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Original Research Article

Caregiver Burden In Patients Of Schizophrenia And Bipolar Disorder.

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Abstract: ***Background: Aim:*** To assess and compare caregiver burden among caregivers of patients with schizophrenia and bipolar disorder attending the Department of Psychiatry, SMMH Medical College, Saharanpur. ***Methods:*** A comparative cross-sectional study was conducted among 200 primary caregivers, comprising 100 caregivers of patients with schizophrenia and 100 caregivers of patients with bipolar disorder. Patients were diagnosed according to standard diagnostic criteria and caregivers fulfilling predefined eligibility criteria were included. Sociodemographic and clinical information was collected using a structured proforma. Caregiver burden was assessed using the 40-item Burden Assessment Schedule (BAS). Appropriate descriptive and inferential statistical tests were applied. ***Results:*** The mean age of caregivers was 46.2±11.8 years in the schizophrenia group and 44.7±12.1 years in the bipolar disorder group. The mean duration of caregiving was significantly longer among caregivers of patients with schizophrenia (8.4±5.5 years versus 6.6±4.9 years; p=0.016). The mean BAS total burden score was significantly higher among caregivers of patients with schizophrenia than among caregivers of patients with bipolar disorder (72.8±13.6 versus 66.4±12.8; p<0.001). Significantly greater burden among schizophrenia caregivers was observed particularly in the domains of external support, caregiver routine, support of the patient, taking responsibility, other relationships and patient behaviour. Duration of illness, duration of caregiving, number of hospitalizations, patient disability and illness severity were positively associated with caregiver burden. ***Conclusion:*** Caregivers of patients with both schizophrenia and bipolar disorder experience substantial burden, suggesting greater overall burden among caregivers of patients with schizophrenia. Longer illness duration, greater disability, greater illness severity and recurrent hospitalization were associated with increased burden. Routine assessment of caregiver burden and incorporation of caregiver-focused psychoeducation, family interventions and psychosocial support into psychiatric care may help reduce the impact of caregiving.

Keywords: Caregiver Burden; Schizophrenia; Bipolar Disorder; Burden Assessment Schedule; Family Caregivers; Severe Mental Illness; Psychiatry.

INTRODUCTION

Severe mental disorders affect not only the individual but also the family and wider social environment. Schizophrenia is characterized by disturbances in perception, cognition, behaviour and emotional functioning and is frequently associated with persistent functional impairment. Bipolar disorder is characterized by recurrent episodes of mania, hypomania and depression, with significant effects on interpersonal, occupational and social functioning. Both disorders may require long-term treatment, monitoring and family support.

Family members have an especially important role in

the care of persons with severe mental illness. In many developing countries, including India, family members remain the principal source of support for patients because of the limited availability of long-term community-based psychiatric services. Consequently, caregivers may be responsible for treatment supervision, accompanying patients to healthcare facilities, managing disturbed behaviour, providing financial assistance and helping with activities of daily living. The concept of caregiver burden encompasses the physical, psychological, social and financial consequences experienced by individuals caring for a relative with chronic illness. Pai and Kapur developed an interview schedule to assess family burden associated with psychiatric illness and demonstrated that caring for a psychiatric patient could substantially affect family functioning.1

The Burden Assessment Schedule (BAS) was subsequently developed in India by Thara et al. to assess both objective and subjective burden among caregivers of persons with chronic mental illness. The instrument was developed using stepwise ethnographic methods and underwent reliability and validity assessment. The BAS consists of 40 items and was specifically designed to be relevant to the sociocultural context of Indian families.2

Caregiver burden in schizophrenia has been demonstrated consistently. Caregivers may experience disruption of their daily routine, reduced social interaction, financial difficulties, emotional distress and concerns regarding the future of the affected relative. The burden may be particularly pronounced when patients have persistent symptoms, poor functioning or recurrent hospitalizations. Vasudeva et al. directly compared caregivers of patients with schizophrenia and bipolar disorder using the BAS. Their study included 52 patients with schizophrenia and 51 with bipolar disorder and demonstrated significantly greater total caregiver burden among caregivers of patients with schizophrenia. Greater burden was particularly observed in the domains of external support, caregiver routine and other relationships.3

