগ্রহনের সম্ভাব্য সুবিধাগুলি নিয়েও আলোচনা করেছি। এই

গবেষণা সম্পর্কে ব্যাক্তির যে প্রশ্নগুলি ছিল তার সমস্ত উত্তর দেওয়া হয়েছে এবং ভবিষ্যতেও ওনার যে কোনো প্রশ্নের সমাধান করার জন্যে আমরা সর্বদা উপলব্ধ থাকব।

স্থানঃ আগরতলা, পশ্চিম ত্রিপুরা।

তারিখঃ

সম্মতিপ্রাপ্ত ব্যক্তির স্বাক্ষরঃ

নামঃ

পিআই স্বাক্ষরঃ

Gosimung Koktun

Bukhak-1 (Manjaknairokni Gosimung koktun)

Kokbokhorok: “Compare the caregiver burden among Psychiatric illness and medical illness in Tripura Medical College and Dr. BRAMTeaching Hospital, Agartala, Tripura West”.

Naitukphiniknai Okra: Miss. Sharmistha Shil Sharma

Kokphang: Ang Sharmistha Shil Sharma, Tripura Medical College and Dr. Bram teaching hospitalni, Hapania, Agartala, Salthang Tripura Agartalao, Kaisa amjoknaitukmungni samung khwlaio tei o amjoknaitukmungni bagwi kokthum khwlaio boni mung “Compare the caregiver burden among psychiatric illness and medical illness in Tripura Medical College and Dr. BRAM Teaching Hospital, Agartala, Tripura West.”

Nono manmung lamao o naitukphinik samungo manjaknani bagwi koijao kubun samungni bagwiya. O form kaisa naitukphinik rwgwi joto kokthum rwnai. Nwng o naitukphinigo manjaknani/khwlainani Wansungo hinkhe, tinini salmario nono o gosimung form o mung soi rinani nangnai. Nwng manjaknani muchungkhe, tei nwng soi rwimaya eba rinani muchungya hinkhe khoroksa phunukmung nini bagwi rwthai bwlaio siriwi rinai.

Naitukphinikmani naharmung: o naitukphinigo yaphangPhurungmung rijakha, Agartala, Salthang Tripurani chongjak hospitalni phyciatric illness tei medical illness tubujak bemarrokni caregiverrokni bardenni bisingo.

Naitukphiniknani Kokbwrwng: Kokthum thumnani swkang chongjak Hospitalni ang gosimung naharnai. Kokthum thummani puila salo ang hospitalo thangnai tei naharmani phunukmung sep bai manjaknairokni chongjaknai.Boni logi ang manjaknairokni naitukphinikmani naharmung, tomung tei kokthum thummani raida swrai swraikhe sanai. Aboni ulo borogni bisingni khabai muchungwi manjaknairokno gosimung form riwi rinai, aro borogni soi namani ulo socio demography praphorma tei Zarito burden interviewni bisingtwi borogni yaktwi kokthum thumnai. O raidatwi ang bebak bedeknuini yaktwi kokthum thumnai.

Naitukphiniknani borok bangmung: 60 (khorokdokchi) borok caregiver.

Naitukphinik o manjaknani kebengmung tei chamung:

Kebengmung: Naitukphinigo manjagwi norok jesaphano kok swngmani eba joto kok swngmani phirokmung rwi mano ahaiyakheba jese jorao o naitukphinikni nini manjakmani rosai namano.

Chamung: O naitukphinigo manjak norok siwi manai kubui tamoni bagwi norok bemarogni sebuk khwlaithani tektode wngjak.

Romdi nwng naitukphinigo manjakya hinwi chongkha hinkhe o naitukphinigo nini manjakmung saktharmani samungse. Manjaknai eba manjakya abo nini muchungmase. Nwng naitukphinigo manjakmani ulo romdi sakbaithang manjakmani rosanani muchungkhe abo rosai narmano.

Phaijanai: Ang o naitukphinikni bagwi jeswk kokthum nini thani nanai abo joto hwi tonjaknai. Naitukphiniknai karwi o kokthum tei khoroksano phunukjakgwlak.

Naitukphinikmani rwgwi jwngjal : O naitukphinik rwgwi naitukthani nini thaisa thainwi kokswngnani tongkhe norok Agartala, Salthang Tripurao tongnai Tripura College of Nursingni Mental Health Nursing bedekni MissSharmistha Shil Sharma bai kwrwnglai mannai. Kokduk rem: +91 9612363676

Bwkhak 2 (Consent form)

Kokchapmani pandao phainaisongbai khabaksa wngmani:

O pandao nwng muchungkhe phaimano tei khabaksa wngnani bagwi nwng muchungkhe swrwngmano:

Ang o khabaksa wngnani kokno kahamke swrwngwi bujiwi nakha tei ang aro pandao khabaksa wngna muchungo. Ang siwi ang muchungkhe jephuru aroni panda yakai phaimano. Ang bujikha ani huijaknai kokrokno norok buino sayaanokokrodi. Ani tabuk tei kirijaknai kwrwikha. Ang ani bwkha muchungmanibai o kok chapmani pandao khabaksa wngna muchungo. Ang ani khabaksa wngthani swijakni solnonok swijak kogo nango. Ang bujikha, ang bujiya phuru nirokhor swngmani. Ang o kokchapmani pandani yagulo mungsaswk swijaknai tongkhe swngwi manai. Ang o pandao ang siyakho hai kwtal kokno sajaknani holong rojakha. Ang sikha o panda paimani yagulo ang khabaksa wngnaini kokrimani bo painai.

Nikuma tei kokduk remrok:

Okra naituk phunuknaini mung tei kokduk	Bo tongmani nikuma
Miss Sharmistha Shil Sharma Kokduk rem +919612363676	Mental health nursing Tripura College of Nursing P.O:- ONGC colony, Agartala, West Tripura Pin- 799014

Thai: Agartala, Salthang Tripura. Mung:

Salmari: Pandao manjaknaini mungswimung tei salmari:

Pandao manjaknaini yasima mari:

Logio tongnaini mung tei halok:

Logio tongnaini mungswimung tei salmari:

Logio tongnaini nikuma:

Borom bwlai:

Ang borom bwlai rikha, ang Shri/Shrimoti …..... ni “Compare the caregiverburdenamong psychiatricillness and medical illnessinTripura Medical College and Dr.BRAMTeaching Hospital, Agartala, Tripura West” mungwi naitukphinikmani samung-humung Tai bini naharmungno twiwi kahamkhe amjoknaikha tai ang o naitukphinikmani samungo kosonwi manthothok sepsaproknobo kahamkhe sukurubwi naikha. O

naitukphinikmanino rwgwi borokni swngmungrokno bebakno phirokmung rwjakkha tai thinango bini jesa swngmungno charwna bagwi chwng naisingwi tongnai.

