Research report

PSYCHOPATHOLOGY AND COPING BEHAVIORS AMONG WIVES OF PATIENTS WITH BIPOLAR AFFECTIVE DISORDER

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ABSTRACT

Background: Bipolar Affective Disorder (BPAD) is a challenging psychiatric illness which burdens both the patient as well as the caregiver. As a consequence, many psychiatric symptoms are reported in the spouses and caregivers of patients with BPAD. Caregivers adopt various coping behaviors to tackle their stress and overcome these situations. The objective is to study psychopathology and coping strategies among wives of inpatients with BPAD admitted under the psychiatry department of a tertiary care teaching institute. **Methods:** This cross-sectional observational study was done at the inpatient wards of the Department of Psychiatry of Jubilee Mission Medical College & Research Institute, Kerala. The sample size was 70 and the study duration was 18 months. After approval from the institutional ethics committee, the study was done. Psychopathology was assessed using Comprehensive Psychopathological Rating Scale (CPRS) and psychiatric morbidity using Mini International Neuropsychiatric Interview Plus (Mini-Plus). Coping behavior was assessed using Brief-COPE. **Results:** Most commonly reported psychopathology was reduced sleep (71.4%). Nearly three-fourth were having psychiatric morbidity, with a majority having adjustment disorder – brief depressive reaction. The most commonly used coping behaviors were approach coping/problem-focused coping rather than avoidant coping. **Conclusion:** From this study, it was found that the majority of the wives of patients with BPAD had depressive symptoms and most of them were diagnosed to have adjustment disorder. Therefore, while planning the management of patients with BPAD we have to ensure that adequate psychosocial support is being provided to their primary caregivers also.

Keywords: Bipolar affective disorder, psychopathology, coping

INTRODUCTION

Bipolar affective disorder (BPAD) is characterized by episodic and recurrent patterns of distinct mood episodes, which causes significant psychosocial disability.[1] Epidemiological studies globally have suggested a lifetime prevalence of around 1% for bipolar type I among the general population.[2,3] According to a study from India, the prevalence of mood disorders was found to be 31.2 per 1000 population.[4] Residual or subsyndromal symptoms in BPAD are found to be strongly associated with social, occupational, and cognitive impairment.[5-8] Manic episodes of the illness are more

Access the article online:
https://kjponline.com/index.php/kjp/article/view/320
DOI: https://doi.org/10.30834/KJP.36.1.2023.320
Received: 25/03/2022. Accepted: 19/01/2023
Web publication: 06/04/2023

QR code:

Please cite this article as: James A, Valsan N, Beevi KS, Joseph N. Psychopathology and coping behaviors among wives of patients with bipolar affective disorder. Kerala Journal of Psychiatry 2023;36(1):12-20.

disruptive to daily activities, work, and family relationships.[9]

A caregiver is a family member who has lived with the patient for more than a year and has been closely involved in their everyday life, health care, and social interaction activities.[10]The spouses and caregivers of patients with BPAD are reported to have various psychiatric symptoms due to the different levels of burden.[11] The burden of the caregiver refers to the substantial amount of stress and problems experienced by the caregiver or family of mentally ill persons, including a variety of psychological, emotional, social, physical, and financial problems[12-16] and high-frequency use of mental health services. The sum of the caregiver burden results in an increase in the development of individual psychiatric disorders in the caregivers. Sintayehu et al. (2015) found the overall prevalence of mental distress among caregivers to be 56.67%. Caregivers with poor social support experienced more mental distress than those with good support.[17] Steele et al. (2010) found that among caregivers of patients with BPAD, 46% reported depression, and 32.4% reported the use of mental health services.[11] Dias (2013) also found that among the wives of BPAD patients, the most commonly reported condition was depressive disorder; out of it, adjustment disorder was the most common.[18] The caregiver's stress was positively associated with emotional over-involvement and negatively with the patient's adherence to medication. Thus, a vicious cycle is formed between family burden and patient illness, each negatively impacting the other.[9, 19]

Coping means trying to overcome the factors causing stress and may refocus the significance associated with the difficulties, guide the individual's life, and keep them physically, psychologically, and socially healthy.[20] Caregivers adopt various coping behaviors to tackle their stress and overcome these situations. Two major categories of coping strategies widely recognized are problem-focused and emotion-focused ones.[21,22] Problem-focused/approach strategies refer to constructive coping efforts undertaken to modify difficult situations and include problem-solving, seeking information, or using positive methods of communication. In contrast, the less adaptive emotion-focused/avoidant strategies are attempts at modulating the caregiver's stress-related emotional response by measures such as avoidance or resignation.[21-23]

