ISSN Print: 2664-8962
ISSN Online: 2664-8970
Impact Factor: RJIF 5.44
IJPR 2024; 6(2): 01-05
www.psychiatryjournal.in
Received: 01-05-2024
Accepted: 05-06-2024

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Family focused therapy on frequently relapsing bipolar disorder: A study of care giver's stress and quality of life

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DOI: https://doi.org/10.33545/26648962.2024.v6.i2a.68

Abstract
Background: Bipolar Disorder were no longer viewed as victims of pathological family environments but rather, individuals with genetically based disorders who often lived in families that were distressed because of their lack of access to information on effective. Utilizing a "biopsychosocial" framework, family-based approaches to bipolar disorder seek to balance protective and risk factors in the social and family environments. Family psychosocial treatments for early onset bipolar disorder attempt to catch families when conflict and criticism play their most influential role on the development of emotional competence.
Objective: The present study aims to assess the Family Focused Therapy in reducing the level of stress and increasing quality of life for key caregivers of BPAD with history of frequent relapses.
Methodology: The objective of this study is to evaluate the impact of Family Focused Therapy on reducing stress levels and enhancing quality of life among key caregivers of individuals with bipolar affective disorder (BPAD) who have experienced frequent relapses.
Results: Caregivers in the Experimental group were notably older (mean age = 36.70 years) compared to the Normal control group (mean age = 26.10 years), with significant differences noted ($t = 3.423$, $p = 0.003$). Initially, both groups reported similar stress levels related to caregiver issues, family concerns, and financial stressors. However, after intervention, caregivers in the Experimental group reported significantly reduced stress in caregiver and family issues ($p = 0.000$ and $p = 0.047$, respectively). Quality of life assessments at baseline showed no significant differences, but following family therapy, the Experimental group showed marked improvements in overall quality of life, physical health, psychological well-being, social relationships, and environmental satisfaction (all $p \leq 0.006$) compared to controls.
Conclusion: The present study highlights that intervention should be the primary concern for caregivers of individuals with frequently relapsing bipolar disorder. It is well-established that interventions can increase well-being and quality of life (QoL) while reducing stress. However, the impact of such interventions on bipolar disorder (BD) has been less extensively studied.

Keywords: Family focused therapy, caregiver's, bipolar disorder, stress, quality of life

Introduction
The family environment is an important context for understanding the development and maintenance of severe psychopathology [1] and mood disorders in particular [2, 3]. Current thinking about the relapse–remission course of bipolar disorder emphasizes a bio-psychosocial model that incorporates the interactive roles of genetic vulnerability, biological predispositions, family or life events stress, and psychological vulnerability.
Depending on the nature of an individual's illness and how well the illness is managed, the family can be affected in a variety of ways. When mood swings are mild, the family may experience some distress but, over time and with education about mental illness, they can learn to live with the demands of the illness. Caring for someone with more severe symptoms can be very stressful for the family, especially if they are not given the opportunity to develop the skills needed to cope with mental illness.
Relatives of people with bipolar disorder experience high levels of burden which are associated with physical and mental health problems and increased use of medical and mental health services [4], particularly amongst caregivers living with patients [5]. Among people with bipolar disorder, there is a perception that carers and families are often excluded

from management decisions and ignored by health professionals to the distress of family members who remain uninformed about bipolar disorder [6]. Most families report wishing for support and education from services, but that they rarely receive it [7].

The family focused therapy Promote understanding of illness, vulnerability-stress model, and patient's inner experience; emphasize the importance of medication adherence; improve communication between patient and family with concrete strategies (e.g., active listening, requesting changes in others' behaviour); strengthen family's ability to resolve stressful situations.

"Psycho-education", communication enhancement training, and problem-solving skills are integral components of "Family-focused therapy", contributing to improving family functioning and patient outcomes. Evidence from empirical studies underscores the positive impact of "Family-focused therapy" when combined with medication.

The holistic nature of addressing family dynamics and patient symptoms enhances psychosocial functioning and symptom reduction. Ultimately, "Family-focused therapy" integrative approach offers promise for improving the well-being of caregivers and patients with bipolar disorder, emphasizing the significance of involving families in the treatment process. This comprehensive review underscores the importance of "Family-focused therapy", providing insights into its benefits and implications for mental health professionals, patients, and families.

Objectives

The objective of this study is to evaluate the impact of Family Focused Therapy on reducing stress levels and enhancing quality of life among key caregivers of individuals with bipolar affective disorder (BPAD) who have experienced frequent relapses.

