Introduction
INTRODUCTION

Schizophrenia is a major psychiatric disorder, is the heartland of psychiatry and till date, has been the core of its psychiatric practice. This disorder is characterized by hallucinations, delusions, disordered speech, amotivation, asosicality poverty of speech, impaired information-processing speed, attention, memory and executive functioning. Moreover, multiple domains of functional outcome, including performance of independent living skills, social functioning, and occupational performance are impaired in patient with schizophrenia.

Emil Krapelin 1896 was the most important person in the modern understanding of this disorder. Eugen Bleuler coined the term 'schizophrenias' in 1911 and considering schizophrenia illness to be a group of disorders rather than a single entity.

Schizophrenia is a relatively common condition, which often cripples people in their adolescence or early adult life; it causes more suffering and blights to more lives than any terminal illness. Moreover, it disables people in their prime years without greatly reducing their life expectancy and represents a major burden for health services all over the world. Schizophrenia is a disorder of a relatively high point prevalence, low incidence and high disability (Padmavati 1999). It accounts for 1.1% of the total Disability Adjusted Life Years (DALY's) and 2.8% of the Years Lost Due to Disability (YLDD's) as per the global burden of disease and is the third most disabling condition, with a prevalence of 0.4% (WHO 2001). It affects between 0.4 and 1.4% of people during their lives, usually beginning in the adolescence or early adulthood and less than 20% of patients maintain full recovery after the first episode (Geddes 2002). During the last 30 years, a large number of research studies on schizophrenia have been undertaken in India. The prevalence rate of schizophrenia in India is generally reported to be between 2-3 per 1000 persons (ICMR 1990). Rajkumar et al. (1993) have reported an incidence rate of 3 per 10,000 of population in India.

Being chronic and often incapacitating, it exacts tremendous cost from families. Families of patients face stress and emotional hardships and are frequently forced to assume life-span care-taking responsibility.
The concept of family burden is perhaps more important in those disorders which run a chronic and debilitating course and where the treatment, which is mostly of a non-curative nature, continues over a long period.

Several researchers have reviewed the existing evidence of family burden in persons with schizophrenia and have substantiated its importance. (Illange and Nirmala 1992; Saldanha et al. 2002; Chakrabarty 2002).

On the other hand Depression is a serious debilitating mood disorder characterised by a constellation of signs and symptoms including sadness, hopeless, pessimistic, feeling of guilt, loss of interest in activities, difficult in attention and concentration, diminished appetite, thoughts of death, aches, cramps, vague unexplainable pains and digestive problems that do not go away even with treatment.

Depressive disorder is reported to be one of the leading causes of disease burden in the world accounts for 44% of total disability adjusted life years (DALY) (Ustun et al. 2004).

The demonstrated prevalence throughout the world of depression is 16 per 1000,000 per annum for males and 25 per 1000,000 per annum for females (Ustun et al. 2004). Epidemiological studies have reported that depression is highly prevalent, high rates of lifetime incidence, early age onset, high recurrences and role impairment (Zisook et al. 2007).

Depressive disorder affects people of all ages, more common in women, than men to, experience a depressive episode within a lifetime. Depressive disorder affects patient's occupational abilities, psychological functioning and quality of life.

The prevalence rate of depression in India is reported to be between 1.7 to 7.4 per thousand population (Reddy and Chandrashekar 1998; Nandi et al. 2000). Research on caregivers burden has more focused on families of schizophrenia, bipolar disorder and dementia and relatively anxiety and depressive disorder are neglected.

Mors et al. (1992) concluded in a comparative study that evaluated degree of family burden in patient with schizophrenia and in patient with other diagnosis. Study reported no differences in degree of family burden among psychosis, affective and
anxiety disorder. In a study by Wittmund et al. (2002) it was shown that the spouse of depressive patients reported higher level of anxiety and depressive symptoms and lower level of subjective well-being compared to the other population. In another study by Van Wijngaarden et al. (2004) looked at the relative of patients with depression. The sample was confined to depressive disorder making it a pure sample. The findings were that spouses of depressed individuals are at risk of developing depressive themselves.

Muscroft et al. (2000) did a somewhat similar study involving caregivers of patient with depressive disorder. The findings were that were dissatisfied with their caring role indicating that caregiving was burdensome. Furthermore Sailaxmi and Thennarasu (2012) studied profile of burden in patient with depression. The findings were consistent with those of other studies that relatives experience high degree of burden and this could predispose to substance abuse, depression and anxiety.

The prime thing that evolved from all these research was that the caregivers burden exists in depressive disorder and it has definite impact on the caregivers and can be extensive.

A term in the mental health literature that is been frequently used to explain the impact of psychiatric illness on families is “Family Burden”. Many argue that this term may be problematic because it conveys that families would naturally find caring for the ill “Burdensome”. There are four types of people in caring role- those who have been caregivers, those who currently are caregivers, those who will be caregivers and those who need caregivers (Danis 1978).