Thai: Agartala, Salthang Tripura. Gosimung manjak borokni mungswimung:-

Salmari: - Mung:

P.I ni mungswimung:

ANNEXURE-XIV

TRIPURA COLLEGE OF NURSING

In this study, tool is divided into 2 parts.

Part-I: Socio-demographic data &

Part-II: Standerdized tool on Zarit Burden Interview Scale.

Part-I: SOCIO-DEMOGRAPHIC DATA

Purpose- To assess the demographic data

Instructions:

-Interviewer will ask the questions & write the response given by the participants.

Code no……. Date…….

Caregiver's Socio-demographic Proforma

1. Age:

a. 18 years -27 years [ ]

b. 27 years -37 years [ ]

c. 37 years -47 years [ ]

d. 47 years -57 years [ ]

e. Above 58 years [ ]

2. Gender:

a. Male [ ]

b. Female [ ]

c. Transgender [ ]

3. Religion:

a. Hinduism [ ]

b. Muslim [ ]

c. Christian [ ]

d. Others (if so, specify) ……. [ ]

4. Place of the residence:

a. Urban area [ ]

b. Rural area [ ]

5. Educational qualification of caregiver:

a. No formal education [ ]

b. Primary school passed [ ]

c. Higher school passed [ ]

d. Graduate& above [ ]

6. Marital Status:

a. Single [ ]

b. Married [ ]

c. Widow/Widower [ ]

d. Divorced /Separated [ ]

7. Occupation of the caregiver:

a. Unemployed [ ]

b. Govt. employee [ ]

c. Private employee [ ]

d. Pensioner [ ]

e. Self employed/ Business/ [ ]

f. Farmer [ ]

8. Income of the caregiver : ……

9. Type of family:

a. Neuclear family [ ]

b. Joint family [ ]

c. Extended family [ ]

10. No. of family members:

a. Less than 06 [ ]

b. 06 [ ]

c. More than 06 [ ]

11. Type of relationship with patient:

a. Spouse [ ]

b. Parents [ ]

c. Offsprings [ ]

d. Siblings [ ]

e. Others (if so, specify) …… [ ]

12. Duration of stay with patient:

a. 6 months-1 years [ ]

b. 1year 1 day -3 years [ ]

c. 3 years 1 day -5 years [ ]

d. More than 5 years (if so, specify)..... [ ]

13. Relationship of person who bearing the financial responsibility of the patient & his/ her income in Rupees per annum ……..……

Patient's socio-demographic proforma

14. Age of the patient: .....

15. Diagnosis of the patient: .....

16. Self care ability of the patient:

a. Partial [ ]

b. Assisted [ ]

17. Duration of illness:

a. 6 months-1 years [ ]

b. 1year 1 day -3 years [ ]

c. 3 years 1 day-5 years [ ]

d. More than 5 years (if so, specify)..... [ ]

18. Occupation of the patient:

a. Unemployed [ ]

b. Govt. employee [ ]

c. Private employee [ ]

d. Pensioner [ ]

e. Self employed/ Business/ [ ]

f. Farmer [ ]

19. Income of the patient : …….

20. Patient receives any type of financial benefit from other sources:

a. Yes [ ]

b. No [ ]

If yes, mention the sources: …..……

Tool-II:Standerdized Tool on Zarit Burden Interview Scale

Purpose:To assess burden among the caregivers

Instructions:

-Interviewer will ask the questions & put a circle against the response given by the participants.

Question	Score				
	Never	Rarely	Sometimes	Quite Frequently	Nearly Always
1.Do you feel that your relative asks for more help than he/she needs?	0	1	2	3	4
2. Do you feel thatbecause of the time you spend with your relative that you don't have enough time for yourself?	0	1	2	3	4
3.Do you feel stressed between caring for your relative and trying tomeet other responsibilities for your family or work?	0	1	2	3	4
4. Do you feel embarrassed over your relative's behavior?	0	1	2	3	4
5. Do you feel angry when you are around your relative?	0	1	2	3	4
6. Do you feel that your relative currently affects your relationships withother family members or friends in a	0	1	2	3	4

negative way?					
7.Are you afraid what the future hold foryour relative?	0	1	2	3	4
Question	**Score**				
	Never	**Rarely**	**Sometimes**	**Quite Frequently**	**Nearly Always**
8.Do you feel your relative is dependent on you?	0	1	2	3	4
9. Do you feel strained when you are around your relative?	0	1	2	3	4
10. Do you feel your health has suffered because of your involvementwith your relative?	0	1	2	3	4
11. Do you feel that you don't have as much privacy as you would likebecause of your relative?	0	1	2	3	4
12. Do you feel that your social life has suffered because you are caringfor your relative?	0	1	2	3	4
13.Do you feel uncomfortable about having friends over because of yourrelative?	0	1	2	3	4
14. Do you feel that your relative seems to expect you to take care of him/her as if you were the only one he/she could depend on?	0	1	2	3	4
15.Do you feel that you don't have enough money to take care of yourrelative in addition to the rest of your	0	1	2	3	4
Question	**Score**				
	Never	**Rarely**	**Sometimes**	**Quite Frequently**	**Nearly Always**

Expenses?					
16. Do you feel that you will be unable to take care of your relative muchlonger?	0	1	2	3	4
17. Do you feel you have lost control of your life since your relative'sillness?	0	1	2	3	4
18. Do you wish you could leave the care of your relative to someone else?	0	1	2	3	4
19. Do you feel uncertain about what to do about your relative?	0	1	2	3	4
20. Do you feel you should be doing more for your relative?	0	1	2	3	4
21. Do you feel you could do a better job in caring for your relative?	0	1	2	3	4
22. Overall, how burdened do you feel in caring for your relative?	0	1	2	3	4

Interpretation of score:

Standerdized ZARIT BURDEN INTERVIEW SCALE was used to assess the level of burden among the caregivers of psychiatric ill & medically ill patients by using 5 point Likert scale. The ZARIT BURDEN INTERVIEW SCALE consists of 22 statements on never, rarely, sometimes, quite frequently & nearly always.

The minimum score was 22 & maximum score was 88.