Methodology

The study employed a case-control design involving caregivers of 20 bipolar patients selected purposively due to their history of frequent relapses (at least 2 or more episodes of illness). It was conducted at the Ranchi Institute of Neuro-Psychiatry & Allied Sciences and involved a total of 20 caregivers of patients with Bipolar Affective Disorder (BPAD), divided into two groups: Experimental and Control, each consisting of 10 participants. Sampling for both groups was conducted using the purposive sampling method. In the Experimental Group, caregivers underwent Family Focused Therapy (FFT), while in the control group, caregivers did not receive FFT; instead, their associated bipolar patients received Treatment as Usual (TAU). A total of 8 FFT sessions were completed within 2 months.

Inclusion criteria for the Key caregivers

- Carers living with the BPAD patients at the same household and actively involved in patient care.
- The Duration of patient care must be more than 2 year.
- Carers must have educational background of minimum 5th standard.
- Age range between 20 to 60 years.
- Willing to give Written Informed Consent.

Exclusion Criteria for the Key caregivers

Carers with educational background of below 5th standard.

- Age range between below 20 or above 60 years.
- Carers not staying with the patients in the same household.
- Providing care to patients less than 2years.

Tools

1. **Kingston Caregiver Stress Scale (KCSS) (Sadak *et al.*, 2017):** The Kingston Caregiver Stress Scale (KCSS) is primarily a scale that allows a family caregiver to express their level of perceived stress. It can also be used to monitor changes, in stress levels over time, as the caregiver's situation changes. The scale is designed for community living lay caregivers, not institutional care staff. The caregiver is the individual who provides care on a day-to-day basis in the home; usually a spouse or other relative. The reliability and validity of the scale were satisfactory and the tool had high reliability a=0.85.
2. **WHOQOL-BREF (Hindi version: Saxena *et al.*, 1998):** Hindi version of the WHOQOL-BREF has been derived from world Health organization quality of life scale. The Hindi version WHOQOL- BREF was adopted by Saxena *et al*. (1998). WHOQOL- BREF is a short version of whoqol-100questionnaire. WHOQOL-BREF has been tested in 15 centers including New Delhi and Chennai from India. WHOQOL- BREF contains 26 questionnaire 4domains (i.e. physical health, psychological health, social relationship and environment) to measure the quality of life. This scale emphasizes subjective experiences of respondents rather than their objective life conditions. The alpha score of all domains ranges from 0.59 to0.87. Cronbach alpha of all domains is 0.87, the factor loading of item ranges 0.52 to 0.84.The WHOQOL- Brief is highly valid measure of quality of life across cultures. The validity ranged from 0.53 to 0.73 (Yao *et al*., 2000). The two week test retest reliability for domians and individual items ranged from 0.71 to 0.88 from 0.56 to 0.84 (Amir *et al*. 2000). On reducing stress levels and enhancing quality of life among key caregivers of individuals with bipolar affective disorder (BPAD) who have experienced frequent relapses.

The module of family focused therapy

The sessions of Family focus therapy was given with the aims of enhancing patients' and family members' knowledge of the disorder and their communication, problem solving skills, and in developing strategies for effectively managing the disorder. The module is structured to assist caregivers in the following areas:

1. Integrate the experiences associated with episodes of mood disorder or psychosis, assist the patient and key caregivers in accepting the patient's vulnerability to future episodes.
2. Accept the current or future role of psychopharmacology to manage symptom states, enhance social and occupational functioning, recognize and learn to cope with stressful life events that trigger recurrences of mood disorder or psychosis.
3. Assist the family in re-establishing functional family relationships after an episode

The Intervention consists of three phases: the initial phase, intermediate phase, and maintenance phase.

1. **Initial phase: Goal Setting:** It consisted of 2(two sessions) started to establish a therapeutic alliance and develop a treatment plan with the caregivers. Overview of Treatment & discussion of Symptoms,
2. **Risk factors:** Anything that can make an illness more likely to occur, or get worse, Identification of relevant stressors that may elicit symptoms and Identification of coping skills.
3. **Intermediate phase:** The next 3 session of the study was primarily focused on optimizing family support & drafting prevention plan, communication skills, and expressive positive feelings, active listening, making positive request for change and expressing.
4. **Maintenance Phase:** The maintenance phase was consisted of 3 sessions which was focusing on the context of communication clarity, problem solving skills and practice. The sessions was discussed how effectively communication clarity, problem solving skills and practice can be maintained among key care givers negative feelings about specific behaviors.

Procedure

Participants were recruited from the Out-Patient Department of the Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) based on specific inclusion and exclusion criteria. After obtaining their consent, demographic information was collected from each participant. The Experimental Group received 8 sessions of Family Focused Therapy (FFT), lasting 45 minutes to 1 hour each, once a week. In contrast, the Control Group did not undergo FFT, but both groups' patients received Treatment as Usual. Caregivers were assessed using the Kingston Caregiver Stress Scale and WHO Quality of Life measures at baseline and after completing the sessions.

