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CASE REPORT

Family intervention with a case of bipolar I disorder with family conflict

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Abstract

Bipolar disorder is a major mental illness. Inherited treatment of bipolar disorder has been focused on pharmacological treatments. Though, psychosocial variables appear to be important antecedents of bipolar disorder, poor drug compliance, expressed emotion or faulty communication and life events play a vital role in relapse. Conflict is commonly seen in family due to this disorder, particularly when family member have less knowledge about illness or has poor coping capabilities. So, integrating psychosocial treatments with the widely used drug regimens could be more effective as various researches have shown the evidence. Family-focused treatment (FFT) with the goal to enhance family function through communication, problem-solving and coping skills training, psychoeducation, and relapse preparedness has known efficacy along with interpersonal and social rhythm therapy (IPSRT). This social casework report illustrates the positive outcome of individual as well as family intervention using FFT and IPSRT with an individual with bipolar I disorder having strained interpersonal relationship with his family due to his illness.

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Theoretical and research basis for treatment

Bipolar disorder is a major psychiatric illness, with a lifetime prevalence of one to three per cent. It is estimated that an adult developing bipolar affective disorder (BPAD) in his/her mid 20s effectively loses nine years of life, 12 years of normal health, and 14 years of work activity.[1] Bipolar I disorder is a mood disorder that is characterised by at least one manic or mixed episode. Bipolar I disorder sometimes occurs along with episodes of hypomania or major depression as well.[2] Inherited treatment of bipolar disorder has been focused on pharmacological treatments but well-controlled studies have demonstrated that lithium and other mediators are effective for only 60% of the persons with BPAD. Even so, there are several reasons to consider adjunctive psychosocial treatment, such as the high rates of noncompliance and relapse with medication treatment alone.[3] For example, 69% of individuals in naturalistic trials relapse within two years[4] and 59% are re-hospitalised within five years.[5] In one five years follow up study by Mai *et al*.,[6] it is revealed that only 23.4% of persons with BPAD remained episode free on lithium. Beyond the evidence that outcomes can be poor with only medication, psychosocial variables appear to be important antecedents of episodes. For example, expressed emotion[7] and life events[8] play a powerful role in relapse, and the life events' effect is not buffered by medication.[9] In addition, the psychosocial consequences of this disorder, such as disability, are severe.[10] It has been estimated that psychosocial factors may contribute 25-30% to the outcome variance in bipolar disorder. So, psychosocial factors, as well as quality of life (QOL) and cost of care can be improved by integrating psychosocial treatments with the widely used drug regimens.[1]

Family-focused treatment (FFT) for bipolar disorder is an adaptation of a successful family therapy approach to schizophrenia which is based on the premise that the illness is associated with bidirectional stresses that influence the ability of the family to cope with the illness, as well as the severity of symptoms and the risk of relapse of the family member with bipolar disorder. The goal of treatment is to improve family functioning through a combination of communication, problem-solving and coping skills training, psychoeducation, and relapse rehearsal.[11] Clarkin *et al*.[12] reported encouraging results using a structured psychoeducational intervention for persons with BPAD and their spouses. Honig *et al*.[13] used a psychoeducational program for persons with BPAD and their key relatives focused on developing coping skills and recognising the need for social supports and found significant reductions in expressed emotions in families, with an associated decrease in relapses. According to Miklowitz *et al*.,[14] FFT for bipolar disorder is based on the assumption that acute episodes of bipolar disorder have disorganised effects on the family unit that are reflected in disturbances in affective and communication styles of key family members. Based on behavioural family management techniques, FFT involves not only the

