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FAMILY CARE GIVING TO PSYCHIATRIC PATIENTS: ITS IMPACT ON CARE GIVERS

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Abstract

Caring of a mentally ill family member is time, money and energy consuming. The care giving responsibility may put many restrictions on the life of key informal caregiver such as distorted family ties, reduced leisure time activities, difficulty in keeping active participation in social gatherings, reduced friendship circle, shift in employment, role overload etc. It affects the familial, financial, occupational, psychological and social life of the informal care giver, depending on the duration of care giving, chronic nature of illness, level of familial and social support, and ability to cope with the role overload. Caregivers, engaged in prolonged care giving, may not get adequate time to take care of their own health. Research studies have revealed that a considerable percentage of caregivers are at increased risk of physical and psychological distress such as coronary heart disease, anxiety and depression in varying degrees. The professional mental health services should focus more on reducing the stress of care giving through engaging the family caregivers in the treatment programmes. The programmes — both institution and community based — may include education on mental illness, training in effective care giving and coping strategies, and formation of self-help groups in the community.

INTRODUCTION

Mental illness has been a serious concern of all times, so much so the term 'mental health' has often been used as a euphemism for mental illness. The mentally ill face various forms of reactions from the community. Mental health does not start or end with one's mind. Maintenance of mental health is a collective responsibility. Anybody having a mind can undergo mental stress at one time or other. It means that all human beings are vulnerable to stress in varying degrees at

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any point in their life. The community needs to be aware of it and prepared to take care of the situation.

Mental illness such as psychosis is a serious disorder that needs timely intervention and careful treatment. Due to the debilitating effects of this disorder, a considerable percentage of victims are subjected to drastic changes in their life. These changes include weakening of family bonds, loss of employment, social withdrawal, passive friendship circle, loss of importance in the main decision making events in the family and work place etc. As a result rehabilitation of mental patients into the social mainstream becomes a serious challenge to formal and informal carers.

Mental patients have been treated and taken care of both in institutions and by the family within the community. Today there is greater emphasis on the community based care of the mental patients. Internationally community based care of the mentally ill received impetus since the experiment of the communitarian mutual aid approach to mental illness in the Belgian village of Geel in early 13th century. Since then, the trend has been to move people with mental illness from psychiatric hospitals into their home communities all over the world. However, the merits of family care programmes have still not received the full support of professionals and planners, to the extent that it becomes a routine part of psychiatric care. As we enter the 21st century, this practice must become commonplace for everyone around the world.

Family Care of Mentally Ill

In the community-based care of the mentally ill, family assumes the role of caregiver. Sompron *et al.* (2000) have critically analysed the problems of family carers who have a family member with severe mental illness. Family wants to take care of its loved one with mental illness. But the family usually becomes the primary caregiver with little education about mental illness and assumes the role of primary care giving for which it may have virtually no training and is not equipped to cope with it. Symptoms of mental illness can upset the family unit, especially when they happen without warning. Even when there are no problems, living with a family member who is mentally ill can be stressful. As a result the family task of care giving may leave the members of the family at risk of stress related to physical and emotional problems. The strain experienced by the family caregivers of mentally ill people may lead to changes in the family, that include changes in life expectancy, sibling relations, marriage, delayed introduction of children into independence etc. Among the family members generally it is the spouse of the mentally ill who assumes the role of the main caregiver. For instance, in a study conducted by Patterson *et al.* (1996) it was found that spousal caregivers were significantly more likely to provide assistance to the patients as compared to other family caregivers.

Family involvement in the care and rehabilitation of persons with mental illnesses is being recognised world-wide as the key factor in successful treatment of the mentally ill, stated the World Health Organisation, while pointing out the fact that family has been an essential part of mental healthcare programmes in South Asia for 50 years (U.S. Department of Health and Human Services 1990). Following the acceptance of community based treatment, families of persons with severe and persistent mental illness have increasingly assumed care giving responsibilities for their adult family members. Some estimates have indicated that between one-third and two-thirds of persons with long-term psychiatric disabilities reside with family members in the world as a whole (U.S. Department of Health and Human Services 1990).

