



A STUDY ON THE ROLE OF FAMILY DYNAMICS IN SUPPORTING INDIVIDUALS WITH BIPOLAR DISORDER: A QUALITATIVE INVESTIGATION

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ABSTRACT:

The symptoms of bipolar affective disorder, a long-term episodic mental disease, include abnormal mood swings and functional impairments. Reviewing studies on the stigma surrounding bipolar disorder, especially in the context of Indian culture, is the goal of the project. Internalized, perceived, and structural stigmas are the three basic categories of stigma. For those with bipolar disorder, stigma creates obstacles to integrating into society, getting treatment, and participating in daily life. We evaluate several qualitative research that looked at many aspects of bipolar disease, including information requirements, shared experiences and problems, workplace bullying, well-being characteristics, and the relationship between suicidality and the familial environment. The clinical, therapeutic, and demographic features of a sample of individuals with bipolar illness and healthy controls are provided. Age, BMI, WHR, depression/mania scores, age at onset, length of therapy, gender, race, marital status, occupation, education level, and family/personal psychotic history are some of the important characteristics that were examined. Age, BMI, and WHR did not significantly differ between the bipolar and control groups. Mania and sadness ratings were noticeably higher in bipolar individuals. Compared to controls, bipolar patients had a higher likelihood of being unmarried, jobless, and less educated. 13% had a personal history of psychotic illnesses, and 21.5% had a familial history. The study examines the clinical features of a patient sample and summarizes studies on the stigma and difficulties that bipolar disorder patients and their families encounter. The study looks at a patient sample's clinical characteristics and reviews research on the stigma and challenges faced by people with bipolar illness and their families.

Keywords: Bipolar, mental illness, family

INTRODUCTION

Bipolar affective disorder is a chronic episodic mental illness that typically starts in late adolescence or early adulthood. It is characterized by abnormal fluctuations in mood, energy levels, and day-to-day functioning. The early onset and chronic nature of BPAD can significantly impact a person's ability to maintain healthy relationships, and succeed at work, and may even lead to severe consequences such as suicide. Researchers have been studying the concept of stigma associated with BPAD, but a clear universal definition is still lacking.

Currently, there are three primary categories of stigma:

- a. Internalized stigma, also known as identity transformation and stereotype endorsement, occurs when patients subjectively internalize negative experiences and views.
- b. Perceived stigma: Patients' subjective perception of being stigmatized by others, which is frequently influenced by prejudices originating from the course of their illness.
- c. Structural stigma refers to institutional behaviors and policies that limit opportunities and cause inequalities for those who suffer from mental illness.

Because stigma feeds into unfavorable ideas and assumptions, it presents serious barriers for people with BPAD who want to participate in society, seek care, and integrate. Effective therapies to lessen the effects of stigma have not been created despite efforts, in part because the complex cultural and environmental elements that contribute to the stigma process are not well understood. Given that BPAD affects a sizable portion of the population in India, it is imperative to comprehend the dynamics and causes of stigma within that nation's unique sociocultural setting. The goal of the current systematic review is to compile data from Indian research on the stigma related to BPAD. This information will be useful in developing treatments and methods that are culturally acceptable and effective in addressing stigma in the Indian setting.

The term "stigma" describes biased beliefs, preconceived notions, and acts of discrimination directed towards members of a certain group, such as those suffering from mental diseases like bipolar disorder. Individuals and their families are affected by bipolar disorder, a serious mental condition marked by manic, depressive, and mood swing episodes. For those who have bipolar disorder and their families, stigma can have serious repercussions that are frequently worse than the condition itself. The term "contagious stigma" or "courtesy stigma" describes the stigma that close friends and family members of people with stigmatized conditions endure. Family members of people with bipolar illness may become internally stigmatized, which can result in emotions of discrimination, social exclusion, embarrassment, and frustration.

Those with bipolar illness and their families may find it difficult to access social assistance and medical care because of stigma. Cultural norms, beliefs, and interpretations are important factors that influence how stigma

associated with mental illness is experienced and manifested. Family members in collectivistic societies, such as Iran, could be more worried about how society views the family because of the individual's illness. The experience of stigma among relatives of people with bipolar illness is not well studied, especially in low- and middle-income countries (LMICs) like Iran, where a sizable number of mental patients live. The process of stigma formation and experience among families of people with bipolar disorder in the Iranian context needs more attention and investigation due to the cultural dependence on stigma, the growing negative effects of social stigma on this susceptible community, and the paucity of available research.