patient but also the significant others. The programme consists of four modules: (1) assessment of family and marital milieu, (2) psychoeducation for person with BPAD and their family about bipolar disorder, (3) communication enhancement training, (4) problem-solving skills training. A recently concluded randomised controlled trial[15] showed that persons with BPAD assigned to FFT had fewer relapses (especially depressive episode); the most dramatic improvement in persons with BPAD whose families were high in expressed emotion in comparison to persons with BPAD who received crisis management. Interpersonal and social rhythm therapy (IPSRT) of Frank *et al*.[16] integrates interpersonal therapy with social rhythm therapy. It focuses on stabilising social rhythms, such as patterns of social stimulation and sleep-wake schedule, and on improving interpersonal relationships as a means to develop better coping skills. IPSRT begins while the patient is in the acute episode of illness. Sessions are initially focussed on assessing the contribution of life events and social rhythm disruptions to previous episodes. When the patient has stabilised, the maintenance phase focuses on tracking social rhythms and identifying triggers that disrupt these rhythms. The final phase focuses on prevention of episodes. It is established through trial that IPSRT helps persons with BPAD to achieve more stable social rhythms.[17,18]

In this social casework with an individual with BPAD with strained interpersonal relationship in his family due to his illness, individual as well as family intervention were done effectively.

Case introduction

Index client Mr RR, 20 years old, unmarried, male, studying in Bachelor of Science (BSc) part I, hailing from a nuclear, upper middle class Hindu family, from Patna, Bihar.

Sources of information

The client himself, his parents, maternal grandfather and case record file were sources of information which were reliable and adequate.

Reason for referral: The case was referred for family intervention.

Brief clinical history

Presented with complaints of inflated self-esteem, irritability, impulsive behaviour, disregard towards parents and increased expense for one month, with insidious onset, episodic course, improving progress and was precipitated by discontinuation of medication. Diagnosed as bipolar I disorder currently hypomanic (second) episode, treated with mood stabiliser and shown improvement to some extent. First contact with Central Institute of Psychiatry (CIP), Ranchi on 1 October 2004 and he was on regular treatment on outpatient basis. He was referred to psychosocial block (unit) on 19 October 2004 for family intervention (since the family had regular conflict with parents). On that time, he was on regular medication.

Past history

One manic episode on May 2003 with same complaints (but more intense) as mentioned above with acute onset, continuous course, deteriorating progress, precipitated by failure in Indian Institute of Technology (IIT) entrance examination, treated by a consultant psychiatrist with mood stabiliser and improved within two months.

Family history

Family history of illness: There is no family history of any major physical/psychiatric illness or substance abuse except one paternal aunty died of tuberculosis (TB).

Family composition

Father: Father is 49 years old, studied up to graduation; he is a teacher in a government high school. He has sinus problems but was maintaining well with medication.

Mother: Mother is 44 years old, studied up to intermediate. She is a teacher in government primary school. She is reported to be loving and caring.

First sibling: Client himself.

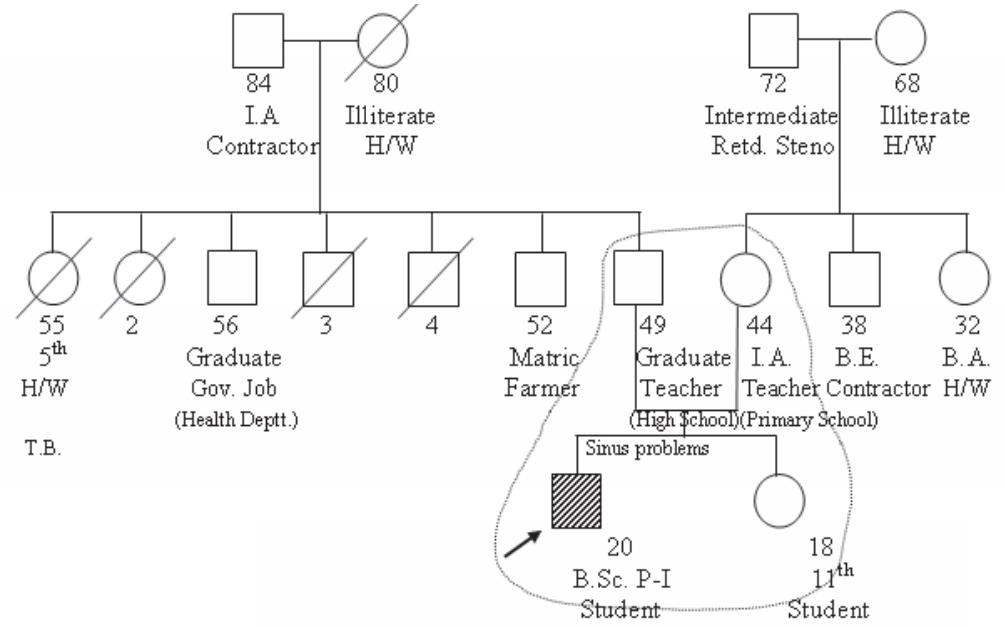
Second sibling: Client's sister is 18 years old. She was studying in class XI.

