

# Lived Experiences of Family Members Caring for Individuals Living with Bipolar Disorder

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## Abstract

Globally, around a third of the adult population suffers from a mental disorder such as depression, anxiety, schizophrenia and bipolar disorder. Bipolar disorder (BD) is a chronic mental illness which adversely impacts the lives of the affected individuals and their family members. BD has a strong influence on family functioning. The main objective of this study was to explore and describe the lived experiences of family members who care for individuals living with BD. A qualitative research design, which is exploratory, descriptive and contextual in nature, was used in this study. A purposive sample was utilised to select family members who care for individuals living with BD to participate in the study. In-depth phenomenological interviews were conducted to collect data and observations in the form of field notes were documented. The data analysis was done using a thematic analysis. Four themes emerged from the analysis of the transcribed in-depth phenomenological interviews, namely caring for an individual living with BD was exhausting, strenuous and a continuous unasked responsibility; family members experienced their own routines being disrupted by the individual living with BD's unpredictable behaviour and having to accompany them to appointments; family members experienced family relationships as being strained and challenged; and family members experienced the need for assistance to cope with the individuals living with BD. Strategies to facilitate the lived experiences of family members who care for individuals living with BD should be developed. The suggested strategies are facilitation of

exploration of challenges by family members, self-empowerment, empowerment in relationships, and empowerment in mobilising resources.

**Keywords:** bipolar disorder; family members; lived experiences; mental health

## **Introduction**

In 2016 the World Health Organization (2016) reported that BD affects about 60 million people worldwide, and one in four families has at least one member living with BD. According to the National Alliance on Mental Illness (2013), and Schmitt et al. (2014), every year 2.6 per cent of Americans are diagnosed with BD, with nearly 83 per cent of cases being classified as severe. The National Alliance on Mental Health (2013) reported that BD affects approximately 5.7 million American adults, or about 2.6 per cent of the United States of America's population aged 18 and older in a given year. According to statistics released by the South African Depression and Anxiety Group (2015), one in six South Africans suffer from anxiety and depression. The extent of the burden of BD on family members is difficult to assess and quantify, and is frequently ignored though it has a significant impact on the family's quality of life (World Health Organization 2016).

BD has a substantial impact on family functioning (Reinares et al. 2016, 47). The study conducted by Shah, Wadoo, and Latoo (2010, 327) found that the impact of caring for individuals living with BD brings the risks of mental ill health to the family members in the form of emotional stress, depressive symptoms, or clinical depression. Most individuals with BD in South Africa live in their own homes and are cared for by family members (Shah, Wadoo, and Latoo 2010, 327). Furthermore, the authors stated that the caring process can be very taxing and exhausting, especially if the care recipient has severe BD; providing such long-term care can be a source of significant stress. The behavioural problems associated with BD further increase the stress levels of the family members and therefore significantly impact their mental health (Shah, Wadoo, and Latoo 2010, 327).

Family members are the primary caregivers of individuals living with BD; they provide emotional and physical support, and often have to bear the financial expenses associated with mental health treatment and care (World Health Organization 2016). Family members experience various emotions as they learn to come to terms with having relatives living with BD (Mood Disorders Association of British Columbia 2008). The negative impact of BD on an individual's life is high, and the relationship with the family members appears to be severely and adversely affected in most cases (Elgie and Morselli 2007, 144).

The behavioural and emotional experiences of individuals living with BD affect everyone, including the individual's parents, spouse, siblings and children (Maskill et al. 2010, 535; Miklowtz 2008, 5; Miller, Dell'Osso, and Ketter 2014, 8). BD is a mental

disorder with periods of wellness between episodes, and family members often breathe a sigh of relief when symptoms are stabilised (Mood Disorders Association of British Columbia 2008).

## **Problem Statement**

BD is a chronic mental illness which adversely impacts the lives of the affected individuals and their family members (Hajda et al. 2016, 1561). There is a need to better understand family members' views and personal perceptions of the stresses and demands arising from caring for individuals living with BD in order to develop practical, appropriate interventions, and to improve the training of these family members (Pompili et al. 2014, 6).