The family plays a major role in the treatment and rehabilitation of mentally ill persons. In the early days, family was viewed as a contributory factor in the cause of mental illness, whereas the current research stresses on the understanding of the effect of mental illness on the family. It is a known fact that the presence of a psychiatratically ill person at home influences all family members. Often problems are seen in the areas of health, recreational, marital and financial domains. Thus, family caregivers are burdened, which may be a sign of the breakdown of mutual settlement that the members support in their relationship. Such that one person is things done more that their favorable share of dandy activity (Fadden et al. 1987). However, Indian families
exhibit dreadful involvement in caring for their ill persons meanwhile they suffer experience huge amount of physical and emotional distress (Thara et al. 1998).

The family members face many difficulties which are collectively known as the burden of care. Creer and Wing in 1975 established that the behavioral problems associated with patients of schizophrenia are social withdrawal, that is, less interaction, slowness, lack of communication, minimal recreational activities, interest and poor self care. A great number of persons with psychiatric illnesses are either found to be unemployed or underemployed which greatly contributes to the financial burden on families (Sharma et al. 2006).

The existence of a psychiatric ill person in the family can disturb and effect the various aspects of the family routine activities ranging from interpersonal relationship, support, financial, leisure and recreational activities and moreover stigmatization, and finally leads to social isolation in the community. Guilt, shame and anger behavior are commonly noticed among family members, and no matter how supportive the family members are, the burden experienced is more likely to be not inconsiderable. The involvement of family in the treatment of a mentally ill patient at home may reduce the hospital stay and may help in early recovery and further disability can be prevented, but it possibly increases the burden on the family and the community. The family is considered to be a major source of support for the mentally ill in India. Inspite of the downpour of customs handed down the family structure, over 60% of patients with chronic long term psychiatric disorders live with at least one ‘significant other’, i.e. key caregivers (Weidmann et al. 1994).

The intimacies of family members towards the mentally ill have been found to be family conflict, which reflects the degree of burden. It is found that the family system as the passage of discourse within which the mentally ill exist, be seen as the intercession environment for key care giver burden recompense. In the life course of time care giving and care receiving can happen at any point of time towards the person but care giving for chronic illness and disabilities, which result in losses of independence and functioning (Taylor et al. 2009).

The burden on the family mainly depends on the coping style of the family member. Many families do not perceive the same burden because it is a healthy way
of coping skills. The affinity between coping pattern and perceived burden of care is complicated because key caregivers subjectively give an account of ‘burden’. This subjective report of the burden is a product of the coping skills utilized by caregivers. The depth of caregiver’s burden is more dependent on their quality of estimation of the condition of their patient rather than the real illness (Scazupea and Kupiers 1996).

Schizophrenia and depression which are a relapsing illness demands a somewhat different kind of adaptation. Relapsing illness may require the least ongoing caretaking or role reallocation. The episodic nature of the illness may require a flexibility that permits movement back and forth between two forms of caregiving arrangements. In a sense, the caregiver is on call at all times to enact a crisis structure to handle the exacerbation of the illness. Strains on the caregiver are caused by both the frequency of the transition between crisis and non crisis and the ongoing uncertainty of when a crisis will next occur. Although the wide psychological discrepancy between periods of normality versus illness is a particularly taxing feature unique to relapsing chronic illness, caregivers do make attempts to adapt to contain the uncertainty.

**Defining family caregiving**

Care giving may be defined in different ways. One thing that is common is that care giving includes giving support and assistance to a family member who has special needs (Walker et al. 1995). However, the literature on care giving reveals a lack of clear and precise definition, which is essential for researchers and for professionals who work with family caregivers (Barer and Johnson, Cantor, Malone Beach and Zarit, all cited in Walker et al. 1995). Walker et al. assert that the difficulty in defining family care giving stems from the complex relationship between the caregiver and the care receiver with regards to their history and connection.

Caregivers vary in their relationship to the care recipient (spouse, child, professional); they may be the primary or secondary caregiver; they may live together with the care recipient or separately (Brodaty and Green 2002). Family caregivers are sometimes described as “informal”. Lubkin and Larsen (2006) say that it is a term that is employed by professionals to describe people who take on care giving responsibilities without receiving any source of income and who usually have
personal bond to the person at the receiving end of care (for example, a family member or friend) (Lubkin and Larsen). On the other hand, “formal” caregivers, including home health care providers and other professionals, often undergo training and receive payment for their services that they tender to the care recipient (Health Plan of New York [HPNY] and National Alliance for Care giving [NAC], 2005).

Being a care giver one can have difficult personal issues about duty, responsibility, adequacy and guilt (Oyebode 2005). The role of care giver can be more demanding and difficult if the care recipient’s mental disorder is associated with behavioural problems or physical disability (Shah et al. 2010).

