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Comparison of Positive Psychological Capital among Caregivers of Depressed Patients with Different Marital Status

การเปรียบเทียบต้นทุนทางจิตวิทยาเชิงบวกของผู้ดูแลผู้ป่วยซึมเศร้าที่มีสถานภาพสมรสแตกต่างกัน

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Abstract

Major Depressive Disorder (MDD) or Depression is a psychiatric disorder involving with a serious mood disturbance and mostly co-occurrence with physical symptoms; those symptoms raise a higher burden for their caregivers. Previous scholar pointed out that caregivers with positive psychological capital (PsyCap) were able to perform proper care to their depressed patient. Therefore, this study aimed to (1) identifying the levels of PsyCap in the caregivers of depressive patients and (2) comparing the levels of PsyCap as classified by caregiver's marital status. Samples were 192 caregivers of depressed patients (62 males, 130 females) who continuously received the hospital services at the HRH Princess Maha Chakri Sirindhorn Medical Center. They were asked to complete questionnaire on demographic information and Positive Psychological Capital scale. Descriptive statistics and One-Way ANOVA with Scheffe Test were employed for analyzing the data. The results revealed that (1) caregivers had an overall score and a domain score of PsyCap at a high level (mean ranged from 4.04 to 4.20), and at a very high level for a domain of hope (mean = 4.40). The analysis of One-way ANOVA and Scheffe showed significant differences for overall scores and domain scores of PsyCap according to the caregiver’s marital status, especially the differences between single-divorced and single-married. These findings shed on the importance of a support from spouses effecting on a difference of PsyCap of caregivers; it provides useful information for planning intervention fitting with a characteristic of these caregivers.

Keywords: Positive Psychological Capital; Caregivers; Depressed Patients; Marital Status

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บทคัดย่อ

โรคซึมเศร้า (Major Depressive Disorder หรือ MDD) หรือ ภาวะซึมเศร้า เป็นความผิดปกติทางจิตเวชที่เกี่ยวข้องกับการมีอารมณ์ทางลบที่รุนแรงและส่วนใหญ่มีอาการทางกายร่วมด้วย ผู้ป่วยโรคนี้จะเพิ่มภาระให้กับผู้ดูแลในหลายด้าน วรรณกรรมที่ผ่านมาระบุว่า ผู้ดูแลที่มีต้นทุนทางจิตวิทยาเชิงบวกจะสามารถดูแลผู้ป่วยโรคซึมเศร้าได้อย่างเหมาะสม ดังนั้น การศึกษาครั้งนี้จึงมีวัตถุประสงค์เพื่อ (1) ศึกษาระดับต้นทุนทางจิตวิทยาเชิงบวกของผู้ดูแลผู้ป่วยโรคซึมเศร้า และ (2) เปรียบเทียบระดับต้นทุนทางจิตวิทยาเชิงบวกของผู้ดูแลผู้ป่วยโรคซึมเศร้าจำแนกตามสถานภาพสมรส กลุ่มตัวอย่างเป็นผู้ดูแลผู้ป่วยโรคซึมเศร้า จำนวน 192 คน (เพศชาย 62 คน และเพศหญิง 130 คน) ที่ได้รับบริการทางการแพทย์ ณ ศูนย์การแพทย์สมเด็จพระเทพรัตนราชสุดาสยามบรมราชกุมารีอย่างต่อเนื่อง เก็บข้อมูลด้วยแบบสอบถามข้อมูลทั่วไปและแบบวัดต้นทุนทางจิตวิทยาเชิงบวก วิเคราะห์ข้อมูลด้วยสถิติเชิงพรรณนา การวิเคราะห์ความแปรปรวนทางเดียว และการวิเคราะห์รายคู่ด้วยวิธี Scheffe ซึ่งผลการวิจัย พบว่า (1) ผู้ดูแลผู้ป่วยโรคซึมเศร้ามีคะแนนรวมและคะแนนรายด้านของต้นทุนทางจิตวิทยาเชิงบวกในระดับสูงทุกด้าน (คะแนนเฉลี่ยระหว่าง 4.04 ถึง 4.20) และมีคะแนนอยู่ในระดับสูงมากในด้านความหวัง (คะแนนเฉลี่ยเป็น 4.40) และ (2) ผลการวิเคราะห์ความแปรปรวนทางเดียวและวิเคราะห์รายคู่ด้วย Scheffe พบว่า ผู้ดูแลที่มีสถานภาพสมรสแตกต่างกัน จะมีคะแนนรวมและคะแนนรายด้านของต้นทุนทางจิตวิทยาเชิงบวกแตกต่างกันอย่างมีนัยสำคัญทางสถิติทุกด้าน โดยเฉพาะความแตกต่างระหว่าง โสด-หย่าร้าง และโสด-สมรส ซึ่งข้อค้นพบครั้งนี้ช่วยชี้ให้เห็นถึงความสำคัญของการได้รับการสนับสนุนทางสังคมจากคู่สมรส ที่ส่งผลต่อความแตกต่างของระดับต้นทุนทางจิตวิทยาเชิงบวกของผู้ดูแล ช่วยให้ได้ข้อมูลที่เป็นประโยชน์ในการวางแผนการช่วยเหลือที่ตรงกับคุณลักษณะของผู้ดูแลผู้ป่วยกลุ่มนี้ต่อไป