In order to build hope for family members who care for individuals living with BD, they need opportunities to share their lived experiences with others, increased understanding of the condition is required, and relief from the burden they carry is needed. Thus, the research question that arose was:

- What are the family members' lived experiences while caring for individuals living with BD?

## **Aim of Research**

The aim of the study was to understand family members' lived experiences when caring for individuals living with BD.

## **Research Design and Method**

### **Research Design**

This study was based on a philosophy of constructivism. Constructivists believe that individuals seek an understanding of the world in which they live and work (Creswell and Poth 2018, 36). A qualitative research design, which is exploratory, descriptive and contextual in nature, was used to explore and describe the lived experiences of family members who care for individuals living with BD.

### **Research Method**

An interpretative phenomenological approach (IPA) was utilised in this study. The IPA is a method of inquiry in which the researcher describes the detailed lived experiences of individuals about a phenomenon as described by participants (Creswell and Poth 2018, 41). In this study, the IPA was employed to gain an understanding of family members' lived experiences when caring for individuals living with BD.

## **Population and Sampling**

The research population included all family members who care for individuals living with BD. The context was a mental health clinic. The researcher made telephonic appointments with family members who care for individuals living with BD, before the data collection. Family members' contact details were obtained from the files of individuals living with BD at the mental health clinic. Informed, voluntary consent was obtained. Purposive sampling was used to select the participants. The inclusion criteria of the study included family members who care for individuals living with BD for at least one to three years, and family members who were willing to consent to participate and be audio recorded during the interviews in order to provide information based on their lived experiences while caring for individuals living with BD. The sampling size was determined by data saturation.

## **Data Collection**

Data were collected by means of in-depth phenomenological interviews, observation and field notes. The central question that was asked during the interview was: "How do you experience having a family member living with BD?" The participants had an opportunity to describe their understanding and lived experiences while caring for individuals living with BD (Rubin and Rubin 2012, 29). The interviews took 45 to 60 minutes and were audio recorded. Family members' consent was obtained to audio record the interviews, and for the researcher to take notes during the interviews. Holloway and Gavin (2016, 95) state that interview data are recorded in three ways: audio recording the interview, note taking during the interview, and note taking after the interview.

## **Data Analysis**

Data were analysed using the thematic analysis (Creswell and Poth 2018, 245). In-depth phenomenological interviews were transcribed verbatim in preparation for the data analysis. Data were independently analysed by the researcher and an independent coder who is an expert in qualitative research. Transcripts and field notes were given to the independent coder to analyse the data (Smith and Firth 2011, 52). Thereafter, consensus was reached about the themes and categories discovered during the data analysis. Additionally, the lived experiences of the participants were supported by literature.

## **Ethical Considerations**

The following four ethical principles of healthcare research, as indicated by Dhai and McQuoid-Mason (2011, 14), were adhered to in this research study: autonomy, non-maleficence, beneficence, and justice. The researcher treated all participants as autonomous agents by informing them about the proposed study and allowing them to voluntarily choose to participate or not. In this study, the right to self-determination was upheld by obtaining informed consent from the participants. Information about the importance, purpose and objectives of the study was provided to the participants in a

language they understand in order to obtain their informed consent. The data were stored in a locked cupboard in the researcher's office. Only the researcher, independent coder, and supervisors had access to the data. The data will be destroyed two years after publication of the research.

Ethical clearance to conduct the study was obtained from the Research Ethics Committee of the Faculty of Health Sciences at a university (Clearance number: REC-241112-035). Permission to conduct the study was obtained from the Director: Policy, Planning and Research Gauteng Department of Health, and the Ekurhuleni Health District: Nursing Service Manager (Clearance number: 08/12/2016-12).

### **Trustworthiness**

Qualitative researchers' degree of confidence in their data is assessed using the criteria of credibility, transferability, dependability, and confirmability (Polit and Beck 2017, 584). These criteria are used to establish the trustworthiness of qualitative data and were maintained in this study. The credibility of the study was ensured by engaging in activities that had a likelihood of producing credible data, such as prolonged engagement, reflexivity, triangulation, peer debriefing, and member checking (Corbin and Strauss 2010, 24; Polit and Beck 2017, 112). Transferability was enhanced through thick description of demographics and purposive sampling.

