Discussion
DISCUSSION

THE INFERENCES FOUND OUT OF THESE FINDINGS WERE DISCUSSED UNDER THE FOLLOWING SECTIONS

SECTION I: COMPARISON OF DEMOGRAPHIC PROFILE OF PATIENT WITH SCHIZOPHRENIA AND DEPRESSION.

SECTION II: COMPARISON OF CAREGIVERS DEMOGRAPHIC PROFILE OF PATIENT WITH SCHIZOPHRENIA AND DEPRESSION.

SECTION III: COMPARISON OF BURDEN BETWEEN FAMILY CAREGIVERS OF PATIENTS HAVING SCHIZOPHRENIA AND DEPRESSION.

SECTION IV: CAREGIVER FACTOR ASSOCIATED WITH FAMILY CARE BURDEN IN PATIENT WITH SCHIZOPHRENIA

SECTION V: INDIVIDUAL FACTORS RELATED TO BURDEN ON FAMILY CAREGIVERS CARING FOR PATIENTS WITH SCHIZOPHRENIA.

SECTION VI: THE EFFECTS OF SOCIAL SKILLS TRAINING ON INDIVIDUALS WITH SCHIZOPHRENIA.
SECTION I: COMPARISON OF DEMOGRAPHIC PROFILE OF PATIENT WITH SCHIZOPHRENIA AND DEPRESSION

Schizophrenia disorder is more prevalent in men than women (Kraepelin 1919). The age of onset in females is about 5 years later (late 20s) than males (early 20s) Seeman (1982). The nature and course of depressive illness severely affects the quality of life and productivity of the individual Ozgul (2002). Depression is higher among women compared to men (Klose and Jacobi 2004).

