The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 2, April- June, 2023
DIP: 18.01.178.20231102, DOI: 10.25215/1102.178
https://www.ijip.in

The International Journal of INDIAN PSYCHOLOGY

Research Paper

Self-Care and Its Correlates in Adults Seeking Outpatient Psychiatric Services

Dr. Vimal Kumar S. V.[1]*, Dr. Seema Mehrotra[2], Dr. Paulomi M. Sudhir[3]

ABSTRACT

The study aimed at examining the nature of self-care practices in a sample of individuals seeking psychiatric outpatient services and the relationship between engagements in self-care with selected socio-demographic and illness and treatment variables as well as with indices of recovery. It also explored the nature of self-perceived barriers and facilitators for engagement in self-care. A cross-sectional survey method was utilized. 62 participants with severe and common mental illness who had been seeking outpatient psychiatric services at a tertiary care hospital were recruited in the study. A self-care survey was also developed as part of the study. Participants with higher educational level, those currently engaged in regular work, having lower severity of illness and absence of comorbidity had significantly higher scores on one or more self-care variables as compared to their counterparts. The illness itself, financial constraints and lack of support from significant others were reported as major perceived barriers to self-care. Informal and formal support, facilities/resources in the locality, social resources/opportunities and. personal resources emerged as major facilitators of self-care. The findings also suggest that perceived support plays an important role as a facilitator of self-care in persons with psychiatric illness.

Keywords: *Self-Care, Outpatient Psychiatry, Quality of Life*

Living with an illness is an ongoing and dynamic process that involves a complex interaction between individuals and their healthcare contexts and the importance of actively engaging patients in their own care is widely recognized. Patient engagement in their healthcare is now seen as a process that involves transition from a disease-centric model to maximizing individual potentials and recovery of important life, despite the disease (Graffigna & Barrello, 2015). One of the important ingredients of person- centred health care involves supporting patients to recognize and develop their own strengths and abilities so as to facilitate living an independent and fulfilling life (Armstrong et al, 2015). When only the disability component is taken into consideration in the calculation of the burden of disease, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low-and middle-income countries, respectively (Funk et al, 2010). WHO (2007) has

[1]Assistant professor, Department of clinical psychology, Institute of Mental Health and NeuroSciences, India.
[2]Former HOD, Professor, Department of clinical psychology, National Institute of Mental Health and NeuroSciences, India.
[3]Professor, Department of clinical psychology, National Institute of Mental Health and NeuroSciences, India.
*Corresponding Author

Received: May 25, 2023; Revision Received: June 01, 2023; Accepted: June 5, 2023

© 2023, Vimal, S.V., Mehrotra, S. & Sudhir, P.M.; licensee IJIP. This is an Open Access Research distributed under the terms of the Creative Commons Attribution License (www.creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any Medium, provided the original work is properly cited.

recommended the deployment of an optimal mix of different kinds of interventions to address the unmet needs in the field of mental health. This mix of services includes empowerment of individuals and communities to employ appropriate self-help methods to deal with mental health issues.

METHODOLOGY

The study design was single group, cross sectional design and the study sample has been selected from outpatient follow-up services at National Institute of Mental Health and Neurosciences (NIMHANS), based on the inclusion and exclusion criteria as well as their informed consent. Diagnosis of a psychiatric disorders- either a common mental disorder or severe mental illness (except disorders mentioned in the exclusion criteria) as established through detailed routine clinical assessment based on ICD-10. The basic data sheet, clinical global impressions (CGI) scale (Guy (2000), work and social adjustment scale (WSAS), the stages of recovery instrument (STORI-30) and the newly developed self-care survey were used for the study.

The present study was divided into two phases. The pilot phase was aimed at development of a simple self-care survey and during main phase, Individuals who fulfilled the selection criteria was approached for informed consent. The tools for the data collection were administered on a one-to-one basis in a single session, on all those willing to participate in the study. The sample comprised of 62 participants who were eligible for the study and provided written informed consent for participation.

Descriptive statistics in terms of frequencies and percentages were used to describe the socio-demographic and clinical data. Normality of the data was examined through Kolmogorov- Smirnov Z test. Reliability of the measures were assessed through Chronbach's alpha. Kruskal-Wallis test was used for examining the differences among three and the corresponding Kruskal Wallis Chi square values are reported. Post hoc comparisons as well as comparisons between two subgroups were carried out using Mann Whitney U test. Content analysis was carried out for responses to open-ended items to identify emergent themes. The study was initiated after obtaining necessary approvals from the Department and Institute Ethics review boards.

