A qualitative study of bipolar disorder: Exploring caregiver-patient relationships

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Supervised by: Dr David A. Holmes  March 2010
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ABSTRACT

Bipolar Disorder is a mood disorder characterized by episodes of mania and depression, conflicting states within a mood spectrum (Stahl, 2000). Bipolar disorder is a chronic relapsing and remitting illness, which can undermine a patient in their own emotional stability, and causes disruptions to their loved one’s lives (Keitner et al, 2002). Previous research indicates that bipolar disorder has a detrimental effect on relationships, characterized by its unpredictable nature and the burden experienced by caregivers. This qualitative study was designed to explore caregiver-patient relationships. Caregivers of bipolar patients (N=3) and bipolar patients (N=3) were interviewed, with questions derived from previous research. Through analysis of the data, it emerged that although caregivers and patients faced challenges, relationships were mainly strengthened via an emotional journey, and positive effects were also reported on external relationships. Although there are limitations to this study, it provides an optimistic contrast to previous research, whilst also highlighting the need for further research in to this relatively under investigated area in psychology.

KEY WORDS: BIPOLAR; RELATIONSHIPS; PATIENT; CAREGIVER; EXPERIENCES.
Introduction

Bipolar Disorder: Classification and Symptoms

Bipolar disorder is a ‘spectrum of disorders occurring on a continuum’ (DSM-IV-TR), consisting of Bipolar I, Bipolar II, Cyclothymic disorder and Bipolar not otherwise specified (NOS). Bipolar NOS incorporates disorders which show symptoms characteristic of bipolar, but do not clearly meet the criteria for a specific classification; it is sometimes used as a provisional diagnosis.

The onset of bipolar disorder typically occurs in late adolescence to early adulthood, and prevalence is equally split between men and women, although the course of illness may vary. It has been reported that females exhibit more depressive symptoms, and less manic symptoms than males (Taylor and Abrams, 1981), and that women typically experience greater severity within episodes, more mixed state and a more severe course of illness (Braunig et al, 2009).

There is not one definitive medical test to diagnose bipolar disorder, which creates complications in reaching an accurate diagnosis. Mania can be hard to pinpoint, since manic behaviour can involve an increase in goal directed activity and increased productivity (Stahl, 2000). Bipolar ranks second in psychiatric disorders as patients having a high rate of concurrent alcohol and substance abuse (Tohen and Zarde, 1999), which may adversely affect responses to pharmacotherapy, as well as catalysing early onset symptoms (Newman et al, 2002). Furthermore, comorbidity with anxiety and personality disorders highlights the need for an in depth understanding of its nature, in order to arrive at a precise diagnosis and apply effective treatment.

Aetiology

Early studies rationalized the origins of bipolar disorder as psychosocial and pertaining to life events, yet contemporary research demonstrates that there is a potent genetic and neurophysiological basis to the disorder (Miklowitz, 2004). Although environmental influences may contribute to eliciting manic or depressed episodes, bipolar disorder is mainly attributed to being hereditary (Roukema, 2003). It has been found that the lifetime risk of bipolar disorder in monozygotic twins ranges from 40-70% and 5-10% for other first degree relatives (Goldstein, 2002). However, the role of genetics serves as only one of several possible explanations.

The Diathesis-Stress model of depression (Pinel, 2006) suggests that susceptible individuals are exposed to stress early in life, becoming permanently sensitized and overreact to mild stressors for the rest of their lives. The fact that symptoms can be controlled by certain medication (MIND, 2010) gives credibility to the neurobiological approach to causation of bipolar disorder, yet it is evident that a more integrative and advanced collaboration between various schools of thought is required, in order to combat bipolar disorder effectively (Bauer and McBride, 1996).
Treatment and Prognosis

Medical professionals cite the prevention of reoccurrences at the forefront of treatment, adopting pharmacotherapy as the first line offence against mood episodes (Miklowitz, 2000). Since each episode can intensify as the course of the illness progresses, treatment should be provided as early as possible (Cutler and Post, 1982).