Family interaction pattern

Interaction between parents: It was reported to be normal but during assessment of the family, it was found that many faulty interaction patterns existed between the couple. Client's father wanted to dominate his wife; he used to try to implement his decision but his wife comes up with her own plans and tries to implement that. If father has to give any instruction to anyone, especially the client, in the family, he used to repeat the same instruction several times and this was disliked by the mother.

Interaction between the parents and the children: Parents were over permissive, and they used to provide more than whatever the children demand. Prior to illness of the client, interaction was reported to be good but after client's illness, he (the client) use to demand more and more and whenever there is any delay in fulfilment, he gets angry, irritable, at times become disobedient or shows disregards to parents in terms of being rough to them and all these lead to conflict in the family.

Figure 1. Genogram: family of origin.



Interaction between the siblings: Prior to illness, interaction was reported to be good but after client's illness, it became faulty. Client's illness behaviour - irritability, impulsive behaviour and disregard towards parents and herself (i.e., patient's sister) - was not liked by her.

Family dynamics

Boundaries: Close/rigid boundaries found in the family; all members had their own rigidity.

Family developmental stage: The family was with adolescents.[19,20]

Leadership: Father was the nominal leader of the family and functional head was mother. All decisions pertaining to family matters and financial matters were taken by her. However, she consults with her husband most of the time and even children's opinions are asked when required but there are lots of conflicts between parents as both are trying to implement their own decisions.

Role structure and functions: Role allocation is not clear in the family. Everyone in the family performs their roles but not satisfactorily.

Communication: Unhealthy, though communication of positive feelings like love and affection was present in the family but negative feelings are communicated in an unbalanced way, mostly criticism or blaming and at times hostility was also found.

Reinforcement: Reinforcements were inappropriately used in the family. Works were given the most importance and therefore any kind of achievement in this regard from the children, including the client, was inadequately reinforced in terms of over reinforcement and lack of punishment practices in the family.

Cohesiveness: Family has a good 'cohesiveness' among its members. They share their meals together, work together, and celebrate festivals together and so on. Previously, all the members would care for each other and enjoy each other's company. Now all the members are worried and frustrated about the client's behaviours leading to detached feeling towards the client.

Family rituals: Client's mother is very much religious; she used to perform pooja every day. Besides this, she used to keep 'bratas' (fasts) and 'manauties' (promises to God). She expects and even sometimes forced every one's participations in these activities. She also used to visit so many 'babas' (faith healers), temples and used to bring 'tabiz' (a religious necklace) and wear them around the client's arms or neck, which he (the client) didn't like at all.

Adaptive patterns: Poor adaptive patterns were found in the family. Family members were unable to differentiate between the normal behaviour and illness behaviour of the client; they are also unable to face the problem.

Social support: Family has good primary and secondary support. Among the relatives, maternal (second degree) uncles are more supportive in crisis situations. Family maintains minimal contact with their neighbours. Family uses tertiary support system, whenever the need arises.

General pattern of living: Client lives in own *pacca* house. There are three rooms with all the essential facilities. Client's maternal grandfather frequently visits his home since his sons live outside for job. Client is very much close towards him and used to share his problems. He used to demand those things which are not fulfilled or delayed by his parents and grandfather used to fulfil them. Grandfather has a very good understanding of this family as well as their problems.

Personal history

Birth and early development: It was a full term normal delivery out of non-consanguine marriage with no prenatal, natal or postnatal complications. There was no delay in developmental milestones.

Behaviour during childhood: Client did not have any unusual behaviour or conduct disorders. He reported to have good relationship with his parents and sibling.