Pilot interviews: Brief structured interviews were conducted and patients were asked to list a few activities that they were currently engaging in to take care of their health and maintain/improve their wellbeing. Also certain open-ended questions such as mentioning the things which currently they were not be able to do for self-care, difficulties of doing such things, factors which could help doing such things and how the doctors and family members could help them in this regard were also asked. The interviews were conducted with a sample of 10 patients with severe mental disorders and 10 patients with common mental disorders attending outpatient follow up services at NIMHANS

A draft survey was developed with items on various self-care strategies. This draft survey was given to experts for review and rating. The experts include three mental health professionals with at least 10 years of experience one each from the discipline of psychiatry, clinical psychology and psychiatric nursing. Based on the suggestions and recommendations, the draft survey was modified. After modification, the first section comprised of 23 items with the addition and removal of some items including medicine, diet, and religious activities.

RESULTS

The results of the main phase of the study had 7 sections such as Sample characteristics; Descriptive statistics of the study measures; Self-care strategies and frequency of engagement in specific self-care behaviours and perceived utility in the study sample; Self-reported barriers, facilitators to self-care and related expectations from mental health care system for supporting self-care; Self-care and socio-demographic variables; Self-care and illness and treatment variables; and, Self-care and indices of recovery (symptomatic, functional and psychological recovery). 44% of the sample consisted of females and the remaining 56% were males. The participants of the study were in the age range of 18-70 years and majority of them being in the age range of 18-35 (mean age =34.71 and Standard Deviation=13.34). More than 50 % of the participants were married (61%) and belonged to nuclear families (87%). Majority of the sample were Hindus (81%), 13% were Muslims and about 6% were Christian participants. The sample mostly comprised of graduates (45%) and under graduates (39%) with a few post graduates/those with educational qualification after graduation (16%). Forty three percent reported that they were working. Additionally, in terms of current work status in the past 3 months, it was noted that 52 % were not working, about 16% were working intermittently, 31% were regularly working and one participant was searching for work. 49 of them (78%) reported being able to manage their financial situation comfortably while about 20% indicating difficulty managing their financial requirements.

Both common mental disorders (56%) and severe mental disorders (44%) were represented in the overall sample. As far as further breakup is concerned, the severe mental disorders group consisted of persons dealing with schizophrenia (12), bipolar affective disorder (8) and other psychotic disorders (7). The common mental disorders group included persons dealing with depression (15) and anxiety spectrum disorders (17). Sixteen percent of the sample had an additional psychiatric diagnosis (mostly an anxiety disorder/depressive disorder or personality disorder. More than half of the participants (57%) had illness duration of more than 2 years, while in about 43 %, the duration of illness was 2 years or less. Half of the total sample had developed the illness prior to 25 years of age (50%). In about 80% of the instances the age of onset was 35 years or less.

It is noted that self- reported symptom improvement was within the range of 75-100% for 40% of the participants and 30% of them reported symptom improvement below 50%. In terms of perceived support, slightly more than one third indicated being highly satisfied, while about 43% reported being satisfied to some extent. The rest of them (19%) reported low satisfaction. On clinical global ratings of current illness severity, 35% were rated as having no illness severity, and 40 % as having mild symptomatology. On the other hand, about a quarter were adjudged by the treating clinician as having moderate to severe current symptomatology. In line with these ratings, in terms of global improvement, 35% of the sample were assessed as having no change or worsening of symptoms with 65% of participants were being assessed either very much improved or improved. Sixteen percent of participants reported being seen for any kind of structured psychological interventions currently and 19% of participants reported that they had received such intervention the past. All the participants except two who were currently undergoing psychological intervention were receiving cognitive behaviour therapy, while two were undergoing family therapy. None of them had received more than 3 sessions of psychological intervention at the time of data collection.

Thirty nine percent of participants each reported that they go for a walk or engage in spiritual practices on almost a daily basis. Engaging in yogasana or any workout, communicating over phone or mail with friends and being with nature were reported as self-care activities undertaken almost on a daily basis by about one third of the participants. On the other hand, about a quarter of the participants reported that going for a walk was an activity they engaged in less than once a week basis. For about 30%, being with nature was an infrequent activity and for about a quarter each, engaging in exercise, in spiritual or religious activity was infrequent in occurrence (less than once a week). Taking time to meet with friends/acquaintances and communicating with friends or others over phone or mail was hardly engaged in as a self-care activity by about 11- 16% of the sample. A sizable proportion reported hardly ever spending excessive time (more than 2-3 hours daily) in passive activities or on social media (18% and 29% respectively).

