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The Interplay of Psychosocial Dysfunction and Caregiver Burden in Schizophrenia and Obsessive-Compulsive Disorder

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Abstract: *This study aimed to assess and compare the extent and pattern of psychosocial dysfunction and family burden in schizophrenia and obsessive-compulsive disorder, and to identify interrelationships between the two variables in these two disorders. First-degree relatives/spouses of 35 schizophrenic and 30 OCD patients were interviewed using the Dysfunction Analysis Questionnaire and the Family Burden Interview Schedule. Global score and scores in vocational, personal, familial and cognitive areas on the DAQ, and global score, subjective score, and scores on items such as financial burden, disruption of family-routine, disruption of family leisure and disruption of family interactions on the FBIS were significantly higher in the schizophrenic group. Dysfunction in social area was comparable in two groups. OCD group showed a significant positive correlation between dysfunction and all areas of family burden except physical and mental health. Schizophrenic group showed a significant positive correlation between dysfunction and disruption of family interaction. The implications of these findings are discussed.*

Keywords: Psychosocial Dysfunction, Family Burden, Obsessive-Compulsive Disorder

I. INTRODUCTION

Recently, chronic psychiatric patients' disability evaluation has become more significant. Recent studies have examined disability, clinical symptoms, and course in schizophrenia (Cooper & Bostok, 1988) and OCD (Khanna et al, 1988; Rapoport et al, 1992; Leon et al, 1995; Jayakumar et al, 2002a). Caregivers face several psychological challenges from chronic mental diseases. The burden of caring includes such issues. Schizophrenic patients' families reported the most social withdrawal-related behavioral difficulties, such as limited contact, slowness, lack of discussion, few leisure hobbies, and self-neglect, according to Creer & Wing (1975).

Hatfield (1978) noted that the schizophrenia interrupted family social life and leisure and burdened one member. Later research (Pai & Kapur, 1981; Platt, 1985; Lefley, 1987; Fadden et al, 1987; Raj et al, 1991; Illango & Nirmala, 1992; Saldanha et al, 2002; Chakrabarty, 2002) tend to suggest that burden includes family issues caused by the patient's sickness. De-institutionalization and community psychiatry have made burden assessment crucial. Recent interest has focused on how OCD affects family functioning. Family members often participate in their patients' rituals (Cooper, 1994; Calvocoressi et al., 1995; Steketee 1997).

Veltro et al. (1994) examined the hardship important relatives of schizophrenics and neurotic patients endured and sought to link patient personal/social incapacity to family suffering. Family members also adapt their schedules to their relatives' customs. Caring has the greatest impact on a family member with the most responsibilities (Cooper, 1996). OCD has also been linked to marital discord (Emmelkamp et al., 1990; Cooper, 1996), sexual problems (Stabler et al., 1993), financial hardships (Chakrabarty et al., 1993; Cooper, 1996), inability to maintain relationships, particularly with friends, poor family relationships, and decline in family routines, including leisure. Black et al. (1998) found that OCD patients' spouses often experience family/marital/social disruptions, sexual issues, anger/frustration family disputes, and personal concerns. These authors also found that OCD households had worse communication, emotional participation, and functioning.

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Schizophrenia and depressive disorders have dominated Indian family burden research (Nijhawan et al., 1985; Chakrabarti et al., 1992 & 1995; Roychaudhuri, 1995; Thara, 1998). Neurotic disorder studies are few. Chakrabarti et al. (1993) examined dysthymia, GAD, and OCD families' load. Jayakumar et al. (2002b) found substantially high mean scores for domains, spouse-related factors, and care giver's burden assessment schedule in a comparative comparison of OCD and schizophrenia important relatives' burden of care. OCD spouses and jobless caregivers had considerably higher mean overall burden ratings. Only Black et al. (1998) and Jayakumar et al. (2002) have comprehensively researched OCD's effects on family members.

Even Black et al.'s research has a major limitation: the caregiver difficulty measure is not standardized. Few research compare psychosocial dysfunction and family strain in psychotic and non-psychotic diseases. Thus, this study examined the amount and pattern of psychosocial dysfunction of patients and family stress in schizophrenia and OCD and their interactions.

II. MATERIALS AND METHODS

The Out-Patient Department of the Central Institute of Psychiatry, Ranchi, Bihar, India, was the site of this investigation from September 1995 to March 1996. Consecutive cases that met the following inclusion criteria were selected from both sample groups: (a) patients of either sex within the age range of 15-50 years, (b) ICD-10 diagnosis of schizophrenia and OCD, (c) illness lasting at least two years, (d) a first-degree relative or spouse who is physically and mentally healthy, aged 18 or older, and has resided with the patient for at least the previous three years. (e) written informed assent Patients with co-morbid psychiatric illness, chronic physical illness, and another family member with a psychiatric or chronic physical illness were excluded.

Tools

Pershad et al. (1985) developed the Dysfunction Analysis Questionnaire (DAQ). The DAQ is a standardized instrument that comprises 50 items that are categorized into five categories: cognitive, personal, familial, vocational, and social. Five alternate answers are provided for each item, and they are rated on a scale of 1 to 5. The dysfunction is more pronounced when the ratings are higher. The test-retest and split-half reliabilities of the scale are highly satisfactory, with values ranging from 0.77 to 0.97. (b) The Family Burden Interview Schedule (FBIS) was created by Pai and Kapur in 1981.

