Original Article

Reasons for Living in Patients Suffering from Chronic Mental Illnesses

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ABSTRACT

Background: Chronic mental illnesses like schizophrenia, bipolar affective disorder, depression, alcoholism affect the reasons for living in such patients. This is a study done to findout the reasons for living in such chronic patients.

Aim: To study the Reasons for living in patients suffering from chronic mental illness.

Materials and Methods: Reasons for Living inventory is used in this study. 60 patients suffering from chronic mental illness are used as subjects. SPSS software is used for statistical analysis.

Results: RFL mean score is 140.88. Mean Age is 39.27. Significant p-values (<0.05).

Conclusion: Males have more reasons for living, survival and coping beliefs, responsibility to family, child related concerns, fear of social dissaproval, moral objections, physical health, social relationships and environmental domains .

Keywords: Chronic Mental illness, reasons for living, suicidal behavior

INTRODUCTION

Chronic mental illnesses like Schizophrenia, Bipolar Affective Disorder, Depression, Alcoholism affect the reasons for living in such patients . The more the reasons for living, the less chances for suicidal ideation.

Reasons for living (RFL) are beliefs or expectancies thought to mitigate risk for suicide, and include survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval , and moral objections. [1]

Linehan, Goodstein, Nielsen, and Chiles proposed that cognitions may protect individuals from engaging in suicidal thoughts and behaviors, despite being highly distressed. They argued that one's beliefs can differentiate suicidal individuals from nonsuicidal individuals. SCB refer to positive expectations about the future and the belief that one has the ability to cope with life circumstances.

The beliefs also concern the value of life and the extent to which one feels they have control over their life.[1]

RF encompasses an individual's level of commitment to their family, as well as beliefs about their family's

needs and feelings, including the negative impact that completing suicide might have on their family. CRC specifically refer to the expected negative outcomes that suicide of an individual would have on their children.

FS assesses the extent to which the individual fears the act of suicide itself, as well as death itself. FSD taps the individual's concerns of what others would think of their actions. Lastly, MO assess the extent to which an individual holds religious beliefs that oppose suicide.

There is evidence that these six reasons for living , as assessed by the RFL, are negatively related to suicidal ideation or behaviors. In clinical sample, higher levels of SCB, RF and CRC were related to lower levels of suicidal ideation, and these three reasons for living as well as MO, were related to a reduced likelihood of suicide in the future RFL may also weaken the association between hopelessness and suicide ideation.[1]

Individuals who believe they have more RFL may be better prepared to buffer the negative effects of hopelessness. Just as optimism and attitudes toward suicide have been demonstrated to moderate the relation between hopelessness and suicide ideation , so may RFL.[2]

RFL scale contains different components like survival and coping beliefs, fear of suicide, responsibility to family, fear of social disapproval and moral objections.[3]

Despite receiving chronic treatment , due to various factors patients suffer many relapses and this can badly affect their life and this study is done to identify the reasons for their living and survival which can be used to decrease the suicidal risk .

This study was done to see how the reasons for living in literates are affecting them despite various protective factors and coping.

Objectives

1. To study the Socio - demographic factors of the patients .

2. To study the Reasons for Living in chronic mental illness patients .

MATERIALS AND METHODS

Study design: Cross sectional Study.

Sampling technique: Convenience sampling .

Period of study: March 2018 - May 2018.

Place of study : In-patients of Psychiatry tertiary care Hospital .

Tools : Reasons For Living Inventory (RFL): It is a 48 - item, six subscale inventory, whose internal consistency reliability estimates ranged from 0.72 to 0.93, indicating acceptable levels of reliability. There are several different scores of interest we can calculate from this scale : RFL total score, RFL mean item score, Survival Coping Beliefs subscale, Responsibility to Family subscale, Child-related Concerns subscale, Fear of Suicide subscale, Fear of Social Disapproval subscale, Moral Objections subscale.

Inclusion criteria

- Age 18 - 60 years
- Gender – Male and Female
- Duration of illness > 2 years
- Literates
- Patients who gave consent

Exclusion criteria

- Newly diagnosed psychiatric cases
- Patients with chronic medical illnesses

Methods

Ethical committee approval was taken. A total of 60 in - patients of tertiary care psychiatric hospital were taken as subjects. Informed consent was taken from the patients . Socio-demographic data of individual patient was taken . Reasons for Living inventory was given to the patients and were asked to answer the given inventory questions.