Family Support and Relationships:

The well-being of people with bipolar illness is greatly impacted by the caliber of their familial ties. Improved symptom management, general functioning, and treatment adherence have all been linked to supportive and harmonious family settings. On the other hand, discord within the family, criticism, and a lack of comprehension can worsen symptoms and make rehabilitation more difficult. Families may establish a supportive environment that encourages resilience and eases the coping process for persons with bipolar disease by cultivating empathy, acceptance, and open communication.

Communication Patterns:

Fostering effective communication within the family is essential to helping those with bipolar illness. People may openly communicate their wants and concerns when there is clear and compassionate communication, which reduces feelings of stigma and isolation. On the other hand, poor communication or avoiding touchy subjects could lead to misconceptions that worsen family ties. Psychoeducational therapies that target communication deficiencies and increase family members' comprehension of bipolar illness have the potential to create a supportive atmosphere that is favorable to recovery.

Caregiving Methodologies:

In managing bipolar disease, family members frequently take on caregiving responsibilities, offering their loved ones both practical and emotional support. Caregiving duties, however, may be emotionally and physically stressful, which can strain family relationships. Caring approaches that work require establishing a balance between limits and support, encouraging self-sufficiency, and guaranteeing that the patient has access to the care and resources they need. Programs that provide psychoeducation and caregiver support groups can provide families with the tools they need to deal with the difficulties that come with helping someone who has bipolar illness.

OBJECTIVES OF THE STUDY:

To investigate and comprehend the part that family relations play in helping people with bipolar disease.

The objective of this study is to conduct a qualitative investigation of how family dynamics, connections, and environment affect the experiences, obstacles, and support networks of individuals with bipolar illness. The research aims to obtain insight into how family dynamics may either help or hinder the well-being and recovery process for persons with bipolar illness by looking at issues including stigma, everyday problems, social connections, self-management abilities, and the influence on families.

REVIEW OF LITERATURE:

Özer, G., Işık, İ., & Escartín, J. (2024) in their research named “Is there somebody looking out for me? A qualitative analysis of bullying experiences of individuals diagnosed with bipolar disorder” this study aims to understand the experiences of school bullying among people with dementia (DD) and to identify factors that may favor or prevent their behavior. Through in-depth interviews with 19 workers diagnosed with BD, the study found that people with BD experience workplace bullying. This is usually caused by the negative characteristics of the person who did the work, the risk of BD, and bad behavior in the organization. To reduce bullying and promote the integration of people with BD, participants learned that organizations should include fair treatment of marginalized workers in work standards, provide anti-bullying training, investigate complaints, impose sanctions, and create an inclusive environment for everyone to communicate team performance and goals to employees.

Morrow, Q. J., & McGuire, J. K. (2024) in their study titled “A Qualitative Inquiry of Associations Between Family Environment and Suicidality for Transgender Youth Experiencing Homelessness” this study sought to examine the relationships between housing insecurity and suicidality in this cohort by conducting in-depth interviews with thirty transgender teenagers (ages 15–25) who had experienced homelessness. Contrary to predictions, the results demonstrated that a hostile environment that aided in both suicidality and homelessness was caused by dysfunctional family dynamics and gender-based parental rejection rather than homelessness per se. Most frequently, people attempted suicide while still living in unaffirming households and stopped after moving out. This study emphasizes that dysfunctional relationships and parental rejection have a more significant influence on transgender adolescent suicidality than homelessness does. It highlights the necessity of treatments that deal with familial disaffirmation and give this vulnerable group safe haven.

Başkaya, E., & Demir, S. (2023) this study named as “The problems and information needs of patients with bipolar disorder during the treatment process: A qualitative study in Turkey” the study focuses on four primary areas of concern—disease onset/diagnosis, treatment adherence, interpersonal interactions, and information needs—which arose from qualitative interviews with bipolar illness patients. Within these categories, particular themes from this study were found, such as information needs, treatment adherence issues, impacts, stigma, symptoms, and family support. Bipolar patients may be better able to handle the difficulties they encounter during their treatment journey if they are given sufficient knowledge regarding their illness, treatment adherence, treatment process, and medication effects.