This is a semi-structured interview schedule that consists of 24 items that are categorized into six topics: financial burden, disruption of routine family activities, family leisure, family interactions, and the impact on the physical and mental health of others. The schedule also includes a standard query to evaluate the "subjective" burden, and each item is rated on a three-point scale. The scale's reliability and validity have been demonstrated to be adequate. The authors of the schedule reported that the inter-rater reliability for all items was greater than 0.78.

The severity of the illness was not measured using rating instruments, as the study was intended to be conducted on a single occasion of assessment. Therefore, the DAQ was administered to the relative, and their perspective on the patients' psychosocial dysfunction was recorded. The Chi-square test and the Student's t-test were employed to compare qualitative and quantitative variables between the groups, respectively. Pearson's product moment correlation coefficient was implemented to evaluate correlations.

Results

The survey cohort was composed of 35 schizophrenics and 30 OCD patients, as well as their first-degree relatives/spouses. The sociodemographic and clinical characteristics of the patients were similar in both groups, with the exception of gender and a history of substance addiction. The OCD cohort was dominated by females. The schizophrenic group had a considerably higher number of patients with a positive history of substance addiction. Table 2 illustrates the comparison of global and area-wise DAQ scores in schizophrenia and OCD. In the schizophrenic group, the global score, vocational, personal, familial, and cognitive area scores were significantly higher.

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Table 1: Socio-demographic and clinical characteristics of Schizophrenic and OCD Patients

Variable	Schizophrenia N=35	OCD N=30	Significance
Age (years)	31.43 (8.09)	31.10 (9.75)	t=0.15 NS
Gender Male Female	28 (80) 7 (20)	10 (33.33) 20 (66.67)	c=5.16 ***
Age of onset of illness (years)	24.34 (6.40)	24.25 (10.18)	t=0.04 NS
Duration of illness (years)	7.06 (6.83)	5.13 (5.37)	t=1.28 NS
History of sub- stance abuse Yes No	10 (28.57) 25 (71.43)	1 (3.33) 29 (96.67)	c=5.63 *
Family history of mental illness Yes No	15 (42.86) 20 (57.14)	15 (50) 15 (50)	c=0.33 NS
Type of family Nuclear Joint	22 (62.86) 13 (37.14)	21 (70) 9 (30)	c=0.37 NS
Monthly family income Below Rs. 2500 Rs.2500-5000 Above Rs.5000	7 (20) 17 (48.57) 11 (31.43)	3 (10) 10 (33.33) 17 (56.67)	c=4.54 NS

Table 2: Comparison of Dysfunction Scores between Schizophrenic and OCD Patients

	Schizophrenia Mean (SD)	OCD Mean (SD)	Significance
Social area	36.57 (10.54)	34.26 (5.87)	t=0.112 NS
Vocational area	41.00 (10.89)	35.93 (7.13)	t=2.250 *
Personal area	41.00 (6.57)	32.33 (5.66)	t=5.726 ***
Familial area	40.91 (8.06)	31.93 (6.86)	t=4.861 ***
Cognitive area	37.34 (6.83)	28.17 (6.85)	t=5.399 ***
Global score	197.37 (31.87)	163.83 (21.42)	t=5.037 ***

Table 3 shows comparison of global and area-wise FBIS scores in schizophrenia and OCD. The financial burden, disruption of family routine, disruption of family leisure, disruption of family interactions, effect on physical and mental health, global burden, and subjective burden scores were significantly higher in the schizophrenic group.

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Table 3: Comparison of Family Burden Scores between relatives of Schizophrenic and OCD Patients

Variable	Schizophrenia Mean (SD)	O C D Mean (SD)	A. Level of Significance
B. Financial burden	4.54 (2.13)	3.16 (2.35)	t=2.464 *
Disruption of family routine	5.97 (2.35)	3.73 (2.39)	t=3.767 ***
Disruption of family leisure	4.23 (1.95)	3.00 (2.24)	t=2.337 *
Disruption of family interactions	4.91 (2.28)	3.13 (2.16)	t=3.227 ***
Effect on physical health	0.83 (1.05)	0.43 (0.67)	t=1.849 NS
Effect on mental health	1.17 (0.91)	0.90 (0.47)	t=1.543 NS
Global burden score	21.74 (7.50)	14.23(7.62)	t=3.998 ***
Subjective burden score	1.60 (0.49)	1.30 (0.46)	t=2.652 *

Table 4 shows the correlations between objective family burden and other relevant variables in schizophrenia and OCD. Objective family burden score was positively & significantly correlated with subjective burden in both the groups. Psychosocial dysfunction of OCD patients was significantly associated with objective family burden.