STATISTICAL ANALYSIS

Statistical analysis was done using SPSS software for statistical analysis version 22. Socio - demographic data of the patients was obtained using frequencies, descriptive statistics. Chi-square test was done to verify differences between the categorical variables . Means for scales were calculated. ANOVA test was done to find out variance between continuous variables. Pearson Co-relation test was done to see the co-relations between different parameters. P-value was set at significance of <0.05 .

RESULTS

Our study table 1 shows the Socio-Demographic data of the patients. Table 2 shows the descriptive statistics mean and standard deviation for Socio-demographic variables and RFL subscales. The overall RFL score was found to be high (140.8833) in this study population.

Table 3 shows Means and standard deviations for males and females against RFL subscales survival and coping beliefs (SCB), Responsibility to family (RF), Child - related concerns (CRC), Fear of suicide (FS), Fear of social disapproval (FSD), and Moral objections (MO). Age for RFL scores scores were found to be statistically insignificant. Co-relation scores for Age and Diagnosis for RFL subscales Survival and coping beliefs (SCB), Responsibility to family (RF), Child-related concerns (CRC), Fear of suicide (FS), Fear of social disapproval (FSD), and Moral objections (MO) were also found to be insignificant.

Chi - square tests done showed significant values for education and diagnosis, occupation and gender, domicile and diagnosis as shown in Table 4. There was a statistically significant difference between the groups as determined by the one-way ANOVA as shown in Table 5.

Table 1: Socio - Demographic Characteristics

		FREQUENCY	PERCENTAGE
GENDER	Males	25	41.7
	Females	35	58.3
EDUCATION	Graduates or Post graduates	7	11.7
	Intermediates or Post high school diploma	7	11.7
	High school certificate	32	53.3
	Middle school certificate	10	16.7
	Primary school certificate	4	6.7
SOCIO-ECONOMIC STATUS	Upper middle	7	11.7
	Lower middle	10	16.7
	Upper lower	26	43.3
	Lower	17	28.3
OCCUPATION	Profession	1	1.7
	Semi-Profession	3	5.0
	Clerical, shop-owner ,farmer	8	13.3
	Skilled worker	2	3.3
	Semi-skilled worker	11	18.3
	Unskilled worker	20	33.3
	Unemployed	15	25.0
MARITAL STATUS	Married	38	63.3
	Unmarried	14	23.3
	Separated/Divorced	8	13.3
TYPE OF FAMILY	Nuclear Family	32	53.3
	Joint Family	6	10.0
	Broken Family	21	35.0
	Extended Family	1	1.7
DOMICILE	Urban	21	35.0
	Rural	39	65.0
RELIGION	Hindu	45	75.0
	Christian	5	8.3
	Muslim	10	16.7
DIAGNOSIS	Schizophrenia	35	58.3
	Bipolar Affective Disorder	11	18.3
	Depression	5	8.3
	Alcoholism	4	6.7
	Schizoaffective disorder	3	5.0
	Obsessive Compulsive disorder	2	3.3

Table 2: Descriptive Statistics showing Mean and Standard Deviations

	N	Mean	Std. Deviation
Age	60	39.27	11.339
Age of Onset of illness	60	29.50	10.087
Duration of Illness	60	10.32	6.954
Survival and Coping Beliefs	60	3.1118	1.11036
Responsibility to Family	60	2.9323	1.32091
Child Related Concerns	60	2.9792	1.64123
Fear of Suicide	60	2.4848	1.26997
Fear of Social Dissaproval	60	3.0677	1.22090
Moral Objections	60	2.9922	0.67820
Reasons for living total score	60	140.8833	46.73042

