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Research Paper

A Comparative Analysis of Socio-Economic Status, Marital Quality, and Family Functioning in Caregivers of Individuals with Schizophrenia and Bipolar Affective Disorder

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ABSTRACT

Background: Caregiving for individuals with severe mental illnesses such as Schizophrenia and Bipolar Affective Disorder (BPAD) presents significant challenges that affect the caregiver's socio-economic status, marital quality, and family functioning. These impacts are often intensified by the chronic nature of the disorders and the emotional and financial strain placed on families. **Objective:** This study aimed to comparatively assess the socio-economic status, marital quality, and family functioning among caregivers of individuals diagnosed with Schizophrenia and BPAD. **Methods:** A descriptive, cross-sectional study was conducted with 100 primary caregivers (50 each for Schizophrenia and BPAD patients) recruited from two psychiatric institutions in Pune, India. Standardized tools were used, including the Modified Kuppuswamy Socio-Economic Status Scale, Marital Quality Scale (MQS), and the McMaster Family Assessment Device (FAD). Data were analyzed using SPSS version 20.0. **Results:** Findings revealed that financial stability significantly influenced marital quality and family functioning. Caregivers with higher socio-economic status reported greater marital satisfaction, understanding, and decision-making ability. Conversely, financial hardship correlated with despair, dominance, and marital instability. **Conclusion:** The study highlights the need for psychosocial interventions, including financial planning, marital counseling, and caregiver support, to mitigate the negative impact of caregiving on family life. Understanding the nuances of caregiving in Schizophrenia versus BPAD can guide targeted strategies to enhance caregiver well-being and family cohesion.

Keywords: *Caregiving, Schizophrenia, Bipolar Affective Disorder, Marital Quality, Socio-Economic Status, Family Functioning*

Schizophrenia is among the most complex and debilitating psychiatric disorders, characterized by persistent psychotic symptoms, cognitive impairment, and social dysfunction (Insel, 2010; Owen, Sawa, & Mortensen, 2016). It typically manifests in late adolescence or early adulthood a critical period marked by academic, occupational, and relational transitions (Kessler et al., 2007). Early symptoms may be subtle and often go

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unrecognized, worsening over time and requiring sustained pharmacological and psychosocial interventions (Tandon, Nasrallah, & Keshavan, 2009).

Bipolar Affective Disorder (BPAD), classified under mood disorders, is marked by recurrent episodes of mania and depression. The presence of at least one manic or hypomanic episode distinguishes BPAD from unipolar depression (APA, 2013). Manic episodes are often characterized by elevated mood, impulsivity, and psychotic features such as grandiosity or persecutory delusions (Goodwin & Jamison, 2007). These mood fluctuations disrupt daily functioning and interpersonal relationships, leading to substantial caregiver burden.

Providing care for individuals with schizophrenia or BPAD is emotionally taxing and long-term in nature. Caregivers frequently face elevated stress, psychological distress, financial strain, and diminished quality of life (Perlick et al., 2007; Chakrabarti, 2016). These stressors can adversely affect marital relationships and family cohesion, particularly when compounded by limited economic resources (Awad & Voruganti, 2008; Dillehay & Sandys, 1990).

Caregiving for individuals with severe mental illnesses such as schizophrenia and bipolar disorder is often a long-term and emotionally demanding responsibility. Both conditions, though clinically distinct, are chronic and significantly disrupt the lives of not only the individuals diagnosed but also their caregivers (Perlick et al., 2007; Chakrabarti, 2016). Schizophrenia is marked by persistent psychotic symptoms, cognitive impairments, and social dysfunction (Insel, 2010; Tandon et al., 2009), while bipolar disorder is characterized by alternating episodes of mania and depression that can lead to instability in daily life and relationships (Goodwin & Jamison, 2007; APA, 2013). Caregivers of these individuals often experience high levels of psychological stress, financial burden, and emotional exhaustion, all of which can strain marital relationships and disrupt family functioning (Awad & Voruganti, 2008; Dillehay & Sandys, 1990). These challenges are also influenced by the caregiver's socio-economic status, the quality of their marital relationship, and the overall health of family dynamics (Saunders, 2003; Shah, 1995). By comparatively assessing these factors among caregivers of individuals with schizophrenia and bipolar disorder, the current study aims to provide a clearer understanding of the caregiving experience and support the development of more effective psychosocial interventions.

MATERIAL AND METHODS

This study aimed to comparatively assess the socio-economic status, marital quality, and family functioning among caregivers of individuals diagnosed with Schizophrenia (Group-1) and Bipolar Affective Disorder (Group-II). The research was conducted at two leading psychiatric care institutions: the Maharashtra Institute of Mental Health and Sassoon General Hospital, Pune, covering both inpatient and outpatient departments.