The available literature suggests that the schizophrenia illness occurs at a much younger age than depression, which is about 30 or late. The present study results were consistent with the previous studies. The study revealed that males dominated the schizophrenia group, whereas there was a predominant distribution of female was seen in the depression cohort, which was statistically significant (p<0.001). The study indicates that the prevalence of schizophrenia in men and women was equal when compared to depression, where females were more than males. The present study findings were similar to a previous study by (Heru and Rayan 2002). The life time prevalence of depression in women is 4.9% to 8.7% and in men 2.3% to 4.4%. One in four women and one in ten men have depression during their lifetime (Donahve and Pincus 2007). This could be because females are more vulnerable to stress, like daily hassles, role expectations, major life events that require adaptive change in individuals. All these factors may contribute to the onset of depression. Stigma is a powerful weapon, which comes in the way of treatment, not only labeling a person as mentally ill, but also mental health services as a whole. The schizophrenia onset in females is about 5 years later (late 20s) than males (early 20s). This could be because females’ hormones act as protective factors against abnormalities in neurotransmitter nervous system (Seeman 1982). The study found a significant difference in both groups with regards to marital status (p<0.001). The study found that the ratio of unmarried people in the schizophrenia group was 57% and in the case of depression 8%. This difference could be due to the early onset schizophrenia illness as compared to depression in which age of onset is in 30 years or 40 years. Therefore, due to illness people with schizophrenia choose not get married as it can lead to adjustment problem for the partner and for themselves to too, adjustment
in the martial life, whereas people with depression got married before the onset of illness. The divorce ratio in schizophrenia was high that of 14% and 1% in the case of depression. This is due to the fact that a married schizophrenic person could find difficulty in role expectation in terms of social, emotional, moral, and sexual. The study revealed no significant difference between the two groups with regards to religion. Majority of them were Hindus in both cohorts (91% vs, 95%) and rest were Muslims (5% vs. 2%). The study showed a significant difference in the acquisition of education between the schizophrenia and depression cohort. The acquisition of education in the schizophrenia group was much less when compared with the depression group. Cornblatt and Keip (1994) reported that person, who is genetically vulnerable to schizophrenia, would be having significant cognitive impairment; similarly person, who is assessed on cognitive parameter before they cultivate schizophrenia, is observed to have impairment in many of the cognitive domains. This could be one of the reasons why in our study many schizophrenics were studied up to high school that corresponds to age 14-17yrs. Once the onset starts organizational ability, cognitive deficits significantly manifest impairment in persons with schizophrenia. Hence, it block education career of schizophrenia, whereas depression is a late age of onset and it does not manifest much disability, hence, in our study 34% of depressives were could able to complete graduate course whereas 0% in case of schizophrenia. With regards to duration of illness, schizophrenia group had continued longer duration of illness while compared to depression that was statistically significant (p<0.001). This indicates depression is more of episodic in nature, whereas schizophrenia is continuous, chronic in nature. There was no significant difference between the two groups in the type of family, which was statistically non significant (p=0.107). However, both groups were dominated by nuclear family. This could be as a result of industrialization due to which there is an increasing trend towards changing to nuclear families. Earlier studies show that most of the mental illness occurs more in nuclear families, this is due to the joint family system breaking up and this transitional period of social life leads to higher disturbance in nuclear family. Moreover, dysfunctional family may precipitate mental illness and the presence of mentally ill in family can cause disturbed family. There was a significant difference between two groups when comparison made in history of mental illness in the family which was statistically significant (p<0.001). The study indicates that
schizophrenia not only tends to run in families but that it is largely due to genes. The study findings are consistent with family studies done by Bogerts (1985) and Woodruff (1997) reported that schizophrenia illness could be observed in those biological parents where they were diagnosed as schizophrenia disorder. Whereas it was observed that the cause of depression could be explained in the parameters of environmental life stressors, cognitive, behavioral, and interpersonal conflict factors. There was a significant difference between two groups with regard to income ($p<0.001$). The study found schizophrenic population group were higher degree in low income category than depression. There could be many reasons, like problems in area of role functioning such as schooling or working typically starts with the onset of illness and which continues throughout the life time of ill person. Moreover, psychotic symptoms impair the vocational ability. Thus, person may find difficulty in work and consequently person may not earn adequate money, whereas, in depression symptoms are episodic which may not lead to vocational disability. Therefore, there are continued to earn. The study did not find much difference between the two groups with regard domicile concern ($p=0.241$). Fifty nine percent of schizophrenia subjects came from urban area and 67% in case of depression and 39% of schizophrenia group were seen in rural area and 32% in case of depression. The study did find the same results of study by Van et al. (2006) where they reported, urban living environment has been consistently found to be a risk factor for schizophrenia. MC Gurk (2004) reported social disadvantages like poverty, racial discrimination, unemployment, family dysfunction and poor housing condition are high risk factor. Depression was also found more in urban area, which could be because of more stressors seen in urban area as compared to rural area. The current available literature also finds that depressive illness are more seen in urban than rural area. The literature on schizophrenia is almost double in urban area than rural and the present study findings are consistent with literature. As per effect on occupation of the client is concerned it was observed that schizophrenia group was significantly affected while compared to depression cohort which was statistically significant ($p<0.001$). Anthony (1979) suggested that the person with schizophrenia would be having persistent disabilities in the areas of vocational and intellectual skills which are required to work in the community. The present study findings are consistent with the previous findings. Brekke (1997) found the same results which reported that occupational functioning is
almost universal feature of schizophrenia. This could be because person with schizophrenia are noticed to be having impairment in vocational ability, which includes getting, and retaining employment. The other possible impaired factor could be lack of adequate social competence and necessary social skill in work place. Many people with schizophrenia have deficits in communication skills like receiving, processing and sending information, and job survival skills like grooming, personal appearance, and politeness. Hence, due to all these factors person may not be able to get into employment. Depressive patient evaluate themselves negatively including their social and vocational abilities. Hence, this may not much interfere with their employment.

SECTION II: COMPARISON OF DEMOGRAPHIC PROFILE AMONG CAREGIVERS OF SCHIZOPHRENIA AND DEPRESSION

Caregivers can be explained in various ways. Caregivers may be spouse, child parent, professional having relationship with the patient. Such caregivers may be either primary or secondary caregivers wherein they may reside together with the patient or separately (Brodaty and Green 2002). The role of these caregivers may be providing required assistance to the needy of the family member (Walker et al. 1995). Lubkin and Larsen (2006) describe about caregivers wherein they explain these caregivers are named as informal caregivers, where they assume caregiving responsibility without accepting any source of income. The reason could be emotional attachment towards the patient. On the other hand, formal caregivers are those who except payment for their service towards the patient. HPNY and NAC (2005) found that more than 44.4 million people are informal caregivers. NAC and American Association of Retired Person (2004) stated that 83% of caregivers are emotionally related to the patient. Walker et al. (1995) viewed providing care to their relative is often perceived as women because most of the needs of ill person are fulfilled by women in the family. Bedini and Phoenix (2004) asserted that 80% of informal caregivers are women. If the spouse is absent then it is the daughter or daughter in law who may assumes caregiving responsibility. The literature suggested that about 40% caregivers are male gender.
The present study provided clear evidence that age of caregiver in both respondents differ (p<0.001). This further supported by the findings of age of onset that schizophrenia disorder tends to start at an earlier age as compared to depression. The other explanation could be depressive disorder people tend to come for treatment early in the course of their illness, whereas schizophrenia symptoms may go unnoticed by key caregivers and this may arrest the treatment. This element may block their education and occupational carrier and further more they would not establish independence in their life. Hence, due to unemployment, financial strain, these people remain with their parents. Due to all these reasons parents of such a population did not prefer them for marriage. Moreover, people may not choose their partner who is mentally ill. By any means if they get into marital life the divorce risk is high due to people with schizophrenia find difficulty performing family role.