Role of Family Caregiver

The role of family in caring a mentally ill member is multifaceted. Usually one of the members who is closely related to and is capable of taking care of the needs and demands of the patient performs the role of the 'key carer'. This person has to take care of tasks such as feeding, medication, treatment, follow up and rehabilitation of the sick family member along with his/her own needs and sometimes of other members of the family, if the key carer is the head of the family or the only earning member of the family. The debilitating effect of mental illness such as psychosis may result in loss of employment, dissolution of marriage, loss of custody of children, social isolation, denial of the right to child bearing and rearing etc. When any of such misfortunes happens in the life of the patient, it is mostly the chief caregiver who may have to find solutions for it, because the patient will be seeking more attention and dependence on the carer than any other member of the family. So the multiple roles of the caregiver range from carer of the patient to care taker of the patient's family if any.

The family member who takes care of the mentally ill person may have to face incoherent behaviour of the patient in his/ her routine caring, including personal care. If the caregiver is the head of the family, may it be the husband or wife, his/her workload increases due to various responsibilities other than the caring of the patient. He/she has to look after the patient along with attending to other household duties, such as care and education of children, and searching for sources of livelihood. Moreover, the social attitude towards such a family is rarely helpful. The family may have to cope with the situation of being branded as mentally abnormal.

When there is a mentally ill patient in a family, all those who are closely related to that person, i.e. spouse, children, siblings etc., may have to enter into a different relationship. It has its special implication in the case of marriage. Since mental illness has got roots in heredity, even if the family is financially sound, the chances of getting a good alliance in the personal life of a family member is curtailed by the presence of a mentally ill person in that family. Thus the caregiver of the mentally ill person may be subjected to both internal and external pressures. Internal pressure includes the stresses and tensions he/she experiences within the family while external pressure includes the stigmatic attitude of the society. Sometimes the caregiver may not be in a position to manage the demands of the patient as well as the other dependents.

Context of Family Care Giving

A family caregiver of a mentally ill person performs his/ her role in the context wherein the interrelationships within the family are variously affected by the presence of a mentally ill person. The nature and extent of the impact of the presence of the mentally ill on the relationships within the family depend on the seriousness of the illness and the position of the ill member in the family. Marks *et al.* (2002) in their study have pointed out that parents with mental illness consider their relationships with children as extremely important in terms of dispensing the duties assigned to parenting role. They may prioritise their children's needs, and neglect their own. They may struggle to fulfil the multiple role demands, and experience stress as they maintain the household, cope with the demands of work, and manage the behaviour and activities of their children. Their marriages and family life may suffer under these circumstances, just as those of parents living without mental illness.

Children are variously affected by the incidence of mental illness in the family. Research clearly indicates that children of parents with mental illness are at increased risk in emotional and behavioural development (Gallahghee and Jally1996). As with any illness, the effects of parental mental illness vary with the age of adults and their children at illness onset, illness severity and duration, nature of any consequent impairment in parental functioning, and the strengths and resources of the parents and children. Young family members are especially vulnerable to disruptive or traumatic events such as the mental illness of a close relative. Compared with adults, children have less coping skills and strategies, are more dependent on other people in their lives, and have fewer psychological defences. Moreover, early development accomplishments provide the foundation for later ones, and delays or disruptions in development may have long-term consequences, including a residue of "unfinished business" that reverberates through future years.

Children may be subject to a "survivor's syndrome" that exposes them to feelings of guilt for having been spared. In addition, there may be adverse effects on their academic life and peer relationships. For instance, children may experience a sense of social deviance, have difficulty in straddling the different worlds inside and outside their family, and be reluctant to bring friends to an unpredictable home environment. In addition to the family burden, children are at risk of traumatic reaction that causes intense emotional and physical distress or even post-traumatic reaction that persists for many months or years. Post-traumatic symptoms may include heightened fears and anxieties, recurrent images or thoughts, intrusive flashbacks, emotional numbing or constriction, loss of interest in normal activities, and withdrawal from other people.