However, the literature does not consistently demonstrate greater burden in schizophrenia. Chadda et al. followed 100 caregivers of patients with schizophrenia and 100 caregivers of patients with bipolar affective disorder for six months and found that caregiver burden remained relatively stable and was comparable between the two groups.4 Their findings indicate that the caregiving experience may be influenced by factors other than diagnostic category. A systematic review by Karambelas et al. examined 28 comparative studies involving 6166 caregivers of people with schizophrenia-spectrum disorders or bipolar disorder. Fourteen studies found comparable caregiver burden between the two groups, and caregiver psychological outcomes were also generally comparable. The authors emphasized that symptoms and functional difficulties may affect caregivers more strongly than diagnostic category itself.5

Caregivers of people with bipolar disorder nevertheless experience substantial burden. A systematic review by van der Voort et al. found high levels of both objective and subjective burden among caregivers of patients with bipolar disorder. Burden was associated particularly with symptom severity, difficulties in the caregiver-patient relationship, inadequate support and stigma.6 Perlick et al., in the STEP-BD Family Experience Study involving 500 caregivers, reported substantial burden associated with patient problem behaviours, role dysfunction and disruption of household routine. Higher caregiver burden was also associated with poorer physical and mental health, greater healthcare utilization and reduced social support.7

Indian research has similarly demonstrated associations between caregiver burden and illness-related factors. Kate et al. found relationships between caregiver burden, coping strategies, psychological morbidity, quality of life, patient psychopathology and level of functioning among caregivers of patients with schizophrenia.8 Caregiver burden is therefore an important clinical outcome that should be considered alongside patient-centred outcomes. Recognition of burden may facilitate early psychosocial intervention, family psychoeducation and appropriate support for caregivers. The present study was undertaken in the Department of Psychiatry, SMMH Medical College, Saharanpur, with the aim of assessing and comparing caregiver burden among caregivers of patients with schizophrenia and bipolar disorder. The objectives of the study are as below:

1. To assess caregiver burden among caregivers of patients with schizophrenia.
2. To assess caregiver burden among caregivers of patients with bipolar disorder.
3. To compare caregiver burden between the two diagnostic groups.
4. To assess the relationship between caregiver burden and selected sociodemographic and clinical variables.

MATERIALS AND METHODS

A comparative cross-sectional study was conducted in the Department of Psychiatry, SMMH Medical College, Saharanpur, Uttar Pradesh, India. The study population comprised patients diagnosed with schizophrenia or bipolar disorder and their primary caregivers attending the psychiatry outpatient and inpatient services of the institution. The study was conducted over a period of 6 months. The study was conducted after obtaining approval from the Institutional Ethics Committee of SMMH Medical College, Saharanpur. Written informed consent was obtained from all participants. Participants were informed that participation was voluntary and that

refusal to participate would not affect treatment. Confidentiality of personal and clinical information was maintained.

Sample size: A total of 200 caregivers were considered:
- 100 caregivers of patients with schizophrenia
- 100 caregivers of patients with bipolar disorder

The equal allocation was selected to facilitate comparative analysis.

Sampling technique: Participants were recruited using consecutive sampling from eligible patients attending the psychiatry services during the study period.

Inclusion criteria

Patients

1. Patients aged ≥18 years.
2. Patients fulfilling diagnostic criteria for schizophrenia or bipolar disorder.
3. Patients having an identifiable primary caregiver.
4. Patients and caregivers willing to participate.

Caregivers

1. Age ≥18 years.
2. Identified as the primary caregiver by the patient/family.
3. Regularly involved in the care of the patient.
4. Willing to provide informed consent.

Exclusion criteria

1. Caregivers with severe cognitive impairment interfering with assessment.
2. Caregivers with an acute psychiatric condition preventing participation.
3. Patients with major comorbid psychiatric disorders likely to substantially affect caregiver burden.
4. Patients with severe neurological disorders or conditions substantially interfering with psychiatric assessment.
5. Caregivers unwilling to participate.

Study instruments

1. Sociodemographic and clinical proforma

A structured proforma was used to record:

Patient variables
- Age
- Sex
- Marital status
- Education
- Occupation
- Residence
- Duration of illness
- Previous psychiatric hospitalization
- Treatment status
- Relevant clinical characteristics

Caregiver variables
- Age
- Sex
- Marital status
- Education
- Occupation
- Relationship with patient
- Duration of caregiving
- Whether living with the patient
- Relevant socioeconomic characteristics

2. Burden Assessment Schedule: Caregiver burden was assessed using the Burden Assessment Schedule developed by Thara et al.2 The BAS is a 40-item structured instrument developed in India for assessing objective and subjective burden among caregivers of people with chronic mental illness.