The distribution of caregiver age in schizophrenia group is fairly high compared to depression group. The reason may be schizophrenia continues and has relapse course of illness. The symptomatology of illness may block their marital life. Hence, they remain unmarried and stay with an immediate family member who has a close association with patient. The other reason may be it is often difficult for caregivers to accept that their relative has schizophrenia. Therefore, the families of people with schizophrenia hide the illness may not allow them for marriage life. Stigma is another factor that has identified as a barrier to patient marriage life. The other reason may be that family is afraid that after marriage, their ill relatives will be rejected by the partner. Due to these entire reason patient with schizophrenia stay with their parents.

There was apparent difference in two groups with regard to gender of care giving (p<0.001). The results indicate that more patients in depressive group were married, whereas major proportion of schizophrenia remained unmarried. This could be again explained on the basis of age of onset where in depression before the age of onset of illness people get into marital life.

Male gender of care giving in schizophrenia group constitutes 34% where as 70% were assumed cares giving responsibility in depression. The female gender constitutes 66% in schizophrenia group and that of 30% in depression.
allows for formation of strong bonds of emotional attachment considerable social and economic support all of which either have a positive influence on accepting care giving. In schizophrenia positive symptoms behaviour such as hallucinations and delusions together with a high degree of social dysfunction and recurrent relapse are often linked with greater distress for caregivers and burdening. Moreover, male member may be having more of economic responsibility and female may assumed family caring responsibility. The other reason may be care giving is often perceived as an excluding providence of women because many of the requirements of the ill persons are mostly met by women in families. In depression due to symptomlogy male gender may be much distressful although caring for their ill relative, but caring may benefited to them includes satisfaction, reciprocity, and personal growth. Overall care giving broadened caregiver horizons and assisted them grow as people.

The groups did not differ with regard to education status of care giver. It may be apparent that the education status of caregiver does not effect in caregiving of their ill relatives.

As regard to occupation of the caregivers, there was significant difference between two groups (p<0.002). Both groups with the majority of respondents being occupied as a house wife (43% vs. 25%) Certain socio-cultural factors unique to the Indian setting could have contributed to the particular pattern of women work; where in majority of women are assigned to household work. The majority of rural respondents were engaged in agriculture work (23% vs. 14%). An explanation for this the greater numbers of rural people are accessible to agriculture work. The results of the present study perhaps evident that schizophrenia illness impact on caregivers occupation. The distress of caregivers may reflect on their occupation. Many of schizophrenia patients may not attend to work or not earn, may not care for personal hygiene and were considered most distressful and thus relative need to spend extra time in caring. Moreover, historically schizophrenia has been considered to be a chronic mental illness with less hope of remission or recovery. This may not be in case of depression disorder. Hence, therefore, more responsibility lies on caregivers. These are considerable factors for group differences.
There was significant difference in family income of both groups, i.e. greater income affect was observed in schizophrenia group although compared to depression ($p<0.001$), which is probably due to disability, schizophrenia patient participate in work training skills, and once they reach to the task level, they might be placed in a sheltered workshop. Unfortunately, although after work skill training person with schizophrenia may not work productively. This work would be part time for less than minimum wage. People may not achieve independence in work; hence, they are placed in supportive employment. This is because person with schizophrenia manifest some level of cognitive impartment, mostly in the functional areas of memory, attention, and higher executive functioning. The other possible reason is that person with schizophrenia finds it difficult in accessing services at community level after discharge from inpatient services. Whereas, depressive patient may return to a state of remission. Thus, all these factors in schizophrenia disorder affect financial status of caregivers.

There was significant difference between two groups with regard to length of caregivers contact ($p<0.001$). Most of the patients in the schizophrenia group were remained unmarried. Despite of positive, negative, affective and cognitive symptoms family extend their care giving towards their ill relative. This could be because of social, emotional bondage of family. The other reason may be care giving may benefit caregiver, which is may be psychological satisfaction. The course of illness in schizophrenia lengthens the caregiver contact. The other reason may be care giver of schizophrenia typically tolerates the difficulty behaviours of their ill relative. Probably, these people may have knowledge about the nature of their patient illness and also receives help from professionals in the management of difficult behaviour. Another explanation may be this population may have accepted their relative illness and adopted a healthy coping skill, which reduces adverse effect on their own health, both psychical and psychological.