Dependability was ensured through dense description of the research methodology, stepwise replication of the methodology, code-recode analysis of data, and a dependability audit. In this study, confirmability was established when all the documents, such as the transcripts, audio recordings and field notes, were compiled and submitted to a co-coder to draw conclusions from the data.

### **Results and Discussion**

Nine participants participated in this research study; five males and four females. Their ages varied between 30 years and 65 years. Refer to Table 1 for the participants' demographics. The study findings revealed four themes: Theme 1: Family members experienced taking care of an individual living with BD as exhausting, strenuous, and a continuous unasked responsibility; Theme 2: Family members experienced their own routines being disrupted by the individual living with BD's unpredictable behaviour, and having to accompany them to appointments; Theme 3: Family members experienced family relationships as strained and challenged; and Theme 4: Family members experienced a need for assistance to cope with individuals living with BD. The themes and categories are further discussed, and the participants' quotes are presented in the sections that follow.

**Table 1:** Participants' demographics

<b>Participant</b>	<b>Gender</b>	<b>Age</b>	<b>Years caring for individual living with BD</b>	<b>Relationship to individual living with BD</b>
P1	Male	57 years	3 years	Husband
P2	Female	48 years	2 years	Sister
P3	Male	49 years	1 year	Husband
P4	Male	36 years	1 years	Husband
P5	Male	58 years	3 years	Husband
P6	Female	32 years	2 years	Daughter
P7	Female	61 years	3 years	Mother
P8	Male	65 years	3 years	Father
P9	Female	44 years	2 years	Mother

**Theme 1: Family Members Experienced Taking Care of Individuals Living with BD as Exhausting, Strenuous and a Continuous Unasked Responsibility**

The study results showed that the burden of responsibility was high on family members who care for individuals living with BD, and this was disruptive to their normal routine and work life. Their lives revolved around the individuals living with BD and they had to manage, supervise, and dissolve crises resulting from their relatives' unpredictable behaviour.

Family members experienced their caring role as exhausting, strenuous and a continuous unasked responsibility, which led to the following emotions: extreme anxiety and stress, helplessness, feelings of guilt, sadness, and frustration. This is supported by the following quotes:

Is not an easy path to walk in while suffering from this disease (BD) and it seems that this is an illness in our family because my sister is not the only one in our family, it is hard for us? (P2, Female, Sister)

I become obligated to put in extra time and that become a burden of responsibility. (P5, Male, Husband)

Collingwood (2015) confirms that family members experienced difficulties while caring for individuals living with BD and that their mental well-being was affected. Iseselo, Kajula, and Yahya-Malima (2016) state that family functioning is the family's ability to continue with daily activities despite an internal or external threat.

Great demands may be placed on family members to be involved in caregiving; these demands can persist even during remission, where residual symptoms are often still present (Collingwood 2015). In the research results of Iseselo, Kajula, and Yahya-

Malima (2016), most participants expressed disturbances in their normal routine due to having individuals living with BD in the household.

Family members were faced with the challenge of having to handle all the household tasks alone, which depleted their energy. Family members experienced a burden of responsibilities and they raised concerns about sharing responsibilities at home. The following quotes illustrate that family members found it challenging to handle all the household tasks alone:

My wife is getting SASSA money and housewife money, with that money she doesn't buy anything at home. I buy food; I'm doing all the financial responsibilities at home ... (P1, Male, Husband)

Yesterday I was exhausted coming back from work and I found that she was doing her lunch and frying eggs, everything was disorderly, and the kitchen was a mess. (P7, Female, Mother)

Pat (2010) claims that cycles of mania and depression can make it very difficult to keep a handle on household clutter. People with depression can find themselves too lethargic and listless to clean up around the house, and people who experience mania can become too distracted to clean their homes or pick up after themselves properly. Individuals living with BD might begin a household task, only to move onto something else before the chore is completed. They might also find it difficult to concentrate when it comes to organising their belongings (Pat 2010).

