TITLE: IS FAMILY SUPPORT AND INTERVENTION IMPORTANT IN THE NON-PHARMACOLOGICAL MANAGEMENT OF BIPOLAR DISORDER?

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Abstract

A 30-year-old single lady has been diagnosed with bipolar disorder since 9 years ago. She is maintained on a combination of medications. She lives with her family. How much impact can family members have on patients with bipolar disorder? This paper aims to explore the role of family support and intervention in the treatment of patients with bipolar disorder.

Keywords: bipolar disorder; family support; family intervention; non-pharmacological management

Introduction

Living with bipolar disorder can be difficult. It is a life-long condition that impacts not just the lives of patients, but also their relatives. However how big a role does the family play in a patient’s condition and how big an influence do they have in the outcome? This paper explores the role of family support and intervention in management of bipolar disorder.

Clinical Case Summary

A single patient in her early 30s, a known case of Bipolar Disorder Type 2 came for an interview. She was on Lamotrigine 100mg OD and Vortioxetine 10mg OD. Detailed history taking revealed that she had been diagnosed with the condition for the past 9 years. At 10 years of age, she started experiencing high levels of pressure from her parents and was continuously stressed to be an overachiever. She was also always compared with her sister and disregarded by her parents. She frequently experienced episodes of low mood since this time and this continued throughout her high school and even through university. In her first year of university, other than her symptoms of depressed mood most of the day, she started experiencing symptoms of markedly diminished interest in activities, significant loss of weight, insomnia, feeling of worthlessness, diminished ability to think or concentrate as well as recurrent suicidal thoughts. There were no symptoms of fatigue or psychomotor agitation. The symptoms she did experience were constant with no specific duration and they continued intermittently for the next five years.

In her final year of university, she went overseas to study. She was rather lonely and received little support from her family. She started to experience hypomanic symptoms, lasting for 5 days. The symptoms she experienced were elevated mood, impulsivity, decreased need for sleep, flight of ideas and psychomotor agitation. She did not however experience symptoms such as grandiosity, irritability, distractibility, impairment of functions and involvement in high-risk activities such as substance abuse. That same year, she was involved in a hit-and-run accident where she lost consciousness, was bedridden for 3 months and had to defer her studies for a year. Without much support from her family or friends,
this led to worsening of her hypomaniac and depressive episodes. However, she did not experience symptoms of visual or auditory hallucinations or delusions.

After finishing her degree, she came back from overseas and finally went for a consult where she was diagnosed to have Bipolar Disorder Type 2. Her family support was slightly better after her official diagnosis but she does still struggle with acceptance from them. After her diagnosis, she was started on Quetiapine but she experienced significant weight gain after a few months. Her medication was then changed to a combination therapy of Lamotrigine 100mg OD and Vortioxetine 10mg OD. She is compliant to her medications and there has been no side effects thus far. After her diagnosis, she does not experience hypomaniac episodes anymore but does struggle with depressive episodes intermittently. She started working at a bank but stopped after a few years due to not being able to tolerate the pressure and toxic environment. She started helping in her family clinic but then started experiencing severe migraines associated with vertigo and had to be bedridden intermittently. She had actually started having migraines since late primary school and it was also a significant stressor to her life. However, the migraines only got worse after she resigned from her job at the bank. She was diagnosed to have vestibular migraines from 1 year ago and has been much better in general after both her medical and psychiatric treatment. Her older sister has an underlying psychiatric disorder with a diagnosis that hasn’t been confirmed. However, there was no other significant history in this patient and her premorbid personality was devoid of any hyperthymic traits.

Her mental state examination was generally normal. Her speech was normal. There were no abnormal thoughts and her mood was congruent to the affect. She has good judgement and insight on her condition. Routine physical examination and investigations have always been normal over the years.

Currently, the patient’s condition is overall improving and heading in a positive direction toward recovery. She still struggles with certain symptoms but she seems to be resilient and wants to get better which is important.