There was a significant difference between two groups with regard to relationship with patient ($p<0.001$). In schizophrenia group, spouses constitute 23% and in depression group spouse constitute 64%. This indicates despite of nature of illness small part of schizophrenia population get married and spouse extent their caring support. Such spouses may not be having more choices for their economic
independence or probably they might have some benefit for their life. In female counterpart once they married their parents may force them to lead a life with ill person and parents of such females counter may not extend their support. The other reason may be these spouses may not use projection defence mechanism. The use of projection is more prone to increase interpersonal conflict. In depression male counterpart extends their caring support. This could be because possibly due to discrete nature of the episodes. The other reason may be their own children may extend their caring support or they take active part in caring process. That is why present study showed out of 30 samples 26% caregivers were children in depressive disorder group and while 4% in schizophrenia group. As a consequences of illness patient remains unmarried. Hence, the majority of the caregivers in schizophrenia group were parents that constitute 58% and that of 7% in depression. The reason may be parent may find solution to the problem and feel that they are doing fair to improve the situation. With the longer course of management, the parents could have learned to handle the stages of crisis. Moreover, continuation of illness management may gradually improve interpersonal relationship of the family members.

SECTION III: FAMILY BURDEN IN PATIENT WITH SCHIZOPHRENIA AND DEPRESSIVE DISORDERS

Schizophrenia is a continuous, life time major psychiatric disorder that may affect children, adolescents and adults. Depression is episodic, recurrent in nature, characterized by low mood, decreased psychomotor activity and depressive cognitions. Caregivers play a significant role in caring people with chronic mental illness. Caring role is not an easy task and that may impact on their personal life. Individuals with schizophrenia are less likely to gain employment and to marry, which produces grater amount of burden on caregivers. As a consequence, the remaining family members need to undertake the care of the ill person. Family burden in caregiving of severe mental illness includes missed work, domestic routine disturbance, financial strain, effect on social and leisure activities, and decreased caring role to the other family member (Kreisman and Joy 1974; Hatfield 1997).

Family burden care extensively studied in schizophrenia illness and reported significant burden on caregivers. This number account 90% of caregivers experiences
moderate to severe burden (Magliano et al. 2005; Provencher 1996; Gautam and Nijhawan 1984; Bury 1998; Jenkins and Schumacher 1999; Mors et al. 1992). Perlick et al. (2007) did report caregivers of depression patient experience higher degree of burden. In a study Carpentier (2005) found that the caregivers of patient with depressive disorder experience greater burden care. Apart from these studies few other studies reported uniplor depression and bipolar depression have some common feature of burden that is prevalent to families of schizophrenia (Jacob et al. 1987; Fadden et al. 1997). Chakrabarti et al. (1995) compared the burden of care among schizophrenia and affective disorder.