คำสำคัญ: ต้นทุนทางจิตวิทยาเชิงบวก; ผู้ดูแล; ผู้ป่วยซึมเศร้า; สถานภาพสมรส

Introduction

Major Depressive Disorder (MDD) or Depression is a common psychiatric disorder frequently found in Thai's context with all ages. The disorder involves a serious mood disturbance and mostly co-occurrence with physical symptoms. American Psychiatric Association (2013) outlines the diagnosis criteria for MDD that an individual must be experience symptoms either depressed mood or loss of interest/pleasure during the same 2-week period. These symptoms cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The clinical diagnosis criteria to MDD includes, for example, depressed mood nearly every day, markedly diminish interest/pleasure in almost all activities, slowdown of thought and reduce of physical movement, fatigue or loss of energy nearly every day, feelings of worthlessness or inappropriate guilt, diminish ability to think, concentrate or indecisiveness, as well as a recurrent thoughts of death and suicidal ideation. Statistical data showed that MDD was a significant loss of Disability Adjusted Life Years (DALY) at the fourth rank in females and tenth rank in males, comparing to 135 illnesses caused by health loss and injury among Thai's people (Department of mental health, 2016). Meanwhile, the statistics for the psychiatric outpatient department at the HRH Princess Maha Chakri Sirindhorn Medical Center, Srinakharinwirot University (2018) found that MDD was the disorder with the highest number of patients, accounting for 22.71%, followed by schizophrenia 16.85% and ADHD 11.58%. The MDD patients also showed a higher rate of relapse and increased risk of suicide. In this regard, depressed patients need to be closely care by a caregiver who is well-understanding to the depressed disorder and able to provide vital care to the patient in order to prevent the recurrent of the illness and risk to suicide.

The caregiver is a key-person for a patient with depression. They have to spend an extensive amount of time interacting with their care recipients, while providing care in a wide range of activities. Since symptoms of depressive disorders is complex condition, caregivers have to responsible for a lot of burdens. They should have a knowledge on the disorder, well-understanding to the dynamic of the disorder, patience with mood swings, have a positive attitude towards the patient, maintain good relationship with a patient, able to deal with patient’s physical symptoms, able to cope with unexpected behavior which patients themselves perform unintentionally, and responsible for taking a patient to the doctor as appointment (Zivin, Wharton, & Rostant, 2013) Taking a proper care to the depressed patient is not simple and differs from taking care to other illness patient. Most of the caregivers of the depressed patient reported a higher stress due to the feeling of unprepared to provide care, having inadequate knowledge to deliver proper care, and receiving little guidance from the formal health care providers. Those affect negatively to caregivers’ quality of life and their family relationships. (Reinhard, Given, Petlick, & Bemis, 2008; Mthembu et al., 2016)

Positive Psychological Capital (PsyCap) is a current concept in psychology which is proposed by Luthans and his colleagues in 2004. This concept has been developed through a paradigm of positive psychology and positive organizational behavior in order to define an individual’s positive psychological state of development. PsyCap indicates the value of human resources representing that the individual with PsyCap is able to function effectively even facing with obstacles or problems. The core areas of PsyCap include of four domains i.e. hope, self-efficacy, optimism and resilience (Luthans, Luthans, & Luthans, 2004; Luthans, Avolio, Avey, & Norman, 2007). In this study, the definition of positive psychological capital for caregivers of depressed patients refers to a positive mental characteristic of caregivers to perform proper care to their depressed patient even facing with various difficulties. Caregivers with high PsyCap have positive motivation on achieving the intended goals through various pathways, self-confidence to perform a task and to face challenges, make specific attributions for positive events and maintains a positive attitude. They also able to recover quickly and grow from adversity or dramatic events.

