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Assessment of Family Burden in Patients with Schizophrenia and Bipolar Affective Disorder (Manic Cases).

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ABSTRACT

Background: Pai and Kapur (1981) reported that the lack of acceptance of the patient in the family and the negative attitudes towards the patients in the community, lead to frequent relapse on mental illness, which is turn, increase the burden on the family. The term family burden can be defined operationally as the extent of suffering experienced by the family of a psychiatric patient. Family caregiver burden may be defined as the problems, difficulties, and negative life events influencing the life of family members caring for a loved one with a mental illness. Schizophrenia and Affective Disorders (mania) are found in all societies and geographical areas, incidence and life time prevalence are roughly equal worldwide. **Methodology:** The research work was done at the outpatient department of Gwalior Mansik Arogyashala, Gwalior, India. It was cross-sectional hospital based study and using purposive sampling technique. The sample consisting of 60 samples (30 each group from Schizophrenia and BPAD,Mania) of family members were taken for the study as per inclusion criteria. Socio-demographic and clinical data sheet, Family Burden Interview Schedule and General Health Questionnaire were used. **Results:** Results indicated that, in schizophrenia, there was positive relationship found between Effect of mental health of others in family burden domain and duration

of illness and in Bipolar Affective Disorder (Mania) there was negative relationship found between disruption of family interaction in family burden domain and duration of illness. **Conclusion**: It can be concluded from the current study that caregivers of both the groups, individuals with schizophrenia and bipolar affective disorder (mania) have burden in the terms of financial, leisure time, daily activity routine, physical and mental health.

KEYWORDS:- Family Burden, Schizophrenia, BPAD(Mania).

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BACKGROUND

Family is the primary unit in which an individual is a member from womb to tomb. That being the case, everyone is the family plays a major role or takes part in the welfare and difficulties of a persons. If a person's performance or social functioning is inadequate or affected; its leads a greater burden on the family.

According to Pai and Kapur (1981) caregivers burden has two dimensions, "objective burden" (effects on the household including financial loss; effects on health, on children, and family routine; and the abnormal behaviors shown by the patient) and "subjective burden" (the extent to which relatives felt they carried a burden like grief, anxiety etc**).** Pai and Kapur (1981) also reported that the lack of acceptance of the patient in the family and the negative attitudes towards the patients in the community, lead to frequent relapse on mental illness, which is turn, increase the burden on the family.
The term family burden can be defined operationally as the extent of suffering experienced by the family of a psychiatric patient. Due to various problems encountered with regards to financial conditions, routine, family interaction, leisure time activities, physical and mental health of the member of the family can be accessed on the basis of the global rating by the key informant of the suffering owing to the patient's illness.
Hoening & Hamilton (1966) were the make a clear destination between objective and subjective aspects of burden. In their view, objective aspects of burden meant identifying anything that occurs as disrupting factor in family life owing to the patient's illness. Subjective burden refers to the feeling that a burden is being carried in a subjective sense.

AREA OF FAMILY BURDEN:

a) Financial Burden, b) Disruption of family routine activities, c) Effect on family Leisure, d) Effect on physical health of family members, e) Effect on mental health of r family members, f) Effect on mental health of others and subjective burdens.

The term schizophrenia was introduced by the Swiss psychiatrist Bleuler. It refers to a major mental disorder, or group of disorders, whose causes are still largely unknown and which involves a complex set of disturbances of thinking, perception, affect and social behaviour. So far, no society or culture anywhere in the world has been found free from schizophrenia .Schizophrenia and Affective Disorders (Mood Disorders) are found in all societies and geographical areas, incidence and life time prevalence are roughly equal worldwide. Schizophrenia begins early in life, causes significant and long lasting impairments, makes heavy demands for hospital care, rehabilitation and support services and therefore, the cost of treatment is higher than that of mood disorders. Bipolar affective disorder is a type of psychiatric disorder classified under 'mood disorders' or 'affective disorders'. It is a diagnostic term used to describe the medical condition characterized by patterns of abnormal and severe mood swings, ranging from periods of depression to

elevated mood termed as mania. Mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in over activity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence.