Score	Levels of burden
Never & Rarely(0 & 1)= (0-22)	Little or no burden (25%)
Sometimes (2)= (23-44)	Mild burden (50%)
Quite frequently (3)= (45-66)	Moderate burden (75%)
Nearly always (4)= (67-88)	Severe burden (100%)

ত্রিপুরা কলেজ অফ নার্সিং

এই গবেষণার তথ্যগুলি ২ ভাগে বিভক্ত।

অংশ-১ ঃ সামাজিক ও ব্যাক্তিগত তথ্যাদি।

অংশ-২ ঃজারিত বার্ডেন ইন্টারভিউ প্রশ্নাবলি।

অংশ-১ ঃ

সামাজিক ও ব্যাক্তিগত তথ্যাবলী

উদ্দেশ্যঃ ডেমোগ্রাফিক তথ্যাদি মুল্যায়ন করা

নির্দেশাবলীঃ

ইন্টারভিওয়ার প্রশ্ন করবেন এবং অংশগ্রহণকারীদের দ্বারা প্রদত্ত প্রতিক্রিয়া লিখবেন।

কোড নং ..... **তারিখ .....**

পরিচর্যাকারীর সামাজিক ও ব্যাক্তিগত তথ্য

১। বয়স:

ক) ১৮বছর-২৭ বছর [ ]

খ) ২৭বছর-৩৭ বছর [ ]

গ) ৩৭ বছর-৪৭ বছর [ ]

ঘ) ৪৭ বছর-৫৭ বছর [ ]

ঙ) ৫৮এর ঊর্ধ্বে [ ]

২। লিঙ্গ:

ক) পুরুষ [ ]

খ) মহিলা [ ]

গ) উভলিঙ্গ [ ]

৩।ধর্ম :

ক) হিন্দু [ ]

খ) মুসলিম [ ]

গ) খ্রিষ্টান [ ]

ঘ) অন্যান্য ( )..... [ ]

৪। বসবাসের এলাকা:

ক) শহর [ ]

খ) গ্রাম [ ]

৫। পরিচর্যাকারীর শিক্ষাগত যোগ্যতা:

ক) অশিক্ষিত [ ]

খ) প্রাথমিক পাশ [ ]

গ) উচ্চমাধ্যমিক পাশ [ ]

ঘ) স্নাতক ও স্নাতকোত্তর [ ]

৬।বৈবাহিক সম্পর্কঃ

ক) একক [ ]

খ) বিবাহিত [ ]

গ) বিধবা/ বিপত্নীক [ ]

ঘ) তালাকপ্রাপ্ত/বিচ্ছিন্ন [ ]

৭।পরিচর্যাকারীর পেশা :

ক) বেকার [ ]

খ) সরকারি কর্মচারী [ ]

গ) বেসরকারি কর্মচারী [ ]

ঘ) পেনশনার [ ]

ঙ) স্বনির্ভর/ ব্যবসায়ী [ ]

চ) কৃষিকাজ [ ]

৮।পরিচর্যাকারীর আয়ঃ .....

৯।পরিবারের ধরন:

ক) একক পরিবার [ ]

খ) যৌথ পরিবার [ ]

গ) একান্নবর্তী পরিবার [ ]

১০।পরিবারের সদস্য সংখ্যা:

ক) ৬ এর কম [ ]

খ) ৬ [ ]

গ) ৬ এর বেশি [ ]

১১।রোগীর সাথে সম্পর্ক:

ক) স্বামী / স্ত্রী [ ]

খ) বাবা/ মা [ ]

গ) সন্তানসন্ততি [ ]

ঘ) ভাই/ বোন [ ]

ঘ) অন্যান্য ( ) ..... [ ]

১২।রোগীর সাথে থাকার সময়কাল:

ক) ৬ মাস-১ বছর [ ]

খ) ১ বছর ১ দিন-৩ বছর [ ]

গ) ৩বছর ১ দিন-৫ বছর [ ]

ঘ) ৫ বছরের বেশি( ) [ ]

১৩। রোগীরআর্থিকদায়িত্ববহনকারীব্যক্তিরসাথে রোগীর সম্পর্কএবংতারবার্ষিকআয়ঃ

.....

রোগীর সামাজিক ও ব্যাক্তিগত তথ্য

১৪। রোগীর বয়স .....

১৫।নির্ণীত রোগ (ডায়াগনোসিস) .....

১৬।রোগীর স্ব-যত্ন ক্ষমতাঃ

ক) আংশিক [ ]

গ)সহকারী প্রয়োজন [ ]

১৭। অসুস্থতার সময়কাল:

ক) ৬ মাস-১ বছর [ ]

খ) ১ বছর ১ দিন-৩ বছর [ ]

গ) ৩বছর ১ দিন-৫ বছর [ ]

ঘ) ৫ বছরের বেশি ( ) [ ]

১৮। রোগীর পেশা :

ক) বেকার [ ]

খ) সরকারি কর্মচারী [ ]

গ) বেসরকারি কর্মচারী [ ]

ঘ) পেনশনার [ ]

ঙ) স্বনির্ভর/ ব্যবসায়ী [ ]

চ) কৃষিকাজ [ ]

১৯। রোগীর আয়ঃ .....

২০। রোগীকি অন্যান্যউৎসথেকেআর্থিকসুবিধাপায়ঃ

ক) হ্যাঁ [ ]

খ) না [ ]

যদি হ্যাঁ হয়, তবে এর উৎস উল্লেখ করুন .....

অংশ-২

জারিত বার্ডেন ইন্টারভিউ স্কেল

উদ্দেশ্যঃ যত্নশীলকারীদের মধ্যে বোঝার মান মুল্যায়ন করা।

নির্দেশাবলী: ইন্টারভিওয়ার প্রশ্ন করবেন এবং অংশগ্রহণকারীদের দ্বারা প্রদত্ত প্রতিক্রিয়া নিম্নোল্লেখিত মানে বৃত্ত দ্বারা প্রতিস্থাপন করবেন।

প্রশ্ন	মান				
	কখনই না	অস্বাভাবিক ভাবে	কখনও কখনও	বেশ ঘন ঘনভাবে	সর্বদাই
১। আপনি কি মনে করেন যে, আপনার আত্মীয় তার প্রয়োজন এর চেয়ে বেশি সাহায্য চায়?	০	১	২	৩	৪
২। আপনার কি মনে হয় যে, আপনি আপনার আত্মীয়ের সাথে সময় ব্যয় করার কারনে আপনার নিজের জন্য পর্যাপ্ত সময় পান না?	০	১	২	৩	৪
৩। আপনি কি আপনার আত্মীয়ের যত্ন নেওয়া, পরিবারের কাজ এবং অন্যান্য দ্বায়িত্বগুলি পূরণ করার মাঝে নিজে খুব চাপ অনুভব করেন?	০	১	২	৩	৪
৪। আপনি কি আপনার অন্যান্য আত্মীয়দের আচরণের জন্য বিব্রত বোধ করেন?	০	১	২	৩	৪
৫।আপনি যখন আপনার আত্মীয়ের আশেপাশে থাকেন তখন আপনি কি রাগ অনুভব করেন?	০	১	২	৩	৪
৬। আপনি কি অনুভব করেন যে, আপনার আত্মীয় বর্তমানে আপনার পরিবারের অন্যান্য সদস্য বা বন্ধুদের সঙ্গে নেতিবাচক উপায়ে আপনার সম্পর্ককে প্রভাবিত করছে?	০	১	২	৩	৪
৭। আপনি কি আপনার আত্মীয়ের ভবিষ্যৎ নিয়ে ভয় করেন?	০	১	২	৩	৪
প্রশ্ন	**মান**				
	কখনই না	অস্বাভাবিক ভাবে	কখনও কখনও	বেশ ঘন ঘনভাবে	সর্বদাই