Apart from these risks, however, children have the potential for a resilient response to the tragic family situation. Resilience is the ability to rebound from adversity and to prevail over the circumstances of our lives. Second, children need skills to cope with the mental illness in family and with its impact on their own lives. For example, they need to learn to deal with the symptoms of their parent's illness and with their own anxiety and stress. Third, children need support for themselves. In addition to their needs for information, skills, and support, many children face a special challenge — to recognise that their needs and desires matter. So often they deny or minimise their own needs in their effort to meet the needs of their family.

Siblings are likely to experience a range of emotional problems in response to the mental illness of a brother or sister. In addition to the emotional burden, siblings face many everyday problems. They must learn to cope with the symptoms of their relative's illness, possibly including hostile, abusive or assaultive behaviour, mood swings and unpredictability, socially offensive or embarrassing behaviour, and self-destructive behaviour. Siblings often live with a high level of illness-related stress. They may also find their social life restricted because it is sometimes impossible to take their brother or sister out in public—to shopping, movie or restaurant.

There is the risk that siblings will take on a "caregiver" role as they are growing up and then carry that care giving role into adulthood, with adverse consequences for their adult relationships. On the other hand, some siblings may avoid intimate relationships to protect themselves from further vulnerability and pain. Either way, their adult relationships may be negatively affected. If they marry, siblings frequently have additional concerns about their own children in the light of the genetic risks associated with mental illness. Throughout their life, siblings typically struggle to achieve a balance that allows them to fulfil their family responsibilities without sacrificing their own life. This is easier said than done.

A family caregiver assumes the responsibility of caring for the mentally ill member of the family in a situation wherein the family members variously respond and react to the presence of mental illness in the family. The caregiver has to not only provide care to the ill member but also manage the responses of other members if they are problematic. The quality of the care provided by the caregiver also depends on the situation of the family with regard to the acceptance and response of the family members.

Quality of Family Care

Study of the quality of family care is complicated by several factors (Wolff *et al.* 2007). Researchers and clinicians have failed to define operationally both the ends of the continuum of quality of care given by informal care providers. By default, adequate to excellent care has been defined by the absence of abuse or neglect. Operational definitions of abuse and neglect, however, are neither definitive nor clear and, clinically, these definitions are confounded by legal issues such as degree of intent, amount of harm and assignment of blame (Phillips1989). Some clinicians have tried to circumvent these problems by defining quality of informal home care by the degree to which the recipient's needs for physical and/or emotional support are met by the informal care providers (Fulmer and O'Malley 1987). There is, however, no appropriate measurement standard against which the care provided by informal care providers can be judged. Without a measurement standard, judgments about the adequacy of home care will continue to be confounded by factors such as socio-economic status, ethnicity and the care recipient's personal characteristics. Unlike care provided in hospitals, care outcomes in the home rely primarily on the skills and expertise of family members and secondarily on the counselling and educational roles of the professionals (Rakowski and Clark 1985; Couper and Sheehan 1987; Hirst and Metcalf 1986). This presents a special dilemma for the evaluation of quality indicators. The quality of home care has to be focussed primarily on evaluating the care provided by professionals or non-professional staff (Mumma 1987).

Other factors also contribute to the problems of studying the quality of informal home care. For example, there are currently no acceptable alternatives to the service provided by the informal care system. Therefore, care of lower quality is generally tolerated and, to some degree, supported if identifying that care as less than adequate could jeopardise the living arrangements and autonomy or independence of the care recipient. In addition, prevailing social attitudes dictate against questioning the "good intentions" of family members or violating the sanctity of the home setting. Monitoring the quality of home care generally is viewed as the responsibility of the care recipient and/or the care recipient's family regardless of whether they are physically or emotionally capable of assuming that responsibility. Thus regardless of the level of quality, family care has assumed an important place in caring for the mentally ill.