Lithium is widely prescribed within bipolar disorder, and is a mood stabilizer which inhibits the rapid transition between depression and mania. Other drug groups prescribed include selective serotonin re-uptake inhibitors (SSRI’s), tricylclic anti-depressants, monamine oxidase inhibitors (MAO’s) and anti-convulsants which are successful in treating acute mania. However, it has been reported that compliance with medication is sometimes evaded. This can pertain to the side effects associated with particular medications, and the fear of ‘missing a high’. A lack of compliance can catalyse the onset of an episode, and concern those who are around the patient.

Cognitive behavioural therapy has shown to be successful as an adjunct to pharmacotherapy, in focusing on irrational and dysfunctional attitudes of the patient which trigger episodic symptoms. Self help groups meanwhile offer a network of support for patients to share their experiences and encourage their personal growth (De Luca, 2009). Adjunctive family therapy has proved to help bipolar patients to recover from depressive and manic episodes (Miller et al, 2004), as well as being beneficial to caregivers. However, availability to the patient may vary significantly in each case.

The need for a close network of support for the bipolar outpatient is supported by the nature of relapse, and longitudinal studies have shown that outpatients may suffer an average of 3.0 prolonged mood episodes during five years of follow up (Winkour et al, 1993).

The role of the Caregiver

The severity of symptoms within bipolar sufferers often alters the lives of caregivers ‘in unwelcome and disturbing ways’ (Newman et al., 2002). However, it is evident from previous literature that the perspective of the caregiver is somewhat neglected. The informal ‘caregiver’ role refers to anyone deemed as being actively involved in the daily life of a person suffering with a mental disorder (Eisdorfer, 1991).

It is possible that caregiver literature is sparse due to the episodic nature of bipolar disorder. Therefore, health professionals have placed little emphasis on the caregiver, which has marginalized the caregivers dedicated to the sustenance of their loved ones (Lefley, 1996). Providing care for an individual with bipolar disorder may differ significantly from caregiving for other mental illnesses, due to the unpredictable course of the disorder.

Family caregiving demands investments for the long term (McLeod, 1999). It has been promoted that ‘successful management of major mental illness in the community relies significantly on an informal or non professional network of caregivers’ (Dores and Romans, 2001). The support of one or more caregivers of an individual with bipolar disorder is imperative in facilitating the recovery from manic or depressive episodes.
Within colonial times, the role of the family was to provide effective caregiving within mental illness (Reisser and Schorske, 1994), which endured until the 18th century, based on the principle of societal responsibility for the poor and dependant (Grob, 1994). Throughout the age of asylums, institutions appeared to abandon this paradigm and patients were isolated from family members, since their presence may pose a threat to the ‘insane’ individual (Rothman, 1971). Following deinstitutionalization in the 1960’s, the shift reverted back to the family caregiving model and ‘catapulted family members in to being the primary caregivers’ for individuals diagnosed with mental illness (Lefley, 1996).

Although it is evident that families have a key role in the mental illness of their family member (Maurin and Boyd, 1990), this can cause strains on the caregiver, and elicit subjective or objective caregiver ‘burden’, a disruption to a families dynamics of habitual peace. Such burden can potentially influence the clinical prognosis of the patient with bipolar disorder. Renaires et al (2006) found that nearly 70% of caregivers felt distressed by changes to their lives which were simultaneous to their loved ones onset of illness. In consideration of the patient, hostile, critical and over involved attitudes from relatives which is conceptualized as ‘expressed emotion’ has been shown to elicit dysregulation of mood amongst bipolar patients, henceforth contributing to the break down of relationships (Bebington and Kuipers, 1994; Kim and Miklowitz, 2004). Although this research is not intended to examine expressed emotion, it is acknowledged as something which has proven to act as detrimental to caregiver-patient relationships.

Bipolar disorder is a lifelong disorder, thus the caregiver may feel distress at being unable to ‘take time off’ from the patient (Steele et al, 2010). Such distress may be detrimental not only to the relationship with the patient, but also to external relationships. Furthermore, it is also suggested that caregiver burden and illness in the key patient may cause disturbance in the close relatives (Tantam, 1989).