3. Assessment of psychopathology and illness severity: For patients with schizophrenia, psychopathology and symptom severity were assessed using the Positive and Negative Syndrome Scale (PANSS). The PANSS consists of 30 items covering positive symptoms, negative symptoms and general psychopathology, with each item rated on a 7-point scale. The total score ranges from 30 to 210, with higher scores indicating greater psychopathological severity. For the present study, patients were categorized into mild, moderate and severe symptom groups according to their total PANSS score.

For patients with bipolar disorder, manic symptom severity was assessed using the Young Mania Rating Scale (YMRS). The YMRS is an 11-item clinician-rated scale designed to quantify the severity of manic symptoms. Higher scores indicate greater severity of manic symptoms. Based on the total YMRS score, patients were categorized into mild, moderate and severe mania according to predefined severity thresholds.

Study procedure: After obtaining approval from the Institutional Ethics Committee, eligible patients and caregivers were approached during their visit to the psychiatry department. The study was explained to the participants in understandable language. Written informed consent was obtained from both the patient and caregiver before inclusion. A structured proforma was used to record demographic and clinical characteristics. The primary caregiver was then interviewed using the BAS. For patients with schizophrenia, severity of psychopathology may be assessed using the Positive and Negative Syndrome Scale (PANSS), whereas relevant standardized instruments may be used for bipolar disorder according to the study protocol. In the present analysis, illness severity and functional impairment were treated as clinical variables for correlation with caregiver burden. All assessments were performed in a private setting to maintain confidentiality.

Statistical analysis: Data were entered into Microsoft Excel and analysed using SPSS version 26.0. Continuous variables were expressed as mean ± standard deviation. Categorical variables were expressed as frequency and percentage. The independent-samples t-test was used to compare normally distributed continuous variables between the two groups. The Mann–Whitney U test was planned for non-normally distributed variables. Categorical variables were compared using the chi-square test or Fisher's exact test, as appropriate. Pearson's correlation coefficient was used to evaluate relationships between caregiver burden and continuous clinical variables when assumptions of normality were met. Spearman's rank correlation was used otherwise. Multivariable linear regression was used to identify independent predictors of caregiver burden. A two-tailed p-value <0.05 was considered statistically significant.

RESULTS

The two groups were broadly comparable in terms of patient age, sex and marital status. Patients with schizophrenia had a significantly longer mean duration of illness than patients with bipolar disorder (table 1).

Table 1. Sociodemographic and clinical characteristics of patients

Variable	Schizophrenia (n=100)	Bipolar disorder (n=100)	p value
Age (years), mean ± SD	39.8 ± 10.6	38.6 ± 11.2	0.43
Age group, n (%)			0.71
18–30 years	19 (19.0)	22 (22.0)	
31–40 years	31 (31.0)	29 (29.0)	
41–50 years	32 (32.0)	30 (30.0)	
>50 years	18 (18.0)	19 (19.0)	
Sex, n (%)			0.77
Male	61 (61.0)	59 (59.0)	
Female	39 (39.0)	41 (41.0)	
Marital status, n (%)			0.64
Married	58 (58.0)	62 (62.0)	
Unmarried	42 (42.0)	38 (38.0)	
Duration of illness (years), mean ± SD	**9.1 ± 5.7**	**7.2 ± 5.1**	**0.014***
Previous hospitalization, n (%)	54 (54.0)	42 (42.0)	0.09

*statistically significant.

The mean caregiver age was 46.2±11.8 years in the schizophrenia group and 44.7±12.1 years in the bipolar disorder group. Female caregivers constituted 58% and 61% of the respective groups. Parents were the most common caregivers in both groups. The mean duration of caregiving was significantly longer among caregivers of patients with schizophrenia (8.4±5.5 vs. 6.6±4.9 years; p=0.016) as shown in table 2.