IMPACT OF FAMILY CARE GIVING ON CAREGIVER

The impact of care giving on the family caregiver may vary from case to case. They may suffer various forms of stress and strain or find care giving a burden. From time immemorial family has played a vital role in the development of the personality of an individual. Parents particularly play a crucial role in shaping and caring young ones in all possible ways. The family comes under stress when any of the members has special needs due to any sort of impairment, either physical or mental. Almost all persons who are taking care of a mentally ill person staying in their family suffer from chronic sorrow throughout their life. The extent of this sorrow may differ from one person to another but most will have its manifestation in varying degrees. Family's reaction to stress is highly variable ranging from healthy adaptation to mal adaptation. In the case of some, the stigma of mental illness could be one of shame and inferiority, which make a person as tinted and discounted. For the mentally ill person and his/her family, the most devastating consequences of being mentally ill are often not the direct physical or mental results of impairment itself, but rather the attitudes and reaction of those in the society who are not handicapped. Carer can be vulnerable to poor health and depression and so it is essential for the carer to be aware of the need to look after his/her own health and mental well-being. It is advisable to have regular breaks from caring activities. Isolation can be a major problem and so it is important for carer to maintain and cultivate relationships outside the home.

Women Caregivers

Care giving to the mentally ill within the family has its own impact on women. A study on "Sources of Burdens on Families of Individuals with Mental Illness" (Tsang *et al.* 2003) found that middle-aged and older women who provided care for an ill or disabled spouse were almost six times as likely to suffer depressive or anxious symptoms as were those who had no care giving responsibilities. It is not merely care for a spouse that can affect mental health; factors like severity of disability and duration of time spend for caring are also very crucial. The same study found that women who cared for mentally ill parents were twice as likely to suffer from depressive or anxious symptoms as non-caregivers (Tsang *et al.* 2003).

Another study showed that 25 per cent of women caregivers had health problems as a result of their care giving activities. Coronary heart disease (CHD) was one physical risk factor of care giving. Women who spent nine or more hours a week caring for an ill or disabled spouse increased their CHD risk two fold. Other health effects included elevated blood pressure and increased risk of developing hypertension, poorer immune function, slower wound healing and lower life expectancy (Horwitz *et al.* 1996). Another study found that 77 per cent of employed women, who were also family caregivers to the mentally ill, reported experiencing conflict between work and care giving demands (Bureau of National Affairs 1988). Gender differences have been found in the type of care provided and the coping behaviours of caregivers (Barusch and Spaid 1989). Some other researchers (Fitting *et al.* 1986) reported that important differences in age and sex of caregivers were related to care giving burden, and that women's subjective reactions to care giving tended to be more negative than those of men. Their research has found that women reported higher levels of burden and psychological distress associated with care giving, lower morale, higher depression and more negative symptom feelings (Zarit *et al.* 1986; Fitting *et al.* 1986).

Several reasons for women's greater sense of burden have been suggested. Since women caregivers are typically younger than men, they may experience greater "role" overload due to the other responsibilities that compete with care giving. Men are harder to care for than women since they may rely more exclusively on the primary caregiver. Male caregivers receive more support from informal and formal sources to ease the burden of care, and may cope more effectively with life stresses and also with care giving.

Spouse Caregivers

Spouses have different worries than children and report a greater degree of physical and financial strain than children and other relatives (Cantor 1983). The study conducted by George and Gwyther (1986) also describes the heightened vulnerability of spouse caregivers. They reported that spouse caregivers had significantly more doctor visits and poorer self-rated health than adult children and other relatives. Sheehan and Nuttall (1988) found that the most frequently mentioned problems of the wife-carers were isolation, loneliness, economic hardship, and role overload. On the other hand, the overwhelming concern of children and younger relatives involved with caring of mentally ill relative is often their ability to obtain necessary help.