The mean score of financial burden was significantly high in patient in schizophrenia group compared to depression. The possible differences in both groups could be the fact that schizophrenia is a continuous, chronic illness in which a patient is unable to achieve economic independence, whereas depression is an episodic illness where the amount of disability may be lesser. Schizophrenia required long term treatment as compared to depression. Another possible reason for the difference in burden could be the fact that productivity is impaired in the schizophrenia group much more when compared to depression. It may be possible that the longer duration of illness of schizophrenia might have contributed to the increased financial burden of the key caregivers. In the present study, the majority of the patients with schizophrenia were observed to be unemployed as compared to depression. Patients of schizophrenia have much more disruption in the work place due to the predominant negative, cognitive, and affective symptoms whereas patients of depression may not be having predominant negative symptoms, which may not disrupt their work. Hence, they could earn and bear treatment expenditure. Moreover, loss of employment in patients with schizophrenia still contributes to a greater financial burden on caregivers. The loss would be both direct and indirect costs that significantly contribute to the financial burden of family members. Many people with schizophrenia get into paid employment with great difficult, but they find difficult in holding jobs consequently caregivers may need to carry a large amount of financial burden. Another reason may be the limited number of psychiatric treatment facilities in rural areas. Hence, caregivers largely spend money on travelling. If the primary physician trained them, indirect costs can be minimized.
The mean of effect on family routine in schizophrenia disorder group was significantly high compared to the depressive group. An analysis of the difference in total mean score for effect on family leisure activities revealed that burden was significantly high among schizophrenia group compared to depressive group. The reason for differences may be schizophrenic behavior could deter family routine, and leisure activities. The nature and severity psychotic symptoms may cause social withdrawal like less interaction, lack of conversation, and few leisure interests in family members. Schene et al. (1998) reported that caregivers avoid their social and leisure activities, to make reciprocity balance in role. Caregiver of schizophrenia group not only hesitate or restrict to social contact as a result of symptoms but also because of the guilt, stigma, and discrimination. Hence, it appears this population group requires more practical support from social network whereas in case of depression the discrete nature of the episodes makes patients return back to their premorbid level of functioning. It is worthwhile to note here that the caregivers of schizophrenia patient spent more time looking after their patients compared to depression. Genduso and Haley (1997) asserted that schizophrenia is an early onset illness and the one who is affected may be from a younger age group and subsequently may not able to work for themselves. As an impact caregivers are forced to cut down their work hours to provide care for their patient. Another study done by Awad and Voruganti (2008) reported that family members who leave their jobs to provide care for their ill relative with schizophrenia ranged from 1.2% for first episode and 2.5% for long term patients. The present study findings are consistent with these previous studies. The fear of leaving a schizophrenic patient alone makes the caregivers reside at home most of the time and consequently themselves isolate from social contact or the outside world. Availability of residential care may not be sufficient for the current schizophrenia population, hence, residential resource and manpower need to enhance which would reduce the objective burden. The present study findings are consistent with those previous studies done by Winefield and Harvey (1994) who revealed that the burden would impact caregivers who were in greater contact with the patient. Families having patient with schizophrenia feel humiliated, isolated, and meeting the needs of patient may disturb their lives.
The schizophrenia group had significantly high impairment in family interaction than depressive group. Disruption of family interaction was another significant variable of family burden. Due to symptoms of schizophrenia caregivers become tense and irritable as a consequence of which ambivalence may arise in the family system regarding caring of ill person. Schizophrenia, which is a continuous relapsing disorder, family member requires somewhat different sort of adaptive skills. Relapsing disorder would need the role reallocation in the family system where as the episodic depressive disorder may be flexible and permit caregiving arrangements. For depressive illness, there are relatively lesser strains as the caregivers may divide the energy in caring for the ill. In patient with schizophrenia, the amount of readjustment in family system, roles, problem solving might be different and caregivers require more rapid mobilization of crisis, and treatment management. Nevertheless, the family interaction with the schizophrenia patient and the impact of the disorder on the family member remain substantial. The symptoms of schizophrenia may be unpredictable, even frightening at times which disrupt the family dynamics. In schizophrenia negative symptoms of apathy, amotivation, asociality often disrupt the family interaction. It is more when a patient falls prey to poor sanitation, excessive smoking and reversal of sleep. Such a sleeping habit may affect the family members’ need for rest and family system. Due to the illness the family may feel rejected by the extended family members, and this is often mixed with a feeling of anger, guilt, and hopelessness. Our clinical observation states that most family members use denial defense mechanism about their ill relatives’ illness. This also tends to add on burden. Raj et al. (1991) evaluated the significant correlation in social burden in caregivers by comparing positive and negative symptoms of schizophrenia at initial assessment and at the end of the period of follow up. They asserted that at the time of initial assessment in positive schizophrenia cohort, no significant correlation between rating on psychopathology and social burden was observed; however, at the end of the period of follow up, significant reduction in rating on psychopathology and social burden as well as significant correlation between severity of psychopathology and burden of care were noted. In the negative schizophrenia cohort, the severity of psychopathology and social burden were significantly correlated, but at the end of six months no significant change either in severity of psychopathology or social burden
emerged. These findings can be attributed as result of role of adjustment by caregivers in due course of disorder.

There was no significant difference of effect on physical health of other family members between two groups. Examination of differences on psychological health revealed that there was significant difference among two groups with more psychological problem among caregivers of schizophrenia group. The reason for the greater psychological burden among caregivers of schizophrenia group could be the continuous, chronic nature of the illness, which could precipitate a feeling of isolation, anxiety, depression and frustration in the caregiver in contrast to discrete episodic nature of depressive disorder. Moreover, chronic illness with loss of insight would significantly enhance the extent of psychological burden of caregivers. With the paucity of residential care, the majority of schizophrenia patients live with their relatives and providing care for a lifetime which may later lead to psychological distress among caregivers. Boye et al. (2001) reported that anxiety depressive behaviors are high in caregivers of chronic illness. The other reason could be relapsing chronic illness manifest more psychological discrepancy in caregivers. Thornicroft (2006) has suggested that in the west people somewhat more flexible and open, expressing enduring greater tolerance towards mentally ill people, but negative attitudes were still predominately evident. Even more Reid et al. (2005) found negative emotions regarding schizophrenia illness are markedly consistent over the course of illness and across different places. One possible reason for the difference could be fact that coping strategies of caregivers in depressive disorder are found better possible reason could be the nature of illness. Moller (2006) studied to ascertain elements which moderate the influence of patient illness on the stress experienced by his key relatives' indifferent dimensions. He compared caregivers of depression and schizophrenia patient and revealed that the most possible pertinent predictors of stress are caregivers expressed emotion and neuroticism, their negative stress response and life stressors, having predominant direct and indirect impact on relatives stress outcome. Stressors reduction was mainly caused by a communication of relatives' generalized positive stress response and patients' residual symptom concluded and supported the transactional character of the stress process in caring for a patient with a severe mental disease.
Examination of differences on subjective burden revealed that there was a significant difference among two groups with more subjective burden in caregivers of schizophrenia group. Subjective burden delineates the personal distress or pain as a result of illness, which are psychological reactions which caregivers undergo. These include grieving for the ill, feelings of loss, and loss of the person who might have been. The family members of schizophrenia group experience tremendous psychological stress with regard to caring of ill person, which may precipitate subjective burden. These family members experiences considerable grief about not enough has been carried out for the ill and may feel that they are the cause or contributed for the patient illness.