Knowing how caregivers cope may be useful in understanding how they adapt to the demands of living with and caring for a mentally ill person.[24,25] Adopting dysfunctional coping behaviors, in turn, will negatively affect a patient's clinical outcome. Chadda et al. (2007) showed that caregivers of bipolar patients use problem-focused coping strategies more often than seeking social support and avoidance strategies.[26]

Family burden and psychiatric morbidity in caregivers of BPAD patients have been extensively studied. But there is a paucity of studies on psychopathology in wives/spouses of patients with BPAD. Coping in caregivers of patients with affective disorders has been a comparatively neglected area. Although there are many studies on the coping methods of caregivers in severe and chronic disorders such as schizophrenia, there are limited studies on bipolar disorder.

Objective

The objective is to study the psychopathology and coping strategies among wives of inpatients with bipolar affective disorder admitted to the psychiatry department of a tertiary care teaching institute.

MATERIALS AND METHODS

This cross-sectional, observational study was done at the inpatient wards of the Department of Psychiatry of Jubilee Mission Medical College & Research Institute, Kerala. The study was approved by the Institutional Ethics

Committee. The duration of the study was 18 months (December 2018 – June 2020). Based on an earlier study by Dias (2013)[18], taking the proportion of psychiatric disorders among wives of patients with alcohol dependence syndrome as 60%, with 95% confidence level and 20% relative allowable error, the minimum sample size was calculated to be 70 using the formula $N=4pq/d^2$.

Inclusion criteria:
Wives of inpatients diagnosed as BPAD according to the International Classification of Diseases (ICD-10) classification of Mental Health & Behavioral Disorders – Diagnostic Criteria for Research (DCR-10)[27] who consented to participate in the study and belonging to the age group 18-65 years.

Exclusion criteria:

- Wives with a history of psychiatric morbidity prior to marriage
- Wives with an organic mental disorder
- Wives with mental retardation
- Wives with multiple medical co-morbidities.

Tools used:

- Psychopathology was assessed using Comprehensive Psychopathological Rating Scale (CPRS)[28]
- Psychiatric morbidity using MINI-Plus. [29]
- Coping behavior was assessed using Brief-COPE.[30]

CPRS: It was specifically developed to assess psychopathology and its improvement. It consists of 67 items, including 40 items (symptoms) reported and 23 items observed. All the items are scored on a 4-point Likert scale (0-3). A score of 0 indicates the absence of the particular symptoms, 1 occasional presence, 2 continuous presence and 3 an extreme degree of symptoms. Item 66 is a global rating of BPAD, showing the severity of the disease, and item 67 demonstrates the degree of reliability. CPRS has established reliability and variability. The use of CPRS does not require special training. It is comprehensive enough to cover signs and symptoms which are relevant to ICD-10 categories.[28]

Mini International Neuropsychiatric Interview-Plus (MINI-Plus): It is a short, structured diagnostic interview developed in 1990 for DSM-IV and ICD-10 psychiatric disorders.[29] It takes 30 minutes to administer the test and it was designed for a short but accurate structured psychiatric interview for clinical trials, epidemiological studies and also as a first step in non-research clinical settings.

Brief-COPE: It is a 28-item self-reported questionnaire designed to assess how individuals cope with traumatic life events including diagnosis of serious or terminal illnesses. It is an abbreviated questionnaire based on the complete 60-item COPE Inventory. It comprises items that assess the frequency with which a person uses different coping strategies and are rated on a scale ranging from 1 to 4, ("I haven't been doing this at all," to "I've been doing this a lot"). There are 14 two-item subscales within the Brief-COPE,[30] and each is analyzed separately. Total scores vary from 2 (minimum) to 8 (maximum). On each of the subscales, total scores are calculated by summing up the appropriate items. No items are reverse-scored. The scale can determine someone's primary coping styles as either approach coping, or avoidant coping.[31] Scores for the two coping styles are provided. Avoidant coping includes the subscales of denial, substance use, venting, behavioral disengagement, self-distraction and self-blame. Subscales of active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking informational support come under approach coping.

The questionnaires were translated to Malayalam and back-translated to English and then used.

The study was started after approval from the Institutional Ethics Committee. The data were analyzed based on sociodemographic factors and illness factors. Statistical analysis was

performed using the IBM Statistical Package for Social Sciences (SPSS) Version 25.[32] Categorical variables were expressed as frequency and percentages. The main outcome variables were expressed as proportions.