Schooling: Client's schooling started at the age of six years. He was very good in studies from the beginning. In 1998, went he went to Sainik School at Tilaiya and although there were some adjustment problems but he passed his matriculation examination with 82% marks in 3 March 2003, then went to Delhi for preparation of IIT entrance examination, failed in May 2003 and returned home in October 2003. During his stay in Delhi, one paternal uncle used to visit his residence frequently and enquired about his study expenses and even daily activities and keeps informing his parents. This was not liked by the client. Initially, the client was living with this uncle but later he lived separately due to above mentioned reasons but even after living separately, problem remained the same.

Sexual history: Client gained sexual knowledge from his friends when he was in tenth standard. Any history of sexual abuse or premarital sexual contact is not reported except occasional masturbation.

Premorbid personality: Client had good working habit, he was ambitious, had good level of self-esteem, and good interaction with peer and family members. So, he had well-balanced premorbid personality.

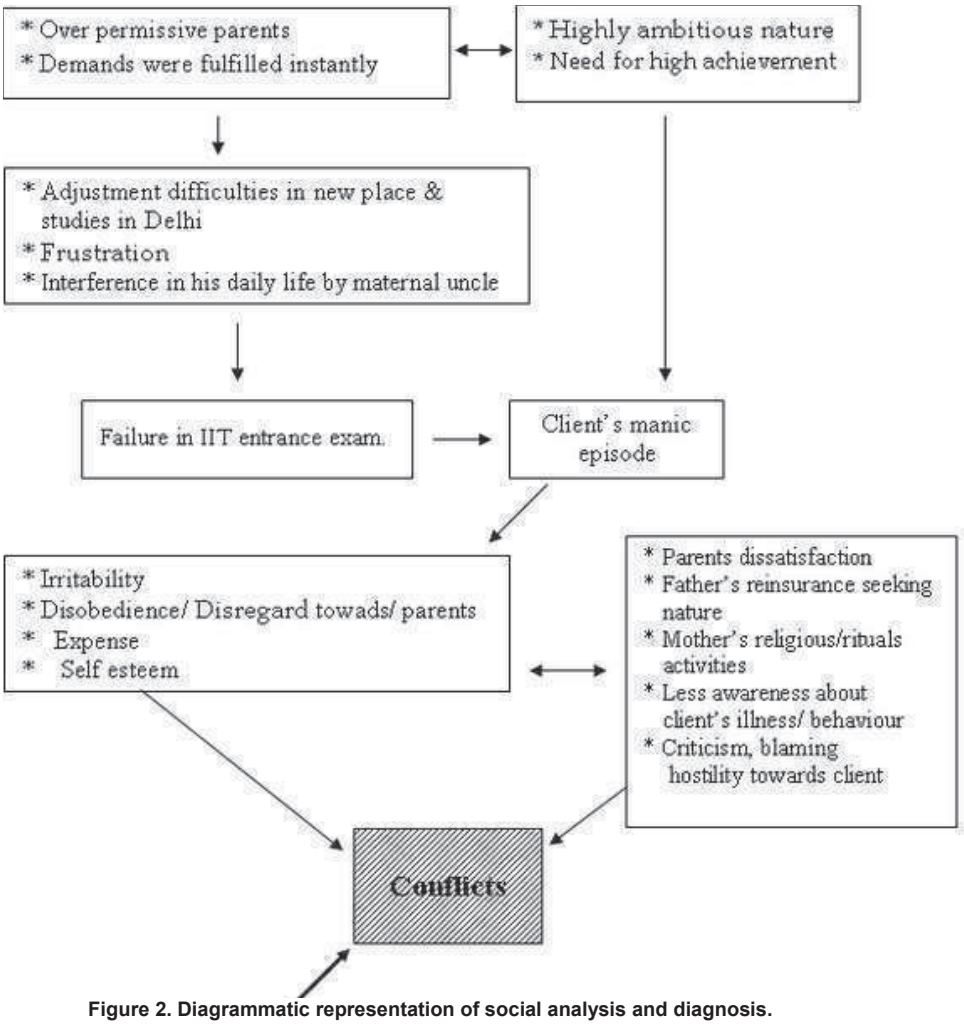


Figure 2. Diagrammatic representation of social analysis and diagnosis.