The mean FBIS global burden score in relative of schizophrenia group was significantly higher compared to depression group. The study carried out by Nehra et al. (2005) reported that both groups bipolar affective disorder and schizophrenia were similar in the areas of coping and care giving experiences.

SECTION IV: CAREGIVER FACTOR ASSOCIATED WITH FAMILY CARE BURDEN IN PATIENT WITH SCHIZOPHRENIA

Results from this study revealed that caregivers age was positively correlated with family burden. This is consistent with previous study carried out by Juvang et al. (2007) who investigated association between demographic characteristic of caregivers burden when providing care for a member with schizophrenia. Result revealed that the age of caregiver was positively correlated to burden of caregiver. When caregiver becomes older, they are worried about who will take care of their ill relative in the future. Even older caregiver also cannot provide adequate care to the ill relative. In addition, younger age of caregiver which has to provide caring for ill member, results in increasing sense of life is worth living (Fujino and Okamura 2009). The old age caregivers not only have to take care of their ill relative but they also have to look after their own health, which may result in a higher burden they perceived (Chien et al. 2007).

With regard to education, the study showed that education level had a negative relationship with burden. The study findings are consistent with previous studies which found that caregivers who had higher level of education, reported less burden.
education level and caregiver burden may be explained by a view that caregivers with higher educational background may have higher knowledge of the illness and are able to find and access to social and financial resources. These characteristics allow them to obtain better care and treatment for their ill relative. Juvang et al. (2007) reported that the education level has negative correlation with caregivers burden. It was assumed that higher the level of education, higher the salary would be. High salary will minimize financial strain related to providing care for their ill relative. Even more education level of the caregiver also tends to have adequate knowledge to handle stressful life event. Therefore caregivers education status influences burden of the caregiver.

Results from this study revealed that caregivers family income was positively correlated with burden. Lower income may be a stressor that influence stress feeling during the caring process. Beside caregivers providing care for their ill relative, they also had to solve financial problem and find out source of money. From this data, it is apparent that family income plays a key role in predicting caregivers level of burden. The reason may be low income is a stressor which influences the feelings during the caring process. Besides caregivers may have financial strains in finding out sources of money. Srinivasan and Thara (2001) revealed that the highest challenges experienced by Indian families in caring for persons of psychiatric illness are financial and social isolation. The growing socio-economic changes, industrialization, minimal job opportunities and facilities have driven the agrarian sectors of our economy to difficulty. Therefore family income associated with burden in schizophrenia disorder caregivers.

Regarding duration of time spent to look after patient, the present study results indicated that length of contact positively correlated with burden in families of schizophrenia. The higher the duration of contact for taking care of their ill relative, the greater burden the caregivers experienced. The present study results were consistent with previsions studies (Chang et al. 2010; Chiou et al. 2009; Koukia and Madianos 2005). When a caregiver spends time with their ill relative, it may result in having less time for themselves in terms of attending to their own daily routine activities. Approximately 60 to 80% of impaired people are cared by the family.
member (Clement et al. 1995). Usually these people require assistance in performing activities of daily living, such as bathing, grooming, medication management and routine follow-up. It is obvious when care is provided for a longer duration of time particularly for patient of schizophrenia caregivers may experience burden. Hence, this marked negative effect may predict family care burden in patient with schizophrenia.

SECTION: V INDIVIDUAL FACTORS RELATED TO BURDEN ON FAMILY CAREGIVERS CARING FOR PATIENTS WITH SCHIZOPHRENIA

The correlation between age and burden shows that there is a significant relation between the age of the patient and burden, i.e. the older the patient the greater the burden. Juvang et al. (2007) reported that there was correlation between patient age and family burden. Younger age group patients with schizophrenia are unable to take care of themselves, which may be due to the early stage of illness. Therefore caregiver felt burden while providing care to the younger patient in long time period. Yet another study found that caregivers of schizophrenia patient displayed a very high degree of burden, especially while taking care of younger patients (Caquezo-Urizar and Gutierrez-Maldonado, 2006). The younger patients might require intensive caregiving, therefore the caregiver needs to spend more time with patient.