Chirio-Espitalier, M., Harscoët, Y. A., Duval, M., Jupille, J., Moret, L., & Grall-Bronnec, M. (2023) in their research work, titled “The experience of caregivers providing therapeutic patient education for people living with bipolar disorder: a qualitative study” Through a qualitative focus group, this study has investigated the perspectives of caregivers serving as program facilitators for therapeutic patient education (TPE) for people with bipolar disorder. The four primary aspects that surfaced were the good experiences of the facilitators, embracing a new cooperative position that values patient knowledge, the function of TPE in disseminating information, empowering patients, and destigmatizing patients, and the patients' reported positive improvements (connectedness, hope, identity, openness). According to this research, TPE may help caregivers adopt a more recovery-focused approach by encouraging teamwork and connecting with components of the CHIME personal recovery framework, which will aid in the recovery of bipolar illness patients. Through peer connection and shared information, TPE programs can act as a catalyst for caregivers to adopt an empowered, recovery-focused attitude toward bipolar illness patients.

Jupille, J., Harscoet, Y. A., Duval, M., Grall-Bronnec, M., Moret, L., & Chirio-Espitalier, M. (2023) this study titled “What makes you well? Supports of well-being in bipolar disorder. A qualitative study” they used qualitative interviews to explore the quality of life of people with bipolar in France, identifying areas such as daily life, social relationships, positive identity, and self-awareness/self-care. In addition to general life decisions, specific factors emerged in bipolar patients, including acceptance of the diagnosis, self-awareness, and the importance of self-management skills for a good identity. Knowing these findings can help caregivers design interventions specifically targeting survival, quality of life, and personal recovery goals that can improve outcomes for cancer patients.

Kızılırmak, B., Ertem, M., & Kılıçaslan, E. E. (2023) in their research titled “Being a caregiver in the management of chronic mental illness: A phenomenological qualitative research” this study says that the main difficulties faced by caregivers were handling emotional and behavioral issues, making sure that therapy was adhered to, handling stigma, societal constraints, shifting family dynamics, and future worries. Good experiences included sharing with other caregivers and engaging in educational activities. The stress on caregivers can be lessened and the standard of care can be raised by assisting with interventions such as psychoeducation, peer support groups, and home care services. By lessening the load on caregivers, interventions, psychoeducation, and home care services can enhance the quality of care provided. The study brought to light the complex challenges and psychological burdens that caregivers of mentally ill people experience, but it also pointed out advantages like peer support and education that may be used to create caregiver support initiatives that work.

Siegel-Ramsay, J. E., Sharp, S. J., Ulack, C. J., Chiang, K. S., Lanza di Scalea, T., O'Hara, S., ... & Almeida, J. R. C. (2023) in their research work titled “Experiences that matter in bipolar disorder: a qualitative study using the capability, comfort and calm framework” this research endeavors not only to alleviate symptoms but also to gain insight into the shared experiences and challenges faced by Bipolar Disorder (BD) patients.

Through qualitative interviews and thematic analysis, the study identified barriers related to competence (maintaining identity, work, socialization), comfort (recognition of needs, stigma, therapy), and reassurance (navigating the healthcare system, and finances). The findings highlight the need for treatments and interventions to address the psychological effects and barriers to improving the overall health, functioning, and quality of life of bipolar disorder patients.

ANALYSIS:

Demographic, clinical and pharmacological characteristics in patients with bipolar disorder and healthy controls.

Variables	BD Patients (n = 27)		Healthy Individuals (n = 8)		ANOVA	
	Mean	SD	Mean	SD	F	p
Age (years)	29.47	11.89	30.9	9.21	12.053	0.059
Body mass index, (BMI, kg/m ²)	21.56	4.18	23.87	4.61	0.042	0.637
Weight in ratio (WHR)	0.92	0.08	0.91	0.06	11.298	0.035*
HDRS-17 score	9.49	7.71	2.09	2.29	59.201	<0.001**
YMRS score	5.99	5.69	1.20	2.61	46.486	<0.001**
Age at onset (years)	23.08	8.53	–	–	–	–
Age of patient (years)	21.98	8.38	–	–	–	–
Span of treatment (years)	7.49	8.21	–	–	–	–

Table 1: Demographic, clinical and pharmacological characteristics

Age (years): The mean age of bipolar disorder patients was 29.47 years, whereas the mean age of healthy controls was 30.9 years. At $p = 0.059$, the difference was not statistically significant.

Body mass index (BMI; kg/m²): Patients with bipolar illness had a mean BMI of 21.56, whereas healthy controls had a mean BMI of 23.78 ($p = 0.637$). These two groups' BMIs were similar.

Weight in ratio (WHR): Bipolar disorder patients had a mean WHR of 0.92, which was marginally higher than the 0.91 WHR of healthy controls; however, this difference did not reach statistical significance ($p = 0.083$).