Spouse caregivers, possibly due to their enhanced sense of commitment to the care recipient, display a strong tendency to cope with the burdens of care giving often until deterioration of their own health prevents them from providing care. The relationship of the caregiver to the patient is one of the factors in determining the probability of institutionalisation of the care recipient, spouses being much less likely than others to institutionalise the patient.

Burden of Care Giving

Impact of care giving on the caregiver is often equated to the burden, stress, or strain of care giving although several studies show that there are caregivers who do not feel burdened by care giving (Li *et al.* 2000). Their studies have shown that there is a continuum of experiences ranging from full satisfaction to dissatisfaction or extensive role strain with care giving. A number of factors have been found to be associated with the negative aspects, or the burden of care giving. For example, the circumstances of care giving, including the characteristics of the caregiver and care recipient, health and functional status, and severity of the care recipient's health condition play a role in the impact of care giving on the caregiver. And many caregiver families may have to cope with the often significant aspect of the financial cost of care giving.

Special categories of caregivers may face unique challenges. Caregivers who work or who have other family responsibilities or who live in geographically isolated areas may have special difficulties in managing all of their roles. Caregivers often feel guilty if they turn over their duties to others. But they are likely to burn out if they don't take steps to relieve the emotional pressure. This manifestation of stress can leave a person emotionally exhausted with the feeling that there is nothing left to give and no life beyond care giving.

The emotional and physical demands of the care recipient can also cause stress among caregivers. Caregivers experience more stress if the care recipient's impairment results in disruptive behaviour and improper social functioning (Blieszner and Alley 1990). Several studies have shown that the degree of caregiver's stress increases as the care recipient's level of functional impairment becomes more severe (Select Committee on Aging 1988). The study by Stephens and Christianson (1986) found a decrease in life expectancy of distressed caregiver spouses.

A particularly strong factor in determining the mental health impact of providing care is the amount of time spent in care giving. Spouses of persons with schizophrenia often experience guilt and shame, and they may even blame themselves in some way if the illness was diagnosed after the marriage. Personality changes, social withdrawal, irrational thoughts and behaviours, agitation, and difficulty in relating to others — all aspects of schizophrenia — can make the spouse feel alienated, hurt, and resentful of the burden imposed by the partner's illness.

Providing personal care 24 hours a day can cause stress by isolating oneself from friends, family and other avenues of social life. The caregiver may find himself/herself too tired or unable to have an evening out even once a week, or once a month. It can result in build-up of anger and resentment toward the very person receiving the care, as the care receiver is the cause of the missed social life. All of these factors often result in tremendous emotional stress. Compounding these sources of stress are the difficulties in managing one's time, juggling multiple responsibilities, and feeling the pressure of the increased dependency. For family members providing care, the various forms of stress can result in indifferent feelings, or even resentment and bitterness about the constant responsibilities, deprivation and isolation.

It is also possible that at this juncture some of the unresolved conflicts from parent-child relationships resurface and intensify, causing anxiety and frustration. There might even be the unspoken desire, at times, to be relieved of the burden through institutionalisation or even death of the care receiver. This desire is frequently and swiftly followed by feelings of guilt. All of these can be felt, and then denied because they seem unacceptable. The person giving care needs to be assured that such feelings in fact are common even though they may not be expressed.

Some studies in India (Thara and Rajkumar 1992; Kulhara 1994) have revealed the fact that majority of the caregivers are subjected to exhibit anxiety and depressive symptoms in varying degrees. A community based study on family burden among caregivers of mentally ill patients attending community mental health centres in Thiruvananthapuram district of Kerala, India, done by Jiji and Gireesh (2002), found that the care givers of psychiatric patients (Schizophrenia and Bipolar) experienced the feeling of burden in various degrees. The study showed that male carers felt more burdened than the female carers. Another pertinent finding of this study is that those carers who are less educated and belonged to lower socio-economic strata felt care giving a greater burden than the others. This points out the need of the caregivers for not only financial assistance but also increased awareness regarding mental illness and care giving. The study also revealed that type of illness and duration of illness are significant in determining the severity of burden experienced by the caregivers. Obviously, longer the duration of illness, greater is the experience of burden. The burden experienced by the carers of bipolar patients was found to be greater than that of the carers of schizophrenics.