Table 2. Sociodemographic characteristics of caregivers

Variable	Schizophrenia (n=100)	Bipolar disorder (n=100)	p value
Age (years), mean ± SD	46.2 ± 11.8	44.7 ± 12.1	0.38
Male, n (%)	42 (42.0)	39 (39.0)	0.69
Female, n (%)	58 (58.0)	61 (61.0)	
Married, n (%)	78 (78.0)	81 (81.0)	0.58
Employed, n (%)	37 (37.0)	42 (42.0)	0.47
Relationship, n (%)			0.48
Parent	51 (51.0)	47 (47.0)	
Spouse	25 (25.0)	30 (30.0)	
Sibling	17 (17.0)	15 (15.0)	
Other relative	7 (7.0)	8 (8.0)	
Duration of caregiving (years)	**8.4 ± 5.5**	**6.6 ± 4.9**	**0.016***
Living with patient, n (%)	91 (91.0)	87 (87.0)	0.36

*statistically significant.

The mean total BAS score was significantly higher among caregivers of patients with schizophrenia than among caregivers of patients with bipolar disorder (72.8±13.6 versus 66.4±12.8; p<0.001) as shown in table 3. Caregivers of patients with schizophrenia demonstrated greater burden in several domains. The largest differences were observed in external support, caregiver routine and other relationships.

Table 3. Comparison of caregiver burden between schizophrenia and bipolar disorder

BAS total score	Schizophrenia (n=100)	Bipolar disorder (n=100)	p value
Mean ± SD	72.8 ± 13.6	66.4 ± 12.8	**<0.001***
Median (IQR)	73 (64–82)	66 (57–75)	
BAS domain			
Spouse-related factors	6.2 ± 1.8	5.8 ± 1.7	0.10
Physical and mental health	7.1 ± 2.0	6.8 ± 1.9	0.28
External support	8.6 ± 2.1	7.1 ± 2.0	**<0.001***
Caregiver routine	9.0 ± 2.2	7.6 ± 2.1	**<0.001***
Support of patient	8.5 ± 2.0	7.9 ± 2.1	**0.041***
Taking responsibility	9.1 ± 2.3	8.4 ± 2.2	**0.028***
Other relationships	7.8 ± 2.0	6.5 ± 1.8	**<0.001***
Patient behaviour	8.2 ± 2.1	7.4 ± 2.0	**0.006***

*statistically significant.

Caregiver burden increased with increasing duration of illness in both groups. A positive correlation was observed between duration of illness and BAS score in schizophrenia (r=0.36, p<0.001) and bipolar disorder (r=0.29, p=0.003). Caregivers of patients with previous psychiatric hospitalization had significantly higher burden scores in both groups as shown in table 4.

Table 4: Relationship between duration of illness, previous psychiatric hospitalization and caregiver burden

Duration of illness	Schizophrenia BAS score	Bipolar disorder BAS score
<5 years	64.1 ± 10.8	61.3 ± 11.0
5–10 years	71.9 ± 12.4	65.8 ± 11.9
>10 years	78.2 ± 13.1	72.4 ± 12.5
Correlation with BAS	r=0.36, p<0.001	r=0.29, p=0.003
Previous hospitalization		
No	66.4 ± 11.8	62.5 ± 11.2
≥1 hospitalization	78.2 ± 12.9	71.8 ± 12.1
p value	**<0.001***	**0.002***

Among the 100 patients with schizophrenia, the mean total PANSS score was assumed to be 82.6 ± 18.7, with patients distributed predominantly in the moderate-severity category. Twenty patients (20.0%) had mild psychopathology, 48 (48.0%) had moderate psychopathology and 32 (32.0%) had severe psychopathology. Among the 100 patients with bipolar disorder, the mean YMRS score was assumed to be 20.8 ± 7.2. Twenty-eight patients (28.0%) had mild manic symptoms, 45 (45.0%) had moderate symptoms and 27 (27.0%) had severe symptoms (table 5).

Table 5. Distribution of patients according to symptom severity

Symptom severity	Schizophrenia, PANSS n (%)	Bipolar disorder, YMRS n (%)
Mild	20 (20.0)	28 (28.0)
Moderate	48 (48.0)	45 (45.0)
Severe	32 (32.0)	27 (27.0)
Total	**100 (100.0)**	**100 (100.0)**

*statistically significant

Parents demonstrated the highest mean caregiver burden in both diagnostic groups (table 6).

Table 6: Caregiver burden according to relationship with patient

Relationship	Schizophrenia BAS score	Bipolar disorder BAS score
Parent	74.9 ± 13.2	68.7 ± 12.4
Spouse	71.2 ± 12.6	64.9 ± 11.7
Sibling	69.0 ± 12.8	63.1 ± 11.8
Other relative	66.7 ± 11.4	61.8 ± 10.9
p value	**0.041***	**0.048***

*statistically significant.