The families have assumed a greater role in looking after schizophrenia, patient. They have at present a greater role in providing care for relatives with schizophrenia, understanding the determinates of burden has become an increasingly important focus of research. There is long term burden associated with bipolar illness. Financial difficulties, home and child neglect, marital problems, loss of status and prestige constant tension and fears of recurrence of acute illness may contributing to the experience of burden. Burden in this sense may be considered the socioeconomic cost to the family over the course of the illness resulting from acute episodes and intermittent course.

Family caregiver burden may be defined as the problems, difficulties, and negative life events influencing the life of family members caring for a loved one with a mental illness (Platt, 1985). Nearly 93% of caregivers of patients with bipolar disorder reported a moderate or higher degree of caregiving strain when their relative was admitted to a psychiatric facility, and that 70% continued to report moderate or higher burden 15 months later (Perlick et al., 2007).

REVIEW OF LITERATIURE

Bhatti et al (1988) in a review of studies on family burden of psychiatric patients noted that, the Indian families often tolerate considerable burden without complaint. Wig et al (1987) noted that Indian families had no complaints with regard to their family burden. However due to the rapid industrialization and urbanization and subsequent changes in the family structure and role, care for psychiatric patients imposes a significant burden on the families in developing countries like India.

Burden in families of patients with schizophrenia:

Research studied highlights the relationship between expressed emotion and family burden in the families of 20 adults with either schizophrenia or bipolar affective disorder. One key relative from each family was interviewed using the social behavior assessment schedule. The EE level was determined through videotape analysis of the interview. High incidence of critical remarks was associated with higher level of burden with regard to disturbed behaviors and social performance deficits. Higher level of burden was associated with low level of hostility, low emotional over involvement and over all EE.

Gautam & Nijhawan (1984) compared the burden on families of schizophrenic patients with chronic lung disease. The sample was randomly selected with 25 relatives in each group, using a structured interview schedule. Caregivers of patients with schizophrenia reported greater burden, financially, on family leisure, family routine, family interaction and mental health of other family members. The financial burden was higher when the male member had the illness.

Burden in families of patients with Bipolar disorder:

Roychaudhri et al. (1995) assessed the subjected and objective burdens of the caregivers of schizophrenic and bipolar affective disorder patients. Caregivers of 30 schizophrenic and 24 bipolar patient were interviewed. Burden was found to be higher among the caregivers of schizophrenic, young, male, low income and unemployed patients. This study has shown a more comprehensive way of assessing family burden with due emphasis on positive mental health and coping resources of the careers.

Perlick et al (2001) studied on the impact of family burden and patient symptom status on clinical outcome in bipolar affective disorder to examine the effect of family burden on the occurrence of subsequent episodes of illness, in a sample of 264 patients diagnosed with Bipolar Affective Disorder. Results showed that the degree of burden reported by family caregivers of patients diagnosed as bipolar affective disorder influences the course of recovery in both the acute and stabilization phase. In the acute phase, patients whose caregivers report higher levels of burden are more likely to meet criteria for a major affective episode at follow up. During the stabilization phase the effect of burden is moderated by the degree of affective and psychotic symptomatology that is present. Thus, when symptom levels were relatively high during stabilization caregiver burden did not significantly impact on patients' outcomes; when symptom levels were relatively low, however, patients' whose caregivers reported higher level of burden were significantly more likely to meet criteria for a major affective episode at follow up.

METHODOLOGY:

AIM OF THE STUDY:

The aim of the present study is to assess the family burden of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).

OBJECTIVES OF THE STUDY:

- To assess the level family burden of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).
- To assess the socio demographic and clinical variables of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).
- To assess the relationship among duration of illness and family burden of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).

HYPOTHESIS OF THE STUDY:

- There will be no significant difference in burden between families of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).
- There will be no significant relationship among duration of illness and family burden of patients with Schizophrenia and Bipolar Affective disorder (Manic cases).