Table 4: Correlations between Objective Family Burden and other Relevant Variables in Schizophrenia & OCD

	Monthly income	Duration of illness	Duration of treatment	Psycho- social dysfunction	Sub- jective burden
Objective Family Burden in Schizo- phrenia	-0.210 NS	0.110 NS	0.142 NS	0.275 NS	0.741 **
Objective Family Burden in OCD	0.272 NS	0.277 NS	0.033 NS	0.682 **	0.686 **

Table 5 shows the correlations between psychosocial dysfunction of patients and areas of family burden in schizophrenia and OCD. In schizophrenia, there was a significant relationship only between dysfunction and disruption of family interactions. In OCD, there were significant positive correlations between dysfunction and financial burden, disruption of family routine, disruption of family leisure, and disruption of family interactions.

Table 5: Correlations between Dysfunction of Patients and Areas of Family Burden in Schizophrenia & OCD

	Financial Burden	Disruption of Family Routine	Disruption of Family Leisure	Disruption of Family Interactions	Effect on Physical Health	Effect on Mental Health
Dysfunction of Schizophrenic patients	0.194 N S	0.224 N S	0.281 N S	0.665 **	0.179 N S	-0.059 N S
Dysfunction of OCD patients	0.466 **	0.466 *	0.775 **	0.762 **	0.336 N S	-0.012 N S

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III. DISCUSSION

Research has consistently underlined the importance of the family in psychiatric disorders. Most of the well-designed studies have focused on families of schizophrenic and affective disorder patients. Non-psychotic disorders have been relatively neglected. The present study arose from the concern that non-psychotic patients, particularly OCD patients, also have dysfunction in psychosocial areas and that these families experience considerable burden due to the ill member. The findings of the present investigation reveal that patients with schizophrenia have more psychosocial dysfunction than the OCD group.

However, there was no significant difference between schizophrenic and OCD patients with regard to dysfunction in the 'social area'. This shows that both schizophrenic and OCD patients were equally impaired in social functioning. Dysfunction in other areas such as vocational, personal, familial and cognitive functioning was significantly high in schizophrenic group. These groups differed significantly with regard to global dysfunction as well. This finding is in conformity with the results of the study by Veltro et al (1994). In the present study, families of schizophrenic patients reported greater burden than the OCD group.

This finding is not in line with assessment by Veltro et al (1994) who found only modest qualitative and quantitative difference between key relatives of schizophrenic and neurotic patients with regard to their perception of burden. In the present investigation, it was found that family finances, family routine, family leisure and family interactions were particularly affected. Financial burden was primarily a direct outcome of the loss of the patient's income, and secondarily due to expenses of treatment. In the present study many relatives of schizophrenics had reported that the illness of their kin had considerably reduced their savings; some families were even forced to take loans. Jayakumar et al (2002b) in a comparative analysis of the burden of care between the key relatives of OCD and schizophrenia reported significantly high burden in OCD group especially in spouse and unemployed caregivers.

Some possible reasons for the greater extent of burden in OCD could be due to longer duration and increased severity of symptoms, which the authors have not specifically addressed. However, in this study the difference was not due to the duration of illness or duration of treatment as they were comparable in both groups. Disruption of family routine was another area in which burden was experienced in schizophrenia. Most families found the patient's inability to work distressing and inconvenient. Disruption of family interactions was another important and significant aspect of burden in schizophrenics. As a consequence of the patient's illness, family members tended to be tense and irritable, and had frequent misunderstandings among themselves about caring for the patient.

A significant number of caregivers of schizophrenic patients reported reduced interaction with friends and neighbours. Creer & Wing (1975) reported that families of schizophrenics experienced a great deal of internal distress and physical, financial and emotional burden. Hatfield (1978) found that schizophrenic patients disrupted the family's social life and leisure. Tynes et al (1990) found that relatives experienced frustration with the symptomatic behaviour of their family member with OCD. The mental and physical health of family members can be affected if an index patient has a psychiatric disorder.

The burden of illness on mental and physical health of the family members was, however, comparable in the two groups, suggesting an equal impact in both the illnesses. The extent and pattern of family burden in schizophrenia in this study is in conformity with the findings reported from India (Gautam & Nijhawan, 1984; Ali & Bhatti, 1988; Gopianth & Chathurvedi, 1992; Chakraborti et al, 1993; 1995; and Roychaudhuri et al, 1995). Certain socio-cultural factors unique to the Indian setting (Giel et al, 1983) would have contributed to this particular pattern of burden. For generations, life in India revolved around the joint family

IV. CONCLUSION

Both schizophrenia and obsessive-compulsive disorder (OCD) lead to significant psychosocial dysfunction and place a considerable burden on families. Individuals with schizophrenia often experience severe cognitive and emotional disturbances, leading to challenges in daily functioning, social interactions, and employment, which in turn impacts their family members' emotional and financial well-being. OCD, although often perceived as less disabling, can also severely disrupt the quality of life of affected individuals and their families due to the compulsive behaviors and intrusive thoughts. Families of individuals with either condition often assume caregiving roles that can lead to stress, anxiety, and social isolation, as they navigate the complexities of managing the symptoms, treatment adherence, and the

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social stigma associated with these disorders. Addressing these issues through comprehensive support for both patients and their families is essential for improving outcomes and enhancing the overall well-being of those affected by these conditions.

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