A possible long lasting impact of care giving is that the caregivers may develop a negative attitude towards life as they feel that they are not well trained or experienced in their care giving role and most of the time they find difficulty in maintaining a balance among other areas of life such as familial, financial, occupational and social. When all of a sudden one realises the fact that one's life is changed owing to the responsibility of care giving to a sick family member, one may feel isolated and exhausted especially when there is no sufficient external help from other family members.

Coping Response

The nature and extent of the burden experienced by caregivers depends on their capacity to handle the problem situation and to cope with the burden. The caregiver burden is not directly influenced by the specific behavioural problems of the patient but is mediated by the caregivers' ability to tolerate these problems. Caregivers' ability to tolerate problem behaviours often increases over time, even though the disease (and behaviours) may worsen. Caregivers themselves indicate that, in course of time, they learn to manage problems more effectively or learn not to let problems bother them as much. Over a period of time, the daily routine for providing care, which many caregivers fix and follow, although not without its stresses, may not be felt as excessively demanding or burdensome.

The main coping response of the caregivers to the burden of care giving is to have recourse to various resources available to them. Caregiver resources, such as coping capacity as well as social support are found to be linked to the level of experience of burden. These personal and social caregiver resources appear to be particularly important to cope with the burden of care giving.

The most common coping response of the care giving spouses studied by Barusch and Spaid (1989) was to seek help when they had problems, especially in the areas of care management and health problems. The second most common coping response was to simply not cope. Spouses reported not coping with sexual problems, guilt feelings, feeling of over dependence of spouse, arguments with spouse, excessive demands made by others, worries about future financial problems, managing money, and worries about their own health. Another study found that 12 per cent of caregivers drank alcohol to cope with the psychological strains of care giving (Bureau of National Affairs 1988).

As a result of successful coping strategies, some of the caregivers carry on their task with no serious problems. They may derive full satisfaction from care giving and find it useful in their life. The 1982 Long-Term Care Study in the United States (Bureau of National Affairs 1986) found that about 75 per cent of caregivers felt the experience of being a caregiver as useful. In addition, the caregivers indicated that care giving improved their sense of self-worth, and that the person they cared for was a major source of companionship. Two other positive consequences of care giving noted in this research study are: personal affirmation of the caregiver through the care giving experience, and personal meaning gained through the care giving experience. Personal affirmation was investigated by Lawton *et al.* (1989) in a study of care giving satisfaction, care giving mastery, care giving ideology, perceived care giving impact, and subjective care giving burden that tested a proposed framework of care giving appraisal.

HELPING FAMILY CAREGIVERS

While we argue for promoting family care of mental patients as against institutionalisation, we should realise that family care giving places different degrees of burden on the family caregivers. It is necessary that they receive the necessary help to meet the different needs faced by them in taking care of the mentally ill family member at home. DeAngelo (1988) identified the needs of caregivers as regular respite, short-term respite, home nursing assistance, housework, emotional counselling, transportation, legal counselling, and support groups. In the nursing literature about the needs of caregivers, specific discussion is made on their educational needs (Hirst and Metcalf 1986). In some studies caregivers reported that just talking to some one about their worries and difficulties could help them relieve their inner repressed feelings (McFarlane *et al* 1995). In particular, the family caregivers of mentally ill patients need assistance to cope with the stresses and strains of care giving.

Challenges to Helping Caregivers

The reluctance of family caregivers to use services for which they are eligible and the preference of caregivers to solve problems on their own present challenges to those trying to provide services to family caregivers. Caregivers who have little time to meet their family, work, and care giving responsibilities often feel that they do not have any time left for support groups or other interventions. Simply locating family caregivers in need of support and getting them to accept such support may prove difficult. Many family caregivers do not seek outside help until they have reached a crisis point.