SAMPLE SIZE

- The present study was conducted in the Out Patient Department (OPD) of the Gwalior Mansik Arogyashala, Gwalior (*Madhya Pradesh*.). Total 60 family members (caregivers) out of which 30 family members of patients with Schizophrenia and 30 family members of patients with bipolar

affective disorder (Mania) were selected for study. It was cross sectional hospital based study and purposive sampling technique was used.

- **INCLUSION CRITERIA**
- Family member (caregivers) whose patients diagnosed with Schizophrenia or Bipolar Affective disorder, current episode mania as per ICD-10 DCR, WHO, 1993.
- Family members or caregivers staying with patients more than 2 years and actively involved in care of the patient.
- Age ranges of Family member were between 18-60 years.
- Both sex included
- Family member who give written informed consent.

EXCLUSION CRITERIA

- History of any major Physical or neurological disorders and mental retardation etc.
- Age range of family member's below18 and above 60 years.
- The family member who are not living with patients with last 2 years.
- Family member who not give written informed consent.

TOOLS USED:

1. Socio demographic and clinical data sheet.
2. Family Burden Interview Schedule (FBIS) (Pai & Kapur, !981).
3. General Health Questionnaire-12 (GHQ-12) (Golderg & William, 1978)

1. **Socio-Demographic & Clinical Data Sheet-**

It is semi-structured, self-prepared Performa especially drafted for this study. It contains information about patients and their family socio-demographic variables (like age, sex, religion, education, marital status, domicile and occupation and socio-economic status etc.) and clinical variables (like- duration of illness, family history of mental illness and treatment etc.)

2. **Family Burden Interview Schedule (FBIS) (Pai & Kapur, 1981)** –

This is semi structured interview schedule comprising of 24 items grouped under six domains; i.e.- (a) Financial burden (b) Disruption of daily routine family activities (c) Disruption of family leisure time (d) Disruption of family interaction, (e) Effect of physical health of other, (f) Effect of mental health of other. The burden has been rated on a three point scale for each item and a standard question to assess the schedule. This scale has been developed in Indian setup, keeping in mind the socioeconomic and the cultural condition in India. The validity and reliability for each item was reported to be more than 0.78 by authors which medicates that the present schedule is reliable tool. The validity of schedule was also assesses by co-relating objective burden rating with subjective burden as reported by the relatives of patients. The correlation was found to be .72 which can be considered significant. All the item of this scale are rated on 3 point scale (viz, severe burden, moderate burden and No burden). This is a widely used instrument for measuring of family burden with high degree of validity and reliability.

3. General Health Questionnaire-12 (GHQ-12) (Golderg & William, 1988).

General Health Questionnaire is used to screen any psychiatric morbidity in healthy person. It is the short version of the original General health Questionnaire containing 60 items for the detection of the psychiatric illness. Internal consistency was observed for each of the 12 items with Cronbach's alpha value 0.37-0.79, while total score was 0.79 in the population study. Test-retest correlation coefficients for the 12 items score were highly significant. It was widely used to screen for the presence of psychiatric distress. Cut of score is ≤3.

PROCEDURE:

Initially permission was taken from institute for conducting the present study. Caregivers of Individuals with Schizophrenia and Bipolar Affective disorder (Mania) who attended out-patient department (OPD) of Gwalior Mansik Arogyashala, Gwalior (M.P.) during study period selected as per the inclusion and exclusion criteria for sample on the basis of purposive sampling techniques. The objectives of the study were explained to the participants and then consent taken from him. Both the group with the score of 3 or below 3 on GHQ-12 was taken for further assessment. After that the socio-demographic& clinical data sheet was applied on caregivers of patients with Schizophrenia and Bipolar Affective disorder (Manic cases). Then, after the others scale i.e. Family Burden Interview Schedule were administered among the caregivers of both the groups.

