Depression in Caregivers of Patients with Bipolar Disorder

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Abstract

Objective: Bipolar disorder is a chronic illness which affects psychological health of caregiver of the patients. The aim of the study was to determine frequency of depression in caregivers of patients of bipolar disorder and to determine the contributing factors leading to depressive disorder among caregiver of bipolar affective disorder.

Material and Methods: Correlational cross-sectional research design was used for the current study. Convenient sampling technique was used and data from (N=220) caregivers both males and females, aged more than 18 years accompanying the patients coming in OPD of psychiatry department Sir Ganga Ram Hospital Lahore Pakistan were gathered. Through convenient, non-purposive sampling technique data from (N=220) caregivers both males and females, aged more than 18 years accompanying the patients coming in OPD of psychiatry department of Sir Ganga Ram Hospital, Lahore Pakistan were taken. Hospital Anxiety and Depression scale (HAD) was administered for data collection. Descriptive and inferential statistics were used for data analysis.

Results: A score of 8 and above indicated presence of depression. Two hundred and twenty caregivers were included in study and out of them 58 caregivers (26%) had depression.

Conclusion: A difficult emotional environment, anxieties, and everyday challenges can be detrimental to an individual's physical and mental well-being. The ways in which patient traits, caregiver qualities, and support systems interact to ultimately determine the amount of care that caregivers must provide.

Keywords: Depression, bipolar, care-giver, HAD scale.

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Introduction

Bipolar disorder is a chronic mental illness causing extreme shifts in mood and energy levels, from manic episodes of heightened excitement to depressive episodes of deep sadness or hopelessness.[1] Bipolar disorder is a persistent sickness related with seriously debilitating symptoms that can significantly affect the both patients and their caregivers and can have long-lasting unfavorable consequences for the patients' psychological and physical, instructive, and interpersonal relations.[2] Bipolar disorder classified into three types: Bipolar type I, Bipolar type II, and Bipolar disorder not otherwise specified (NOS).[3] Bipolar type I involves manic episodes followed by hypomanic or major depressive episodes. Bipolar type II includes hypomanic and major depressive episodes. Bipolar Disorder NOS encompasses symptoms not meeting criteria for Bipolar type I or type II.[3] For Bipolar type I and Bipolar type II, the overall lifetime prevalence was 1.06% and 1.57% respectively showing Bipolar type II disorder to be more prevalent.[4] These conditions, though not meeting full diagnostic criteria, still significantly impact functioning. Recognition of bipolar disorder as sixth leading cause of disability adjusted life years by the World Health Organization in people of working age (15 to 44 years)

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underscores the need for effective diagnosis and support.[5]

Caregivers are the people who join in or offer types of assistance to a patient. It very well may be a spouse, parent, or it can be an individual who has the most successive contact with the patient and can be reached by treatment staff in the event of a crisis.[6] Formal caregiving involves paid assistance, often professional or institutional, while informal caregiving refers to unpaid care provided by individuals or families to relatives, friends, or neighbors.[7] Depression is likely to be high among family caregivers in the form of hopelessness, helplessness, and emotional distress.[8] Clinicians hardly pay any attention to the needs of caregivers.[9] Reports suggest that caregivers experience depressive symptoms at twice the rate of non-caregivers. These individuals fulfill a crucial role in providing support to family members who are ill, incapacitated, or disabled 10 Up to 90% of people with mental disorders live with relatives. The effected person is dependent on the caregiver for emotional support, personal care and practical help. These demands can result in stress to caregivers.[11] Care givers negative experiences not only affect their own health but are also important because their involvement is essential for optimal treatment of patients.[12] Close family members of people with bipolar disorder often bear the burden of emotional anguish, depression, and high rates of mental health care utilization.[2,13] It has been advised that caregiver personal health, older age, female gender and spending more time with the patient are risk factor for caregivers' depression.[14,15] Parents reports high level of depressive symptoms than spouses and more in patients with history of suicidal attempt or ideation.[15]

Many of the previous studies done in Pakistan either focus on depression in patient secondary to a neuropsychiatric illness themselves or focus on caregivers on depression, schizophrenia, and dementia etc. or don't differentiate mental illness separately.[16,17] The objective of current study was to determine frequency of depression in caregivers of patients of bipolar disorder and to determine the contributing factors leading to depressive disorder among caregiver of bipolar disorder.