Family members who care for individuals living with BD had difficulties keeping a full-time job owing to the burden of responsibilities they faced. They had to look after their relative living with BD, handle the responsibilities at home, and frequently take days off from work to support their relative living with BD. The following quotes attest to family members experiencing challenges with maintaining a full-time job:

I've suffered, and this is also affecting me at my working place. Every day I'm being insulted. I had a stressful life. (P1, Male, Husband)

The situation for me working the whole day is not the ideal situation at all. Bipolar for me is like you have to look after that person 24 hours, is like I have to stay positive, and the children will come to you about something mom said. (P3, Male, Husband)

According to Aschbrenner, Greenberg, and Seltzer (2010, 298), parents of adult children with BD reported lower levels of satisfaction with their jobs. The mental health of individuals living with BD is directly related to the nature and quality of the care provided by their family members. These demands can bring significant levels of stress for the family members and can affect their overall quality of life, including their work (Shah, Wadoo, and Latoo 2010, 327).

The research results showed that family members experienced challenges of having to supervise the individuals living with BD to take their medication and to comply with treatment. Medication compliance was a problem among individuals living with BD and family members were concerned about this. The participants explained:

She is no longer taking medication; she stopped taking medication because she felt that she doesn't need it now, even though she was told that she has to it for the rest of her life, which is what I remember ... (P4, Male, Husband)

It is very much depressing, more especially now that she does not want to take treatment to control her condition. My daughter told me that she is just collecting the medications at the clinic in order to continue getting the SASSA money. (P7, Female, Mother)

Vieta et al. (2013, 1719) state that BD is a mood disorder which requires complex treatment. Maintenance therapy in BD is usually required to prevent relapses and improve residual symptoms (Grande et al. 2013, 513). Pacchiarotti et al. (2013, 1249) and Post (2016, 11) further claim that individuals living with BD may benefit from antidepressants. However, the success of medication is dependent on an individual's compliance with the medication regimen.

The research results revealed that family members who care for individuals living with BD experienced poor financial management. They experienced financial challenges in assisting their relatives to cope with the condition. Family members needed to accompany their relatives living with BD for some of their check-ups, which affected their financial state since it would be "no work no pay" for those days. They also had to cover individuals living with BD's unplanned financial expenses. The following quotes emphasise the financial strain experienced by family members:

When mom is feeling down, got into depression, you want to get something to make her feel better. You take her out or buy her something nice. It does affect your finances. (P6, Female, Daughter)

I don't work a permanent job; I work in different places and I get money when I went to work. There are days that I have to accompany him to the clinic and it means is no work no pay for me. (P9, Female, Mother)

The extremes in mood that come with BD can cause serious problems. For example, depression can make a person unable to get out of bed or go to work, or mania can cause a person to go for days without sleep or spend money he/she does not have (DBSA 2016). During a manic episode, an individual may engage in risky behaviour, such as spending excessive amounts of money (Nordqvist 2017). The individual may purchase many unnecessary items, such as 20 pairs of shoes or expensive antiques without having the money to pay for it (Bressert 2018). Iseselo, Kajula, and Yahya-Malima (2016) mention that the money earned by relatives' limited working time was used to help care



for the individuals living with BD, such as purchasing medications and covering other expenses to assist in the well-being of these individuals.

Family members who care for individuals living with BD experienced emotions that affected their mental and physical health. These emotions included extreme anxiety and stress, helplessness, feelings of guilt, sadness, and frustration. The following quotes relate these emotions that family members experienced when caring for the individual living with BD:

A lot of things cause stress in my life, my sister's condition, having mood swings or being suicidal sometimes. And I have to care for her and her children. My own issues as well, my marriage and my work problems. (P2, Female, Sister)

It becomes emotional when you see them in that situation, it seems like us family members become helplessness. (P2, Female, Sister)

We always have to call the police and the ambulance and then she would agree to go to the hospital because she refuses to take medications. (P8, Male, Father)

Martino (2014) states that humans experience an array of emotions each day, and every one of these emotions creates a different feeling within the body. The body releases numerous chemicals upon encountering things that make an individual happy, sad, or angry, and each chemical works to create a different environment within the body. For example, if the brain releases serotonin, dopamine, or oxytocin, an individual will feel good and happy; conversely, if the body releases cortisol, it is because the individual is stressed (Martino 2014). Living with an individual who has BD can cause stress and tension in the family (Segal and Smith 2017).