**Discussion**

Family-oriented interventions were part of the psychosocial interventions that could be done in patients with bipolar disorder. It was noted that this form of intervention involved areas such as communication, problem-solving skills and psychoeducation in order to manage the stresses and triggers in the home environment which lead to high amounts of emotional expression in the bipolar patients.

In this patient, it was noted that a lot of her stress and a vital trigger in her condition was her family and their lack of support. Thus, it poses the question whether if her family had given her the right amount of support with less pressure, would that have allowed her to have a place to express herself in a healthy, loved environment and thus led to her not developing this condition? It is difficult to say. MacPherson, H. A. et. al (2018) stated that familial dysfunction is a common factor that is present in the occurrence of bipolar disorder in patients. Their results indicated that participants with bipolar disorder had significantly worse family functions in many areas (affective responsiveness, affective involvement, problem-solving, behaviour control, communication roles and general functioning) compared to those without bipolar disorder. They stated that it is important to identify and treat the family dysfunction early so that the patient can achieve the best outcome. (MacPherson, H. A. et al, 2018).

This was consistent with a study by Gitlin, M. J. & Miklowitz, D. J (2017) in the United States of America which found that persistence in functional impairment is associated with chronic stressors such as family distress. While this patient did not have symptoms of severe functional impairment, the same study found that high conflict family relationships were related to a higher incidence of mood disturbances in bipolar disorders where patients with mood disorders generate high levels of personal stress. This was seen in this patient as she did have a lot of trouble with pressure from her family and their lack of understanding of her condition. This was also consistent with Alibiegi, N. & Momieni, F (2018) from Iran, who stated that they found that family-related therapy was useful in improving coping
styles and decreasing emotion expression in families who had patients with the disorder. It allowed them to understand the patient better and be more accepting to them thus leading to an improvement in the severity of symptoms in patients.

Lower parent-child functionality, communication cohesion was noted in parents with patients with bipolar disorder compared to families with no psychiatric disorders (Stapp, E. K et. al, 2020). Parent-reported cohesion involves the communication between the parents and their children and their openness to each other. Stapp, E. L. et. al (2020) also noted that families which had a child with bipolar disorder had more conflict than families who had no children with psychiatric disorders. This was consistent with a study in the United Kingdom by Barron, E. et. al in 2014, who noted that bipolar disorder families experienced an environment with higher amount of stress and conflict with lower levels of expressiveness compared to healthy control families. This is understandable as parents with a child with any form of psychiatric disorder would have a lot more stress in the sense of wanting the child to get better mentally. However, it is key that the stress is not relayed back to or put onto the child so that they receive the support they need to get better. In the patient, the levels of conflict in the family were much higher and it would have been better if she would have received support and help so that she would not have felt so lonely. A lot of stress and pressure was placed on her to be better in life and that interfered with her condition and her recovery.

Heru, A. M. & Mednick, A. (2013) stated that home environments that are emotional can be overwhelming and contribute to relapse. They noted that high levels of “expressed emotion” (overinvolvement or excessive criticism) can lead to higher risks of patient relapse independent of demographics, baseline symptoms and medication compliance. This was seen in the patient as despite being very intelligent and with a high level of education, the excessive criticism from her parents is causing her to take a very long time to recover from her symptoms. Family support in a healthy environment is vital to the health of bipolar patients.

Families with a child with bipolar disorder as patients show dysfunctional patterns related to personal growth and interactions which means a distressed family environment should be addressed when treating children with bipolar disorder (Belardinelli, C. et. al, 2008). As such, family-focused therapy was found to be more efficacious than usual care (psychoeducation and pharmacotherapy alone) in improving social functioning and overall satisfaction in life (Gitlin, M. J. & Miklowitz, D. J, 2017). Family intervention was also concluded to be a good supplementary treatment to pharmacotherapy in patients with bipolar disorder (Alibieg, N. & Momeni, F, 2018). Fristad, M. A. & MacPhearson, H. A. (2013) inferred that along with skill building, family psychoeducation has the most empirical support and is more efficacious in treatment compared to other forms of psychosocial interventions in patients with bipolar disorders.