The use of adjunctive family interventions has been shown to catalyse the rate of recovery from bipolar episodes (Miller et al, 2004). Although it is not clear what effect adjunctive family therapy has on caregivers, it is envisaged that it helps to improve their understanding of bipolar disorder, and developing the necessary skills in order to provide the best level of support possible for their loved ones. This would subsequently have a positive effect on the caregiver-patient relationship.

Exploring caregiver-patient relationships

Literature has indicated that the presence of bipolar disorder has a profoundly negative impact on relationships. Dores and Romans (2001) pursued a study which explored relationship effects, amongst other aspects with regards to caregivers’ experiences. It was revealed that there was a negative effect on relationships with the patient, characterized by volatility and unpredictability. Furthermore, it has been reported that up to 59% of bipolar patients may exhibit suicidal ideation or behaviour (Allen et al., 2005), therefore contributing to the distress of caregivers.
The unpredictability of bipolar disorder can make it extraordinarily difficult to withhold a relationship between caregiver and recipient, since each discrete episode of mental illness may differ from those that preceded it (Karp, 2001).

With the onset of manic illness, ‘the family may be alarmed by a bewildering restlessness and recklessness and find that tentative attempts to caution or restrain their relative are met with hostility’ (Howe, 1989). Henceforth, this may cause frustration and distance between the patient and caregiver. Furthermore, families are often left ignorant of what is essentially ‘going on’ by mental health professionals throughout the diagnosis process, thus disempowering their role as a caregiver at a time when their support is crucial to the patients’ road to stability. This is illustrated by Jones (2002) and the case of ‘Mr Doors’, who stated when he had questioned whether his daughter was manic depressive, ‘they either didn’t want to tell me or they didn’t know’. Therefore, disruptions to relationships can sometimes originate from external factors beyond the control of the caregiver and patient.

A break down in communication can manifest between the caregiver and patient, which is amplified by the relatives’ belief that despite the nature of the disorder, their relative still has complete control over their symptoms (Perlick et al, 1999).

However, it has also been suggested that in terms of relationships, the support of the caregiver is the backbone of the patient maintaining good health (De Luca, 2009). Moreover, many caregivers report satisfaction and a sense of reward from caregiving (Heru and Ryan, 2004). Family members have been reported as rigorously attempting to understand the diagnosis of a mental illness, which Karp (2001) rationalizes is a period of actively learning about the mental illness, a heroic effort to ‘save’ the emotionally ill person. This optimistically implies that the presence of mental illness may not always necessarily be detrimental to relationships

**Research aims**

- To explore the experiences of caregivers and patients, in conjunction with relationships and any changes which may have been encountered.
- To discover how the caregiver-patient relationship is documented with time.
- To conclude whether the presence of bipolar disorder is reported as being detrimental to caregiver-patient relationships, as previous literature would indicate.

**Method**

**Design**

Qualitative methods aim to provide rich, descriptive accounts of the phenomena under investigation. Since the research was designed to explore human experience, qualitative methods were deemed as an appropriate data collection method, in order to grant a degree of control to the perspective of participants, as opposed to quantitative methods which are predominantly concerned with
‘objective stimuli and measurable responses’ (Coolican, 2004). The data collection was driven through the research question.

Semi-structured interviews were used (N=6), to explore the reported experiences of three caregivers and three bipolar outpatients, which were anticipated to vary across cases. Certain questions may have been appropriate to some individuals but not to others, thus the semi structured form allows the researcher to tailor questions towards individual needs. Semi-structured interviewing allowed for relaxed verbal communication between the researcher and participant, whilst simultaneously allowing the researcher to comprehend with the reality of the participant’s social world. The interview abided to the ‘rapport’ type (Massarik, 1981), in which uncovering personal experience is the ultimate goal of the researcher.

Thematic analysis was the chosen method of data analysis, since it allows the researcher to be flexible within their approach and analysis of the intricate data. Thematic Analysis abides to essentialist methods, since it is upmost concerned with exploring the experiences, meaning and reality of the participants of study. Themes convey relevant issues within the data, with relation to the research question thus representing some level of ‘patterned response or meaning within the data set’ (Braun and Clarke, 2006). Thematic Analysis involved the generating of ‘codes’ when transcribing the data, and was a multi step procedure (Flick, 2002). Codes are designed to assist with the ‘observing of people, groups, organizations, cultures and events’ (Boyzatis, 1998).

