

# Caregiver Fatigue Syndrome in Relatives of Psychiatric Patient

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**Abstract:** *Currently there is an increase in psychiatric, chronic-degenerative diseases, which is surrounded by little visibility and taboos that flood society. This study was carried out with a sample of 25 informal caregivers of users with a mental illness, where the caregiver is in the age range between 18 and 70 years. It was carried out with a qualitative, descriptive approach, where the perception of primary caregivers was known through a semi-structured interview, the results showed that excess burden has a direct effect on the quality of life of the caregiver, finding high levels of stress, anxiety, depression, this expressed in the behavior of the interviewees, in addition to physical injuries directly related to the care burden. To lighten the burden of care, nursing staff must be responsible for establishing effective strategies that provide tools to form favorable environments for caregivers. This will help reduce the burden and improve the quality of life, creating integrity among the caregivers, caregiver and patient, focusing on the strengths of the sick person and the family, as well as obtaining more information about the care that a mental illness entails and the resources that exist in the community, creating a supportive environment, improving skills coping skills of primary caregivers.*

**Keywords:** caregivers, psychiatric, tools, family, conditions, skills.

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## INTRODUCTION

Being a recent concept in the year 2022; The World Health Organization (WHO) defines mental disorders as a clinically significant alteration of cognition, poor regulation of emotions or inappropriate behavior of an individual. There are different types of mental disorders, which are surrounded by misinformation and zero visibility by society, this being the main obstacle to obtaining a timely diagnosis and adequate treatment. The increase in mental illnesses has become a characteristic of today's society, however, they continue to have little visibility, little government support and little family acceptance. All these factors trigger a particular member of the family to adopt the role of primary caregiver, which plays a fundamental role in the stability of the psychiatric patient. If he or she does not have the necessary support and knowledge to carry out this task, he or she becomes in a starting point to trigger various conditions in the health of the caregiver.

Despite the current role of women in society, the family member in charge of care, who assumes responsibility for the user with some mental deficiency, is mostly female, due to the high feminization that this task entails. , with the performance of a traditional role, which reduces the social participation and autonomy of the caregivers (Acevedo, 2020). We can define a psychiatric patient as a person who has lost his or her state of well-being, who does not have the ability to cope with the normal stresses of life, and cannot make a favorable contribution to his or her community; therefore, he or she requires medical assistance and many of the Sometimes he is subject to professional or family care to improve his health (Malpica, 2020).

The needs of the psychiatric patient vary according to certain social factors, such as economic factors, the emotional support provided by family members, the level of attention and care provided by health personnel and the family, as well as the user's degree of codependency. throughout your treatment (Caraveo, 2019). Nowadays families are smaller, so the task of caring for the dependent person is divided among a smaller number of people; This phenomenon, added to the incorporation of women into the workforce, makes the task of care increasingly difficult (Martínez, 2020). The recovery of the psychiatric patient is a path that has to be followed accompanied by the family as a containment fence to keep the patient on the path, which is why the family must implement resources such as adopting a lifestyle different from the one they were used to, It must be clarified that the disease is not an individual process and only with the support of the family environment will the desired goal be reached.

The family is responsible for accompanying, supporting, detecting, informing and receiving adequate information for the continuity of good patient care, becoming the communication channel between society and the patient, especially in periods of decompensation. If the health of the primary caregiver is not in an optimal state, the desired objectives with the patient cannot be achieved, which are to make him a useful individual for society and not a burden on it, which is why health as the The general well-being of the caregiver must be an essential part of the family, with the fixed objective of preventing exhaustion,

illnesses and family failure (Perdomo, 2017).

Social support is used as an important strategy to care for a family member with a mental disorder. Family, friends, religion, consultations with doctors, other resources from the health system and the community are the most commonly used forms of social support, as well as the most commonly used coping strategies by family members of subjects with mental illness, becoming a crucial part of social support and the resolution of problems that may arise when providing care (Frari, 2019). The primary caregiver is the person responsible for attending to all the basic needs of the sick individual. Various studies in Mexico have agreed in reporting a profile of caregivers, considering as the most frequent characteristics, people of the female sex, married, with an average age between 36 and 67 years, having a kinship with the patient as a wife or daughter, and who generally do not receive help from other people (Sierra, 2020).

Not receiving the necessary help becomes a factor that triggers the affectation of the quality of life, causing an excess of burden on the caregiver, this also associated with adverse conditions related to aspects that affect individuals, such as few economic resources, causing the modification of their lifestyles, in addition to becoming dependent on long hours in the care of their relatives, this leads them to transform their personal, work and social relationships. All of these aspects make the practice of caring a negative event, which leads to the experience of caring being defined in terms of burden, stress, exhaustion, and demands from the patient towards the caregiver (Feldberg, 2020).