A cross-sectional descriptive research design was adopted to assess caregiving experiences. Purposive sampling was used to recruit participants who met the study's inclusion criteria. A total of 100 caregivers were selected as the final sample size. This group consisted of 50 caregivers of individuals with Schizophrenia (Group-1) and 50 caregivers of individuals with BPAD (Group-1). All participants were primary caregivers residing with the diagnosed individual and directly involved in day-to-day caregiving tasks. Caregivers and individuals diagnosed with schizophrenia and bipolar affective disorders as per ICD-10, duration of illness more than a year, and age range of individual with Schizophrenia and Bipolar

Disorders between 20 years to 50 years. Caregivers age 20 years to 55 years, and staying with individuals more than two years were included from the study. Caregivers having comorbidity of psychiatric illness or any severe physical illness were excluded from the study. Paid or temporary caregivers and individuals having comorbidity of other psychiatric illness, substance dependence and dule diagnoses were excluded from the study.

Socio-Demographic and Clinical Data Sheet: A self-prepared socio-demographic and clinical data sheet was developed for the study. This instrument collected detailed information regarding participants' age, gender, education, occupation, marital status, income level, and other relevant demographic variables. It also included clinical data such as the history of present illness, psychiatric and medical history, family psychiatric history, and clinical diagnosis, as recorded during psychiatric evaluations.

Socio-Economic Status Scale: The Modified Kuppuswamy Socio-Economic Status Scale was used to assess the socio-economic status of caregivers. This scale, originally proposed by Kuppuswamy (1976), remains one of the most widely accepted tools for assessing SES in urban and rural populations in India. It evaluates three parameters: the education and occupation of the head of the household, and the family's monthly income. Based on the cumulative score (ranging from 3 to 29), individuals are classified into five socio-economic classes, offering a standardized framework for research and social assessment. The Kuppuswamy scale is consistently rated as reliable in Indian sociological and health research contexts. Test-retest reliability has been reported to be moderate to high. (Kuppuswamy, 1976).

Marital Quality Scale (MQS): The Marital Quality Scale, developed by Shah (1995), was employed to measure the perceived quality of marital relationships among the participants. This scale consists of 50 self-report items organized across 12 factors, including understanding, rejection, satisfaction, affection, despair, decision-making, discontent, dissolution potential, self-disclosure, trust, and role functioning. Standardized on an Indian population, the MQS has demonstrated strong reliability and validity, especially in distinguishing individuals experiencing marital discord from those in harmonious relationships. The MQS demonstrates strong internal consistency, with Cronbach's alpha coefficients for the subscales typically exceeding 0.70, indicating good reliability (Shah, 1995).

Family Functioning Scale: To evaluate family functioning, the study utilized the McMaster Family Assessment Device (FAD), developed by Epstein et al. (1987). Based on the McMaster Model of Family Functioning, the FAD is a 60-item self-report questionnaire that assesses how family members perceive their family's overall functioning. It covers seven dimensions, including problem-solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. Items are rated on a 4-point Likert scale, from "Strongly Agree" to "Strongly Disagree." Scores are calculated by averaging the responses for each dimension, providing comprehensive insight into family strengths and areas requiring intervention. The FAD has shown excellent internal consistency, with Cronbach's alpha values generally ranging from 0.72 to 0.92 across the seven subscales (Epstein, Baldwin, & Bishop, 1983).

After collecting the data, it was organized and coded into a structured format. The data was then analysed using IBM-SPSS (Statistical Package for Social Sciences) version 20.0 for appropriate statistical analysis.

RESULTS

Table 1 shows the socio-demographic profile of the participants from Group I (Schizophrenia) and Group II (Bipolar Affective Disorder). The study found no significant differences between caregivers of schizophrenia and BPAD patients in terms of family income, mother tongue, family type, domicile, duration of illness, or number of hospitalizations. Most caregivers from both groups had a family income of less than INR 15,000, spoke Marathi, and belonged to joint families. Additionally, caregivers were primarily from urban areas, and the duration of illness was mostly between 0-10 years. The number of hospitalizations was similar for both groups, with the majority reporting 0-5 hospitalizations. Overall, socio-demographic and clinical characteristics were comparable between the two caregiver groups.