Duration of illness and clinical symptoms may have an influence on caregivers burden. Positive symptoms may be associated with caregivers burden more than the negative symptom (Grandon et al. 2008; Tang et al. 2008). Other factor associated with burden of caregiver is the severity of patient symptoms (Shu-Ying et al. 2008). A symptom caused by illness is associated with disability, which influences the patients behavior and capacity to carry out activity of daily living. Hence all these cause patients dependence on caregiver. Moreover in case of chronic illness, caregiver may feel burden in caregiving due to symptoms of disease of the patient and illness, which need long term care.

Correlations analysis to determine the associations of family burden indicate that low income emerged as a significant factor of family care burden. Symptoms of illness affect working ability of the patient. Fujino and Okamura (2009) found that the patient disability in daily life was related to family care burden. It may result
dependency of patients on caregiver to carry out their daily activities. It may be due to the fact that schizophrenia is considered as a chronic and major psychiatric disorder. The patients of schizophrenia may experience impairment in thought process that influences their behavior. More often, their behaviors are odd (Pompili et al. 2009) or harmful to others (Vivera et al. 2005). In addition, the illness may recur during the phase of treatment and recovery (Bostrom and Boyd 2005). Patients with schizophrenia may have impairment in independent living skills which may lead to poor or loss of functional outcome. Impaired levels of functioning are mainly in the areas of loss of learned skills and the failure to learn new ones. This affects the patient’s productivity. This may contribute to family care burden both in terms of patient’s dependence on social and economic factors (Lefley 1987 and Lefley 1989). Maurin and Boyd (1990) found that low employment of patient may lead to increased dependence on the caregivers for meeting basic needs, which results in burden on relatives. Mueser et al. (2002) shows that poor occupational functioning is considered as a universal feature of schizophrenia, with employment rate of range 10% to 20% and this population fall under the age group of 26 to 30 years. Due to these entire factors patient become less productive. So, therefore it directly correlated family care burden.

SECTION VI: THE EFFECTS OF SOCIAL SKILLS TRAINING ON INDIVIDUALS WITH SCHIZOPHRENIA

Individual with schizophrenia shows greater rates of social skill impairments. The impairment could be linked with poor premorbid learning abilities, resisted environmental stimulation, psychopathology, and the diminished skills due to prolonged or more number of hospitalizations.

The pre intervention and post intervention score of SAFE of the control group did not showed significant differences. This outcome may be because control group did not receive the SST. A significant difference between the pre and post intervention SAFE scores in the experimental group was noted and possibility for this outcome may be the effect of the SST on schizophrenia disorder. This tendency was absent in the control group. Social skills in experimental group after social skill training was superior to that before training, this findings support previous studies
This difference may be attributed to the fact that SST consisted of explanation, instruction, modelling, role playing, and feedback and reinforcement techniques. The intervention were designed in accordance with clinical requirement of the respondents and moreover, majority of them participated in the group therapy were motivated to learn. Perhaps the behavioural rehearsal obtained in the skill intervention sessions serves the purpose of repetition which might have helped in acquiring social skills. The effect may be behavioural with lasting changes occurring with information processing system. Another explanation may be therapist provided an opportunity for the patient to acquire and practice new skills; moreover competence practice between interventions is needed in order to generalize social skill into real life setting. Therefore all the respondents were regularly provided homework assignment to utilize the acquired particular skill during session with family members/friends before step into the next session. Another possibility for the significant differences may be that all respondents were community living residents of their respective places. It is well known fact that social interaction is often contaminated in hospital setting. As a result such a protected and restricted environment may not be greater helpful to the patients. Glynn et al. (2002) in their study pointed out that SST is more effective in those who reside in the community and they show significantly greater or quicker improvement rather institutional/hospital based skill training or closed indoor patient. Another explanation may be that individual with schizophrenia disorder who were less attentionally impaired were able to acquire social skills. Another apparent reason may be that less chronic patients may have benefited more from the SST. These respondents might have adequate verbal memory where in they recall of words from the word list which may be a stronger factor and may have benefited from SST. Auslander and Jeste (2002) suggested that physical health, memory and social functioning are the good treatment response factors. Muser et al. (1991) illustrated that verbal memory is one of the strongest predictor of improvements of SST for schizophrenic patient. A study done by Spaulding et al. (1999) revealed that patient whose scores adequately on verbal learning test, were more likely to improve on the interpersonal problem solving skills. It may be apparent that verbal memory may be an indicator of better acquisition and performance of social skills. Yet another explanation may be continuous and planned systematic feedback might have benefited experimental group. During the
process of feedback experimental group might have learned reading cues from the social environment about their interpersonal behaviour; such issues were addressed in the therapy. Green (1996) concluded that verbal memory and attention influences the competence. In the present study patients participated in the intervention group were schizophrenic patient who lacked social skills due to psychiatric syndrome. Hence social skill with more repeated instruction on multiple areas resulted a improvement in SAFS scores in the experimental group.