A variety of coping skills are often needed by caregivers in order to deal with a variety of problems. Barusch (1988) recommends training programmes in imparting techniques for personal control in order to help caregivers cope without outside assistance. The objective of such training programmes can be also to provide information about community resources and discuss caregiver feelings about seeking and accepting help in an effort to prepare the caregivers for a time when they may be unable to cope alone.

An important resource for coping with the burden of care giving that can be made available to the caregivers is the caregiver support group. Such a group can provide a unique forum for caregivers to come together and share their feelings in a supportive environment. The group can help caregivers feel less isolated and create strong bonds of mutual help and friendship. Participating in a support group can help manage stress, exchange experiences, and improve skills as a caregiver. Sharing of coping strategies in a group setting lets the carers to help others while helping themselves. It may also help them realise that some problems have no solutions and that accepting the situation is reality.

Professional Intervention

Family caregivers have to be encouraged and helped with whatever resources that are available within the community, such as community based caregiver support group. More needs to be done to strengthen the relationship between family caregivers and mental health professionals. Research done by Dunn *et al.* (1986) has confirmed that educating and supporting caregivers is positively associated with prolonged community tenure and reduced recidivism rates. Mental health professionals, who often cite statutes about patient's confidentiality as the reason for not involving the family in the treatment of a patient, must find ways and means through which they can educate the family members and help them in the task of care giving. They need to collaborate with family members using a competency-based approach that is built on family strengths and on the belief that the family will do the best it can. Family members may want better communication and more interaction with mental health professionals and should be involved in the treatment of their patient.

The delivery of educational services to the family caregivers should occur in a setting that is non-threatening to the family members. An assessment of family members' knowledge of their relative's illness allows for individualised action based on their self-reported knowledge of different subject areas. Family members could also be involved in the selection of the materials and aids, such as written documents, videos or didactic discussions, in the programme of knowledge dissemination. Mental health professionals must find suitable methods to ensure that these families receive the needed services.

The mental health practitioners, such as psychiatrists, social workers, psychologists and other para-professionals should take the lead in providing adequate information, training and support for the caregivers. If the caregivers from the economically lower sections of the society are given opportunities for earning, such as training in some skills for self-employment, it will be of great help to them to take care of the financial aspect of care giving and also their daily living. The government and non-government organisations could take the initiative in commencing such services and forming self-help groups of the caregivers in local communities.

Social work profession can play its own role in dealing with this social issue. With the emphasis on community based social intervention, family has become the prime source of informal care giving to mentally ill patients. The social work profession has its methods, such as case work, group work and community organisation, that are of help in the field of informal care giving for alleviating the tensions, fears and worries of family caregivers. The students, teachers and professional practitioners of social work can get involved in the field through activities such as survey to identify family caregivers in need of professional help and organise programmes in the local community itself. They can form self-help groups of family caregivers, and undertake activities for awareness building and education, counselling services, and regular periodic meetings of self-help groups. They can also liaison with local non-government agencies for the training of caregivers and the rehabilitation of mentally ill patients in the community itself. Involvement of local support groups will be of help to meet the needs of the family for emotional support and to provide the opportunity to get to know other families with similar problems. Research in the field of social sciences should also focus on such issues to widen the horizon of social work intervention.

CONCLUSION

Care giving and its social and personal consequences do not take place in a cultural vacuum. The willingness and ability of families to assume long-term responsibility for a loved one with psychiatric disorder will be influenced by the traditions and values of the family, the composition of the family, the general economic conditions in the country, the availability of and access to alternative measures of support, and so on. The family is the most important source of support for its member experiencing mental illness and a valuable resource to mental health professionals. Family can provide information about its ill member, monitor services and supply feedback to providers, and advocate for services. However, family needs information, coping skills, and support from mental health professionals to adequately assist its member who has been diagnosed with mental illness.

Management of mental illness requires a functional partnership between mental health professionals and the informal family caregivers. Each group needs to understand the difficulties encountered by the other and should be ready to provide all possible help to each other for effective care giving.

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