Engagement in activities such as music or relaxation to get them a sense of calmness was found to be the most useful by about one third of the participants. About a quarter of the participants reported that taking medications regularly as prescribed to be most useful. About 16% percent of the participants reported that helping others at home/work regularly as much they could- was a useful self-care strategy for them. Support from friends and others including healthcare systems emerged as the most important perceived facilitator. Financial support was also seen as a factor facilitating their self-care. Keeping a cycle, cycling, to take a break/vacation, easy availability of /access to community engagement, spiritual groups, facilities such as gyms in the nearby locality etc. were some of the other facilitating factors which were reported.

Several participants who responded to this open-ended item expressed the importance of having access to mental health services in non-traditional formats (through telephonic contact, through online forum and mobile apps) services, starting of mobile apps). Participants also opined that continuity of care in terms of having the same professional available at follow-ups as well as short waiting time were likely to strengthen their own self-care. The need for emergency telephone services from mental health professionals was also expressed.

DISCUSSION

In the present study, a majority of the participants were young adults with two third of the participants (67%) being in the age range of 18-35 years and only 14% of them being above 50 years. About two third of the sampled participants were married. As far as clinical characteristics of the sample is concerned, both common and severe mental disorders were fairly represented in the sample. A slight underrepresentation of persons with severe mental disorders (44%) could be attributed to sampling issues as those not amenable for responding to the survey could not be included. Within these broad groups, various disorders were sampled (such as generalised anxiety disorder, OCD, recurrent depressive disorder, schizophrenia, bipolar affective disorder and other psychotic disorders), thereby achieving the goal of obtaining an overall sample with sufficient heterogeneity. As far as clinician rated current severity of illness is concerned, there was fair representation of persons in remission (no illness symptoms), those with mild as well as moderate to severe illness symptoms; although those with severe illness symptoms were understandably underrepresented. Similarly, the sample represented persons who had experienced significant improvement (very much/much improved, about 32% each) as well as those whose status had not changed or worsened (35%) as per clinician ratings and self-reported improvements reflected broadly similar patterns. All the subscales of psychological recovery

as well as scale for functional recovery (work and social adjustment scale) had high internal consistency reliability in the study sample (0.81 to 0.98). Five content-based subscales were formed for section -1, capturing extent of applicability of self-care strategies, namely active collaboration with healthcare system for illness management, support mobilization from informal sources, use of positive self-talk, engagement in meaningful activities and general health care. Each of these sub-scales were found to have satisfactory reliabilities (0.71 and above). In terms of engagement of specific self-care activities, going for walk, spiritual practices, interactions with friends, doing yogasana, or engaging in any kind of exercise for 20 minutes or more, communication to friends over phone and also being with nature were reported as self-care activities being engaged in on an almost daily basis by about one third of the participants. These were the most used specific self-care behaviours

CONCLUSION

The present study was aimed at exploring self-care practices in a sample of individuals seeking psychiatric outpatient follow up services and examining relationship of engagement in self-care with selected socio-demographic, illness and treatment variables as well as indices of recovery in this sample. Support mobilization from informal sources, active collaboration with health care systems, engagement in exercise, spiritual practices, interactions with friends/others and keeping one's focus on improvements and small gains emerged as some of the most used self-care strategies and behaviours by a significant proportion of participants. Educational level, current work status, clinician rated illness severity and presence/absence of comorbidity emerged as the socio-demographic and illness -related correlates of self-care. The findings suggest that perceived support plays an important role as a facilitator of self-care in persons with psychiatric illness in the Indian context and that engagement in self-care is strongly correlated with symptomatic, functional and psychological recovery.

REFERENCES

Affifi, M. (2007). Gender differences in mental health. *Singapore Medical journal, 48*(5), 385-391.

Allott, P., Loganathan, L. & Fulford, K. W. M. (2002). Discovering hope for recovery. *Canadian Journal of Community Mental Health*, 21(2), 13-34.

Armstrong, N., Tarrant, C., Martin, G., Manktelow, B. & Brewster, L. (2015). Independent evaluation of the feasibility of using the Patient Activation Measure in the NHS in England: Early Findings. Department of Health Sciences: University of Leicester.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, 37,122-147.

Bellack, A. (2006). Scientific and Consumer Models of Recovery in Schizophrenia: Concordance, Contrasts, and Implications. *Schizophrenia Bulletin*, 32(3), 432-442.

Deegan, P. (1996). Recovery as a Journey of the Heart. *Psychosocial Rehabilitation Journal*, 19(3).