**Materials**

Semi-structured interviews were recorded using a Dictaphone, to capture the experiences of individuals, and a transcription machine was used to transcribe the raw data.

Two interview schedules were formulated- one of which was specifically designed for bipolar patients, and another designed for use when interviewing caregivers (see Appendices II and III). Interview schedules provide a framework for the researcher, effectively guiding the research process and allowing the researcher to touch upon significant aspects from the previous research. There is also the opportunity to ‘expand further as relevant issues arise’ (Rubin and Rubin, 1995). Prompts for topics were employed as opposed to questions, since questions can be perceived as influencing the interviewees’ responses. Both interview schedules were refined after the first interviews for the bipolar patient and caregiver, which ran as pilot studies and acted to highlight any discrepancies with the method of data collection. These pilot interviews were used within the study, due to time constraints.

**Participants**

Participants were recruited via an opportunity sample of individuals meeting a specific criterion. Posters outlining the details of the study were placed within several of the university campuses (see Appendix I). The posters provided contact details, and included the criteria for willing volunteers- it was envisaged that between six and eight participants would be recruited, equally split between caregivers and bipolar sufferers. The criterion was designed to make the research as relevant and compelling as possible, and stated that-
- Participants must have received a diagnosis of bipolar disorder, or if a caregiver should have resided in the same household as the patient for a minimum duration of 12 months;
- If the participant is a bipolar patient, they should have received a firm diagnosis at least six months ago;
- If the participant is a caregiver, they should be actively involved in the bipolar patient's life.

The criterion was influenced by previous qualitative studies, and although quantitative research would make use of a greater proportion of participants, the recruitment six participants was deemed to be appropriate in the end. It was anticipated that if a greater number of participants were used, the depth and complexity of the data would be jeopardized.

When all participants had been recruited, suitable times for interview were arranged. In order to protect the identities of all participants, pseudonyms have replaced their real names, as well as the people they discourse of.

Participant 1 is a 28 year old male, and was diagnosed with bipolar II four years ago. In this study, he will be referred to as Damien.

Participant 2 is a 22 year old female, and was diagnosed with bipolar II one year ago. In this study, she will be referred to as April.

Participant 3 is a 54 year old female, and was diagnosed with bipolar I 9 years ago. She will be referred to as Deborah.

Participant 4 is a 39 year old male, and is a caregiver to his wife who suffers with bipolar disorder. He has been in a relationship with his wife for 13 years, and they will be referred to as Keith and Tina respectively.

Participant 5 is a 28 year old female, and will be referred to under as Rachel. She has previously resided with her Father and Brother, who both had bipolar disorder but were diagnosed at different times.

Participant 6 is a 47 year old female, and will be referred to as Heather. She is a caregiver to her daughter who was diagnosed with bipolar II three years ago, who will be referred to as Megan.

**Procedure**

Posters were formulated to recruit participants, and were distributed throughout several university campuses. When participants had been recruited, a suitable time to pursue an interview was arranged.

Interviews took place in Elizabeth Gaskell campus in a secure interview room, which was sound proof- this facilitated the comfort of the participants to speak freely and honestly, in terms of discussing their subjective experiences.
Participants were asked to read a consent form (Appendix IV), and to sign it to certify they understood what the research entailed, and were informed that their experiences would be used within the analysis section of the study. They were provided with contact details should they have any further queries, and informed of their right to anonymity, and right to withdraw from the study at any point. Other various ethical issues were addressed both verbally and in the consent form.

Participants were informed that the interview would be recorded using a Dictaphone, and encouraged to answer as freely as possible regarding their experiences. The establishing of rapport was essential, in order to facilitate the participants confidence in the researcher (Bogdan and Taylor, 1975). Relevant interview schedules were followed, which allowed the opportunity to tailor questions towards individuals’ experiences.