The capacities of all dimensions of PsyCap are correlates with variables of, for example, stress, burnout, coping strategy and work engagement (Herbert, 2011; Ding et al., 2015).

Marital status, as the independent variable in this study, refers to a type of social support received from family members and able to be identified as a ‘spouse support.’ A previous scholar indicated the high responsibility and burden that caregivers of persons with mental illness have to face with (Pakenham, 2011) while the caregiver’s quality of life depends on various factors including caregiver’s demographics, caregiver-recipient characteristics (e.g., type of illness, gender) and caregiving context variables (e.g., co-residence, caregiving duration, type of relationship) (Mo¨ller-Leimku¨hler & Wiesheu, 2012; Reinares et al., 2016). There are only few studies that give priority to marital status (as a support from the spouse) that effect on PsyCap of the caregivers of mental illness patients.

A gap of knowledge arises when a key-person for depressive patients is his/her caregivers and previous scholar point out that caregivers with high PsyCap are able to perform proper care, well-function and maintain a positive attitude. However, there are not many studies focus on PsyCap in the caregivers of depressive patients. Therefore, this study aims to fill a gap by (1) examining the levels of PsyCap in the caregivers of depressive patients and (2) comparing the levels of PsyCap as classified by the caregiver's marital status. The benefits of the study point out the important of PsyCap in caregivers of mental illness patient as well as provides a guideline for developing PsyCap interventions later on.

Research objective

1. To investigate the level of positive psychological capital in caregivers of depressed patients
2. To compare the level of positive psychological capital in caregivers of depressed patients as classified by the caregiver's marital status

Research hypothesis

The level of positive psychological capital in caregivers of depressed patients were differed regarding to their marital status

Methodology

This study employed the cross-sectional research design to test whether there were any differences in level of positive psychological capital among caregivers of depressed patients with differing marital status. The methodology of population and samples, measurement, research procedure and data analysis were explained as followed;

1. Population and sample

1.1 Population was 368 caregivers of depressed patients who continuously received the hospital services at the HRH Princess Maha Chakri Sirindhorn Medical Center, during January 1 to December 31, 2017. Those population was recorded based on the number of depressed patients who received a service individually, without repeatedly count the same person. (HRH Princess Maha Chakri Sirindhorn medical center, 2018)

1.2 Samples were 192 caregivers of depressed patients who continuously received the hospital services at the HRH Princess Maha Chakri Sirindhorn Medical Center, during January 1 to December 31, 2017. The adequate number of sample size was calculated based on Yamane's formula for known population with ±5% precision level, 95% confidence level and P = .5. The method of simple random sampling was employed for data collection until the number of samples have been completed.

2. Measurement

This study employed two measures i.e. the questionnaire on demographic information and the positive psychological capital scale as followed;

2.1 The questionnaire on demographic information included questions of gender, age, educational level, marital status, number of family members, family style, relationship with the patient, duration of treatment and duration of taking care to the patients

2.2 The Positive Psychological Capital scale; the scale was generated based on the fundamental concept of Luthans et al. (2007). It was a 5-point Likert scale, consisted of four domains i.e. hope (9 items), self-efficacy (9 items), optimism (9 items), and resilience (9 items). The scale was verified of its validity by the confirmation of three professional in the field of psychology (an average IOC were greater than 0.70 for all of the items). The reliability was tested with 30 patients who were similar condition as the actual sample. The internal consistency of Cronbach's Alpha for the whole items was .946 (representing very high reliability) and ranging from .817 to .902 for the separate domain (Cronbach's Alpha = .834 for hope, .902 for self-efficacy, .817 for optimism and .888 for resilience).