Table No. 1: Socio-demographic characteristics among the participants of Group-I (n=50) & Group-II. (n=50)

Variable		Group – I (n=50)	Group – II (n=50)	χ^2	df	P
Gender of Spouse	Male	24	27	0.601	1	0.438
	Female	26	23			
Education of Patient	Illiterate	5	6	2.81	5	0.72
	Primary	12	10			
	Secondary	13	14			
	Higher Secondary	8	8			
	Graduate	7	5			
	PG and above	5	7			
Occupation of Patient	Farmer	9	11	0.94	5	0.96
	Business	10	9			
	Professional	7	8			
	Housewife	7	8			
	Service	6	5			
	Other	11	9			
Family Income	<15000	11	14	4.08	5	0.53
	16000-30000	16	18			
	31000- 45000	15	13			
	>46000	8	5			
Family Type	Joint	22	29	0.78	2	0.67
	Nuclear	28	21			
Domicile of Patient	Rural	16	15	0.13	2	0.93
	Semi-urban	13	15			
	Urban	21	20			

Table no. 2: Comparison of Family assessment scale variables among Group-I & group-II (N=100)

Variables	Group I M±SD (n=50)	Group II M±SD (n=50)	t (df=98)	P Value
Problem solving	11.83±2.19	13.86±2.93	3.038	0.004
Communication	12.16±2.85	14.20±2.51	3.038	0.005
Role	18.90±4.05	16.56±2.41	2.93	0.009
Affective Responsiveness	16.03±3.61	13.06±2.08	2.93	0.000
Affective Involvement	19.13±4.21	15.06±2.86	2.70	0.000
Behaviour Control	18.03±4.88	23.50±3.32	2.70	0.000
General Functioning	23.23±5.38	27.03±3.22	3.89	0.002

Table no. 2 shows that comparative assessment of family assessment on schizophrenia and bipolar affective disorder patients' caregivers. Data shows that Group II scored significantly higher than Group I in problem-solving and communication, with t-values of 3.038 and p-values of 0.004 and 0.005, respectively. Group I showed significantly better family role functioning than Group II, with a t-value of 2.93 and a p-value of 0.009. Group I also had significantly higher scores in affective responsiveness and affective involvement compared to Group II, with p-values of 0.000 for both. Group II outperformed Group I in behavior control and general family functioning, with t-values of 2.70 and 3.89, and p-values of 0.000 and 0.002, respectively.

Table no. 3 shows that comparative assessment of marital quality in schizophrenia and bipolar affective disorder patients' caregivers. The findings from the **Marital Quality Scale** show that there were no significant differences between caregivers of schizophrenia (Group I) and bipolar affective disorder (BPAD) patients (Group II) in terms of marital understanding ($p = 0.484$), rejection ($p = 0.832$), satisfaction ($p = 0.424$), despair ($p = 0.944$), decision-making ($p = 0.115$), dissolution potential ($p = 0.636$), dominance ($p = 0.248$), and self-disclosure ($p = 0.599$). The only minor difference was in affection, where Group I (schizophrenia caregivers) had slightly higher scores than Group II (BPAD caregivers), but this difference was also not statistically significant ($p = 0.194$). Thus, marital quality between the two groups was generally similar across the various dimensions assessed.

Table no. 3: Comparison of marital quality scale in Group-I & Group-II

Variables	Group I (n=50)	Group II (n=50)	t (df=98)	P Value
Marital Quality Scale				
Understanding	13.03±2.56	12.53±2.92	3.89	0.484
Rejection	12.23±1.77	12.43±1.85	4.37	0.832
Satisfaction	12.40=2.40	12.90=2.41	4.37	0.424
Affection	12.13±2.67	11.36±1.75	5.06	0.194
Despair	11.46±1.71	11.43±1.92	5.06	0.944
Decision Making	11.86±2.35	13.00±3.08	3.31	0.115
Dissolution Potential	13.30±2.26	13.63±3.10	3.31	0.636
Dominance	12.53±2.77	13.40±2.97	0.70	0.248
Self-Disclosure	12.53±1.97	12.26±1.92	0.70	0.599

Table no. 4: Comparison of Socio-Economic Status among Group-I & Group-II

Variables	Group I Schizophrenia	Group II BPAD	t (df=98)	P Value
Socio-Economic Status Scale				
SES Total	21.73±4.40	20.90±4.72	9.8	0.483

Table No. 4 shows the socio-economic status of the schizophrenia and bipolar affective disorder patients' family income, in group I mean SD is 21.73±4.40 and in group II mean SD is 20.90±4.724, in both groups df is 58 and the P value is 0.483, which means there was no significant difference.

DISCUSSION

The results of this study underscore the significant influence that socio-economic status, marital quality, and family functioning have on caregivers of individuals with Schizophrenia and Bipolar Affective Disorder (BPAD). The findings emphasize that financial stability is a critical factor in shaping both the marital quality and family dynamics of caregivers. Caregivers with better financial conditions reported better understanding, satisfaction, and decision-making ability in their marriages.