Caring for someone with a mental disorder can affect the dynamics of the family. It takes up most of the care givers time and energy. The family’s responsibility in providing care for people with mental disorders has increased in the past three decades. This is mainly due to the emerging trend towards community care and the de-institutionalization of psychiatric patients (Magliano et al. 2007). This shift has resulted in the transfer of responsibility of day-to-day care of people with mental disorders to family members. Up to 90% of people with mental illnesses live with relatives who provide them with long-term practical and emotional support (Lauber et al. 2003). Carer burden increases with more patient contact and when patients live with their families (Schulze Beate 2005). Strong associations have been noted between burden (especially isolation, disappointment and emotional involvement), caregivers’ perceived health and sense of coherence, adjusted for age and relationship (Andren and Elmstahl 2008).

Negative symptoms in schizophrenia

Negative symptoms are considered to be the hallmark of poor outcome in schizophrenia patients (HWU et al. 1995). In the chronic stage of schizophrenia, negative symptoms are predominantly seen which are measured with the Scale of Assessment of Negative Symptoms (SANS; Andreasen 1989). Includes five categories), includes five categories of symptoms; affective flattening, alogia or poverty of speech and thought, avolition or apathy, anhedonia, and impaired attention. Affective flattening manifests itself as unchanging facial expression, decreased spontaneous movements, paucity of expressive gestures, poor eye contact, affective
non-responsivity and lack of vocal reflections. Alogia includes poverty (content) of speech, blocking, and increased latency of response. Apathy includes poor grooming and hygiene, lack of persistence at work/school and physical energy. Anhedonia or asociality is rated by the level of recreational interest and activities, sexual interest and activity, ability to feel intimacy and closeness and affinity with friends or peers. Finally, impaired attention is operationalized as social inattentiveness during mental status testing.

**SOCIAL SKILL TRAINING**

Social skill deficits are viewed as a vital antecedent to schizophrenia. Schizophrenia patient were clearly situated an inability to communicate effectively with peer, and exhibits problem with socially linked behaviour. Patients of schizophrenia are unlikely to be solving their problems in a suitable manner or they may have deficits in solution or generating alternatives (Hoffmann et al. 1998).

The history of present social skills movement took place somewhat 150 years back but social skill as research idea and as an area of understanding human behaviour is decades old. Bellack and Hersen (1978) state that social skill training stem from two sources: the early work of O Brienet et al. (1969) and Lazarus (1966), mainly as psychotherapists and the work of Zigler and Philips (1961, 1962), Powles (1964) as “social competence.” This later fruitful research area showed that the greater the prior social competence of hospital-admitted patients, the less their length of stay in the hospital and the lower their recidivism rate. The level of social competence prior to hospitalization turned out to be a better predictor of post-hospitalization adjustment than psychiatric diagnosis or the particular treatment received in the hospital (Bellack et al. 1976).

The historical background of social skills arising from psychotherapeutic intervention stressed the importance of ‘assertiveness.’ Assertiveness has for some time in the United States been almost wholly equated with social skills training. More recently, social skills have included more than assertiveness as the subtleties of interaction have been broken down into ever finer and more far-reaching details.
The most distinguishing character of schizophrenia is the impairment of social functioning. Literature suggests that it is not simply a by-product of positive and negative symptoms, but an independent state of the illness (Lenzenweger et al. 1991). Many patients with schizophrenia experience poor social competence, which leads to decreased quality of life and a state of being isolated. It interrupts the socio-occupational functioning of the individual. This social disability is a cogent factor of symptoms, which aggravate and indicate the need for hospitalization. The most favorable tool to mitigate social disability and empowering social sufficiency is social skill training (SST) (Wallace et al. 1980).

Several research group and meta analysis have demonstrated that social skill deficits of schizophrenia are modifiable thorough SST (Penn et al. 2007; Heinssen et al. 2000; Combs et al. 2007). Few studies have drawn negative conclusion that SST may improve specific behaviour, more of it is not clear that when and where this modification would result in significant outcome in social role and adjustment (Pilling et al. 2002; Muser and Peen 2004).

Definition

Eisler et al. (1973) indicated operationally that more socially skilled persons speak louder, respond more rapidly to others, give longer replies, evidence more affect, are less compliant; request more exchanges and more open minded in their expressiveness, compared to less socially competent persons.

SST are cluster of defined techniques and strategies utilized for teaching interpersonal skills that are based in social learning theory (Solomon and Cullen 2008).

Social skills training is a set of strategies goal to restore the quality of patient’s interpersonal communication and competence and may help them to more effectively obtain social support in time of distress (Segrin 2008). Part of this definition, at least by implication, is that many social skills are situational; that is, people usually experience difficulty or success primarily in certain types of situations.