STATISTICAL ANALYSIS:

SPSS version 20 (Statistical Package for Social Sciences) used for analysis data. The socio-demographic characteristics of both the groups were initially described using number and percentages. Thereafter both groups were compared on socio-demographic variables stated using chi-square analysis. Scores obtained by participants of both the groups on various scales used in the study viz. family burden questionnaire were described using mean and standard deviation. Chi square test was used for describing & comparing categorical variables and T-test was used for describing and comparing continues variables. The following correlation analyses were done using Pearson (r) correlation method to see the relationship between duration of illness and family burden.

RESULTS:-

Table-1: Comparison of Socio demographic and clinical Characteristics of individuals with Schizophrenia and Bipolar Affective Disorder (Manic cases).

Continuous Variable		Samples (N=60)		df	t	p
		Individuals with Schizophrenia N=30 (Mean ± SD)	Individuals with Bipolar Affective Disorder N=30 (Mean ± SD)			
Duration of Illness (in Years)		5.70 ± 2.38	6.90 ± 3.22	58	-1.641	.106
Categorical variable		N (%)	N (%)	df	X^2	p
Age	18 to 30 Years	4 (13.3%)	7 (23.3%)	2	6.708	.042*
	31 to 45 Years	13 (43.3%)	19 (63.3%)			
	46 to 60 Years	13 (43.3%)	04 (13.3%)			
	Total	30 (100%)	30 (100%)			
Sex	Male	12 (40.0%)	19 (63.3%)	1	3.270	.120
	Female	18 (60.0%)	11 (36.7%)			
	Total	30 (100%)	30 (100%)			
Religion	Hindu	28 (93.3%)	27 (90.0%)	1	.218	1.00
	Islam	2 (06.7%)	3 (10.3%)			
	Total	30 (100%)	30 (100%)			
Education	Literate	12 (40.0%)	10 (33.3%)	3	1.242	.754
	Middle	11 (36.7%)	14 (46.7%)			
	Higher Secondary	05 (16.7%)	03 (10.0%)			
	Above Higher Secondary	02 (6.7%)	03 (10.0%)			
	Total	30 (100%)	30 (100%)			
Occupation	Employed	19 (63.3%)	20 (66.7%)	2	1.026	1.00
	Unemployed	11 (36.7%)	10 (33.3%)			

	Total	30 (100%)	30 (100%)			
Marital Status	Married	06 (20.0%)	07 (23.3%)	1	1.002	.506
	Unmarried	24 (80.0%)	23 (76.7%)			
	Total	30 (100%)	30 (100%)			
Family types	Joint	17 (56.7%)	13 (43.3%)	1	1.067	.439
	Nuclear	13 (43.3%)	17 (56.7%)			
	Total	30 (100%)	30 (100%)			
Socio Economic Status	Low	23 (76.7%)	25 (83.3%)	1	.417	.748
	Middle	07 (23.3%)	05 (16.7%)			
	Total	30 (100%)	30 (100%)			
Domicile	Rural	22 (73.3%)	27 (90.0%)	2	3.377	.177
	Semi-urban	05 (16.7%)	01 (3.3%)			
	Urban	03 (10.0%)	02 (06.7%)			
	Total	30 (100%)	30 (100%)			

*Significant level <0.05

Table- 1 shows the comparison of socio-demographic and clinical variables of individuals with Schizophrenia and Bipolar Affective Disorder (Manic), which indicates that there is significant difference in age (p=0.042*). However no significant difference has been found with regards to duration of illness, sex, religion, education, occupation, marital status. Family type, socio economic status and domicile in both the groups.

Table-1.2: The Comparison of socio demographic Characteristics of families (caregivers) of individuals with Schizophrenia and Bipolar Affective Disorder (Manic Cases).