৮। আপনার কি মনে হয় যে, আপনার আত্মীয় আপনার উপর নির্ভরশীল?	০	১	২	৩	৪
৯। আপনি যখন আপনার আত্মীয়ের আশেপাশে থাকেন, তখন কি খুব চাপ অনুভব করেন?	০	১	২	৩	৪
১০। আপনি কি অনুভব করেন যে আপনার আত্মীয়ের সাথে জড়িত থাকার কারনে আপনার স্বাস্থ্য ক্ষতিগ্রস্ত হচ্ছে?	০	১	২	৩	৪
১১। আপনিকি অনুভব করেন যে, আপনার আত্মীয়ের কারণে আপনি যতটা প্রাইভেসি চান ততটা পান না?	০	১	২	৩	৪
১২।আপনি কি মনে করেন যে, আপনার আত্মীয়ের প্রতি যত্নশীল হবার কারনে আপনার সামাজিক জীবন ক্ষতিগ্রস্ত হচ্ছে?	০	১	২	৩	৪
১৩। আপনিকি অনুভব করেন যে, আপনার আত্মীয়দের কারনে আপনার বন্ধুদের নিয়ে অস্বস্তি বোধ করতে হয়?	০	১	২	৩	৪
১৪।আপনি কি অনুভব করেন যে, আপনার আত্মীয় সম্পুরনরুপে আপনার উপর নির্ভরশীল, যেন একমাত্র আপনার উপরেই তিনি নির্ভর করতে পারেন ?	০	১	২	৩	৪
১৫। আপনিকি অনুভব করেন যে, আপনার অন্যান্য খরচ চালানোর পর আত্মীয়ের যত্ন নেওয়ার জন্য আপনার কাছে পর্যাপ্ত অর্থ থাকে না ?	০	১	২	৩	৪
প্রশ্ন	**মান**				
	কখনই না	অস্বাভাবিক ভাবে	কখনও কখনও	বেশ ঘন ঘনভাবে	সর্বদাই
১৬। আপনি কি অনুভব করেন যে, আপনি আপনার আত্মীয়ের দীর্ঘদিন যাবৎ খুব বেশী যত্ন নিতে পারবেন না?	০	১	২	৩	৪
১৭। আপনিকি মনে করেন যে, আপনার আত্মীয়ের অসুস্থতার কারনেআপনি নিজের জীবনের	০	১	২	৩	৪

নিয়ন্ত্রণ হারিয়ে ফেলছেন?					
১৮। আপনি কি আপনার আত্মীয়ের যত্ন নেওয়া অন্য কারোর উপর ছেড়ে দিতে চান?	০	১	২	৩	৪
১৯। আপনি কি আপনার আত্মীয় সম্পর্কেকি করবেন তা নিয়ে অনিশ্চয়তা বোধ করেন?	০	১	২	৩	৪
২০। আপনি কি মনে করেন যে, আত্মীয়ের জন্য, আপনার আরও কিছু করা উচিৎ?	০	১	২	৩	৪
২১। আপনার কি মনে হয় যে, আপনি আপনার আত্মীয়কে আরও ভালভাবে সেবা করতে পারতেন?	০	১	২	৩	৪
২২। সামগ্রিকভাবে, আপনার আত্মীয়ের যত্ন নেওয়ার ক্ষেত্রে আপনি কি বোঝা বোধ করেন?	০	১	২	৩	৪

মান এর ব্যাখ্যাঃ

কাঠামোবদ্ধ জারিত বার্ডেন ইন্টারভিউ স্কেলটিকে ৫ পয়েন্টলাইকার্টস্কেলব্যবহারকরেমানসিকঅসুস্থএবংচিকিৎসাগতভাবেঅসুস্থরোগীদের পরিচর্যাকারীদের মধ্যেবোঝারমাত্রামূল্যায়নকরতেব্যবহার করা হয়। জারিত বার্ডেন ইন্টারভিউস্কেল ২২ টিবিবৃতিনিয়েগঠিত, যার মধ্যে রয়েছে কখনও না, অস্বাভাবিক ভাবে, কখনওকখনও, বেশঘনঘনভাবে এবং সর্বদাই।

এতে সর্বনিম্ন স্কোর রয়েছে ২২, সর্বোচ্চ স্কোর রয়েছে ৮৮।

স্কোর	বোঝার মাত্রা
কখনই না এবং অস্বাভাবিক ভাবে (০ এবং ১)=(০-২২)	সামান্য বা বোঝাহীন (২৫ %)
কখনও কখনও (২)= (২৩-৪৪)	হাল্কা বা মাঝারি বোঝা (৫০ %)
বেশ ঘন ঘনভাবে (৩)= (৪৫-৬৬)	মাঝারি থেকে গুরুতর বোঝা (৭৫ %)
সর্বদাই (৪)= (৬৭-৮৮)	গুরুতর বোঝা (১০০ %)

TRIPURA COLLEGE OF NURSING

O naitukmungni kokthumno dalnwikhai bakjakkha:-
Bwkhak I: Hoda rwkjak tei baithangni kokthum
Bwkhak II: Zarito burden interview prasnaboli.

Bwkhak 1:

Hoda rwkjak tei baithangni kokthum

Phunuklam (Instruction) : Swngnai swngmungno swngnai tei kokthum rinaibai rijak kokthumno swidi.

Code no. Salmari (date): ...

Bwkhak-1

Demographicni kokthum

1.Omar :

a. Bisi 18 - bisi 27 [ ]

b. Bisi 27 - bisi 37 [ ]

c. Bisi 37 - 47 bisi [ ]

d. Bisi 47 - bisi 57 [ ]

e. Bisi 58saka [ ]

2. Chwla bwrwi sinimung:

a. Chwla [ ]

b. Bwrwi [ ]

c. Guruman [ ]

3. Dharma:

a. Hindu [ ]

b. Muslim [ ]

c. Christian [ ]

d. Kubuni [ ]

4.Tongthani:

a. Auli [ ]

b. Kami amchai [ ]

5. Sak-hamyani logi tongnaini rwngmari:

a. Lekha rwngjakya [ ]

b. Rwngrem ba-dok jora [ ]

c. Kuchuk madhyam jora [ ]

d. Rwngnok kotor jora [ ]

e. Rwngnokyung jora [ ]

6. Nukhung khamani halok

a. Saichung [ ]

b. Khoroknwi tongo [ ]

c. randi/randa [ ]

d.Kaklaijak [ ]

7. Sak-hamyani logi tongnainwng tamo samung khwlaimani:

a. Samung kwrwi [ ]

b. Haste haphangni sebuk [ ]

c. Buini habani sebuk [ ]

d. Lenglamung [ ]

e. Saichung samung khaio/ Baniya khaio [ ]

e.Tangnai [ ]

8.Sak-hamyani logi tongnai nini samungni rang bwswk man ……..