3. Research procedure and ethical consideration

The formal letter requesting for the courtesy had been submitted to the director of the HRH Princess Maha Chakri Sirindhorn Medical Center to ask for a permission to collect the data. The ethical protocol had also been submitted to the ethical committee of the medical center to approve of ethical consideration during study.

Prior to data collection, ethical consideration has been informed to participants. They received a full explanation of the study's purpose and procedure as well as assured of their anonymity and confidentiality. Any of whom who were not volunteer to participate in the study were able to withdraw from the study without any consequences.

4. Data analysis

The statistical standards were employed for analyzing the data as followed; (1) descriptive statistics i.e. frequency, percentile, mean, standard deviation were used for investigating the demographic characteristic and level of Positive psychological capital among caregivers of depressed patients and (2) One-Way ANOVA with Scheffe Test were used for comparing the level of positive psychological capital among caregivers of depressed patients regarding to their different of the marital status.

Results

The results were divided into three parts; (1) demographic characteristic of the caregivers of depressed patients (2) level of positive psychological capital of caregivers of depressed patients and (3) comparison of positive psychological capital regarding to their different of marital status.

Part 1: Demographic characteristic of the caregivers of depressed patients

In this study, the sample included 192 caregivers of depressed patients (62 males and 130 females) who received the hospital services at the HRH Princess Maha Chakri Sirindhorn Medical Center. Most of them were father/mother of the depressed patient; their age ranges from 41-50 years old, some of them were older. Most of them graduated bachelor degree while some finished the high school. Their majority marital status was married and they lived as a single family. They spend approximately 1-2 years for taking care to the patients while most of the patients spend approximately 1-2 years for receiving the medical treatment. More details were described in Table 1.

Table 1 Demographic characteristic of the caregivers of depressed patients

Variables	n (%)
Gender	
Males	62 (32.29%)
Females	130 (67.71%)
Age; Mean (*SD*)	45.53 (*SD*=11.16) years old
20-30 years old	20 (10.42%)
31-40 years old	39 (20.31%)
41-50 years old	74 (38.55%)
Greater than 51 years old	59 (30.72%)
Educational level	
Primary school	26 (13.54%)
Secondary school	59 (30.73%)
Bachelor degree	83 (43.23%)
Higher than Bachelor degree	24 (12.50%)
Marital status	
Single	27 (14.06%)
Married	141 (73.44%)
Divorced	24 (12.50%)
Number of family members	
2 members in the family	63 (32.81%)
3 members in the family	50 (26.04%)
Greater than 3 members in the family	79 (41.15%)
Family style	
Single family	116 (60.42%)
Extended family	26 (13.54%)
Single-parent family	6 (3.12%)
Childless family	44 (22.92%)
Relationship with the patient	
Husband - wife	68 (35.42%)
Father - Mother	81 (42.19%)
Children - Grandchildren	24 (12.50%)
Brother/Sister - Brother/Sister	19 (9.89%)

Table 1 (continued)

Variables	n (%)
Duration of treatment	
1-2 years	84 (43.75%)
3-4 years	58 (30.21%)
More than 5 years	50 (26.04%)
Duration of taking care to the patients	
1-2 years	99 (51.56%)
3-4 years	55 (28.64%)
More than 5 years	38 (19.80%)

Part 2: Level of positive psychological capital among caregivers of depressed patients

Positive psychological capital was the focused variable in this study; its level had been identified in caregivers of depressed patients as showed in Table 2. The overall score represented those caregivers had positive psychological capital in high level (mean = 4.20, *SD* = .521), as well as the high level in domains of self-efficacy (mean = 4.20, *SD* = .796), optimism (mean = 4.18, *SD* = .683) and resilience (mean = 4.04, *SD* = .621). Only in the domain of hope that caregivers scored of very high (mean = 4.70, *SD* = .647).