The subjective burden shows us how to bear an obligation that becomes heavy and oppressive. This is caused by the tasks involved in being the person responsible for care. Most of the burden is made up of the behaviors that the patient presents, especially by negative symptoms, as well as general concerns about the health, safety, treatment and future of the patient that the family develops (Algora, 2018). According to Ferrell, within the bibliography of Afanador, 2020, it has been established that the quality of life in the caregiver from physical well-being is determined by maintaining the functionality for carrying out daily life activities. Caregivers of patients with mental illness often present serious physical health problems, most of which are generated as a consequence of care. Various activities such as bathing and grooming the patient, postural changes and basic activities such as changing clothes cause physical problems for the caregiver, generating effects mainly on the musculoskeletal system, and bringing with them problems such as contractures, cramps, fractures, back and spine pain, among others, which produce difficulties in the well-being and care of those they are in charge of (Afanador, 2020).

Family members are more likely to experience persistent feelings of grief and loss that wax and wane throughout life. Families sometimes feel as if they are riding a roller coaster in response to the periods of relapse and remission that often mark the course of a mental illness. With great difficulty, the vast majority of family members come to accept mental illness. It is estimated that between 60-85% of users with a mental illness live with their families, however, only 10-20% of primary caregivers receive training on how to provide quality care without putting their emotional and physical integrity at risk. The family has

to face the symptoms of their patients without knowledge, as well as the limited capacity to attend to their biopsychosocial development, and provide the comprehensive treatment they should receive (Hayo, 2019).

The treatment and care of patients with psychiatric disorders is one of the major tasks for improving the health status of the patient, which must be carried out jointly by the family and health personnel, never leaving aside the socio-cultural aspect of the user, since this state becomes a difficulty for both the family and the society that surrounds them and the people who live with the user on a daily basis, since the user faces a persistent deterioration, whether progressive or static, that affects daily relational and neurobehavioral activities (Suárez, 2017).

Family care has an intense economic impact within households. Among these negative economic aspects, dependency gives rise to direct costs, which include changes in the availability of resources directly attributable to care. These are expenses on goods and services acquired specifically for the recipient or for themselves because of care: care or support services for the caregiver, adaptation of the home, monetary transfers to the recipient, payment for technical aids, etc. These expenses are often covered by selling assets and consuming accumulated savings. The management of this process is often a source of friction between the patient's family members, relatives and institutions (Rogeró, 2023)

Among the symptoms that appear in the caregiver are stress, anxiety, depression, fatigue, lack of energy, helplessness, continuous exhaustion, difficulty concentrating, irritability, insomnia, inability to relax, palpitations, frequent mood swings, constant apathy, emotional tension, hopelessness, not taking care of their own needs due to lack of time, leaving friendships and leisure aside, becoming impatient, resentful, with family and social isolation (Martínez, 2020)

Taking into account the above, it is important that the nurse and other health professionals, who live with this reality, take on the fundamental role of acting on the patient/family binomial in order to support them and help them identify the stress situation, understanding and recognizing how they face the difficulties, in order to intervene, minimizing suffering and contributing positively for their rehabilitation (Frari, 2019). It has been found that caregivers rarely ask for help and feel that they receive little attention, while formal support services are the most requested by caregivers. It has been proven that these services are rarely used, many caregivers are embarrassed to ask for help because they feel that they have to be capable, that not being able to is something like failing; there are also caregivers who say that they feel guilty for resting (Benjumea, 2017)

The importance of carrying out this research from the nursing area lies in its primary role, which is to provide optimal, quality and warm care, not only to the physically ill patient, but also psychologically; The nursing professional plays the role of health ambassador, through the implementation of measures for

the prevention of diseases, as well as their progression and the reduction of sequelae. All this is possible through the application of knowledge, skills and attitudes in favor of health.

The nurse can educate caregivers on the best practices to maintain good health; The health of caregivers must be addressed as a priority, since they are responsible for providing care. If their optimal health and an improvement in their quality of life are not guaranteed, it is likely that not only the care they provide will not be effective, bringing repercussions in their environment, primarily to the people who depend on them, but they will also develop physical and mental illnesses, becoming a problem for the health sector.