The result indicated no significant decrease in SANS score in experimental group compared to control group (p=.072). The present study finding could be due to a number of factors. However, result indicated significant improvement in alogia, apathy, and anhedonia (p=.007, p= 0.030, p= 0.025) but not in other domains of SANS.

SST may be beneficial over a longer period of training, which may reduce the severity of disability among the schizophrenia sample population. An approximate amount of time is difficult to estimate but however, previous research studies has been carried out over period of few months and even extended up to two years of duration. Overall studies suggest that a longer period of time may be required for the beneficial effect of social skill training on schizophrenia patients. The other reason may be patient’s chronicity and disability due which patients did not get benefit from social skill training. The other possible reason may be that schizophrenia is a severely debilitating and continuous/chronic mental illness which pervasively decline psychosocial functioning and learning abilities, hence the present study group patients did not shown improvement. Holmes (2001) reported that symptoms like hallucinations, delusions, bizarre thoughts which may last for longer period, consequences of which patient may become poorer in learning new skills. National Institute of Mental Health [NIMH] (2007) also reports schizophrenic patients may have unusual thought process, disorganized thinking and difficult in organizing their own thoughts and connecting them logically, which perhaps may be the reason for the current study results. The other reason may be that negative symptoms like blunted effect, apathy amotivation, and diminished drive may cause distraction in learning new skills. Depersonalization, derealization and somatic symptoms are seen and may have reached to delusion proportions (American Psychiatric Association Diagnostic
and Statistical Manual of Mental Disorder forth edition, text revision 2000) which have hampered the acquisition of social skills in the present study population. The other reason may be individual acceptance of mental illness. NIMH (2007) reports that the majority of patient with schizophrenia were unaware of their psychotic illness, therefore they may have poor coping behaviour. Due to poor insight patient with schizophrenia become noncompliance to the treatment, poor functioning and which may cause poorer prognosis of illness. It is obvious that one who denies about their mental illness may not accept treatment because they feel treatment is not required. Hence, therefore teaching social skill acquisition and improvement becomes very difficult. Another possibility is that pre occupation with systematised delusions/hallucinations to a particular theme which may not be in accordance with the pattern. Such pattern may have restricted the social skill training benefit.

The analysis showed significant difference between the two groups across some domains of SANS like alogia, avolition and asociality. It appears social skill training may have some effect on negative symptoms. The possible reason may be that the present study used a role-play measure of social skills. Once the skill was demonstrated the patient was instructed to try to copy the therapist behaviour; a short role-play interaction. This is a prominent domain of social skill training. Talking or viewing required behaviour is less likely to impart the target skill to the patient. The other possible reason may be learning abilities of present study group were contributed to significance difference. As a part of social skill training, social perception training was given to the experimental group, wherein overt response skill and expressive elements which consists of verbal and nonverbal response parameters which involve communication messages to another group individual. A significant difference was observed between the two groups on the asociality measures. A program developed by Wallace (1982) was used which basically improves the information processing skills of schizophrenia population. In this program patients were taught to perceive and process incoming stimuli rightly and subsequently pass the effective verbal and nonverbal measures. Moreover during this patients were taught to elicit various alternatives options and devise them in an appropriate way.
SCOPE OF PRESENT THE STUDY

The research study is having following scope:

- Most of the studies used the concept family burden in schizophrenia but relatively depressive disorder has been neglected. Hence in the current study an attempt is made to assess and compare family burden in patient with schizophrenia and depressive disorder.
- This comparative study intended to help mental health worker to acquire or gain the practical skills needed to handle patient with schizophrenia or depressive disorder.
- The present study intended to develop insight about the experience of illness burden and management of the problem.
- Present study intends to examine the association of family burden in schizophrenia, which provided basic information for psychiatric social workers while rendering appropriate psychiatric care for caregivers to decrease their burden.
- The present study examines the efficacy of social skill training for patient with schizophrenia disorder.
- This study may provide data supporting the efficacy of social skill training for de-institutionalized patient with schizophrenia.
- Taking into consideration that much of the research has been carried out in psychiatric inpatient facilities, the present study may provide significance of undertaking research on patients residing with their family on out-patient basis.
- Study added to their quality of life enhancing their socialization.