It was interesting to note that some of the important goals in family-focused therapy (Miklowitz, D. J., 2010; Heru, A. M. & Mednick, A., 2013). The goals and objectives included to educate the patient and the family about the natural course and progression of bipolar disorder as well as the chronicity of the condition. It is important for patients and families to understand that it is a chronic condition and there is no specific time for recovery. Other objectives of the treatment included helping the patient and family to compare the differences between the patient’s personality and the actual illness as well as to help the patient and the family recognise the importance of medications in controlling symptoms. The final and most important objective is to help the patient and family in dealing with the stressors that could lead to recurrence of the disease. This involves helping the family rebuild their broken relationships since the diagnosis of the patient’s bipolar disorder. Methods to aid in that objective include making a habit to express positive feelings in the family and to actively listen to each other (constructive communication).

Sampogna, G. et. al in 2018 noted that family-based intervention in patients with bipolar disorder have shown a strong and good impact on symptom reduction, patients’ functioning and prevention of relapse in bipolar disorder. In 2018, Fackina, K. A. stated that family-focused therapy is vital in the recovery of bipolar patients. The purposes of it were noted to be evaluation of the family’s
knowledge of the disorder, development of coping strategies and communication skills as well as strengthening interpersonal strengths and weaknesses of the patient and each family member. As both the patient and her sister have an underlying psychiatric condition, it would be ideal to strengthen the family dynamics to help manage their condition.

It was noted that family support and interventions have bigger impact on relapse and recurrence of symptoms as well as mood episodes. They have a better long-term effect in the patient’s outcome compared to in acute treatment (Mansfield, A. K., Dealy, J. A. & Keitner, G. I., 2012). Hence, it is noted that this mode of psychotherapy has a delayed management effect. It helps in the long run in management of bipolar disorder patients and emphasis is placed on relapse prevention. This was consistent with Reinares, M. et al (2016) who noted that the response to treatment as well as the needs of patients and their families in the acute phase of illness almost always differ from patients with chronic bipolar disorder. Family education and skills training has a high chance in reducing the severity of symptoms or functional impairment related to the onset of bipolar disorder (Miklowitz, D. J. & Chung, B., 2016). Another study in Spain suggested that family impairment and expressed emotion do play a part in treatment response. The study concluded that the assessment of family function as a whole is important and should be a part of the standard evaluation of bipolar disorder in psychiatric practice worldwide (Reinares, M. et. al, 2016).

Miller, I. W. et. al (2010) found that the necessity for family intervention depends on the level of family impairment and patients and families with high levels of impairment benefit the most from family intervention therapies. Conversely, in patients and families with low levels of impairment, it was noted that the addition of family intervention did not produce any improvement in the course of illness management on any measure. This is an interesting and important finding as it is noted that family intervention would not be beneficial if there is little or no impairment in the family relationship which would make sense because then it would mean that the family would be unlikely to be a stressor for the patient’s condition in that particular bipolar patient.

However, it was noted that there was a limitation in studies dismantling family-focused therapy and it was unclear whether if there were more studies against it whether it would still be seen as an advantage over a disadvantage (Gitlin, M. J. & Miklowitz, D. J, 2017). In 2018, Sampogna, G. et. al pointed out that in all the studies about family-focused therapy, coping strategies of the family members involved have to be considered as that too can cause a lot of family instability and can have a poor impact on the long-term outcome of the patients with bipolar disorder. A study conducted in Brazil by Studart, P. M. et. al (2015) noted that despite the growing interest in the overall functioning of patients with bipolar disorder, studies on social support and the importance of family still need to be discussed in further detail and depth.

Conclusion

In conclusion, family support and intervention is still noted to be a key in the management of patients with bipolar disorder. While more research needs to be done to compare it’s advantages and disadvantages, it is vital that no matter what the outcome of the further studies, these patients receive the love and support that they need to get better. While family-based therapy is supplementary treatment that can be given with pharmacotherapy, up to this point it is still see as important and should not be overlooked or taken lightly in the non-pharmacological management of patients with bipolar disorder so that they can achieve remission, eventual recovery as well as reduce the recurrence of relapse.

References