Continuous Variable	Samples (N=60)		df	t	p
	Family (caregivers) of Individuals with Schizophrenia N=30	Family (caregivers) of Individuals with Bipolar Affective Disorder			

		(Mean ± SD)	N=30 (Mean ± SD)			
Number of Member in the Family		6.76 ± 2.43	7.03 ± 4.01	58	-.311	.757
Categorical variable		N (%)	N (%)	df	X^2	p
Informant	Parents	7 (23.3%)	11 (36.7%)	3	1.495	703
	Spouse	6 (20.0%)	6 (20.0%)			
	Sibling	10 (33.3%)	7 (23.3%)			
	Others	7 (23.3%)	6 (20.0%)			
	Total	30 (100%)	30 (100%)			
Age of the Informant	18 to 30 Years	9 (30.0%)	5 (16.7%)	2	6.708	.042*
	31 to 45 Years	7 (23.3%)	7 (23.3%)			
	46 to 60 Years	14 (46.7%)	18 (60.0%)			
	Total	30 (100%)	30 (100%)			
Sex of the Informant	Male	26 (86.7%)	19 (63.3%)	1	.741	.671
	Female	04 (13.3%)	11 (36.7%)			
	Total	30 (100%)	30 (100%)			
Duration of Stay With Patients	2 to 5 Years	15 (50.0%)	14 (46.7%)	2	.074	.963
	6 to 10 Years	12 (40%)	13 (43.3%)			
	Above 10 Years	03 (10.0%)	03 (10.0%)			
	Total	30 (100%)	30 (100%)			
Family Monthly Income	Less than 5000	20 (66.7%)	21 (70.0%)	2	2.110	.361
	5000-10000	6 (20.0%)	08 (26.7%)			
	Above 10000	04 (13.3%)	01 (3.3%)			
	Total	30 (100%)	30 (100%)			

Table-1.2 shows the comparison of socio-demographic and clinical variables of families of individuals with Schizophrenia and Bipolar Affective Disorder (Mania). This indicated that there were significant differences found with regards to the age of the informants (family members) of individuals with Schizophrenia and Bipolar Affective Disorder. However no significant difference has been found with regards to sex of the informants, duration of stay of the patients and family monthly income.

Table-2: The Comparison of domains of Family Burden in the Family of individuals with Schizophrenia and Bipolar Affective Disorder (Manic cases).

Domains of family burden interview schedule	Samples (N=60)		df	T	p
	Family (caregivers) of Individuals with Schizophrenia N=30 (Mean ± SD	Family (caregivers) of Individuals with Bipolar Affective Disorder N=30 (Mean ± SD			
Financial Burden	8.90±1.34	9.40 ± 1.22	58	-1.50	.137
Disruption of routine family activities	6.66 ± 1.74	6.60 ± 1.32	58	.166	.869
Disruption of family leisure	3.90 ± 1.39	3.46 ± 1.69	58	1.08	.285
Disruption of family interaction	2.56±1.97	4.20 ±1.64	58	-2.70	.009**
Effect of physical health of others	1.46 ± .819	1.23 ± 1.40	58	.785	.436
Effect of mental health of others	2.70 ± 1.08	1.73 ± 1.33	58	3.07	.003**

**Significant level <0.01

Table-2 Shows the comparison of family burden of the caregivers of patients with Schizophrenia and Bipolar Affective Disorder (Mania) using independent t-test. Which indicated that there were significant difference found in the domains of Disruption of family interaction (p=0.009**) and Effect of mental health of others (p=0.003**) in family burden scale.

Table-3: The Correlations between the duration of illness of the patients and domains of family burden in the Family of with Schizophrenia.

Domains of Family Burden Interview schedule	Duration of Illness
Financial Burden	.117
Disruption of routine family activities	.224
Disruption of family leisure	-.237
Disruption of family interaction	-.029
Effect of physical health of others	-.85
Effect of mental health of others	.710**

** Correlation is significant at the 0.01 level

Table-3 Shows correlation between the duration of illness and domains of family burden in the family of individuals with Schizophrenia, which revealed that there was positive relationship found between Effect of mental health of others in family burden domain and duration of illness of the individuals with schizophrenia.

Table-4: The Correlations between the duration of illness and domains of family burden in the Family of individuals with Bipolar Affective Disorder (Mania).