Table 2 Level of the positive psychological capital and its domains in caregivers of depressed patients

Variable	No. Items	Min	Max	Mean (SD)	Interpret
Hope	9	3	5	4.40 (.647)	Very high
Self-Efficacy	9	3	5	4.20 (.796)	High
Optimism	9	3	5	4.18 (.683)	High
resilience	9	3	5	4.04 (.621)	High
Overall PsyCap	36	3	5	4.20 (.521)	High

Interpretation of the score: Very low level = 1.00-1.80, relatively low level = 1.81-2.61, Moderate level= 2.62-3.42, relatively high level = 3.43-4.23, very high level = 4.24-5.00

Part 3: Comparison the level of positive psychological capital in caregivers of depressed patients as classified by the caregiver's marital status

This key finding was the comparison of the level of positive psychological capital according to the differences in the marital status of the caregivers, representing the difference in perceived social support by the caregivers. The results of One-way ANOVA and post-hoc test by method of Scheffe showed significant differences for overall scores and domain scores. For the domain of hope, there was significant difference of single-divorced caregivers. For the domain of self-efficacy and resilience, there were significant differences of caregivers who were single-married and single-divorced. Meanwhile, the domain of optimism had a significant difference in the three groups. The overall score also presented significant difference, especially single-married and single-divorced, as described in Table 3 and 4.

Table 3 Comparison the level of positive psychological capital in caregivers of depressed patients as classified by the caregiver's marital status

Variables	Mean (*SD*)			*F*	*p* value
	Single	Married	Divorced		
Hope	4.22 (.751)	4.39 (.641)	4.66 (.481)	3.136*	.046
Self-Efficacy	3.59 (.500)	4.29 (.762)	4.33 (.963)	10.144**	<.001
Optimism	3.77 (.697)	4.19 (.667)	4.58 (.503)	9.703**	<.001
resilience	3.44 (.506)	4.09 (.584)	4.41 (.503)	20.945**	<.001
Overall PsyCap	3.75 (.407)	4.24 (.515)	4.50 (.345)	16.389**	<.001

**p* value < .05; ***p* value < .01

Interpretation of the score: Very low level = 1.00-1.80, relatively low level = 1.81-2.61, Moderate level= 2.62-3.42, relatively high level = 3.43-4.23, very high level = 4.24-5.00

Table 4 The post-hoc test by the method of Scheffe

Variables	Group of samples	Mean Dif (S.E.)	*p* value
Hope	Single - Married	-.167 (.134)	.461
	Single - Divorced	-.444 (.179)*	.049
	Married - Divorced	-.276 (.141)	.151
Self-Efficacy	Single - Married	-.705 (.159)**	<.001
	Single - Divorced	-.740 (.213)**	.003
	Married - Divorced	-.035 (.167)	.978

Table 4 (continued)

Variables	Group of samples	Mean Dif (S.E.)	*p* value
Optimism	Single - Married	-.420 (.137)**	.010
	Single - Divorced	-.805 (.183)**	<.001
	Married - Divorced	-.384 (.144)*	.031
resilience	Single - Married	-.647 (.118)**	<.001
	Single - Divorced	-.972 (.158)**	<.001
	Married - Divorced	-.324 (.124)*	.036
Overall PsyCap	Single - Married	-.485 (.101)**	<.001
	Single - Divorced	-.740 (.135)**	<.001
	Married - Divorced	-.255 (.106)	.060

*p value < .05; **p value < .01

Discussion

The discussion is divided into two main points: (1) level of positive psychological capital among caregivers of depressed patients comparing with caregivers of other illness patients and (2) the comparison on level of positive psychological capital in caregivers of depressed patients as classified by their marital status, as followings;

Firstly, this finding revealed the level of positive psychological capital among caregivers of depressed patients that they had an overall score and a domain score at a high level, and at a very high level for a domain of hope (see Table 2). It represented a positive mental characteristic of caregivers to perform proper care to their depressed patient, self-confidence to perform a task and to face challenges, maintains a positive attitude and able to recover from adversity situation. Although there are few studies previously focus on positive psychological capital of caregivers, the discussion could be considerate through information on the burden and responsibilities of caregivers instead. The study of Pakenham (2011) identified three caregiving tasks for caring patients with mental illness, i.e. instrumental care, activities of daily living care and psychosocial care; all of these tasks required a mental capital from caregivers to be able to well-adjustment and function. Moreover, the correlation between the positive psychological capital and its factors have been identified. The mental capital appeared to be positively correlated with well-being and quality of life; while it was adversely correlated with psychiatric problems, stress, burnout and feeling inferiority (Herbert, 2011; Ding et al., 2015).