9. Nokthaini goron:

a. Nok kaisa [ ]

b. Thansa [ ]

c. Kwbangma nukhung [ ]

10. Achaisong khorokbwswk:

a. 6ni swlai kisa [ ]

b. 6 [ ]

c. 6 ni swlai kwbang [ ]

11. Nini bai sak-hamyani halok:

a. sai/hik [ ]

b. pha/am [ ]

c. sajwla/sajwk [ ]

d. Takhuk/ Bukhuk [ ]

e. Kubuni [ ]

12. Nwng salbwswk sak-hamyani logi tongkha:

a. Tal dokni kwbang (6) - bisa (1) [ ]

b. Bisa (1) salsa (1) - bisitham (3) [ ]

c. Bisitham (3) salsa (1) - bisiba (5) [ ]

d. Bisibani (5) kwbang [ ]

13. Sak-hamyano rangthok rohornai borok bai sak-hamyani halok tamo tei bisio rangmari bwswk man:

……..

14. Sak-hamyani omor: ……

15. Tamo bemar hinwi sakha Dr.: ……

16. Sak-hamyao nwng samung khaide mano:

a. Kisa kisa ang samung khai mano [ ]

b. Logio khoroksa tongna nango [ ]

17. Nwng bwswk bosor hamya:

a. Tal dokni kubang (6) - bisa (1) [ ]

b.Bisa (1) salsa (1) - bisitham (3) [ ]

c. Bisitham (3) salsa (1) -bisiba (5) [ ]

d. Bisibani (5) kwbang [ ]

18. Sak-hamya wngnai bo támo khwlai:

a. Samung kwrwi [ ]

b. Haste haphangni sebuk [ ]

c. Buini habani sebuk [ ]

d. Lenglamung [ ]

e. Saichung samung khaio/ Baniya khaio [ ]

e.Tangnai [ ]

19. Sak-hamya rang bwswk man: ……..……..……..……

20. Sak-hamya nwng kubuni bwkhaktwi rangrok naharnani bumukde tong:

a. I [ ]

b. ihi [ ]

I nwng naharwi tongkha hinkhe bini bumuk phunukdi …….....

Bwkhak-2

Zarito burden interview scale

Nwng bahai matong kahamkhe swbaisukurubwi wngmanino kiting mari ridi.

Simung	Lekhamari				
	Waisaboya	Waisa-wuisu	Jora kaisao	Jora jorao	Homnino
1. Nwng tamo chong nini jaiti boni nangkukmani swlai kwbang chubachu naio?	0	1	2	3	4
2. Nwng tamo kha chong, nwng nini jaitibai jora rimani bagwi nini sakni bagwi nangmani jora manya?	0	1	2	3	4

3. Nwng tamo nini jaitini naikani khwlaimani, nukhungni samung tei kubun barjarok supungmani bising sakno belai poja hinwi khade chong?	0	1	2	3	4
4. Nwng tamo nini kubun jaitirokni tongmungni bagwi chapmayakhe matongo?	0	1	2	3	4
5. Nwng jephuru nini jaitini ganagini tongkhe aphuru nwng tamo thamchide bwkhao ka?	0	1	2	3	4
6. Nwng bahaikhe matong nini jaiti tabuk nini nukhungni kubun adong eba kichingrokbai baksa hamya lamtwi nini halokno ….....?	0	1	2	3	4
7. Nwng tamo nini jaitini thinangno twiwi kirio?	0	1	2	3	4
8. Nwng tamo khade chong, nini jaiti nini saka sakbokjak?	0	1	2	3	4
Simung	Lekhamung				
	Waisaboya	Waisa-wuisu	Jora kaisao	Jora jorao	Homnino
9. Nwng jephuru nini jaitini ganagini tongkhe, aphuru tamo belai poja hinwi khade chong?	0	1	2	3	4
10. Nwng tamo khaode chong, nini jaitibai baksa kobolwi tongmani bagwi nini sakham hamya wngkha?	0	1	2	3	4
11. Nwng tamo khaode chong, nini jaitini bagwi nini jeswk sakkaisa naimani aboswk manya?	0	1	2	3	4
12. Nwng tamo khaode chong, nini jaitini naikani khwlaimani bagwi nini luku tongmung-chamungo piyagiy tongo?	0	1	2	3	4

13. Nwng tamo khaode chong, nini jaitini bagwi nini kichingrokbai tongnani tongthokya wngkha?	0	1	2	3	4
14. Nwng tamo khaode chong, nini jaiti paisogwi nini thani sakbokjak jefalnit simise boni naikani khwlainai?	0	1	2	3	4
15. Nwng tamo khaode chong, nini kubun samungo rang swbaimani ulo jaitini naikani khwlainani bagwi nini yago/thani nangmani rang tongrwkya?	0	1	2	3	4
16. Nwng tamo khaode chong, nwng nini jaitini kwbang jora twiwi kahamkhe naikani khwlai mangwlak?	0	1	2	3	4
Simung	Lekhamung				
	Waisaboya	Waisa-wuisu	Jora kaisao	Jora jorao	Homnino
17. Nwng tamo khaode chong, nini jaiti sak-hamya wngmani bagwi nini sakni langmani tongsuk kwrwikha?	0	1	2	3	4
18. Nwng tamo nini jaitini naikani khwlainani juda khoroksani thani yapharwi rinade nai?	0	1	2	3	4
19. Nwng tamo nini jaitini bagwi tamo khwlainai khao chongmanya?	0	1	2	3	4
20. Nwng tamo nini jaitini bagwi teibo kwbang mungsaswk khwlaithai tong?	0	1	2	3	4
21. Nwng tamo kha chong, nwng nini jaitino teibo kahamkhe naikani khwlaimao?	0	1	2	3	4
22.Joto khobwi, nini jaitino naikani khwlaimani bagwi nwng bwswk poja	0	1	2	3	4

wngjak?					