Results

Table 1: Comparison of sociodemographic variables of Experimental group and Normal control group of caregivers of frequently relapsing Bipolar Disorder

Variables		Sample (N=20)		Df	X^2/ Fisher Exact Test	P
		Experimental Group (N=10) (N)	Normal Control (N=10) (N)			
Education	Primary	1	2	4	6.281	.147
	Middle	2	0			
	High School	4	1			
	Intermediate	2	2			
	Graduation	1	5			
Family Type	Nuclear	8	9	1	.392	1.000
	Joint	2	1			
Religion	Hindu	9	9	1	.000	1.000
	Muslim	1	1			
Domicile	Rural	7	9	2	1.588	.582
	Urban	2	1			
	Semi-Urban	1	0			

The table 1. Provides a comparison of sociodemographic variables between the primary caregivers of individuals with frequently relapsing Bipolar Disorder in both the Experimental group and the Normal control group. Each group consisted of 10 participants. In terms of education, there was no significant difference between the groups (p = 0.147), as both groups had participants with varying levels of education. The distribution of family types showed that 8 caregivers in the Experimental group came from nuclear families, and 2 from joint families. In the Control group, 9 caregivers were from nuclear families and 1 from a joint family, and this difference was not significant (p = 1.000). Both groups had 9 Hindu caregivers and 1 Muslim caregiver, indicating no significant difference in terms of religion (p = 1.000). Regarding domicile, the Experimental group had 7 rural, 2 urban, and 1 semi-urban participants, while the Control group had 9 rural and 1 urban participant. This difference was also not significant (p = 0.582). In summary, there were no statistically significant differences between the two groups in terms of education, family type, religion, or domicile.

Table 2: Comparison of Age and duration of stay with patients Experimental group and Normal control group of key caregivers of frequently relapsing Bipolar Disorder

Variables	Sample (20)		Df	T	P
	Experimental Group (N=10) (Mean ± SD)	Normal Control (N=10) (Mean ± SD)			
Age	36.70±7.33	26.10±6.48	18	3.423	.003
Duration of Stay with patients	23.10±5.70	26.10±6.48	18	-1.098	.287

Table 2. Presents a comparison of age and duration of stay with patients between key caregivers in the Experimental group and the Normal control group of individuals with frequently relapsing Bipolar Disorder, each group consisting of 10 participants. The mean age of caregivers in the Experimental group is 36.70 years (SD = 7.33), while it is significantly younger in the Normal control group at 26.10 years (SD = 6.48), with a t-value of 3.423 and a p-value of 0.003. This indicates a statistically significant age difference between the groups. Regarding the duration of stay with patients, caregivers in the Experimental group have a mean duration of 23.10 years (SD = 5.70) compared to 26.10 years (SD = 6.48) in the Normal control group. However, this difference is not statistically significant, as indicated by a t-value of -1.098 and a p-value of 0.287. Thus, while the age of caregivers significantly differs between the groups, the duration of their stay with patients does not.

Table 3: The Kingston caregivers Stress domain of Caregivers of frequently relapsing with Bipolar disorder between baseline and after family therapy

Kingston caregivers Stress		Samples (N=20)				U	P
		Experimental group N=10		Control Group N=10			
		Mean Rank	Sum of the rank	Mean Rank	Sum of the rank		
PRE	Care giver issues	10.35	103.50	10.65	106.50	48.500	.909
	Family issues	9.75	97.50	11.25	112.50	42.500	.562
	Financial issues	11.35	113.50	9.65	96.50	41.500	.466
POST	Care giver issues	5.90	59.00	15.10	151.10	4.000	.000
	Family issues	7.95	13.05	79.50	130.50	24.500	.047
	Financial issues	8.60	86.00	12.40	124.00	31.000	.110

Table 3. Presents data on stress domain among caregivers of individuals with frequently relapsing Bipolar Disorder before (PRE) and after (POST) family therapy, divided into an experimental group (N=10) and a control group (N=10). Initially, at baseline (PRE), both groups exhibited comparable levels of stress related to caregiver issues, family issues, and financial concerns, with no significant differences noted (p-values ranged from 0.466 to 0.909). Following family therapy (POST), substantial improvements were observed in the experimental group compared to the control group. Specifically, caregivers in the experimental group reported significantly reduced stress levels in caregiver issues (p=0.000) and family issues (p=0.047). Although there was also a reduction in stress related to financial issues in the experimental group, this change did not reach statistical significance (p=0.110). These findings underscore the effectiveness of family therapy in alleviating caregiver stress associated with caregiving and family dynamics for individuals with frequently relapsing Bipolar Disorder. The Mann-Whitney U tests confirmed these improvements, highlighting the positive impact of therapeutic interventions on enhancing caregivers' coping abilities and overall well-being in challenging caregiving contexts.