Domains of Family Burden Interview Schedule	Duration of Illness
Financial Burden	.107
Disruption of routine family activities	-.260
Disruption of family leisure	.129
Disruption of family interaction	-.362*
Effect of physical health of others	-.162
Effect of mental health of others	.322

* Correlation is significant at the 0.05 level

Table-4 Shows correlation between the duration of illness of the patients and domains of family burden in the family of individuals with bipolar affective disorder, which revealed that there was negative relationship found between disruption of family interaction in family burden domain and duration of illness of the individuals with bipolar affective disorder (Mania).

DISCUSSION

The present study was conducted at the out patients department (OPD) of the Gwalior Mansik Arogyashala, Gwalior (*Madhya Pradesh.*). The main objective of the study was to assess the family burden in families of patients with Schizophrenia and Bipolar affective disorder (Mania). Findings of the present study should be particularly interesting for mental health practitioner. Burden of family caregivers of the chronic mentally ill impact their financial, physical, emotional and psychological health. Recent models of mental health service provision put an emphasis on community-based treatment and prevention of long-term hospitalization.

The present study is a cross sectional hospital based comparative study based on purposive sampling technique with a total sample size of 60 subjects consisting of 30 family member of individual with Schizophrenia and 30 family member of Bipolar Affective disorder (current episode Mania) diagnosed as per ICD-10 DCR (WHO, 1992). Caring and giving the service to the individuals with mental illness challenging task and it has been found that families with individuals with schizophrenia and bipolar affective disorder have perceived more burden in terms of financial, occupational, physical and mental health. Additionally present study has been quite strict to select the samples as per the stated inclusion and exclusion criteria, so preferably family member or primary caregivers were taken and age range of the caregivers were kept between 18-60 years. Caregivers were taken those who have actively involved in care of the patient (at least more than 2 years). Most relevant instrument has been used “the Family Burden Interview Schedule” (FBIS) to measure the burden of care in the patients’ family.

DISCUSSION OF RESULTS:

Socio-Demographic Characteristics of the Patients:

In the Present study socio demographic result indicated that there was significant difference found in the only Age of the Individuals with schizophrenia and bipolar affective disorder. However there were no significant differences found in the other various socio demographic data. This is because sociodeographic variable matched between both the groups. In the present study the mean duration of illness was 5.70 ± 2.38 years for schizophrenia group and 6.90 ± 3.22 years for bipolar affective group (Mania). The duration of illness was more of bipolar group than schizophrenia because for the bipolar group the current episode illness duration not taken in this study, duration of illness had been taken since the disorder onset first episode. This could be because of in India treatment gap for mental disorders. In the present study it was observed that most of the patients in both the groups were above 30 years of age. Total 86.6% of the patients in schizophrenia group and 76.6% of the patients in bipolar group were above 30 years of age. According to NMHS (2016), people with age group between 30 to 49 years were the most affected by mental disorders (psychotic disorders, bipolar affective disorders [BPADs], depressive disorders, and neurotic and stress-related disorders); contribute to greater morbidity in the productive population. In both the schizophrenia and bipolar groups there were more males than females. This could be just a representation of utilization of the hospital services by male patients as compared to female patients. A similar trend of male preponderance in clinical samples across various diagnostic groups has been observed in the Indian setup. In this context number of referrals of male patients and availability of more number of beds for the male patients. Similarity, total 57.7% of all respondents are male in the National Mental Health Survey (NMHS, 2016).In the present study, a preponderance of Hindu in schizophrenia (93.3 %) and bipolar (90.0 %) groups were found in comparison to the other religions. This could be explained as Hindu is the religion of majority in India and also because of the locality and geographical area from which the patients had come for treatment. Also 73.3 % and 90.0% of patients belong to rural area for both the group schizophrenia and bipolar disorder respectively where the literacy rates are expected to be lower as compared to the suburban and urban areas (Alex, 1998). Recant national mental health survey support our finding as Persons from lower income quintiles, low levels of education and limited employment or unemployment were closely interlinked to mental disorders (NMHS, 2016).