Lekhamarini swbaisukurubwi samani

Waisaboya tei waisa-wuisu(0 tei 1)= 0-22	Kisa eba poja kwrwi (25%)
Jora kaisao(2)= 23-44	Kisa kisa eba poja kisa hilik(50%)
Jora jorao(3)= 45-66	Poja kisa hilik eba kutuk poja(75%)
Homnino (4)= 67-88	Kutuk poja(100%)

ANNEXURE-XV

CERTIFICATE OF ENGLISH EDITING OF RESEARCH TOOL

CERTIFICATE OF ENGLISH EDITING:

I hereby certify that I have done English editing the tool of Miss. Sharmistha Shil Sharma. M.Sc (N) student in Mental Health Nursing. who is undertaking a study **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

Place:

Signature & Seal of Expert

Dr. SOMDEV BANIK
Associate Professor,
Dept. of English,
Tripura University.

Date:

Name & Designation

ANNEXURE-XVI

CERTIFICATE OF BENGALI EDITING OF RESEARCH TOOL

CERTIFICATE OF BENGALI EDITING

I hereby certify that I have done Bengali editing the tool of Miss. Sharmistha Shil Sharma, M.Sc (N) student in Mental Health Nursing. who is undertaking a study **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

17/5/2023

Signature & Seal of Expert

Head
Department of Bengali
Tripura University
Suryamaninagar-799022

Place:

Date:

Name & Designation

ANNEXURE-XVII

CERTIFICATE OF KOKBOROK EDITING OF RESEARCH TOOL

CERTIFICATE OF KOKBOROK EDITING:

I hereby certify that I have done Kokborok editing the tool of Miss. Sharmistha Shil Sharma, M.Sc (N) student in Mental Health Nursing, who is undertaking a study **"COMPARE THE CAREGIVER BURDEN AMONG PSYCHIATRIC ILLNESS AND MEDICAL ILLNESS IN TRIPURA MEDICAL COLLEGE & DR. BRAM TEACHING HOSPITAL, AGARTALA, TRIPURA WEST."**

Place: Agartala

Signature & Seal of Expert

DR. SAMIR DEBBARMA
Assistant Professor
Department of Kokborok
TRIPURA UNIVERSITY
Suryamaninagar, Tripura (W)

Date: 17/05/2023

Name & Designation

ANNEXURE-XVIII

CERTIFICATE OF ENGLISH EDITING OF DISSERTATION

CERTIFICATE OF ENGLISH EDITING:

I hereby certified that, I have done English editing of the dissertation prepared by Miss. Sharmistha Shil Sharma , M.Sc (N) student in Mental Health Nursing, from Tripura College of Nursing, Hapania. Who is undertaking a study titled, **"Compare the caregiver burden among psychiatric illness and medical illness in Tripura Medical College & Dr. BRAM Teaching Hospital, Agartala, Tripura West."**

DATE:

Signature & Seal of Expert

Dr. SOMDEV BANIK
Associate Professor,
Dept. of English,
Tripura University.

Name & Designation

ANNEXURE-XIX

VALIDATORS OPINION REGARDING SOCIO-DEMOGRAPHIC DATA

QUESTIONS	V1	V2	V3	V4	V5	V6	V7	TOTAL			PERCENTAGE			REMARKS
								Relevant	Needs modification	Not relevant	Relevant	Needs modification	Not relevant	
Q1	R	NM	NM	R	R	R	R	5	2		71.42%	28.57%		
Q2	NM	R	R	R	NM	NM	R	4	3		57.14%	42.85%		Add option & change the term ‘sex’.
Q3	R	R	R	R	R	R	R	7			100%			
Q4	R	R	R	R	R	R	R	7			100%			
Q5	R	NM	NM	R	NM	NM	R	3	4		42.85%	57.14%		Modify the options
Q6	NM	R	NM	R	R	R	R	5	2		71.42%	28.57%		Modify the options
Q7	R	R	R	R	R	NM	R	6	1		85.71%	14.28%		
Q8	R	R	NM	R	R	R	R	6	1		85.71%	14.28%		
Q9	R	NM	R	R	NM	R	R	5	2		71.42%	28.57%		Add option
Q10	NR	NM	R	R	R	R	R	5	1	1	71.42%	14.28%	14.28%	
Q11	NM	NM	NM	R	NM	R	R	3	4		42.85%	57.14%		Modify the options
Q12	NM	NM	NM	R	NM	R	R	3	4		42.85%	57.14%		Modify the options
Q13	NM	NM	NR	R	R	R	R	4	2	1	57.14%	28.57%	14.28%	Modify the sentence
Q14	NM	R	NM	R	R	R	R	5	2		71.42%	28.57%		Modify the options
Q15	R	NM	R	R	R	R	R	6	1		85.71%	14.28%		
Q16	R	NM	R	R	R	R	R	6	1		85.71%	14.28%		

R= Relevant, NR=Not relevant, NM- Need Modification

ANNEXURE-XX

MASTER DATA- SHEET OF SOCIO-DEMOGRAPHIC VARIABLES OF PSYCHIATRIC CAREGIVERS

Code	Age	Gender	Religion	Place of the residence	Educational qualification of caregiver	Marital status	Occupation of the caregiver	Income of the caregiver	Type of family	No. of family members	Type of relationship with patient	Duration of stay with patient	Family income per annum	Age of the patient	Self care ability of the patient	Duration of illness	Occupation of the patient	Income of the patient	Receives any type of financial benefit from other sources
1	b	b	b	b	c	b	e	b	b	c	a	d	b	c	b	c	e	c	b
2	e	b	a	b	b	b	a	a	a	a	a	d	b	f	b	d	e	b	a
3	e	b	a	b	b	d	a	a	c	c	d	d	b	e	a	d	e	c	b
4	d	b	a	a	b	b	e	b	c	c	b	d	b	b	a	c	e	b	b
5	a	b	a	b	b	b	a	a	b	c	a	a	b	a	a	a	e	a	b
6	c	a	a	b	c	b	b	b	a	a	a	d	c	b	b	d	e	c	b
7	c	a	a	b	d	b	b	d	a	b	a	d	b	b	a	b	a	a	b
8	d	b	a	b	b	b	a	a	a	a	b	d	b	b	b	d	e	b	b
9	c	b	a	a	b	b	a	a	a	a	b	d	b	a	b	d	e	b	b
10	e	b	a	b	b	b	a	a	a	b	b	d	b	c	a	c	f	b	b
11	d	b	b	b	b	b	a	a	b	b	b	d	b	a	a	c	e	b	b
12	a	b	a	b	c	a	e	b	a	a	c	d	b	d	b	a	a	c	b
13	b	b	b	b	b	b	a	a	b	b	e	c	b	f	a	b	d	d	b
14	c	a	a	a	b	b	c	c	a	a	a	d	b	b	a	b	c	d	b