Material and Methods

Correlational research design was used for the current study. Convenient sampling technique was used and data from (N=220) caregivers both males and females, aged more than 18 years accompanying the patients coming in OPD of psychiatry department Sir Ganga Ram Hospital Lahore Pakistan were gathered. Caregivers who live with the patient, in the same environment, for at least twelve months and was involved directly in giving care to the patient were included. Caregivers who have psychiatric disorder and have any history of psychoactive drug abuse were excluded from the study. Consent was taken from the caregivers, confidentiality and time for finishing the questionnaire was specified to them. Hospital Anxiety and Depression scale (HAD) was utilized for evaluation.[18] There are two questionnaires on it: one for depression and one for anxiety. Seven of the items in even serial i.e. 2, 4,6,8,10,12 and 14 related to depression and items in odd numbers are related to anxiety i.e 1,3,5,7,9,11 and 13. Each item on the scale meant that a person can score from 0 to 21. A cut off of 8/21 was required for the identification of depression. Cronbach's alpha of the scale was .80 which showed good internal reliability. Two hundred and twenty caregivers accompanying the patients coming in outpatient department were included. Written informed consent was taken from the caregivers. Each caregiver was interviewed and then marked down. Additionally, Urdu version of Hospital Anxiety Depression Scale was applied on caregivers to measure the frequency of depression. All data was entered into SPSS version 26 for further analysis. Quantitative data was presented by mean and standard deviation. Qualitative data was presented by frequency and percentages. Data was stratified for gender, duration of disease and poor compliance in patients to address the effect modifiers. Chi-square test was used for post-stratification.

Table 1: *Frequency distribution of caregivers of bipolar patients according to Demographics characteristics (n=220)*

Demographic Characteristics	No. of Caregivers	%
Age (years)		
21-30	22	10
31-40	99	45
41-50	77	35
>51	22	10
Mean ± SD	39.31 ± 8.12 years	
Gender		
Males	90	45
Females	121	55
Relationship with Patients		
Child	88	40
Parents	55	25
Siblings	22	10
Spouse	55	25

Results

A total of 220 caregivers of bipolar affective disorder meeting the inclusion criteria were selected from in-patient department. A detailed interview was carried, and all the answers were recorded on the pre-designed Performa. The presence or absence of depression in care givers of bipolar disorder patients was noted.

Results of table 1 revealed that when caregivers of bi-polar patients were distributed according to different age groups, there were 22 caregivers who were in the age group of 21-30 years making 10% of study group. In age group of 31-40 years, there were 99 caregivers (45%) while 41-50 years age group contained 77 care-givers (35%). There were 22 (10%) caregivers in age group of >51 years. Mean age was 39.31 + 8.12 years in study population. Results showed that 121 caregivers were females (55%) and 90 caregivers were males (45%). The results also indicated the distribution of caregivers according to the relationship with patients. There were 88 children (50%), 55 parents (25%), 22 siblings (10%) and 55(25%) spouses.

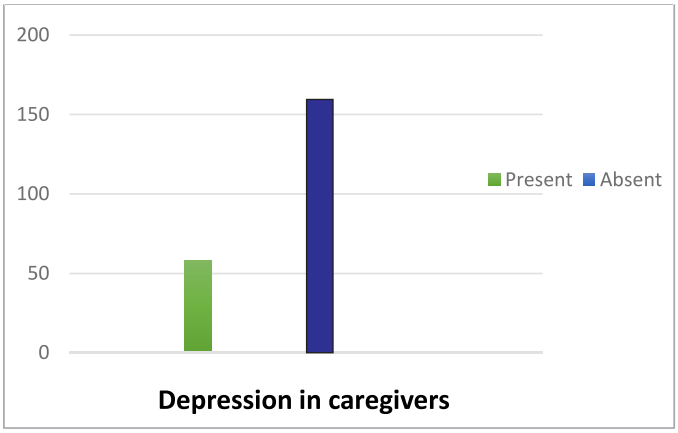

Fig-1: *Frequency of depression in caregivers of bipolar disorder patients (N=220).*

Figure 1 shows distribution of cases according to pre-sence or absence of depression in the caregivers of bipolar patients during their inpatient stay at the hospital. It can be seen that the recent study, 58 caregivers (26%) had HAD scores of more than 8, confirming the diagnosis of depression while 162 (74%) caregivers had no depre-ssion at all. **Fig-2** indicates the stratification of depressed care-givers according to gender, duration of the disease and compliance of the patients respectfully. It can be noted that the gender and duration of disease had significant effect (p value <0.05) on the presence of depression whereas compliance of patient had no clinically signifi-cant effect (p value >0.05).