## **METHODOLOGY**

The type of study used to carry out this research was qualitative, descriptive, cross-sectional; This study consisted of searching, selecting, organizing and analyzing the different responses provided by the interviewees regarding the care of psychiatric patients. The evaluation instrument, which consists of a semi-structured interview, is made up of 42 items with a dichotomous scale in which the main factors that affect the health status to which primary caregivers are exposed are identified. 12 questions correspond to the sociodemographic status; 16 of the questions, apart from the dichotomous response, ask for an open response about the causes that originate the problem and 14 of the questions correspond to the support network that the 25 primary caregivers who participated in this study have. The study population corresponds to primary caregivers of users with a diagnosed mental illness, with an application of the role equal to or greater than 6 months of the Dr. Samuel Ramírez Moreno Psychiatric Hospital. The sample was for convenience for individuals who act as primary caregivers who decided to participate by completing the questionnaire and signing the informed consent letter. Inclusion criteria: the caregiver in charge must be of legal age. Specifically, caregivers must be of patients diagnosed with a mental illness and must be caregivers with care functions, supervision of basic and/or instrumental activities of daily life with the person, and perform the role of primary caregiver for a period of more than 6 months. Exclusion criteria include being caregivers of people with diagnoses not classified as mental illness.

## **RESULTS**

The minimum age of the primary caregivers who participated in this study is 18 years, with the maximum age being 70 years; however, there is an increase in ages above 40 years. It can be observed that the total number of people analyzed, who adopt the role of primary caregiver, are mostly female and are approximately 40 years old, creating a total predominance. 40% of the women who are primary caregivers live in free unions, 30% of these are married, the remaining 30% are single mothers, widows and young adults. The assessment instrument shows that adopting the role of primary caregiver has not interfered entirely with their personal life, since the majority adopted the role of primary caregiver after forming a family.

90% of primary caregivers spend around 12 hours a day caring for the patient, which means that 60% of these female caregivers are dedicated exclusively to housework. This situation is due to the fact that taking on the role of primary caregiver takes up all their time and the little time they have available is spent doing housework. The remaining 40% are dedicated to street trading activities or flexible hours, which allow them to keep an eye on their family, their home, where 100% of the users who are dedicated to care have children, and to generate extra income. The estimated monthly income of these families is less than 4000 Mexican pesos per month, taking into account that the current cost of the basic basket is 1,1000 Mexican pesos. 6 out of 10 people do not have social security, which is a basic service, which represents higher expenses and lower quality health care. People who have social security have IMSS, thanks to the insurance of home providers. 50% of users have between 20% - 30% of their salary for the patient.

80% of primary caregivers have incomplete basic education, which considerably affects them in finding permanent jobs that can provide them with the health services that the person in their care requires, having to add the fact that 40% of these users do not have their own home, which represents a considerable monthly expense. 40% of users do not have internet service, while only 30% have all the basic services. 70% of users who have a physical illness do not have active treatment, in the case of mental health, of the 100% of primary caregivers, 70% do not report having suffered from any mental illness, however, they report symptoms of anxiety attacks, depression and chronic exhaustion, it is important to note that the majority of users do not have enough time to worry about their mental and physical health, of the users who suffer from a mental illness, 66.66% suffer from depression secondary to caring for the patient, who have survived with this condition for more than a year. Despite the time they have had this condition, 90% are not currently in treatment. 80% of users became primary caregivers, since the patient is their child, these users have been sick 1-3 times since becoming a primary caregiver, of which 30% confirm a high emotional stress load, 40% of users perceive their physical load as medium, while 20% perceive it as high. 90% of users spend less than 2 hours on personal care, time seems insufficient to them and this generates a negative emotional burden this considerably affects them in looking for permanent jobs that can provide them with the health services that the person in their care requires, having to add the fact that 40% of these users do not have their own home, which represents a considerable monthly expense, 40% of users do not have internet service, while only 30% have all the basic services.

70% of users who have a physical illness do not have active treatment, in the case of mental health, of the 100% of primary caregivers, 70% do not report having suffered from any mental illness, however, they report symptoms of anxiety attacks, depression and chronic exhaustion, it is important to note that the majority of users do not have enough time to worry about their mental and physical health, of the users who suffer from a mental illness, 66.66% suffer from depression secondary to caring for the patient, who have survived with this condition for more than a year. Despite the time they have had this condition, 90% are not currently in treatment.



## DISCUSSION

One of the main characteristics of today's society is the increase in mental illnesses, from childhood to adulthood, regardless of the stage in which they occur, the symptoms they present or the degree in which they are found, physical, mental and economic support from the family is necessary.

Due to the lack of knowledge, taboos and low visibility that mental illnesses are real and are close to our core, it is common for the family to dismiss this responsibility, designating a single primary caregiver, who fully assumes the role, thereby obtaining not only the responsibility, but also the physical and mental health problems that this entails. But what is it that triggers these problems?

According to the study carried out on primary caregivers, being in charge of caring for a user with a mental illness for more than 12 hours a day becomes the main stress factor, since they are dedicated exclusively to monitoring him, feeding him, supporting him with his basic needs, adding to this the domestic chores and the care of other inhabitants of the home.