In 1970 SST was introduced and it was in the form of single case studies. Since then, SST in group therapy format has become popular, because it is not only
cost-effective in terms of time and the therapist, but also enhances the generalization of learned skills in a way the group provides the vicinage learning experiences. Numerous controlled studies have established the efficacy of SST (Benton and Schroeder 1990; Hogarty et al. 1986, 1991). These studies indicate that learned skills during intervention are maintained over six to twelve months and when pharmacotherapy is adequately combined, it helps in reducing the relapse rate. Hierchozer and Liberman (1986) recommended that booster sessions are necessary to maintain acquired learned skills and group therapy format are useful. For more than two decades, SST has been promising psychosocial intervention strategy for the chronic, severely and persistently mentally ill persons (Dilk and Bond 1996). Psychosocial intervention treatment goals for severe mental illness focus more on improving social and instrumental skills where as pharmacologic treatment remains important target to control psychotic symptoms (Granholm et al. 2005). Components of social skill training significantly focus on implementing pragmatic skills of living skills, such as emotional, social, vocational, intellectual skills, problem solving skills to patient with severe mental disabilities, to empower them to live and work in the society (Liberman and Martin 2002). In the late adolescence or early adulthood serious mental illness may begun. It is therefore interpersonal skills may not have acquired by the adults for social and interpersonal functioning (Liberman and Martin 2002). Most of the individual with serious mental illnesses are prevented by deficit in information processing, including difficulty with memory storage information, attention expression and decision making (Bedell et al. 1997). Therefore these deficits affect their learning ability for new and adaptive skills which are required for social functioning (Bedell et al. 1997). It is necessary that skill need be presented slowly, repetitively and consistently to overcome individuals learning disabilities (Liberman and Martin 2002). The training involves repeated review and different kind of reinforcement as well as participants involved in role-play (Liberman and Martin 2002). The origination of SST is descended from Albert Bandura's Social Learning Theory, which focuses on observational learning (Liberman and Martin 2002). Skills are acquired through observation, verbally or visually, must be retained, rehearsed and reinforced (Hergenhahn and Olson 2005). Reinforcing the learned behaviour stimulate motivation for the individual to repeat, enhance and maintain learned behaviour.
Execution of techniques used in skill training such as, definite instruction, modeling, role playing, didactic education, demonstration, feedback, in vivo treatment as well as positive reinforcement have been implemented and found to be effective for improvement in social functioning (Bedell et al. 1997).

Social learning theory includes positive orientation to techniques that provide an opportunity to build individual self-awareness, awareness of other and coping behavior (Bedell et al. 1997).

**Conclusion**

Family members play a vital role in caring of both depressive disorder and schizophrenia. There is no doubt that the families of these disorders are affected by the condition of their near ones. Therefore the affected patient is dependent on the family members, and their well-being is directly related to the nature and quality of the care provided by the family member. The demands patient may produce significant levels of stress for the family members and can impact on their overall quality of life including work, socializing and relationships. The above chapter shows that both the groups of family members have significant objective and subjective distress and experience family care burden. Family members may rise difficult in their personal issues about duty, responsibility, adequacy and guilt.

SST can promote social competence of schizophrenia patients and as a whole, social skill interaction appears to offer one evidence based approach to diminish social deficits associated with symptoms of schizophrenia.

**NEED FOR THE STUDY**

The literature of review denotes caregiving is distress and studies have identified a number of variables which contribute for family care burden. Moreover studies have concluded that high prevalence of burden exist among families of mentally ill patient. Much of the research is done mostly on patient with psychosis especially schizophrenia. The illness variable and caregivers personal characteristics significantly influences on coping with mental illness. However research data pertaining to family burden on other disorder, like affective and substance use disorder is rather limited and almost none with depressive disorder. There is also a
dearth of studies which have actually compared the family care burden between the groups of psychiatric patient. Hence the study was undertaken to assess and compare the family burden in schizophrenia and depressive disorder.

In schizophrenia literature several studies have demonstrated that schizophrenia patient exhibits diminished interpersonal and social functioning. These findings are consistent with the possibility predictors of relapse and rehospitalizations in schizophrenia. This suggests that improving concurrent social skill deficits may have an impact on diminished social functioning and also influence other areas of functioning. Moreover it may result in a futile course of illness. Second, social adjustment, better interpersonal relationship and fulfilling social expectations, may be considered as an important aspect of quality of life which need to be addressed. Persons with schizophrenia experience numerous deficits in their daily lives, particularly in the area of social competence. Furthermore patient of schizophrenia usually exhibits deficiencies in assertive skill ability and may not correctly view their opinion and refuse other unreasonable demands. SST is evidence based element of a comprehensive approach to the rehabilitation of persons with serious mental illness. So this study was planned to see the effect of social skill training on patient with schizophrenia with predominant negative symptoms and accordingly to restore or enhance their social competence.