Code	Age	Gender	Religion	Place of the residence	Educational qualification of caregiver	Marital status	Occupation of the caregiver	Income of the caregiver	Type of family	No. of family members	Type of relationship with patient	Duration of stay with patient	Family income per annum	Age of the patient	Self care ability of the patient	Duration of illness	Occupation of the patient	Income of the patient	Receives any type of financial benefit from other sources
15	b	a	a	a	d	b	b	d	c	a	d	d	b	b	a	b	a	a	b
16	e	a	a	a	d	b	b	f	b	c	e	d	c	f	b	c	a	a	b
17	a	b	a	b	b	b	a	a	b	c	c	d	c	c	a	c	a	a	b
18	e	a	a	b	c	b	e	b	a	a	b	d	b	b	a	b	e	b	b
19	d	b	b	b	b	b	a	a	a	a	a	d	b	b	a	a	f	b	b
20	c	b	a	a	d	a	c	g	a	a	b	f	c	d	b	d	d	c	b
21	d	a	b	b	b	b	f	b	b	c	a	d	a	c	a	b	a	a	b
22	c	a	b	a	c	b	c	d	c	c	d	c	a	c	a	d	a	a	b
23	b	a	a	a	c	b	c	d	c	c	e	d	c	e	b	c	d	c	a
24	c	a	a	b	b	b	e	c	b	c	c	d	b	g	b	d	a	b	a
25	e	a	a	a	b	b	d	c	b	c	a	d	b	d	b	b	a	a	b
26	a	a	a	b	c	a	e	c	a	c	c	d	b	d	b	b	b	f	b
27	e	b	a	b	a	a	a	a	c	c	b	d	b	b	a	a	e	b	b
28	e	a	a	b	c	b	e	d	a	b	b	d	b	a	a	d	a	a	a
29	a	b	b	b	c	a	e	b	a	a	c	d	b	e	a	d	f	b	b
30	b	b	a	a	b	b	a	a	a	a	a	d	b	d	b	b	e	c	b

ANNEXURE-XXI

MASTER DATA- SHEET OF STANDARDIZED ZARIT BURDEN INTERVIEW SCHEDULE OF PSYCHIATRIC CAREGIVERS

CODE	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	TOTAL
01	3	4	3	4	4	3	4	3	4	3	1	4	3	3	4	4	2	1	2	3	2	4	68
02	3	3	4	4	4	3	4	4	3	4	3	2	3	3	2	2	1	2	4	4	4	4	70
03	3	0	4	2	3	3	4	3	4	2	0	2	3	4	3	0	2	0	3	1	0	4	50
04	4	3	2	1	0	2	3	4	2	2	0	2	0	3	3	3	2	1	4	2	2	3	48
05	3	4	2	2	3	3	4	4	3	0	0	3	3	3	3	0	3	0	3	3	4	3	56
06	4	3	4	4	3	4	3	2	3	2	1	4	2	0	4	0	2	0	4	4	4	2	59
07	3	3	3	2	3	2	4	3	3	3	0	4	3	4	2	3	4	0	3	3	3	4	62
08	3	2	4	4	4	2	4	4	4	4	1	4	1	4	3	4	2	1	4	2	4	4	69
09	3	0	4	0	3	3	4	4	4	3	2	3	3	4	4	2	4	2	4	3	4	4	67
10	4	3	4	3	4	2	4	2	4	3	0	2	1	3	2	0	2	0	3	0	2	2	50
11	2	4	3	2	2	0	3	3	2	3	0	2	4	2	3	4	2	3	3	1	4	3	55
12	0	0	4	3	4	0	3	2	4	4	3	0	3	2	4	0	0	1	3	1	3	4	48
13	4	3	4	2	2	2	4	4	2	2	0	2	0	2	3	0	3	0	3	4	4	4	54
14	0	3	1	2	3	2	3	2	2	3	0	2	3	2	2	2	3	0	3	4	4	3	49
15	1	3	1	3	2	3	4	3	1	0	2	2	3	1	0	2	2	0	3	0	2	2	40
CODE	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	TOTAL
16	0	0	2	4	0	1	3	2	1	0	0	1	0	1	0	0	1	0	2	1	2	1	22
17	4	4	3	2	4	3	4	3	3	3	2	3	2	4	0	0	3	0	3	2	1	4	57
18	1	3	4	1	2	3	4	1	2	3	2	3	0	3	1	3	4	3	4	2	3	2	54
19	2	0	2	1	2	0	3	3	4	1	3	0	2	3	3	1	2	0	3	2	2	3	42

20	0	4	4	4	1	0	3	4	1	2	3	4	3	4	3	0	1	1	1	4	4	0	51
21	0	1	2	0	3	0	4	3	1	2	0	3	0	2	3	1	3	0	4	3	2	3	40
22	1	0	2	0	0	0	3	4	2	0	3	2	2	3	0	2	2	0	3	0	0	3	32
23	1	0	1	0	1	0	3	1	0	0	2	2	0	1	0	0	2	0	4	3	3	2	26
24	2	3	4	4	2	4	4	0	4	3	2	3	4	0	4	3	4	0	4	4	0	3	61
25	3	1	3	1	0	3	4	3	4	2	0	3	0	2	2	3	2	0	3	1	2	3	45
26	4	0	2	3	4	3	4	3	3	2	0	2	4	3	1	0	2	1	4	1	0	3	49
27	2	4	4	3	2	3	4	4	3	2	0	2	0	4	0	3	2	3	4	2	0	3	54
28	0	1	2	3	0	0	4	1	0	2	0	1	0	2	0	2	0	1	0	3	1	2	25
29	0	0	0	2	0	0	4	0	0	2	0	2	2	0	2	0	2	0	0	2	3	2	23
30	0	2	4	3	3	4	4	2	4	3	1	4	2	2	4	3	3	1	3	3	1	3	59

ANNEXURE-XXII

MASTER DATA- SHEET OF SOCIO-DEMOGRAPHIC VARIABLES OF MEDICAL CAREGIVERS

Code	Age	Gender	Religion	Place of the residence	Educational qualification of caregiver	Marital status	Occupation of the caregiver	Income of the caregiver	Type of family	No. of family members	Type of relationship with patient	Duration of stay with patient	Family income per annum	Age of the patient	Self care ability of the patient	Duration of illness	Occupation of the patient	Income of the patient	Receives any type of financial benefit from other sources
1	e	a	a	b	c	b	c	c	a	a	a	d	b	d	a	a	a	a	b
2	c	b	a	a	c	b	a	a	a	a	a	d	b	d	b	b	e	b	b