Comparing the level of positive psychological capital of the caregivers as well as their burden and responsibility to care is one of the main points for discussion, especially between caregivers with depressed patients and caregivers with other ill patients. Comparing with caregivers of patients with bipolar disorder, most of them experienced significantly higher burdens than those with unipolar depression. Caregivers of bipolar patients reported high levels of expressed emotion, including of critical, hostile, or over-involved attitudes because of its cyclical nature and the stresses arising from emotional swinging on depressive and manic episodes, resulting in severe and widespread impairment of function (Ogilvie, Morant, & Goodwin, 2005; Reinares et al., 2016). Comparing with caregivers of patients with schizophrenia, caring of schizophrenia patients also raised as higher stress as caring of affective disorder patients. Those caregivers faced negatively impact on the emotional, financial and physical aspects, as well as elicited some restrictions in their routine, daily hassles and conflicts in family relationships (Hsiao & Tsai, 2015; Kardorff, Soltaninejad, Kamali, & Shahrbabaki, 2016). However, the burden of care for depressed patients and Alzheimer's patients was clearly different. Caregivers of people with Alzheimer's disease mostly experienced a higher burden due to disease symptoms, impairment of functional autonomy, behavioral problems and cognitive impairment e.g. apathy, agitation, aberrant motor behavior, appetite disorders and irritability. Therefore, they had a responsibility to handle finances, food preparation, transportation preparation and responsibility for regulating a patient to take medicine as prescribed by the doctor (Dauphinot et al., 2015), while those responsibility were less serious in caregivers of individual with depression.

Secondly, the key finding of this study was the comparison on level of positive psychological capital in caregivers of depressed patients as classified by the caregiver's marital status. Our finding revealed significant differences for overall scores and domain scores of positive psychological capitals, especially the differences between single-divorced and single-married (see Table 3 and 4). This study identified marital status as the ‘spouse support’ or sometimes ‘family support’ which was a type of informal social support received from family members. The significant differences on the level of positive psychological capital according to caregiver’s marital status, representing the difference in perceived social support by the caregivers and resulting in the effectiveness for caring. Social support from intimate social relationships e.g. spouse, family members, friends or neighbors have positively affect caregivers’ psychological well-being rather than social support gained through formal relationship e.g. professional practitioners, physicians, nurses or social workers (Shiba, Kondo, & Kondo, 2016). Congruence with the study of Brand, Barry, & Gallagher (2016), the psychosocial pathways between benefit finding, social support, optimism and quality of life have been studies in caregivers. Their results showed the associations between benefit finding and quality of life that was explained through social support; caregivers who had greater benefit finding were more likely to report higher perceived social support, and in turn, had a positive effect on their overall quality of life. Meanwhile, the study of Joling et al. (2015) with spousal caregivers of persons with dementia without a clinical depression or anxiety disorder at a baseline revealed that spousal caregivers reported a high risk to develop a mental disorder; 60% of them developed a depressive and/or anxiety disorder within 24 months. This highlights an importance of caregiver-recipient relationships. A recipient requires support from their caregivers, at the meantime, social support for caregivers is a key target of interventions to reduce caregiver burden, especially an informal support from spouse and family members as that found in our study.

The limitations occur in this study due to employing a cross-sectional research design. Although our results clearly shed on the importance of a support from spouses effecting on a difference of positive psychological capital of caregivers with depressed patients, these findings could not confirm the long-term relationship among those variables. Therefore, the future studies may employ longitudinal research design to certify a long-term outcome. Moreover, future studies may additionally employ mixed method research design in order to gain insight for those concerns of caregivers and confirm its finding with standard statistical technique. The mix method provides clear and practical information for planning intervention that meets the needs of caregivers.

Conclusion

This study aimed to identify the levels of positive psychological capital in the caregivers of depressive patients and to compare positive psychological capital as classified by caregiver's marital status. The results revealed that caregivers had an overall score and a domain score of positive psychological capital at a high level, representing a positive mental characteristic of caregivers to perform proper care to their depressed patients. Also, the findings revealed significant differences on the level of positive psychological capital according to caregiver’s marital status, especially the differences between single-divorced and single-married. The findings of this study shed on the importance of a support from spouses effecting on a difference of positive psychological capital of caregivers; it provides useful information for planning intervention fitting with a characteristic of these caregivers.

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