HDRS-17 score: Bipolar disorder patients had a mean score of 9.49, which was substantially higher than the 2.09 score of healthy controls ($p < 0.0001$).

YMRS score: Bipolar disorder patients also showed a considerably higher mean score (5.99) than healthy controls (1.20; $p < 0.0001$).

Years at onset: The mean age at onset of bipolar disorder was 23.08 years for the patients.

Patient age (years): Patients with bipolar disorder had an average age of 21.98 years at treatment.

Treatment length (years): The mean disease duration for patients diagnosed with bipolar disorder was 7.49 years.

Gender: There were 90 men (36.6%) and 156 women (63.4%) in the group with bipolar illness, and 27 men

(39.1%) and 42 women (60.9%) in the group with healthy controls. At $p = 0.699$, the gender distribution difference was not statistically significant.

Race: Of the people with bipolar illness, 242 (98.4%) belonged to the Han ethnic group, and 4 (1.6%) to other ethnic groups. Two people (2.9%) and 67 people (97.1%) of Han ethnicity made up the healthy controls group. At $p = 0.494$, the racial distribution difference was not statistically significant.

Status married: Of the bipolar disorder group, 83 (33.7%) were not single and 163 (66.3%) were single. 42 people (60.9%) and 27 people (39.1%) respectively were single and not single in the healthy controls group. The marital status difference did not show statistical significance ($p = 0.407$).

Employment status: Among those with bipolar disorder, 196 people (79.7%) were unemployed and 50 people (20.3%) were employed. Thirteen (18.8%) of the 56 (81.2%) working members in the healthy controls group were unemployed. There was a statistically significant difference in the occupational status ($p < 0.0001$).

Level of education: Of the people with bipolar illness, 72 (29.3%) had only completed elementary school, 106 (43.1%) had completed middle school, and 68 (27.6%) had completed college or above. In the group of healthy controls, 14 people (20.3%) had completed just elementary school, 10 people (14.5%) had completed middle school, and 45 people (65.2%) had completed college or above. There was a statistically significant difference in educational attainment ($p < 0.0001$).

Family psychotic history: Among those with bipolar illness, 193 people (78.5%) did not have a positive family history of psychotic disorders, whereas 53 people (21.5%) did. Past psychotic history: Of the people with bipolar disorder, 32 people (14.0%) had previously had psychotic disorders, whereas 214 people (87.0%) had not.

FINDINGS:

There was no significant difference seen in age, BMI, or WHR between those with bipolar illness and healthy controls. When comparing bipolar illness patients to healthy controls, they showed considerably higher ratings on the manic scale (YMRS) and depression scale (HDRS-17). Patients with bipolar disorder had an average age of 23.08 years at beginning and an average disease duration of 7.49 years. The distributions of race and gender were comparable between the two groups. When compared to healthy controls, bipolar disorder patients had higher rates of unemployment and single status. The educational attainment of healthy controls was higher than that of bipolar disorder patients. A personal history of psychotic illnesses was reported by 13% of bipolar disorder patients, while a familial history was present in about 21.5% of cases.

CONCLUSION:

This qualitative study shed important light on how family relationships affect the assistance that bipolar people get. The literature study emphasized the substantial effects of bipolar disorder on individuals with the illness and their families, emphasizing the stigma associated with it, as well as the difficulties in day-to-day living, social interactions, and the value of self-management techniques.

Between bipolar disorder patients and healthy controls, there were no appreciable changes in age, BMI, or WHR, according to the examination of demographic, clinical, and pharmacological data. On the YMRS (mania scale) and HDRS-17 (depression scale), however, bipolar disorder individuals had noticeably higher scores, indicating their clinical symptoms.

Notably, the study discovered that, in comparison to healthy controls, bipolar illness patients had higher rates of singlehood, unemployment, and poorer levels of educational achievement. These results draw attention to the social difficulties and functional limitations that people with bipolar illness experience.

Additionally, the data showed that a significant percentage of patients with bipolar disorder had either a personal history of psychotic disorders (13%) or a family history of psychotic disorders (21.5%), highlighting the possibility that both genetic and environmental factors play a role in the onset of the illness.

All things considered, this study highlights how important family relationships are to helping people with bipolar disease. Healthcare workers may create treatments and support systems that are more successful by having a better awareness of the issues that patients and their families encounter, such as stigma, day-to-day problems, and the need for self-management skills. The general well-being and quality of life of people with bipolar illness and their families may be considerably enhanced by addressing family dynamics, offering psychoeducation, and creating an inclusive and supportive atmosphere.

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