Socio-Demographic Characteristics of the Patients' families:

In the Present study socio demographic Characteristics of the Patients' families indicated that there was significant difference found differences found with regards to the age of the informant (family member) of individuals with Schizophrenia and Bipolar Affective Disorder and there were no significant difference has been found with regards to sex of the informant, duration of stay of the patients and family monthly income.

In the schizophrenia group most of the informant (66.7%) had less than 5000 income in a month where, in the bipolar group 70.0% of the informants were earn less than 5000 in a month. The mean number of family member for both the schizophrenia (6.76) and bipolar (7.03) groups was more or less same. The most of the family member were above 45 years of age in both the group, schizophrenia (46.7%) and bipolar

(60.0%). Most of the family member of schizophrenia (86.7 %) and adults (63.3%) were males. This could be because of the cultural influence that males are generally the decision makers of the family and carry out all the outdoor activities and responsibilities, whereas, women are left behind to look after the household and domestic activities. Also pervious study supports the present study finding (Chakrabarti et al., 1995; Gaina et al., 2019; Roychaudhuri, 1995).

Family Burden in the Family of individuals with Schizophrenia and Bipolar Affective Disorder (Mania):

In the present study both the group schizophrenia and bipolar affective disorder indicated the burden in all the areas such as Financial burden, Disruption of daily routine family activities, Disruption of family leisure time, Disruption of family interaction, Effect of physical health of other, effect of mental health of other on family burden interview schedule. However, there is significant difference found only in the areas of Disruption of family interaction and Effect of mental health of others between the families with schizophrenia and bipolar affective disorder (Mania). The burden of those providing care to patients with chronic diseases as a global problem and has announced that caring for these patients requires continuous energy, knowledge, empathy, and economic power and influences daily living to a large extent. While attempting to establish a balance between their jobs, families, and patient care, caregivers usually neglect their own physical and mental health (Perlick et., 2007; Chan, 2011}

Relationship between the duration of illness of the patients and domains of family burden in the Family of patients with Schizophrenia:

The present study indicated that there was positive relationship found between Effect of mental health of others in family burden domain and duration of illness of the individuals with schizophrenia. When duration of illness increased of the patients, the mental health of the patients' family member is affected or becoming worse. Long duration of illness makes the disease chronic and the caregivers have to spend more time caring for chronic patients, chronic illness carries the potential to impact on the life of the family.

A study 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 (Chang, Chiou, & Chen, 2010; Chang, Chiou, & Chen, 2009; Koukia, & Madianos, 2005). Brown et al (1966) have also suggested that a chronic illness would significantly increase the extent of burden. Thus the pervious finding supports the present study finding.

Relationship between the duration of illness of the patients and domains of family burden in the Family of patients with Bipolar Affective disorder (mania).

The present study indicated that there was negative relationship found between disruption of family interaction in family burden domain and duration of illness of the individuals with bipolar affective disorder (mania). This could be because the family members of the patient have been engaged in their care for a long time and also aware the patient's condition and learn how to handle with the patients symptoms. In differently, bipolar affective disorder manic episodes of the illness are very disruptive to daily life, work and family relationships. Due to this, these episodes place great demands on family members involved in caregiving and longer duration of illness also associated with higher caregiver burden (Borowiecka-Kluza et al, 2013;). Thus the pervious finding not supports the present study finding.

CONCLUSION

The present study was conducted to compare the family burden between caregivers of patients with schizophrenia and bipolar affective disorder (Mania). It can be concluded from the current study that caregivers of both the group, individuals with schizophrenia and bipolar affective disorder (mania) have burden in the terms of financial, leisure time, daily activity routine, physical and mental health.Thus, it would be beneficial to provide psycho education, various treatment availability and scheme and provision related to patient's rehabilitation and welfare to the caregivers of individuals with schizophrenia and bipolar affective disorder to prevent the stigma regarding illness, relapse and encourage them to seek professional health support. Also, it would helpful to provide individual and family supportive psychotherapy to enhance the emotional adjustment and improve the social maturity of the caregivers by teaching them stress and coping strategies.

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