RESULTS

We approached 100 women whose husbands were diagnosed with BPAD for the study, out of which 70 gave consent to participate in the study. Table 1. shows the socio-demographic characteristics of the study participants. Two third of the study participants (67.1%) belonged to the 31-45 year age group. Nearly half (44.3%) of the study participants had completed high school. More than half of the study participants were unemployed. A majority of them belonged to the Hindu religion. More than half (54.3%) of them belonged to the lower socioeconomic class. The majority of participants belonged to a nuclear family and 62.9% experienced a physical assault during the episodes. More than one-fourth of the study participants reported that their spouse had BPAD for more than 20 years and half of the patients had less than 5 episodes. Nearly two-third of the BPAD patients had occupational dysfunction. Table 2. shows the psychopathology among wives of BPAD patients. Most commonly reported symptoms are reduced sleep (71.4%),

Table1: Socio-demographic characteristics of the study participants

Socio-demographic variables		Frequency (%) (N=70)
Age (years)	18-30	10 (14.3)
	31-45	47 (67.1)
	46-60	13 (18.6)
Education	Upper Primary	27 (38.6)
	High School	31 (44.3)
	Degree and above	12 (17.1)
Occupation	Skilled	11 (15.7)
	Unskilled	19 (27.1)
	Unemployed	40 (57.1)
Religion	Christian	14 (20.0)
	Hindu	42 (60.0)
	Muslim	14 (20.0)
Socioeconomic status	Lower	38 (54.3)
	Middle	32 (45.7)
Family	Nuclear	59 (84.3)
	Joint	11 (15.8)
Assault	Yes	44 (62.9)
	No	26 (37.1)
Duration of illness (years)	0-10	20 (28.6)
	11-20	31 (44.3)
	> 20	19 (27.1)
No. of episodes	< 5	35 (50.0)
	6-10	20 (28.6)
	> 11	15 (21.4)

Table 2: Psychopathology among wives of BPAD patients assessed by CPRS

Psychopathology	Frequency (%) (N=70)
Reported	
Reduced sleep	50 (71.4)
Sadness	47 (67.1)
Pessimistic thoughts	38 (54.3)
Reduced appetite	38 (54.3)
Lassitude	29 (41.4)
Worrying over trifles	28 (40.0)
Inner tension	28 (40.0)
Concentration difficulties	11 (15.7)
Reduced sexual interest	6 (8.6)
Fatigability	5 (7.1)
Suicidal thoughts	4 (5.7)
Indecision	3 (4.3)
Inability to feel	3 (4.3)
Autonomic disturbances	2 (2.9)
Failing memory	1 (1.4)
Observed	
Apparent sadness	47 (67.1)
Reduced speech	12 (17.1)
Sleepiness	7 (10.0)
Lack of appropriate emotion	4 (5.7)
Perplexity	3 (4.3)
Autonomic disturbances	3 (4.3)
Muscle tension	1 (1.4)

Table 3: Psychiatric disorders among wives of BPAD patients who reported having a psychopathology assessed using Mini-Plus

Psychiatric disorders	Frequency (%) (N=50)
Adjustment Disorder – Brief Depressive Reaction	20 (40.0)
Dysthymia	10 (20.0)
Adjustment Disorder – Prolonged Depressive Reaction	8 (16.0)
Moderate Depressive Episode without somatic syndrome	5 (10.0)
Mild Depressive Episode	4 (8.0)
Anxiety Disorder unspecified	3 (6.0)

sadness (67.1%), pessimistic thoughts (54.3%), reduced appetite (54.3%), lassitude (41.4%), inner tension (40%) and worrying over trifles (40%), whereas the least reported include autonomic disturbance and failing memory. Among the observed symptoms apparent sadness (67.1%) was the most common and the least observed were muscle tension and autonomic disturbance. Table 3. shows the psychiatric morbidity among wives of BPAD patients. Using Mini-Plus, it was observed that 50 women (71.4%) have psychiatric morbidity, of which, 20 (40%) had adjustment disorder – brief depressive reaction, 10 (20%) had dysthymia and 8 (16%) had adjustment disorder – prolonged depressive reaction. Table 4. shows the coping mechanism used by wives of BPAD patients. The most commonly used mechanisms were acceptance, use of emotional support, religion, self-distraction and active coping. None of the wives used substance use and humor as a coping mechanism.