Table 3: Showing Means and Standard Deviations for Gender against RFL subscales

Gender		RFL Total score	Survival and Coping Beliefs	Responsibility to Family	Child Related Concerns	Fear of Suicide	Fear of Social Dissaproval	Moral Objections
Male	Mean	151.5200	3.4364	3.2024	3.2748	2.4796	3.3624	3.0212
	N	25	25	25	25	25	25	25
	Std. Deviation	52.64197	1.16008	1.40206	1.90754	1.42370	1.47975	0.64967
Female	Mean	133.2857	2.8800	2.7394	2.7680	2.4886	2.8571	2.9714
	N	35	35	35	35	35	35	35
	Std. Deviation	41.11789	1.02796	1.24428	1.41265	1.16959	0.96514	0.70651
Total	Mean	140.8833	3.1118	2.9323	2.9792	2.4848	3.0677	2.9922
	N	60	60	60	60	60	60	60
	Std. Deviation	46.73042	1.11036	1.32091	1.64123	1.26997	1.22090	0.67820

Table 4: Significant Chi-square tests for categorical variables

Chi-Square Tests			
		Value	**P-Value**
Education and Diagnosis	Pearson Chi-Square	41.293	0.021
Occupation and Gender	Pearson Chi-Square	14.213	0.027
Domicile and Diagnosis	Pearson Chi-Square	10.967	0.052

Table 5: Table Showing Anova (Analysis of Variance) for Diagnosis

	Value	P-Value
Age	0.622	0.684
RFL Total Score	3.001	0.018

F- Analysis of variance coefficient

DISCUSSION

This study showed that males have higher reasons for living total scores, survival and coping beliefs, child related concerns, responsibility to family, fear of social disapproval than females. Females have more Fear of suicide than males.

A study conducted by Suzanne Mclaren et.al in a community sample of Australian adults (N=970) aged 18 to 95 years, showed that females were associated with higher RFL total, child - related concerns and

fear of suicide scores[4], which in our study, Males had higher RFL total, SCB, CRC, RF, FSD scores.

The Linehan etal (1983) study[1] also revealed gender differences on the Fear of Suicide and Moral objections subscales, to which females attributed more importance. Osman et al (1991)[5] on the other hand, found no gender differences on any of the subscales of the Reasons for Living Inventory. A study conducted by Sahin et al.1998[6], showed that females had more reasons for living with higher RF and FS scores.

In general, RFL may reflect a sense of purpose and meaning [7], that enables people to live through difficult circumstances. [8] In many studies, Reasons for living were assessed and adolescent suicide risk is multiply determined.[9,10,11]

Our study provided insignificant values for age and reasons for living. Much of the existing literature focuses on negative risk factors.[12,13]

Individuals who engaged in suicidal ideation (or) behaviors scored significantly lower on SCB, RF, and MO compared with individuals who had not engaged in suicidal ideation (or) acts[14] It has also been demonstrated that suicide ideators scored lower on the total score of the RFL, as well as SCB, RF, and MO, than nonideators.[15] Overall, there is substantial evidence to suggest that reasons for living are protective factors in relation to suicidal ideation and behaviors.

Gender is the most commonly investigated demographic variable in relation to scores on the RFL, with gender differences being documented among young and middle- aged adults. Women score higher on the total RFL score than men[17]; In relation to the RFL subscales, women consistently report higher scores on FS compared with men. Men have been shown to score higher on FSD than women.[16] In our study, Males had higher RFL total, SCB, CRC, RF, FSD scores. Overall, results indicate that, in contrast to men, women report a range of reasons to stay alive when thoughts of suicide occur.[1,5,14,16,18]

CONCLUSION

Factors improving the reasons for living should be given more importance by a clinician , so that they can be improved and thereby protecting them from suicidal ideation. Females appear to have less reasons for living , so importance should be given to strengthen their reasons for living.

Implications

Early detection of suicidal behavior and tendencies help in preventing suicides which can be done by assessing the Reasons For Living in such patients. Models that focus entirely on risk factors are incomplete and inadequate. Despite the mass of information currently available that should lead to suicide prevention , suicide rates have steadily risen for more than a decade.

Limitations of study

Small sample size and limited to a single hospital.

Future Research

Future research is aimed at identifying how factors affecting quality of life can be used to improve the reasons for living. Future research needs to identify such predictors, with the aim of developing interventions to enhance reasons for living among females.

CONFLICT OF INTEREST :

The authors declared no conflict of interest.

FUNDING : None

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