The interviews were transcribed using a transcription machine, and then analysed employing qualitative data analysis strategies. The analysis of the data involved a number of ‘phases’, and involved immersing oneself in to the data (Braun and Clarke, 2006). Codes were generated preliminarily, to highlight interesting and relevant features of the data, which were collated into potential themes. The themes were reviewed as an ongoing process- the reviewing and defining of themes was of utmost importance in providing a coherent account of the data received.

Results

Method of Analysis

Thematic analysis has previously been conceptualized as a ‘poorly demarcated and rarely acknowledged’ methodology within psychological research (Braun and Clarke, 2006). From a positivist stance, thematic analysis is attributed as a ‘passive’ form of data analysis, denying the researcher an active role in pursuing their research, and themes can be seen as ‘emerging’ from the data (Rubin and Rubin, 1995). This is supported by the justification that themes ‘reside’ in the data (Ely et al., 1997). It has been theorized that there is an ‘anything’ goes notion within qualitative approaches (Antaki et al., 2002), thus removing validity from the research. This is a stark contrast to quantitative methods, which driven through empiricism can be scientifically generalized to populations. Furthermore, qualitative methods often propose challenges to the researcher, due to the voluminous and unstructured nature of the data (Bryman and Burgess, 1994).

However, whilst positivist research can sometimes act as dehumanising and isolating people from their surrounding context (Coolican, 2004), thematic analysis is intended to capture relevant aspects of human experience, in relation to the research question.

Despite the merits of quantitative investigations, this research was predominantly concerned with human experience, as opposed to ‘testing’; therefore justifying it’s use as a research tool within this study.
‘Turbulent beginnings’

The difficulties in loved ones accepting that their family member or partner had bipolar disorder were apparent. It may come as a shock to some, purely because the symptoms are not always be observable-

“Although for a long time I myself had realised something wasn’t right, he really had no idea. He’d heard of manic depression but he really didn’t have a clue what it was, what it entailed or how it affected people” (See Appendix V: Deborah transcript, line 121).

A struggle to accept that a loved one is ill can manifest in denial, and exacerbate a break down in communication. It was implied that public preconceptions of bipolar disorder advocate that it is not a serious mental illness. This can be attributed to originating from a variety of outlets such as media influences; when portrayed within television there is a tendency to portray the manic phase of the disorder, or ‘glamorize’ it,

“If I’m completely honest I thought it was just a euphemism for some celebrity style disorder where they’re in and out of rehab every two minutes.” (Heather transcript, line 108).

Although focusing on bipolar in the media may act to raise awareness, inaccurate representation seemed to infuriate caregivers and patients, especially with its regards to being attributed as a ‘celebrity’ disorder. This was seen as removing sincerity from its status as a form of mental illness, and possibly contributed to the break down of communication in relationships in the initial stages of diagnosis.

Guilt

Guilt was observable from the behalf of the caregiver and the recipient. The caregiver may struggle to accept the fact that their loved one is suffering with bipolar disorder as they feel that they themselves have ultimately failed. Meanwhile, the bipolar sufferer may feel that by opening up about bipolar disorder they are inflicting a burden on their loved ones-

“I felt a bit like she’d taken the whole thing as an insult and that I was depressed because of her which just wasn’t the case at all” (Damien transcript, line 49).

Although it may be human nature to attribute cause and blame, blame led to a stalemate being reached in which the relationship is unable to progress. Attributing blame may serve the purpose of making sense of events which are ultimately ambiguous and beyond ones control-

“Looking back now I could have been a better Mum and I could have been there for her more. Her dad and me separated when she was thirteen and I just didn’t realise the impact it had on her really” (Heather transcript, line 18).

The transition

It became clear that in most cases, communication barriers break down, although it may take drastic events or times of crisis to achieve this. Although such events may be traumatic they were seen as bridging a gap which had developed over time and paradoxically initiating a process of openness and
honesty, as described by Deborah as she explains that she pursued an affair, as a last resort to gain her husband’s attention—

“It was a short lived affair and Mark found out about it and in a sick twisted way I guess I’d wanted him to find out about it in order to finally sit up and take notice of me and what I was going through” (Deborah transcript, line 196).