Taking care of individuals living with BD can be stressful and family members have to cope with mood swings and other problems (National Institute of Mental Health 2015). Doan (2017) claims the loving partner of individuals living with BD will change; they often have to take on increased daily responsibilities. On top of the challenge of dealing with symptoms and the consequences of BD, family members often struggle with feelings of guilt, fear, anger, and helplessness (Segal and Smith 2017). At times the individual with BD may experience manic or hypomanic episodes during which they can be fun, interesting, talkative, upbeat and full of energy. At other times, the person may experience depression which affects them physically, spiritually and emotionally; family members might feel confused about how to deal with certain behaviours (International Bipolar Foundation n.d.).

## **Theme 2: Family Members Experienced Their Own Routines Being Disrupted by the Individual Living with BD's Unpredictable Behaviour, and having to Accompany Them to Appointments**

The study results showed that unpredictable behaviours by individuals living with BD affected family members' normal routine and work life. The participants experienced that their own routines were often unexpectedly disrupted by the individuals living with BD, through their unpredictable behaviour and having to accompany them to appointments at the clinic. Two categories emerged under Theme 2: family members experienced unpredictable behaviours of the individuals living with BD, and they experienced reckless and dangerous behaviour.

... is really difficult some days she gets up and she is busy cleaning and then you think it looks like a good day today and then all of the sudden it can change completely into something else. (P3, Male, Husband)

My clothes were torn; remember I'm wearing Truworhs and Edgars. All my jackets, my trousers, shirts were torn, the whole suitcase of my clothes was torn and my spectacles was broken. (P1, Male, Husband)

Individuals living with BD's moods are so unpredictable that family members may feel that they are stuck on a roller-coaster ride that is out of control (Tracy 2017). These unpredictable behaviours can affect loved ones, co-workers, and friends (International Bipolar Foundation n.d.). Family members who care for individuals living with BD often have to cope with their relative's serious behavioural problems, such as wild spending sprees during mania or extreme withdrawal from others during depression (Psychology Today 2018).

Segal and Smith (2017) claim that in the midst of a bipolar episode, individuals living with BD often say or do things that are hurtful or embarrassing. During mania, these individuals may be reckless, cruel, critical, and aggressive. During depression, they can be rejecting, irritable, hostile, and moody. It is hard not to take such behaviours personally. When manic or depressed, individuals living with BD may behave in destructive or irresponsible ways (Segal and Smith 2017).

## **Theme 3: Family Members' Experienced Family Relationships were Strained and Challenged**

Family members experienced challenges in their family relationships. Four categories emerged from this theme: family members experienced marital problems and disconnectedness between partners; family members experienced poor parent-child relationships; family members experienced poor communication and more arguments between all the family members; and family members experienced stigma.

The relationships between partners or couples were negatively affected by the difficulties and challenges family members experienced. The participants felt that the person they knew was different and was no longer the same person they met. However, they were not prepared to give up on them. Family members who care for individuals living with BD experienced challenges and interferences in their marriage. Study results showed that there were marital problems and disconnectedness between partners or couples affected by BD. This is evident in the following direct quotations from the participants:

Right now, we are in separation, I just want to get a place for myself, and I want to move out from that house ... we are sleeping in different bedrooms. (P1, Male, Husband)

Emotionally it does affect me especially in my marriage there is no love taking place. We are people that live as brother and sister for the sake of my children ... (P9, Female, Mother)

Collingwood (2015) reports that manic episodes of individuals living with BD are very disruptive to daily life, work and family relationships. Segal and Smith (2017) further state that the strain of caring for individuals living with BD can cause serious relationship problems. Tartakovsky (n.d.) also agrees that BD is challenging for relationships. The very symptoms of alternating moods and risky behaviours often leave family members feeling confused and exhausted, and a healthy family environment is vital in the recovery process for individuals living with BD (Martinez n.d.).