Social analysis and diagnosis

Index client Mr RR, 20 years old, unmarried, male, studying in BSc part I, hailing from an upper middle class nuclear Hindu family, from Patna, Bihar, presented with nil contributory personal and past history of one manic episode in May 2003, precipitated by failure in IIT entrance examination and with family history of TB in paternal aunt, currently diagnosed as BPAD, hypomanic (second) episode, currently improving with medication.

Social and family analysis reveals that parents are over permissive. Client's demands were fulfilled then and there. Client is very good in studies and of high ambitious nature. He faced difficulties in new place (Delhi) and in his studies also. At the same time, interference in his daily life by maternal uncle made him more frustrated. He was unable to cope with this situation and was not prepared well for IIT entrance examination and got failure. After this, he had first episode characterised by irritability, disobedience/disregard towards parents, excess expenses and high self-esteem etc. He was treated and improved but stopped medication and relapsed. Parents were dissatisfied with client and use to criticise, blame and at times became hostile towards the client because they had less awareness about client's illness/behaviour. Father's reassurance seeking nature and mother's religious/rituals activities, which were not liked by the client, made the state of affairs more severe. As a consequence, there were frequent conflicts between the client and other family members.

Interventions

Goal of interventions: To facilitate client's insight in to his problem, to educate family regarding the illness of the client, to enhance drug compliance, to enhance communication among the family members, to strengthen the parents-child interaction, to minimise the expressed emotion towards client, to utilise support available for the family.

Interventions offered: Individual session with client (four), conjoint session with the client's and family members (six), individual session with client's father (two), individual session with client's mother (one), interaction through phone (six).

Interventions consisted of psychoeducation, communication enhancement training, limit setting, IPSRT.

Intervention with the client

Building a worker-client relationship: All the rational as well as irrational talks of the patient were listened actively. Some of the concerns reported were genuine, viz., problems faced in living outside home and in studies - vast course, problems to prepare some chapters and due to lack of time, neglect of the daily routine, uncle's interference on this and lastly father's reassurance seeking success. This active listening helped to gain patient's trust and ensured his support in the later intervention.

Psychoeducation: Once the client's trust was gained, psychoeducation was initiated. This consisted of the following steps:

Firstly, the grandiose ideas of the client were mildly confronted and client was oriented to reality that success rate in such an examination is not very high, he can prepare for next time or there are other career options. Client then could discriminate his 'normal mind' and ill mind, which he called the 'mania *wala* mind'.

Secondly, he was educated that the variations in mood were because of his illness. Also he was educated about the relationship between his grandiose ideas, ruminative thinking, and impulsive behaviour. He was educated about the consequences of disregard towards parents.

Following this, client's knowledge about his illness was checked. He was aware that he suffered from an illness called 'mania' but did not know what its symptoms were. Client was educated regarding the signs and symptoms of the illness by explaining what happens when he gets into his 'mania *wala* mind'. This was done by giving illustration from his own experiences. Details of causes, course, prognosis, treatment options and need to maintain prophylactic treatment etc. were discussed in details.

Intervention with the family

Psychoeducation: "The mental health as well as the general health professionals are responsible for providing important and useful counselling and information to the parents regarding parenting".[21] In a conjoint session of the family members (except the client), the education input provided were: the symptoms of 'mania' and 'depression' with specific illustration of client's behaviour i.e. impulsivity, irritability, excess expenses etc.; the role of biochemicals in the brain in influencing client's mood and the subsequent need for continuous medication; the role of genetic inheritance in the manifestation of the illness; detail about medication, need for prophylactic treatment and possible side-effects of any medications; with specific to client's case, his premorbid personality and nature of parenting which he got and subsequently contribution on amplification of his illness; following this education, the importance of the whole family's involvement in client's care and intervention to be followed in future.