In the results of the study it was noted that the caregiver tends not to seek medical-health care, since he prioritizes the health and care of his dependent family member, which postpones and maintains the conditions without diagnosing, according to Mendoza this is what makes him a sick user not countable for the health system, better known as a "ghost patient" (Mendoza, 2017).

The environment both intrafamilial and extrafamilial and the health changes start from feelings of overload to a feeling of constant oppression, which are shared with the patient, such as overwhelm, exhaustion and hopelessness (Rascón, 2018).

The economy of the primary caregiver becomes one of the main triggers of these health problems, the estimated income of these families is less than four thousand Mexican pesos per month, occupying a quarter of that income to be able to cover the basic basket, 6 out of 10 families do not have social security, which represents higher expenses and less attention to the quality of health.

Quoting Algora; The burden that the family brings with it affects various areas of the primary caregiver's life; household chores, couple, personal and social relationships become a problem, personal development is paused, free time becomes scarce or non-existent, the family economy is seriously harmed, mental health decreases and the caregiver's subjective discomfort increases (Algora, 2018).

It is noteworthy in this research that 50% of the primary caregivers who have adopted this role currently have some physical condition, while 10% cannot detect if the condition is due to caring for the patient, this is because they do not have social security, or the time in which they can worry about their health is insufficient, most of these users have been suffering from chronic pain and exhaustion related to patient

care for about a year. 70% of users who have a physical condition do not have active treatment, in the case of mental health, of the 100% of primary caregivers, 70% do not report having suffered from any mental illness, however, they report symptoms of anxiety attacks, depression and chronic exhaustion, it is important to note that most users do not have enough time to worry about their mental and physical health. Of the users who suffer from a mental condition and who have a medical diagnosis, 66.66% suffer from depression secondary to caring for the patient, who have survived with this condition for more than a year. Despite the time they have had this condition, 90% are not currently under treatment. In some families there is the presence of arguments and abuse, lack of independence of family members, failures in communication and lack of support among the people who make up the family group, as well as economic limitations and debts, it is worth highlighting the exclusion by the people who surrounded the mentally ill person, as well as the limited possibilities they have to move to different places and little or no social participation. (Pardo, 2022).

Family members are more likely to experience persistent feelings of pain and loss that increase and decrease throughout life. Families sometimes feel as if they are on a roller coaster in response to the periods of relapse and remission that usually mark the course of a mental illness. Over time, and with great difficulty, the vast majority of family members come to accept the mental illness and continue with the course of their lives. However, they continue to experience pain from the illness of their loved one and the torment that this causes in the family (Diaz, 2019).

Caregivers of patients with mental illness often have serious physical health problems, most of which are generated as a consequence of caregiving. Various activities such as bathing and grooming the patient, postural changes and basic activities such as changing clothes generate physical problems for the caregiver, generating effects mainly on the musculoskeletal system, and bringing with them problems such as contractures, cramps, fractures, back and spine pain, among others, which produce difficulties in the well-being and care of those they are in charge of (López, 2019). Women who are in charge of providing care have a greater chance of suffering from physical problems, these range from non-specific symptoms such as asthenia to more complex ones such as the presence of neurological disorders (tension headache, insomnia, daytime hypersomnia, nightmares, sleep cycle disorders, etc.), respiratory, hematological (anemia, etc.), skin infections, endocrine (diabetes, etc.), gastrointestinal, musculoskeletal (tendinitis, joint pain, myalgia, spinal pain, etc.) and even some immunological disorders (Abanto, 2019). The treatment and care of patients with psychiatric disorders is one of the greatest tasks for improving the health status of the same that must be carried out jointly by the family and health personnel, never leaving aside the sociocultural aspect of the user, since this state becomes a difficulty for both the family and the society that surrounds it and the people who live day to day with the user, since the same faces a persistent deterioration, whether progressive or static, that affects daily relational and neurobehavioral activities (Suárez, 2017).



Social and emotional support often fails because it usually comes from the spouse, who is often the sick person, or from the family and closest friends who are the main sources of social support for caregivers. In 55% of caregivers, isolation, rejection, abandonment, loneliness, decreased or lost free time, etc. appear. This favors the appearance of psychiatric symptoms. (Borella, 2019).

In all institutions providing health services, a formal support system must be organized and managed for people with chronic illness and their family caregivers. This support not only provides the opportunity to provide a quality and equitable service, but also represents an investment that can reduce the social and institutional impact generated as a consequence of the demand for health services, caused by the increase in chronic and disabling diseases. (Escobar, 2018).

## CONCLUSION

The research conducted determined that acting as primary caregiver for a psychiatric family member brings with it mental (such as depression, anxiety), physical and social problems, which negatively influence the caregiver's daily life, and if not treated in time can lead to hospitalization or death. It is essential to make this issue visible in order to raise the integrity of caregivers, remove prejudices from society and at the same time raise the social value they contribute.

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