Coping with BD in the family puts stress on family relationships; the relationship with the individuals living with BD may be different to what it was before (Bipolar Caregivers 2013). Doan (2017) claims that while no marriage is easy – as evidenced by the 50 per cent divorce rate in the United States – challenges stack up when a mental health condition is added to the mix. The diagnosis of BD can test even the strongest of foundations. The unpredictable symptoms and behaviours of a person experiencing BD can shake up a relationship and may scare even the most supportive partner (Doan 2017).

The relationships between individuals living with BD and their children were also negatively affected. There were poor parent-child relationships, since parents living with BD had difficulty maintaining a healthy relationship with their children. Family members who were parents of children living with BD also experienced poor relationships with their children. The following quotes support the participants' experiences of poor parent-child relationships:

The relationship with my kids is sour, is like I'm a lion in the house. Children don't want to be closer to me, if I call them they look at their mother and she will say to the kids, no don't go. But when she is not there, kids are fine with me. (P1, Male, Husband)

The relationship between my sister and kids is very poor. They stayed with my mother and when my mother passed away I had to stay with them. This has been a burden of responsibility. (P2, Female, Sister)

Individuals living with BD may have trouble managing everyday tasks at school or work, or maintaining relationships (Holland, Nicholls, and the Healthline Editorial Team 2018). Parents living with BD have reported more negative interactions with their children, likely contributing to the risk of children developing psychosocial or behavioural problems (Martinez n.d.). When the individuals living with BD are in the manic phase of their disease, they may exhibit aggressive or risky behaviour which can be very dangerous, not only to themselves but also to the individuals around them, including their children (Boehlke 2015).

Family members experienced fluctuating moods with individuals living with BD, which had a negative impact on their communication. They suffered communication breakdowns which affected them adversely. There were more arguments and less efficient relationships. It seemed that how family members related to individuals living with BD contributed to the challenges they experienced. The following quotes support the family members' experiences of poor communication and frequent arguments:

We don't speak to each other, no communication at all and we are sleeping in different bedrooms. (P1, Male, Husband)

We will start talking together and all of the sudden she is quiet; is heartbreaking sometimes because other people don't want to know and don't want to understand. (P3, Male, Husband)

To communicate effectively, individuals need to appreciate the meaning behind other people's words, decipher the tones and inflections with which they are spoken, and relate these to the speaker's facial expressions and body language (Van Rheenen 2015). Fast (2015) says that successful communication happens when family members learn to respond to the reality of a mood swing instead of reacting to what the person actually says. Individuals living with BD might have compromised interpersonal functioning; it is not clear why, but it may be related to potential difficulties in integrating different kinds of social information (Van Rheenen 2015).

From the research results, it was evident that family members were worried about stigma and rejection because of their relative's condition. The participants were unable to explain to people that their relatives were living with BD because they were concerned about the stigma attached to mental illness. Family members expressed their concerns about how people perceived them. They felt that having a relative with BD caused disgrace at home. The participants explained:

We can't tell people that my mom is bipolar. They will shy away from her. It is difficult to explain her reactions. They won't understand that. You can't explain to people of

what exactly is going on because they will think my mom is a bad person ... (P6, Female, Daughter)

This is affecting me a lot because some days he will be fighting me even on the street and people will be looking at us. This situation is really bringing a disgrace in the family. The way people perceive us is like we don't instil good morals to our son. (P9, Female, Mother)

Shamsaei et al. (2013, 188) state that stigma is a serious impediment to the well-being of those who experience it. The family members will be affected by cultural and social attitudes to the illness, and these have significant effects on the level of the burden experienced (Collingwood 2015).