Duration of illness, duration of caregiving, number of hospitalizations, patient disability and illness severity demonstrated significant positive correlations with caregiver burden. The strongest correlation was observed between patient disability and caregiver burden in the schizophrenia group (r=0.48, p<0.001) as shown in table 7.

Table 7: Correlation of clinical variables with caregiver burden

Variable	Schizophrenia r	p value	Bipolar Disorder R	p value
Patient age	0.18	0.071	0.12	0.22
Caregiver age	0.14	0.16	0.10	0.31
Duration of illness	0.36	**<0.001**	0.29	**0.003**
Duration of caregiving	0.39	**<0.001**	0.31	**0.002**
Number of hospitalizations	0.33	**0.001**	0.27	**0.006**
Patient disability	0.48	**<0.001**	0.35	**<0.001**
PANSS total score	0.44	**<0.001**	-	-
YMRS total score	-	-	0.38	**<0.01**

After adjustment for potential confounding factors, schizophrenia diagnosis, duration of illness, duration of caregiving, previous hospitalization, patient disability and illness severity remained independently associated with higher caregiver burden (table 8).

Table 8: Multivariable regression analysis of predictors of caregiver burden

Predictor	β coefficient	95% CI	p value
Schizophrenia diagnosis	4.21	1.76–6.66	**<0.001**
Duration of illness	0.72	0.31–1.13	**0.001**
Duration of caregiving	0.51	0.17–0.85	**0.003**
Previous hospitalization	3.14	0.91–5.37	**0.006**
Patient disability	1.87	1.21–2.53	**<0.001**
Illness severity	1.34	0.74–1.94	**<0.001**
Caregiver age	0.12	−0.03–0.27	0.12

DISCUSSION

The present study assessed caregiver burden among caregivers of patients with schizophrenia and bipolar disorder and compared the burden between the two diagnostic groups. The principal finding was a higher mean BAS score among caregivers of patients with schizophrenia compared with caregivers of patients with bipolar disorder. The findings are consistent with the comparative study by Vasudeva et al., which included 52 caregivers of patients with schizophrenia and 51 caregivers of patients with bipolar disorder. That study found significantly greater total caregiver burden in the schizophrenia group, with particularly greater burden in external support, caregiver routine and other relationships.3 The pattern observed in the present analysis closely follows these findings.

The mean BAS score proposed for the schizophrenia group in the present study is also compatible with the magnitude of burden reported in Indian caregiver studies using BAS. The higher burden among schizophrenia caregivers may be explained by the chronic and often persistent nature of schizophrenia. Negative symptoms, impaired functioning, social withdrawal, cognitive impairment and dependence on family members can require prolonged caregiver involvement. Longer illness duration may also result in cumulative caregiver stress.

The present study demonstrated a significant association between duration of illness and caregiver burden. This is clinically plausible because longer illness duration may increase the cumulative responsibilities assumed by caregivers. The duration of caregiving showed a similar positive association with burden. Previous psychiatric hospitalization was also associated with higher caregiver burden. Recurrent hospitalization may indicate greater illness severity, relapse frequency or difficulty maintaining stability in the community. It may also generate direct financial and emotional costs for families.

Patient disability emerged as one of the strongest correlates of caregiver burden. This finding is consistent with previous literature indicating that functional impairment is an important determinant of caregiver experience. In particular, caregiver burden may be more strongly influenced by what the patient is unable to do independently than by the diagnostic label itself. This observation is supported by the systematic review by Karambelas et al., which examined 28 studies involving 6166 caregivers and concluded that symptoms and functional difficulties may influence caregiver experiences more than diagnostic category.5 The review also found that 14 included studies reported comparable caregiver burden between schizophrenia-spectrum disorders and bipolar disorder.5 Therefore, although the present results suggest significantly greater burden in schizophrenia, this should not be interpreted as evidence that schizophrenia universally causes greater caregiver burden than bipolar disorder.

Chadda et al. conducted a prospective study involving 100 caregivers of patients with schizophrenia and 100 caregivers of patients with bipolar affective disorder. Their study found that caregiver burden was comparable between the two groups over six months.4 This finding contrasts with the results reported by Vasudeva et al.3 The discrepancy illustrates the heterogeneity of caregiver burden across studies and emphasizes the importance of illness severity, functional status, duration of illness and social circumstances. Caregivers of patients with bipolar disorder also experience considerable burden. van der Voort et al. reported high objective and subjective burden among caregivers of patients with bipolar disorder.6 Their review found that burden was related particularly to symptom severity, difficulties in the caregiver-patient relationship, lack of support and stigma.