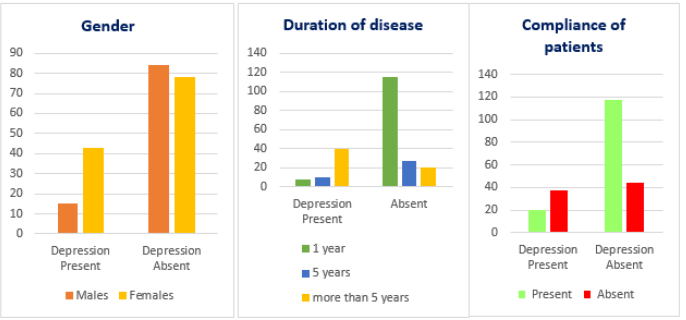

Fig-2: *Depressed caregivers according to Gender, Duration of Disease and Compliance of Patients (N=220)*

Discussion

The effects of bipolar disorder on functioning have been the subject of several research, but the effects on the families of those who are affected have received far less attention. In this research, 26% of caregivers of bipolar patients reported depression. This is consis-tent with recent research findings from Pakistan, which showed that about 29.6% of bipolar patients' caregivers had depression.[19] In a study examining the relationship between the mental health and mental burden of care-givers of patients with chronic mental disorders, as well as the relationship between these variables and social support and coping strategies, the findings indicated that mental health is associated with a lower frequency of positive symptoms and social support, while mental burden is associated with a higher frequency of negative symptoms.[20] The present study found that the source of burden for caregivers in both groups was more objective than subjective. This could be attributed to inadequate social supports, such as long-term and short-term hos-pitalization services, rehabilitation, outpatients, or per-manent patient care. Additionally, the presence of a mental patient may have an impact on the gender and income of the caregiver's family. These results are in line with the demands of caregivers for bipolar illness patients who have severe symptoms and who have to bear a heavier load.

The relationship between the study group's stigma and the caregiver's female gender could potentially be ex-plained by elevated social role expectations. Of the care-givers in the current study, 45% were men and 55% were women. In addition to caring for the bipolar patient and handling home duties, women are more frequently required to socialize with people outside the family. As

a result, family members may experience increased stigma if their female spouse or kid does not fulfill this social role requirement.[15,21] Conversely, because certain behaviors like risk-taking and interpersonal aggression are more socially acceptable in men, female caregivers who take on or restart these responsibilities may face greater discrimination than their male counterparts.[21] Numerous studies have looked at the relationship between carers' physical and mental health and caring for a bipolar patient. The majority of research found a correlation between greater levels of psychological stress and depression and caregiving.[13,15] According to longitudinal studies, caregivers' depression levels rose when they assumed a caregiving duty.[8] It is yet unclear how caregivers' psychological health may be affected over time by stepping into and out of the caring role in addition to other roles like marriage, parenthood, and work. Contextual factors, such as gender, race/ethnicity, and age, have also been found to account for variations in the mental and physical well-being of caregivers, in addition to methodological disparities.[22] According to a meta-analysis on the relationship between caregiver gender and health, female caregivers were shown to be less physically healthy and to have a greater likelihood of depressive symptoms than male caregivers.[23] Understanding factors like expressed emotion and caregiver stress across cultures is vital for managing relapse and enhancing quality of life. High expressed emotion at home raises the relapse risk for bipolar individuals, leading to blame and pressure. Family therapy breaks this cycle. Recognizing stigma around mental illness within families is key for improving patients' and caregivers' quality of life.

Conclusion

Mental illnesses like bipolar disorder disrupt daily life and harm family well-being. Stressful environments and caregiver burdens worsen physical and mental health. Family dynamics are crucial in conditions like bipolar disorder. The process of providing care involves the patient and an individual responsible for their long-term care. In conditions like schizophrenia and bipolar disorder, long-term care is necessary, leading to caregiver burden. Despite increasing research on caregiver distress, nega-tive outcomes, lack of support, and interventions to alle-viate caregiver stress, there is a gap in understanding the mental distress of caregivers and the complexities of their caregiving experiences. The interplay among patient features, caregiver traits, and support mecha-nisms all of which ultimately influence the caregivers' burden of care has received very little research atten-tion. Enhancing the psycho educational supportive program for family caregivers for people with bipolar disorder can help improve depression outcomes in these caregivers by reducing their burden and improving their ability to handle pressure from caring for their patients. The creation of counseling services to enhance adaptability, personal satisfaction, and versatility for caregivers for individuals with psychiatric instability, including bipolar disorder. Furthermore, in order to develop effective treatment and preventative strategies, additional qualitative studies on the burden and coping mechanisms of caregivers for people with bipolar disorder is required.

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Authors Contribution

SB:	Conceptualization of Project
SB, FAK:	Data Collection
SB, FAK:	Literature Search
FAK, ST:	Statistical Analysis
SB, MA:	Drafting, Revision
FAK, ST, MA:	Writing of Manuscript