

# Family Challenges; Living with Bi-Polar Disorder

By Mary de Haan

This paper will examine the impact of psychological illness on family stress. The family unit will be viewed within systems theory and the effects thereof. The nature of the challenge will be addressed using the perspective of the illness being Bipolar Disorder. This will include the adjustments the family needs to make to overcome the negative aspects of Bipolar Disorder describing the most appropriate counselling strategies taken to treat such a disorder, finishing with a personal theological reflection. There are many psychological disorders that can affect families. Major Depressive Disorder is commonly

member having bipolar disorder is one of high tension. The family may not consider the depression to be more than that, unless the family member has been diagnosed. The ill family member has had high and low mood states. They have learnt to live with a person with a depressed mood for over a minimum period of 3 months. This disorder can often be mistaken for Major Depressive Disorder (Seligman, 1988:162). The low, depressed mood lasts for six to eight months and changes to an extreme high mood called manic. These manic episodes last for approximately one week (APA, 1994a:332), they can be frightening for other members of the family. This state of illness includes sleeplessness, agitation, impulsive decision making and assaultive behaviour. They may have delusions or hallucinations, feel they do not have control over their lives and are insecure regarding what is happening in their family home.

The challenge for the family is to gain some control over the situation, to find some stability over the illness. To do so, acceptance and understanding of the illness is necessary. This is a process where the family member seeks professional help from a general practitioner, a psychiatrist, or psychologist to be diagnosed with the illness. This may come as a shock to the other member of the family yet also a relief helping them make sense of the situation.

diagnosed bringing disruption (Papalos, 1988:167) to one's family system. The functioning of one member upsets the equilibrium of the whole system leading to necessary adjustments. Another aspect of Mood Disorders is they may be genetic or environmental. An individual is more susceptible to depression and mood disorders when it has occurred in previous generations (McGoldrick & Gerson, 1985:32). The focus chosen for this essay is that of Bipolar Disorder, originally known as Manic-depressive Disorder.

## DESCRIBE THE NATURE OF THE CHALLENGE

The nature of the challenge facing a family with a

## CASE STUDY

To describe the stress on a family, this case study presents a man who is diagnosed with bipolar disorder. He is married and has three children; thirteen, nine and two years old. His children are adjusting to his illness yet they are often kept in the dark. They feel they are to blame for the situation. The children possibly have experienced fear or trauma if they have seen their father in a manic state, further to be taken away by police to hospital. The mother is so consumed with functioning and solely carries the responsibilities that she is unable to meet all the children's needs. This role is carried out by extended family or friends who offer their support to the wife. The wife also becomes the bread winner and finance



manager of the family.

***“...This state of illness includes sleeplessness, agitation, impulsive decision making and assaultive behaviour. They may have delusions or hallucinations...”***

The members of the family are learning to live with the effects of the illness on their household. The extended family has offered support and has also had to adjust in their expectation of relationships. They offer support to the members of the family suffering the effects of the illness. The challenge for the family is to work out how to keep the routine as normal as possible when living with someone who suffers Bipolar disorder. This disorder is far from normal and its symptoms can range from ‘grandiosity, reduced need for sleep, increased talkativeness, racing thoughts, distractibility, increased activity, excessive pleasure seeking to a potentially self-destructive extent’ such as excessive spending (Seligman, 1988:174). They can also experience hallucinations, and/or delusions. This often results in embarrassing situations for them later and for the family.

### **ADJUSTMENTS NEEDED TO OVERCOME ITS NEGATIVE ASPECTS**

As the family begins to notice some of the symptoms of their loved one’s illness unfold they have a strong sense that something is wrong. Acceptance and understanding are necessary for the family to come to terms with the illness.

***‘Wives often struggle with this reversal of strength and dependence, finding that the adjustment is not easy’***

(Hart, 2001:225).

Seeking help outside the family unit is a huge adjustment in a system that may have previously been self-sufficient. The demands on a family to cope with the illness stretch them to the limits. Financially, the family member may not be able to remain in his job. The dilemma arises whether or not to notify the employer of the situation, particularly in cases of hospitalisation. This may relieve the other adult in the family but gives rise to fears of whether they will remain employed and supported. The illness can become volatile depending on the state the patient is in. In early stages when the illness has not yet been diagnosed, there is no framework to give understanding as to what is occurring. The family discovers that this member of the family cannot be relied upon and is in need of professional help.