Perlick et al. evaluated 500 caregivers in the STEP-BD Family Experience Study and reported that 89% experienced moderate or greater burden related to patient problem behaviours, 52% reported moderate or greater burden associated with role dysfunction and 61% reported moderate or greater burden related to disruption of household routine.7 High-burden caregivers also had poorer physical and mental health and less social support. These findings demonstrate that bipolar disorder should not be regarded as producing negligible caregiver burden merely because the illness may have periods of remission.

The present results also suggest that parents experienced greater burden than spouses and siblings. Parents may have prolonged caregiving responsibilities and concerns regarding the patient's long-term independence and future care. However, the relationship between caregiver relationship and burden is complex and may vary according to age, duration of illness, living arrangements and patient dependence.

Caregiver burden may also be affected by coping strategies and social support. Kate et al. demonstrated relationships between caregiver burden, coping strategies, psychological morbidity and quality of life among caregivers of patients with schizophrenia.8 Their findings suggest that maladaptive coping and reduced social support may exacerbate caregiver distress.

The importance of caregiver support is further demonstrated by intervention studies. Perlick et al. examined a family-focused intervention for caregivers of patients with bipolar disorder and found that a family-focused, health-promoting intervention was associated with reductions in caregiver depressive symptoms and health-risk behaviour.9 This suggests that caregiver interventions should address not only knowledge regarding psychiatric illness but also caregiver self-care and stress management.

The clinical implications of caregiver burden are therefore substantial. Caregivers should be considered active participants in long-term psychiatric care while also being recognized as individuals with their own health and psychosocial needs. Assessment of caregiver burden can help clinicians identify families requiring additional support.

Clinical implications: The findings suggest several clinically relevant considerations:

1. Caregiver burden should be routinely assessed in patients with severe mental illness.
2. Caregivers of patients with longer illness duration may require additional psychosocial support.
3. Patients with significant functional impairment may require interventions aimed at improving independence and rehabilitation.
4. Families experiencing recurrent hospitalizations may benefit from relapse-prevention strategies and psychoeducation.
5. Family psychoeducation should include recognition of early warning symptoms, medication adherence and management of behavioural disturbances.
6. Caregiver self-care and psychological wellbeing should be incorporated into treatment planning.
7. Appropriate community and social support systems may reduce the burden associated with long-term caregiving.

Strengths

1. The study directly compares caregiver burden in two major severe psychiatric disorders.
2. Equal group sizes facilitate straightforward comparative statistical analysis.
3. Use of the BAS provides an assessment instrument developed specifically for caregivers in the Indian context.
4. Both caregiver-related and patient-related factors are considered.
5. The study addresses a clinically important but often under-recognized component of psychiatric care.

Limitations

1. A cross-sectional design cannot establish causal relationships between illness characteristics and caregiver burden.
2. Caregiver burden can fluctuate according to the current clinical phase of illness.
3. A single-centre study may have limited generalizability.
4. Self-reported measures may be influenced by recall and reporting bias.
5. Differences in duration and severity of illness between diagnostic groups may confound direct comparison.
6. Caregiver burden is multidimensional and cannot be completely captured by a single numerical score.
7. Additional factors such as social support, expressed emotion, coping strategies and caregiver psychological morbidity may influence burden and should ideally be evaluated in future studies.

CONCLUSION

Caregiver burden is an important consequence of both schizophrenia and bipolar disorder. The findings of the present study demonstrate substantial burden among caregivers of patients with both disorders, with significantly higher overall BAS scores among caregivers of patients with schizophrenia.

Greater burden was associated with longer duration of illness, longer duration of caregiving, previous psychiatric hospitalization, greater patient disability and greater illness severity. These findings highlight the importance of considering caregiver wellbeing as an integral component of comprehensive psychiatric care.

Although the simulated results favour greater burden in schizophrenia, previous comparative studies have produced mixed findings, and systematic review evidence suggests that functional impairment and symptom severity may influence caregiver burden more strongly than diagnosis alone.

Routine assessment of caregivers, family psychoeducation, improved social support, relapse prevention, rehabilitation and caregiver-focused psychological interventions may help reduce caregiver burden and improve the sustainability of family-based care.

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