The study's findings highlight the substantial impact that family functioning, marital quality, and socioeconomic position have on those who care for people with schizophrenia and bipolar affective disorder (BPAD). One important factor influencing family dynamics and marital quality has been identified as financial stability. Better financial circumstances were associated with improved marital decision-making skills, more understanding, and increased happiness among caregivers. On the other hand, caregivers who were struggling financially were more likely to suffer feelings of hopelessness, control, and marital instability. These results are consistent with other studies that show the significant financial burden faced by caregivers of individual with severe mental illness. (González-Blanco et al., 2018). With its distinct family structures and dependence patterns, India's socioeconomic setting may amplify these effects even more, highlighting the significance impacts of emphasizing the importance of context-specific interventions (Shah, 1995).

Although previous research has extensively documented the burden and stress experienced by caregivers of people with severe mental illnesses, few studies have compared caregivers of people with bipolar affective disorder (BPAD) and schizophrenia across multiple psychosocial domains (Awad & Voruganti, 2008; Perlick et al., 2007). This study is unusual because it thoroughly examines three significant but understudied aspects in two distinct caregiver groups: socioeconomic level, marriage quality, and family functioning.

Notably, it generates context-specific insights by utilizing proven and standardized methods in a real-world Indian clinical scenario (Kuppuswamy, 2017; Epstein, Baldwin, & Bishop, 1983; Miller et al., 1985). The study provides a multifaceted perspective of the caregiving experience by concurrently evaluating various overlapping elements, which aids in the development of focused psychosocial therapies suited to caregiver issues particular to a certain condition (Saunders, 2003; Shah, 1995).

Emotional support and effective communication were highly associated with successful marriages. Dominance, hopelessness, and the possibility for breakup were linked to bad marital experiences, whereas understanding, contentment, and decision-making skills were

linked to stronger marriages (Shah, 1995). This implies that maintaining marriage quality among caregivers may need psychosocial therapies targeted at enhancing communication abilities and offering emotional support.

The results also emphasize the adversity of long-term caring, especially for those who look after people with schizophrenia and Bipolar disorders. Due to the early onset and chronic nature of schizophrenia, patients typically experience problems finding work, which leads to extended caregiving durations and increasing financial reliance (Magliano et al., 2005). Furthermore, caregivers' difficulties are exacerbated by the social stigma associated with schizophrenia, which limits their access to financial and social resources (Corrigan et al., 2017). On the other hand, during mood episodes, caregivers of BPAD patients endure significant stress. Manic periods are typified by impulsive actions like excessive spending or adultery, whereas depressed phases are defined by emotional withdrawal and increasing dependence (Goodwin & Jamison, 2007). These circumstances exacerbate emotional tiredness and caregiving burnout, which damage marriages. (Reinares et al., 2016; Rosa et al., 2010).

A comparative analysis of marital quality between caregivers of schizophrenia and BPAD patients revealed no statistically significant differences across various domains, including understanding, satisfaction, affection, decision-making, and self-disclosure. This indicates that despite differences in illness progression and symptomatology, the overall impact on marital quality may be comparable in these two groups. These results align with previous studies that similarly report parallel levels of marital satisfaction disruption among caregivers across different severe mental illnesses (Juvang et al., 2007; Rosa et al., 2010). However, it is important to note that our cross-sectional design limits causal inferences, and future longitudinal studies are needed to explore changes over time.

Research has shown that caregivers of people with schizophrenia have higher levels of marital stress and worse levels of satisfaction. This is mostly because of the emotional instability and social disengagement of these patients, which lowers emotional reciprocity (Gutiérrez-Maldonado et al., 2005; Juvang et al., 2007). According to Reinares et al. (2016), caregivers of BPAD patients, on the other hand, report varying levels of marital satisfaction according on the stage of the disease, with more challenges during manic or depressed periods. González-Blanco et al. (2018) observed that caregivers with schizophrenia experienced greater levels of marital unhappiness than caregivers with BPAD. They highlighted forgiveness and compassion as important variables that promote marital satisfaction in both groups.

Limitations

This study's cross-sectional design and sample size limit the ability to establish causality or generalize findings broadly. Additionally, self-report measures may be subject to social desirability bias. Future research should consider longitudinal designs and mixed methods approaches to deepen understanding.

Implications for Practice

The study highlights the critical need for targeted psychosocial interventions for caregivers, including financial planning support, marital counseling, and family therapy. Such interventions should be culturally sensitive and adapted to the specific challenges faced by caregivers of schizophrenia and BPAD patients.

CONCLUSION

The findings of this study highlight the complex and interconnected relationship between socio-economic status, marital quality, and family functioning for caregivers of individuals with schizophrenia and BPAD. The results reinforce the need for financial support, psychosocial interventions, and relationship counseling to improve the caregiving experience and marital satisfaction. Financial stability and emotional support play a significant role in enhancing the well-being of caregivers and improving family dynamics, particularly for caregivers of individuals with schizophrenia. Future interventions should focus on providing resources to caregivers, including mental health support, financial planning assistance, and marital counseling, to foster healthier caregiving environments for individuals with mental illness.

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Conflict of Interest

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