3	b	b	a	b	b	b	a	a	b	b	e	b	b	f	b	c	f	b	a
4	b	b	a	b	c	b	a	a	b	b	e	e	b	f	b	c	e	b	a
5	e	a	a	b	b	b	d	e	b	c	c	d	c	h	b	c	d	c	b
6	e	b	a	a	c	c	d	c	a	a	d	d	b	g	a	d	a	b	a
7	a	a	b	a	b	b	f	b	b	b	c	d	b	d	a	b	d	b	b
8	c	a	a	b	d	b	f	b	a	a	c	d	b	f	b	a	a	b	a
9	c	a	a	a	d	b	c	e	b	c	c	d	c	f	a	d	d	b	b
10	a	b	a	b	c	a	f	b	a	c	c	d	a	c	a	a	a	a	b
11	c	a	a	a	d	b	b	d	b	c	a	d	b	b	a	a	a	a	b
12	a	b	a	b	b	b	a	a	b	c	e	c	b	e	b	a	e	b	b
13	c	b	a	a	d	a	b	d	c	c	d	d	b	a	a	d	e	b	b
14	b	b	a	a	c	b	a	a	a	a	e	d	b	d	a	b	a	a	b

Code	Age	Gender	Religion	Place of the residence	Educational qualification of caregiver	Marital status	Occupation of the caregiver	Income of the caregiver	Type of family	No. of family members	Type of relationship with patient	Duration of stay with patient	Family income per annum	Age of the patient	Self care ability of the patient	Duration of illness	Occupation of the patient	Income of the patient	Receives any type of financial benefit from other sources
15	c	a	a	a	c	b	b	e	c	c	e	c	b	f	b	a	a	b	a
16	d	b	a	a	c	d	d	c	a	a	c	d	b	g	a	b	d	d	b
17	c	a	b	a	c	b	c	c	a	a	a	c	b	b	a	a	a	a	b
18	b	b	a	b	b	b	d	b	b	a	e	d	b	f	b	d	f	c	b
19	b	b	a	b	b	b	a	a	a	a	e	c	b	e	b	d	d	c	b
20	b	b	a	a	c	b	a	a	b	c	e	d	b	e	a	d	d	c	b
21	c	a	a	b	b	b	b	d	b	a	c	d	b	f	a	c	a	b	a
22	c	b	a	a	b	c	e	b	a	a	a	e	b	b	a	a	a	a	b
23	b	b	a	b	d	b	a	a	b	c	e	d	c	e	a	a	a	a	b
24	c	a	a	b	c	b	b	e	a	b	e	d	b	e	a	a	a	b	a
25	d	b	b	b	b	b	a	a	b	a	a	d	b	d	a	a	e	c	b

26	d	a	a	a	c	d	e	b	a	a	c	d	b	f	a	c	a	b	a
27	a	b	a	b	c	a	e	b	a	a	c	d	b	d	a	a	e	d	b
28	d	b	b	b	a	b	a	a	b	c	a	d	b	d	b	c	f	b	b
29	e	b	a	b	c	b	a	a	a	a	a	d	b	f	a	c	d	b	b
30	b	b	a	a	b	b	e	c	b	b	e	c	b	e	a	c	e	b	b

ANNEXURE-XXIII

MASTER DATA- SHEET OF STANDARDIZED ZARIT BURDEN INTERVIEW SCHEDULE OF MEDICAL CAREGIVERS

CODE	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	TOTAL
01	1	0	4	4	0	0	4	3	0	3	0	1	2	3	0	3	2	0	3	3	0	4	40
02	3	0	4	2	3	3	4	3	4	2	2	0	3	4	4	0	2	0	3	3	4	4	57
03	2	3	4	4	2	4	4	0	4	3	2	3	4	0	4	3	4	0	4	4	0	3	61
04	2	2	1	0	0	0	4	3	1	0	0	2	0	3	3	0	0	0	2	0	3	2	28
05	3	1	3	0	3	0	4	3	1	3	0	3	0	4	0	2	2	0	2	2	1	3	40
06	4	1	3	1	3	1	4	2	3	2	3	3	1	3	3	3	2	0	2	3	1	3	51
07	2	0	2	1	2	0	3	2	3	3	0	3	1	3	0	3	2	2	3	2	3	4	44
08	2	3	4	1	3	2	4	2	3	`1	0	2	3	2	1	1	1	2	1	2	4	3	47
09	4	3	3	2	3	2	3	4	2	3	1	4	0	2	2	3	0	1	2	2	3	3	52
10	3	3	2	3	0	1	4	3	3	1	0	4	2	3	3	2	2	3	2	3	4	4	55
11	1	0	2	1	2	0	3	1	2	0	0	0	0	3	0	0	3	0	2	3	3	2	28
12	2	2	3	1	0	0	3	2	3	0	0	2	3	2	1	1	0	0	2	1	3	2	33

13	2	0	1	2	3	0	4	1	1	3	0	0	2	0	0	0	2	2	2	0	0	3	28
14	1	0	0	0	0	0	4	1	2	0	0	0	0	2	1	0	0	0	2	3	2	1	19
15	1	0	0	0	0	0	3	2	0	0	0	0	0	2	0	0	0	0	3	4	1	2	18
CODE	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	TOTAL
16	0	0	4	4	3	0	3	1	1	2	0	1	0	2	3	0	2	0	3	1	4	4	38
17	1	0	2	1	0	0	4	2	2	2	0	1	0	1	2	0	1	0	3	4	4	3	33
18	1	3	4	2	1	0	3	4	3	2	1	1	0	3	2	3	2	3	2	0	3	2	45
19	0	0	2	0	3	0	3	1	1	2	0	1	0	2	3	0	2	0	3	1	4	3	31
20	2	3	1	2	1	2	2	3	1	2	4	2	0	0	2	2	1	2	4	0	2	3	41
21	2	3	4	1	2	1	4	3	2	0	0	4	2	3	1	1	1	1	0	3	3	3	44
22	1	2	2	0	0	0	3	0	1	1	0	2	0	4	1	2	0	0	4	2	3	1	29
23	3	4	4	2	0	0	4	4	1	2	0	1	0	4	0	1	2	2	1	0	0	2	37
24	3	2	3	1	0	0	4	3	2	3	0	4	1	2	3	0	0	1	3	3	1	2	41
25	2	4	4	4	0	4	4	3	2	0	0	2	0	0	3	3	1	0	3	1	3	4	47
26	3	1	2	3	2	1	4	2	1	2	0	2	2	2	1	0	3	0	2	0	1	2	36
27	3	2	3	1	1	0	3	2	4	2	0	1	0	4	3	0	1	0	2	2	1	4	39
28	3	1	3	4	2	0	4	4	1	2	0	2	0	4	4	1	0	0	2	1	4	4	46
29	2	0	1	1	1	0	2	3	1	1	0	3	0	4	2	1	1	0	3	0	0	0	26
30	4	2	3	1	0	0	4	2	2	0	0	1	0	2	2	0	1	2	3	1	0	1	31

ANNEXURE-XXIV

PICTURES OF DATA COLLECTION DURING PILOT STUDY

ANNEXURE-XXV

PICTURE OF RESEARCH SETTINGS OF MAIN STUDY

PICTURES OF DATA COLLECTION DURING MAIN STUDY