It was also observed how when caregivers accepted that their loved ones were suffering with bipolar disorder, there was a shift from providing a basic level of practical support, to providing a greater degree of emotional support in order to facilitate the patient through periods of turmoil. Such emotional support was enhanced by the caregivers’ attempts in understand bipolar disorder. Caregivers incorporated themselves into the process of readjustment for the patient, which was beneficial for both the patient’s well being and the caregiver-patient relationship—

“My dad was on the internet he was researching any medication that I had and he bought a book on bipolar that was written by people who had bipolar and it had advice in like what to do when a person is high and what to do if the person is feeling suicidal and stuff… he literally just educated himself as much as possible in order to support me in any way he could really” (April transcript, line 79).

Acceptance

Acceptance of bipolar disorder as a form of mental illness seemed to be the key in maintaining relationships. The realisation that it is a lifelong illness prepared the caregiver and patient alike for obstacles and challenges which they may potentially have to face—

“You have to realise it’s something somebody has got forever, and they will always have it and at times can relapse. It’s kind of like, you can never think ‘oh he’s alright now’ cos just around the corner could be a situation where he’s not” (Rachel transcript, line 325).

Caregivers and patients felt that there is a detrimental stigma attached to bipolar disorder. It was described how some of the older generation hold pessimistic connotations of mental illness, which is depicted by April who spoke of how she felt her relationship with her father’s partner was strained at times—

“She’s quite a bit older than my dad so I don’t know whether she’s got any like preconceived ideas of what bipolar is or if she’s just scared of the term mental illness” (April transcript, line 197).

However, despite external perceptions, for the most part patients and caregivers reported how the label of ‘bipolar’ and effectively living with a mental illness was not of great significance to them, and reported how the illness didn’t define their personality or existence.

Independence

The loss of independence experienced by the bipolar patient, and the maintaining of independence were noted. Keith described how his partner felt that she was not dependent on medication at times, although he recognised that compliance with her medication was essential. Such disagreement over
compliance concerns can potentially act to strain the relationship, since the bipolar patient may feel that a dependence on medication denies them the ability to control their own life.

As explained by Deborah, the aspect which many patients may find hard is admitting help, since this implies a loss of independence. Dissatisfactions with health services were also reported, since therapies such as cognitive behavioural therapy are not widely offered or available. Henceforth when patients were finally offered adjunctive treatment they felt that after such a long time of struggling without psychological guidance, they were able to cope independently-

“ She’s tried CBT and with the CBT she just didn’t find it useful at all and didn’t really put the effort in to which kind of frustrated me to an extent because I thought well if it was me that I’d want to try and put the effort in and make it work” (Keith transcript, line 126).

Although patients felt that they had been supported throughout mood episodes by caregiver, it was implied that they still retained independence in being able to deal with it efficiently alone-

“As much as she supports me, no one is able know exactly what you’re going through so you can’t depend on someone else to pull you out really as it’s never enough and it all comes down to you yourself” (Damien transcript, line 160).

**Strengthening of relationships**

Caregivers and patients mostly reported that relationships were strengthened via an emotional ‘journey’. From the initial turbulence, through to times of crisis which make the importance for stable relationships explicit, communication barriers were eventually broken down and the turmoil experienced by the caregiver and patient manifested a stronger relationship, characterized by honesty and openness-

“It was almost as if you’re completely stripped bare and you’ve got nothing holding you back you’ve got no secrets, nothing left really to hide from anyone so it is just like starting again and wiping a slate clear and the relationship with my dad now has improved so much” (April transcript, line 97).

It was reported how caregivers were able to recognise the onset of a manic or depressive phase before the patient, and were able to successfully use coping strategies to support the patient in such unpredictable times,

“If I’m starting to go on a high the people around me realise sometimes before I do and Russell will just slowly coax me and give me a helping hand really” (April transcript, line 177).