Communication enhancement training: In a conjoint session of the family members including his maternal grandfather, it was explained how countering client's over expense behaviours without adequately listening to them

could arouse irritability and lead to non cooperation from the client. They were educated about the client's inability to comprehend their position due to his disturbed thought processes. Following this explanation of the caseworker to model the communication style to be adopted while dealing with the client, the following aspects of the modelled communication in management of the client were emphasised: the importance of supportive listening; helping the client to calm down and identify his emotional exacerbation by himself and then asking non-offending questions; gaining support and cooperation of the client; involving the client in a discussion regarding present needs; negotiating with the client possible solutions; provide one time clear instruction regarding any thing and wait for his response rather than repetitive instructions; give him responsibilities regarding small daily activities or household and encourage him to complete, on completion appreciate him; client has very good communication with grandfather so he can motivate him regarding above mentioned aspects.

IPSRT: Conjoint session with the client and family members were conducted in order to prepare client and family members for stabilising social rhythms. In this session, client and mother were educated to distinguish between client's expansive and rational ideas when at home. For this, the caseworker facilitated family members to prepare a list of acceptable and unacceptable behaviours of the client. The client was explained the reasons why particular behaviours (such as without prior notice going to Delhi to join coaching) were not rational. Client was helped to identify how such ideas were expansive in nature and was actually due to the residual symptoms of his illness. So, in this way pattern of social stimulation and its evil effects were identified by them and later on practiced during the course of the intervention with monitoring by the case worker. Subsequent to this, a contract structuring client's activities at home was drawn out between the family members and the client which also includes his sleep-wake schedule.

Limit setting: The family members were prepared to be flexible in dealing with client's demands. Also the importance of resolving conflicts through discussions and compromise was emphasised repeatedly. But before fulfilling his demands, it has to be explained that money is valuable and it comes after a lot of efforts; so it should be used for genuine needs. Finally, some limit would be set for daily expenses.

Intervention with father: At the outset, the father's opinions regarding son's problematic behaviour at home were actively listened to. Following this, he was made to reflect upon the reason for son's behaviour at home and particularly the hostility directed towards him. Then he was given the interpretation that his son is not cooperative and cordial with him as he had not treated his son effectively. The importance and need to develop a healthy relationship with the son for both – the son as well as the father's benefit – was emphasised. Poor communication pattern with the son was illustrated from a sample of communication between them and corrective measures were done through modulations.

Intervention with mother: In the individual session with the mother, ventilation of feelings related to her experiences of caring for the husband as well as the son since the past 22 years was facilitated. The mother's concerns regarding the illness of her son were heard with empathy. Mother was counselled about her religious and rituals activities which were not liked by his son. Main focus was given to avoid those which were not liked by son or that could be fulfilled by some other way. Like son should not be forced for rituals - pooja, put on 'tabiz' on son's neck, forbid him to eat nonveg food etc. If necessary, rituals should be explained to him and then involve him after his consent.

Interaction through phone: Whenever need arises, family contacted caseworker and appropriate solution were provided. Once client had fever, family contacted worker whether they should go to a physician or psychiatrist. Improvements in terms of positive changes notice on the client and in family environment and some important moments like client's birthday were also shared with caseworker.

Outcome of interventions: Increased understanding and awareness about the illness and problem related to that in the family, increased involvement and interactions, improve parents-son interaction, improve support for the client, decreased unwanted behaviour of the client, finally family conflicts were significantly minimised.

Future plans (follow-up): To provide continued support to the client and initiate intervention whenever need arises (when case was terminated).

Complicating factors (including medical management, if any): There were no such factors noticed in this case.

Access and barriers to care (if any): There were no such things noticed in this case.

Treatment implications of the case

This social casework report demonstrated the positive outcome of individual as well as family intervention using FFT and IPSRT with an individual with bipolar I disorder having strained interpersonal relationship in his family due to his illness. This casework report also pointed out the important role of the family not only as a casual factor but also in intervention.

Recommendations to clinicians and students

In social casework practice in mental health setting, detail assessment process and case conceptualisation has

very important role and without this, proper intervention cannot be designed. This case may give a good guidance to caseworker.

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