Table 4: The comparison of WHO (QOL) quality of life domain of Caregivers of frequently relapsing with Bipolar disorder between baseline and after family therapy

WHO QOL	Experimental group N=10			Control Group N=10		U	P
		Mean Rank	Sum of the rank	Mean Rank	Sum of the rank		
PRE	Overall quality of life & general health	13.05	130.50	7.95	79.50	24.500	.054
	Physical health	12.10	121.00	8.90	89.00	34.000	.238
	Psychological	10.95	109.50	10.05	100.50	45.500	.753
	Social relationship	11.10	111.00	9.90	99.00	44.000	.668
	Environment	12.90	12.90	8.10	81.00	26.000	.071
POST	Overall quality of life & general health	14.75	14.75	6.25	62.50	7.500	.001
	Physical health	14.00	140.00	7.00	70.00	15.000	.006
	Psychological	15.00	150.00	6.00	60.00	5.000	.000
	Social relationship	15.50	155.00	5.50	55.00	.000	.000
	Environment	15.30	153.00	5.70	57.00	2.000	.000

Table 4. Presents a comparative analysis of WHO Quality of Life (QOL) domain among caregivers of individuals with frequently relapsing Bipolar Disorder before (PRE) and after (POST) family therapy, dividing participants into an experimental group (N=10) and a control group (N=10). Initially, at baseline (PRE), both groups showed similar levels across overall quality of life, physical health, psychological well-being, social relationships, and environmental satisfaction, with no statistically significant differences observed (p-values ranged from 0.054 to 0.753). However, following family therapy (POST), substantial improvements were evident in the experimental group compared to the control group. Significant enhancements were noted in overall quality of life and general health, physical health, psychological well-being, social relationships, and environmental satisfaction for caregivers in the experimental group (all p-values ≤ 0.006).

Discussion

The present study has found no significant differences in socio-demographic variables such as education, domicile, family type and religion between the primary caregivers of individuals with frequently relapsing Bipolar Disorder in both the Experimental group and the Normal control group. The study found significantly difference in age both the group. Early signs of bipolar disorder, known as subthreshold or “high-risk” forms of the disorder, impact around 3%–9% of clinically referred young individuals and can be identified up to 10 years before the onset of full blown Bipolar Disorder [8].

The Kingston caregiver stress domain among caregivers of individuals with frequently relapsing Bipolar Disorder before (PRE) and after (POST) family therapy. The both groups have found no significantly differences in comparable levels of stress related to caregiver issues, family issues, and financial concerns. Following family therapy (POST), substantial improvements were observed in the experimental group compared to the control group.

The present study reveals significantly reduced stress levels in caregiver issues and family issues in the experimental group. Current finding is supported by previous researcher, which suggest that drug therapy and family interventions can reduce family stress, improve psychosocial functioning, and cope with environmental stressors in patients with BD [9]. Another studies of previous researchers have supported with a study conducted by dept. of Psychiatry, Chhattisgarh Institute of Medical Sciences, Bilaspur, Chhattisgarh, India by Sujit Kumar Naik revealed that Family-focused therapy

(FFT) seeks to reduce the high levels of stress and conflict in the families of bipolar patients, thereby improving the patient's illness course [10].

The WHO quality of life has found no significant difference at baseline (PRE), both groups showed similar levels across overall quality of life, physical health, psychological well-being, social relationships, and environmental of primary caregivers of individuals with frequently relapsing Bipolar Disorder in both the Experimental group and the Normal control group.

Present study has found with the intervention of family therapy (POST), significant differences was reveal with the improvements in the experimental group compared to the control group. Enhancements were noted in overall quality of life and general health, physical health, psychological well-being, social relationships, and environmental satisfaction for caregivers in the experimental group.

Researcher found that family focused treatment for caregivers of patients with bipolar disorder benefitted both members of the care dyad and also indicates that targeting aspects of caregiver self-care may be broadly beneficial [11].

Another study found by researcher is caregiver physical activity interventions showed, for instance, that these strategies reduced distress and improved outcomes including physical activity levels, psychological well-being, sleep quality, and self-efficacy related to caregiving and exercise [12].

Conclusion

Living with person with BD can cause lot of stress and tension in the family. In the addition to the challenge of coping with the symptoms of the disorder, family members often struggle with feelings of guilt, fear, anger and helplessness, which causes severe problems in their relationship. Family-focused therapy teaches patients and their caregivers better ways to cope with the disorder and helps them understand their limitations. Learning stress reduction methods, implementing a regular daily schedule, familiarity with signs and symptoms of relapse, appropriate communication skills, and training in problem-solving will be essential steps in treating this disorder. One of the strengths of this treatment is its clarity and ease of implementation and the use of practical examples to better understand the concepts.

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