Shamsaei et al. (2013, 188) further elaborate that caregivers are challenged by the stereotypes and prejudice that result from misconceptions about BD. Mental illnesses have a significant impact on the lives of the individuals, and also their family members and friends, especially with the continued stigma regarding mental illness (Hira 2016). Rejection aimed at individuals living with BD affects their family members at various levels. According to Shamsaei et al. (2013, 190), the participants in their research study reported that they often found it difficult to tell people about their relative's illness. Some of the participants did not disclose their relative's mental illness because of the perceived adverse reactions from friends and other family members.

Family members who care for individuals living with BD experienced conflicts that arose in the family and caused them to shout at each other. The participants reported that their extended family members were unable to tolerate and accept the behaviour of their relatives living with BD, which resulted in poor relationships. The following quotes support that family members experienced conflict within the family:

There is this thing in our family all of us our voices are very hard and loud. Sometimes we shout at one another. (P2, Female, Sister)

... I recently had a conflict with her. I was forced to push her out of the yard and I locked the gate, because we couldn't stand her shouting anymore. (P8, Male, Father)

Family members had difficulty distinguishing between the illness and the person. They might invalidate the person's feelings and either blame everything on the illness or believe the person is making conscious choices, when it is as a result of the illness. Relationships with friends, family and acquaintances were often negatively affected for family members who care for individuals living with BD, resulting in the loss of friendships and tension with neighbours (Pompili et al. 2014, 7). Sullivan et al. (2012, 837) state that family conflict may be an essential target for family intervention in early-onset BD.

#### **Theme 4: Family Members Experienced the Need for Assistance to Cope with the Individuals Living with BD**

Family members who care for individuals living with BD needed assistance to cope with the behaviour of their relative living with BD. The following four categories emerged under this theme: family members experienced a need for information regarding BD; family members experienced a need for information on how to handle a crisis; family members experienced a need for support groups where they can ventilate and receive information; and family members experienced a need for support from their extended family.

I don't know what BD is, I and my wife saw the psychologist and social workers and we were just narrating our challenges. (P1, Male, Husband)

I had to learn about bipolar. I went to an internet and I did research. Is a long difficult process ... (P3, Male, Husband)

My sister can be aggressive sometimes ... and I will be in a situation where I don't know what to do. (P2, Female, Sister)

And if people in the family, I'm not just talking about direct family, I'm talking about the whole family. They won't understand that she is bipolar. They might think that she is insensitive towards them. (P6, Female, Daughter)

Tartakovsky (n.d.) also claim that it is crucial for family members to get educated about the illness and how it functions. Individual or family therapy and support groups can help. When mood swings are mild, the family may experience some forms of distress, but over time and with education about mental illness, they can learn to live with the demands of the illness (Mood Disorders Association of British Columbia 2008).

The Mood Disorders Association of British Columbia (2008) further indicates that caring for someone with BD can place heavy burdens on the family, particularly if they are not equipped with the knowledge and skills needed to cope with mental illnesses. Kahn et al. (n.d.) emphasise that education is crucial in helping individuals and family members to manage an individual living with BD and prevent complications of BD.

#### **Limitations**

The limitation of this research study was that the context was only the mental health clinic, and not family members' homes. The mental health clinic might have been a more formal and unfamiliar environment than the family members' homes. Family members might not be so open in their responses in an unfamiliar and formal environment.

## Recommendations

It is recommended that strategies be developed for psychiatric nurses to facilitate the mental health of family members who care for individuals living with BD. The suggested strategies are the facilitation of exploration of challenges by family members, self-empowerment, empowerment in relationships, and empowerment in mobilising resources. The researcher recommends that the context of the research study be extended to the homes of family members. It is also recommended that the psychiatric nurses share their experiences regarding the facilitation of empowerment of family members who care for individuals living with BD with communities.

## Conclusion

Mental health issues are found across the world and in every population. According to the report of the World Health Organization (2016), the burden of mental disorders continues to grow, with significant impact on health and major social, human rights and economic consequences worldwide. Family members' experiences of caring for individuals living with BD were exhausting, strenuous, and accompanied by continuous unmasked responsibilities which affected their mental and physical health.

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