By seeking professional help from the General Practitioner, Psychiatrist and the Psychologist, the family

can begin to come to terms with the meaning of the illness and gain some understanding. Medication is needed to stabilise the manic state and often this illness can be misinterpreted as a depressive disorder until manic states appear. The G.P. will recommend the patient see a psychiatrist who will administer lithium to stabilise the patient in the manic state. The behaviour of the ill family member is often so extreme that they will make irrational and impulsive decisions and can go on reckless spending sprees. The behaviour is extreme and highly volatile, leaving the only option being to call the police or to admit them to hospital.

Hospitalization is a positive step; the patient is cared for by a medical and psychiatric team. The family is introduced to the illness, they may ask questions, become educated to gain understanding of the illness and gain any professional support they need as a family. They are also offered the option of attending support groups to meet others in similar circumstances. The support groups can help to reduce fears and offer support to the family to cope with such an overwhelming situation, at such an



intense time.

Once the family member is admitted, visiting a psychiatric ward can be traumatic for the family. They often don’t know what to expect and anxiety is high when visiting a locked unit for the first time. The family need to be aware that the patient may speak slowly and have a loss of appetite. As a result of the many changes that occur for the family, it is best to seek advice from hospital staff as to the condition of the loved one, particularly for children. They need to be prepared by an adult prior to the visit. A simple explanation at their level will be valuable to the children if they have witnessed the parent being forcibly removed from the home and taken away. The child needs to be reassured that the family member is receiving the care needed in a safe place (Papolos, 1988:33)





Hospitalisation for the sufferer brings relief for family members. The burden of caring and monitoring their condition is overwhelming when running a family. According to Papalos, the average stay for a bipolar disorder patient is anywhere between two weeks to thirty days.

***“Most areas of family life are affected when a family member is suffering with Bipolar Disorder. The burden of carrying someone with such an illness is a heavy one, and all areas of family life become disrupted and disorganized. The challenge to cope with the illness becomes the new way of life as the family adjusts to the altered situation.”***

The family need to check for quality of care of their loved one whilst in the hospital. Hospital staff are willing to ‘explain the evaluation procedure and the goals and objectives of hospitalization’ (Papalos, 1988:194). Many concerns and questions arise for the family and they have a right to be informed. Conversing with the family about the history of the patient’s disorder, assists in the treatment of the patient. The hospital is a safe, protected environment where the team of professionals can monitor and observe medications and treatments. When the patient leaves, a member of staff is allocated to present a case plan to a family member who takes on the responsibility to monitor medication and professional visits.

The family must prioritise keeping healthy eating habits and good sleep routine. Medication must be taken consistently and communication with psychiatrist re any changes occurring in symptoms must be reported as medication may need adjusting or altering, particularly if the ill family member expresses any delusional thinking.

## **MOST APPROPRIATE COUNSELLING STRATEGIES**

According to Seligman (when using Cognitive Behavioural Therapy), the goals for treatment of this disorder are to alleviate the extreme symptoms being experienced, to prevent further occurrences of dysfunctional mood and to improve interpersonal or lifestyle problems resulting from the disorder. Medication is necessary to alleviate the manic phase of the illness.

***‘Lithium is the standard....and is supplemented by other medications such as antidepressants’***

(Seligman, 1988:178).

Lithium acts primarily on manic symptoms but cannot be depended on to sustain remission, therefore, it is

necessary for the patient to undergo psychotherapy together with other medications to achieve results. Electroconvulsive Therapy (Papalos, 1988:115) is used as another resource when efforts of other treatments have failed.

Cognitive-behavioural approaches encourage involvement of the patient to help chart moods. By charting the nature, duration, frequency, and seasonality of their dysfunctional mood episodes, the patient and family can assist to avoid future episodes. This empowers the client and their family by giving them an active role and simultaneously educating themselves further to form a deeper understanding of the illness. CBT helps to ‘identify and change distorted thinking patterns that contribute to depression’ (Hart & Weber, 2002:46). The therapist also needs to give attention to suicide prevention particularly during the depressed stage of the illness.

Interpersonal psychotherapy is commonly used to treat depression. This model is used to address issues of symptom function, social & interpersonal relations and any personality problems the client may have (Seligman, 1988:158). Another goal is to educate the patient about the diagnosis and the treatment of it, and to help the patient set up a written treatment plan. By using a systemic approach the therapist can reduce stress by involving the family in the therapeutic process (Goldenberg, 2008:178).

Hospitalisation is often necessary and can be the initiation of professional treatment for the patient. Interpersonal psychotherapy is recommended by Drs. Klerman & Weisman (Papalos, 1988:152) working on a person’s social bonds, relationships by improving their self-concept and skills of communication.