Rachel reported how her father who suffered with bipolar disorder had ‘broken the family up’; therefore the strengthening of relationships can not be generalized across a wide spectrum since every case is different. Rachel reported how her father’s issues were largely were pre existing issues within the family which were not related to bipolar disorder, and cited her relationship with her brother who also suffered with bipolar disorder as distant, but rationalized this by stating that she had not lived with her brother for a long time. Therefore it
could be proposed that the strengthening of relationships may be achieved by being within close proximity to the patient on a regular basis. Nevertheless, Rachel reported how one positive thing to emerge from her experiences was the positive affect it had on her own relationships, and the coping strategies which she had acquired-

“I think it has positive affected my own relationships because one thing I really endeavour to do is if I’m not happy, I endeavour to do my best to never let it affect the people I care about” (Rachel transcript, line 230).

Positive relations between caregivers and patients reflected on the rest of the family, reinforcing how it may be times of turmoil which bring a family closer together and establish close bonds,

“One benefit which has come out of this illness is the fact that it’s given me more time with my family, the boys and my grandsons and wonderful daughters in law- it’s really made me appreciate the little things in life and realise that life is too short” (Deborah transcript, line 264).

Discussion

The results depicted how caregivers and patients experience an emotional journey, which originates in the early stages of illness, and experience a period of transition and upheaval in their respective lives.

Interestingly, the analysis indicates how relationships are seen to be strengthened within patients and caregivers, which defies established research in the domain of caregiver-patient relationships. It is thus necessary to re-examine each established theme closely, in conjunction to the reviewed literature.

It was observed how it was often initially difficult for caregivers to accept that their loved ones were suffering with a mental illness. Although caregiver denial may have been subconscious, this could pertain from a lack of clarification from the behalf of health professionals, and abides to the research of Lefley (1996), and Howe (1989) who highlighted that caregivers are essentially ‘left out’ of the diagnosis process, despite their pivotal importance in a patients life. Furthermore, a lack of understanding of bipolar disorder as a legitimate mental illness were seen as initiating a break down in communication between patients and caregivers, henceforth reinforcing the idea that the patient has ‘complete control over their symptoms’, despite the nature of the disorder (Perlick et al, 1999).

It was observed how within the process of diagnosis, health professionals may have failed to communicate with caregivers effectively, despite the seriousness of bipolar disorder. The repercussions this may have on relationships highlights the greater need for caregivers to be integrated in to the diagnosis process, for the benefit of their own understanding, and the relationship held with their loved one.

It was seen that guilt was a mechanism which individuals used to rationalise the disruption to the relationship, and a method of rationalising the tension which may have been present, and the transition can effectively be described as the point in time between the turbulence and attribution of guilt, and moving towards
acceptance. The transition witnessed how the relationship is able to move forward, since communication barriers were broken and the caregiver adopted an active stance in supporting the patient emotionally, and realising that adjustment in life were necessary. This was illustrated by April, who described how her Father had ‘educated’ himself about bipolar disorder, in order to facilitate her road to stability. The process of education reflects the theory of Karp (2001), who advocated that caregivers may actively learn about the mental illness their loved one is experiencing, in an attempt to ‘save’ them.

Caregivers and patients alike progressed towards accepting that bipolar disorder is a ‘life-long’ mental illness, which prepared them for challenges which they may encounter within the relationship, as well as in general every day life.

What was most significant was that caregivers reported how they felt positive in terms of the future, and felt that they were consistently developing skills to support their loved ones. This is a vivid contrast to the distress described as not being able to take ‘time off’ from the patient (Steele et al, 2010). Furthermore, it was suggested in previous research how it proves difficult for caregiver and bipolar patients to withhold their relationships, since each episode may differ from the precedent one (Karps 2001). It became transparent through analysis that the prospect of a profound episode acted to motivate caregivers to provide the best level of support possible for the bipolar patient.

Patients were adamant that they were able to control their episodes independently, an aspect which represented their determination to pursue a normal life. The theme of independence corresponded with Howe’s (1989) description of how attempts to initially help the patient are met with hostility. This was seen as a defensive reaction from the bipolar patient in the initial stages of illness, since it posed a threat to their independence- something highly valued by the patient and feared to be lost throughout the prognosis of the disorder.

The scope of literature identified in this study advocated that the presence of bipolar disorder disrupted relationships, and that the distress, burden and feelings of unpredictability experienced by caregivers affected their relationship with the bipolar patient (Renaires et al, 2006).