Funk M et al (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. World Health Organization: Geneva.

Graffigna, G &Barello, S. (2015). Modelling Patient Engagement in Healthcare: Insight for Research and Practice. In Patient Engagement: A Consumer-Centered Model to InnovateHealthcare.Retrievedfromhttps://sites.google.com/site/patientengagementbo ok.

Guy, W. (2000). Clinical Global Impressions (CGI) Scale. Modified From: Rush J, et al. Psychiatric Measures, APA, Washington DC.

Hatonen, H. (2010). Patient education to support the self-management of patients with mental illness. Department of Nursing Science: Finland
Snyder, C. R. (1999). Coping: The psychology of what works. New York: Oxford University Press.
WHO. (2007). The optimal mix of services. *Mental health policy, planning & service development.* Geneva.

Acknowledgement
The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Vimal, S.V., Mehrotra, S. & Sudhir, P.M. (2023). Self-Care and Its Correlates in Adults Seeking Outpatient Psychiatric Services. *International Journal of Indian Psychology*, *11(2),* 1715-1722. DIP:18.01.178.20231102, DOI:10.25215/1102.178

TABLES

Table 1. Sample of participants in the pilot phase (N=20)

Variables	**Groups**	**Frequency**	**Percentage**
Age (in years)	18-35	11	55
	36-50	5	25
	Above 50	4	20
Gender	Male	10	50
	Female	10	50
Marital status	Married	17	85
	Unmarried	3	15
Type of residence	Rural	5	25
	Urban	12	60
	Sub urban	3	15
Type of family	Nuclear	19	95
	Joint	1	5
Religion	Hindu	14	70
	Christian	5	25
	Muslim	1	5
Education	Up to PUC	6	30
	Graduation	11	55
	Post-graduation	3	15
Occupation	Working	8	40
	Non-working	12	60
Diagnosis	Severe mental illness	10	50
	Common mental illness	10	50
Duration of illness	Up to 5 years	10	50
	Above 5 years	10	50

Table 2. Socio-Demographic Details of Participants (N=62)

Variables	Groups	Frequency	Percentage
Age (in years)	18-35	42	67.74
	36-50	11	17.74
	Above 50	9	14.52
	Mean age & SD= 34.71(13.34)		
Gender	Female	27	43.55
	Male	35	56.45
Type of family	Nuclear	54	87.1
	Extended	2	3.20
	Joint	6	9.70
Marital status	Never married	23	37.10
	Married	38	61.30
	Separated	1	1.60
Religion	Hindu	50	80.60
	Muslim	8	12.90
	Christian	4	6.50
Education	PUC	24	38.70
	Graduation	28	45.20
	Post-graduation	10	16.10
Occupation	Student	12	19.40
	Working	27	43.50
	Not working	23	37.10
Financial situation	Manage very well	23	37.10
	Able to manage	26	41.94
	Manage with difficulty	12	19.35
	Not able to manage	1	1.61

Table 3. Frequency of Engagement in Specific Self-Care Behaviours

I.	**Specific Self-care behaviours- High frequency engagements (Almost daily)**	**Frequency**	**Percentage**
1.	Going for walk	24	38.7
2.	Taking time to engage in spiritual practices of one's preference (e.g. meditation, connecting to a higher power/my inner strength etc.)	24	38.7
3.	Taking time out to meet and interact with friends/ acquaintances	22	35.5
4.	Doing yogasana /any other kind of exercise/workout for 20 minutes or more	21	33.9
5.	Communicating to friends over phone/mail	19	30.6
6.	Being with nature/enjoying nature	19	30.6
II	**Specific self-care behaviours: Low frequency engagements (Not at all)**		
1.	Spending more than 2-3 hours a day on social media/video games, random internet surfing/YouTube etc. (reverse scored)	18	29.0
2.	Spending more than 2-3 hours of time in passive activities such as sleeping, watching TV (reverse	11	17.7

	scored)		
3.	Communicating to friends over phone/mail	10	16.1
4.	Taking time out to meet and interact with friends/acquaintances	7	11.3
III.	**Specific self-care behaviours : Low frequency engagements (Less than once a week**)		
1.	Being with nature	18	29.0
2.	Going for walk	16	25.8
3.	Praying/chanting or doing any religious activity (including attending a prayer group) which is meaningful to oneself	14	22.6
4.	Doing yogasana /any other kind of exercise/workout for 20 minutes or more	12	19.4
5.	Taking time to engage in spiritual practices of one's preference (e.g., meditation, connecting to a higher power/my inner strength etc.)	12	19.4