Dion & Pollack recommend the following model for the treatment of Bipolar Disorder:

***‘An empathic and positive; therapist, didactic education about Bipolar Disorders; plotting of the disorder’s course; symptom management; improvement in the client’s lifestyle and environment; assessment of the client’s functioning and development of the client’s coping skills and supports;’***

(Seligman, 1988:179)

Another consideration when working with the children of an ill parent, is that the therapist needs to be aware of systems issues which work to the benefit of the child (Ward, 2003:3). Their reactions or the way they are coping with the situation are contextual and need to be viewed from that stance.

## THEOLOGICAL REFLECTION

It was God's intention for us to be restored to him. It was in the beginning, in the Garden of Eden, that God created us to be in relationship with him. We have strayed our own way due to sin and we often try to be independent of God, yet he only longs for us to come to him to find rest in him, to come to the place where he is our all sufficiency rather than ourselves but we in our fleshly nature try to do it alone. We put ourselves in God's place, but we are to love the lord our God with all our heart soul and mind and our neighbour as ourselves. We would find so much more wholeness in that place.

Due to sin in the fallen world, our environment, our false thinking, we hold particular beliefs and schemas about life and ourselves. These are unhealthy beliefs and as the Holy Spirit reveals the truth we are to deal with and rectify these wrong beliefs. The book of John tells us we are

***'to know the truth and the truth will set you free'***

(John, 8:32).

Our spirit is renewed and our mind is being restored, God is alive and his word is Truth and it heals today (Isaiah 61:1-3), because Christ came, died and was resurrected to set us free, free from the sins that entangle us.

Unfortunately, there is a stigma amongst Christians regarding mental disorders and the need for medications in their treatment. I believe that taking medication such as anti-depressants and combining them with the help of professionals, psychiatrist and psychologist, one can overcome disorders such as Bipolar. Our mind is a battlefield and the enemy tries to keep us in isolation. He seeks to steal, kill and destroy what God intended for us, but if we humble ourselves to seek help, by bringing our condition, or illness into the light we can then deal with it, rather than pretend it is not there.

The book of Proverbs says,

***'anxiety in the heart of man causes depression, but a good word makes it glad'.***

(Prov.12:25)

And we read in the book of Philippians,

***'be anxious about anything, but in everything by prayer and petition ... present your requests to God'.***

Philippians (4:6)

God offers His people support and this can also be gained from belonging to a church community. Therefore, I agree with Collins that,

***'the word of God can bring solace and guidance ... to the mentally disabled'***

(Collins, 1988:485).

The impact of psychological illness upon a family is immense. Most areas of family life are affected when a family member is suffering with Bipolar Disorder. The burden of carrying someone with such an illness is a heavy one, and all areas of family life become disrupted and disorganized. The challenge to cope with the illness becomes the new way of life as the family adjusts to the altered situation. The negative aspects which the family need to overcome have been stated. Adjustments are able to take place as the disorder unfolds by gaining understanding of the illness through education by support groups and professionals.

The counselling strategies found to be most appropriate for a patient with bipolar disorder are medications, psychotherapy, CBT, family therapy, Mood Disorder support groups and other support services offered. The diagnosis of the illness and support of services gives the family relief and some structure to bring normality to the family.

Mary de Haan is a student at Tabor College (Melbourne), studying for a Bachelor degree, majoring in Counselling. She has a particular interest in working in the area of grief and loss, and also with women in the area of depression & anxiety.

## References

- Barlow, D.H., & Durand, V.M. 2005. Abnormal Psychology. Thomson-Wadsworth. CA
- Collins, G.R., 1989. Christian Counselling. Word Inc., UK Ltd., England
- Godenberg, H., & I., 2008, Family Therapy- An Overview 7th Ed, Thomson Brooks/ Cole, CA,
- Hart, A.D. 2001. Unmasking Male Depression. Thomas Nelson Inc. USA
- Hart, AD., & Hart Weber. C. Unveiling Depression in Women. Fleming H Revell, Michigan
- Lefton, L.A., & Brannon L. 2003. Psychology. Allyn & Bacon. NY.
- McGoldrick, M., & Gerson, R., 1985, Genograms in Family Assessment, W.W.Norton, NY.,
- Papalos, D.F., & J. 1987. Overcoming Depression. Harper & Row. NY
- Seligman, L., 1988. Selecting Effective Treatments. Josey-Bass Inc., San Francisco
- The Holy Bible, NIV. 1984. International Bible Society. N.J.