It became clear that within the initial stage of the patients’ illness, a great deal of turbulence was experienced, characterized by a lack of understanding, denial and guilt. With time and the ability to reflect and comprehend with what having bipolar disorder entailed, it was clear that communication barriers were broken, thus paving the way for the willingness to share feelings and concerns between caregivers and patients. This ultimately initiated the road for rebuilding the disrupted caregiver-patient relationship, which strengthened with the acceptance of bipolar disorder, and readiness from both parties to combat potential challenges and life style changes which may prove necessary.

It can be justified to state that there were changes to the patient-caregiver relationship, characterized by an emotional journey. Such changes were not wholly detrimental to the patient-caregiver relationship as previous literature has evidenced, and indicated that closer, more positive relationships were forged as a by-product of the trauma experienced by patients and caregivers. Such revelation harbours optimism for caregivers and bipolar patients, and provides a
colourful contrast to preceding research which has focused on the detrimental effects of bipolar disorder on relationships.

However, there are limitations to consider. Although the qualitative nature of this study allowed for an in depth exploration of human experience, individuals subjective experiences can not be generalised to populations. Furthermore, time restrictions meant that the original criteria participants had to be loosened. It was initially proposed that caregivers should be currently residing with the bipolar patient they held a relationship with. Although this was true for five of the six participants, the fifth participant no longer resided with the bipolar patient they held a relationship with, which may explain the variability in the experience reported. Nevertheless, the account provided acted to reinforce the subjectivity of each relationship- in that, it is not possible to define the exact course of bipolar disorder as a mental illness, nor is it possible to define the course of any caregiver-patient relationship.

Research to be pursued in the future would possibly make use of quantitative methodologies and a longitudinal structure, with emphasis placed on the relationship at the point of diagnosis, and followed up to reveal the dynamics of relationships at a later point. This may also allow for a greater influx of participants to be used. In addition, this study relied on individuals experiences of their relationship, yet only displayed one of the recipients’ experiences. Future studies should address the patients and caregivers of the same relationship, in order to provide an insight to their shared experiences. The use of focus groups would also be appropriate, in terms of encouraging group interaction and experiences which can be generalized to other patients and caregivers alike.

The results of this study imply that the presence of bipolar disorder is not necessarily detrimental to caregiver patient relationships, yet indicate that a greater level of support offered to caregivers by health professionals is still needed, for their own understanding of bipolar disorder, and facilitating the support they are able to offer to their loved ones. This requires further elucidation from the behalf of health professionals, in terms of providing adjunctive therapies for bipolar patients and caregivers alike. This would optimistically enhance the every day coping strategies which are employed within caregiver-patient relationships, and the realms of mental illness.

**Reflexivity**

Since the researcher controls the rigorous analysis of data, it must be acknowledged that the researchers’ preconceptions may influence the direction of the results.

I am a third year Psychology undergraduate student, with a vested interest in mental health. The literature pertaining to caregiver-patient experiences is plagued with negativity in terms of relationships, and my emotional investment in such issues may have influenced my role as the researcher. The ‘emotional journey’ described within the thematic analysis of the can not relate to each relationship, and bipolar patients may not necessarily attribute their loved ones as ‘caregivers’, since they are able to lead a fairly independent life. Moreover, my own judgement of the patient-caregiver relationship may have influenced the research, since I hold personal connections with two of the participants.
The data produced may be interpreted differently from the perspective of others - the theme of ‘turbulent beginnings’ may have been a presumption in the sense that any diagnosis of illness whether it is physical or mental is usually an unsettling time for individuals and their loved ones.

The level of rapport developed by myself as the researcher may have also affected the extent of information divulged. The theme of ‘strengthening of relationships’ may have resulted from participants being selective in the information shared within the interview, and not feeling comfortable enough to discuss the trauma experienced.

Nevertheless, the findings and limitations of this study provide a base for further exploration into the area of caregiver-patient relationships, and it is anticipated that further elucidation in this area would improve understandings of the role of relationships within mental health.

References