DISCUSSION

The study sample consisted of 70 wives of patients diagnosed with BPAD who were admitted to the psychiatry ward of Jubilee Mission Medical College, Thrissur. They were assessed for psychopathology by CPRS. The common psychopathology symptoms reported were reduced sleep (71.4%), sadness (67.1%), pessimistic thoughts (54.3%) and reduced appetite (54.3%). The most commonly observed symptoms were apparent sadness (67.1%), reduced speech (17.1%) and sleepiness (10%). The findings from this study are similar to other studies wherein depressive symptoms and anxiety symptoms were more prevalent in caregivers of mentally ill patients.[33,34,35,36]

In this study, psychiatric disorders were assessed by using the Mini-Plus questionnaire. The most commonly found psychiatric disorder among wives of BPAD patients was adjustment disorder – brief depressive reaction. Similar results were obtained in studies done by Dias (2013), and Goossens et al. (2008).[18,34] Another study by Tranvag et al. (2008) showed that the majority of spouses/cohabitants had depressive symptoms and some of them developed depressive episodes, which was similar to this study.[35]

In this study, the coping behaviors of wives were assessed by the Brief-COPE scale. Common coping behaviors found in this study were acceptance (40%), use of emotional support (38.6%), religion (34.3%), self-

Table 4: Coping behaviour among wives of BPAD patients

Coping Behaviors	Frequency (%) (N=70)
Acceptance	28 (40.0)
Use of emotional support	27 (38.6)
Religion	24 (34.3)
Self-distraction	21 (30.0)
Active coping	18 (25.7)
Use of instrumental support	14 (20.0)
Behavioral disengagement	14 (20.0)
Venting	14 (20.0)
Positive reframing	6 (8.6)
Self-blame	5 (7.1)
Planning	2 (2.9)
Denial	2 (2.9)
Substance use	0 (0.0)
Humor	0 (0.0)

distraction (30%) and active coping (25.7%). The most commonly used coping behaviors are approach coping/problem-focused coping rather than avoidant coping. Similar findings were obtained in studies by Mothukuri et al. (2020) and Bauer et al. (2013).[37,38] Gania et al. (2019), in their study, found that the majority of caregivers reported using problem-focused coping strategies and avoidance, which was similar to this study.[39] More helpful responses to adversity, including adaptive practical change, improved physical health performance, and more stable emotional reaction, are correlated with approach coping.[31] In this study, 22.8% of wives of patients with BPAD reported the use of avoidant coping behaviors like self-distraction, denial, behavioral disengagement, venting and self-blame. This was similar to the results obtained by Goossens et al. (2008), Suriyamoorthi et al. (2018) and Rammohan et al. (2002).[34,40,41] Avoidant coping is associated with poorer physical health in medical conditions. It is less effective in managing anxiety when compared to approach coping.[31] In the present study, the coping behavior, religion, was used by 34.3% of the wives of patients with BPAD. Humor and religion are not considered under approach or avoidance coping behaviours.[31] Many reviews have found an overall positive effect of religiousness on mental health.[42,43] Whether religion is a positive, intrinsic and functional strategy for coping with illness or a negative, external, dysfunctional strategy is debatable.[37] In studies by Chadda et al. (2007), Bora et al. (2017) and Chakrabarti et al. (2002), the most commonly used coping strategies among caregivers of patients of BPAD included help-seeking (93.33%) followed by religious coping strategies and external attribution.[26,44,45] These findings were similar to the findings obtained in the current study.

Strength of the study:

- Higher response rate (70%).

Limitations of the study:

- The results cannot be generalized as this study was done with a small sample size.
- The psychopathology was only assessed in those women whose husbands were admitted and therefore had a severe illness at the time. The study is unable to account for any caregiver burden experienced by the wives during less severe or subsyndromal episodes.
- Inpatient treatment in itself poses a burden on the caregiver irrespective of the illness for which their loved one is admitted. This study has not been able to eliminate the confounding effects of stresses endured due to hospital stay.
- The study does not take into account the polarity of the episode requiring admission.

CONCLUSION

In this study, it was observed that the majority of the wives of patients with BPAD had depressive and anxiety symptoms and a majority of the wives were diagnosed to have adjustment disorders. The most commonly used coping behaviors were problem-focused/adaptive coping. However, maladaptive/dysfunctional coping was also being used by many of the participants. Timely detection of these disorders and maladaptive coping in caregivers and their correction is essential in the long-term care of BPAD patients. If adequate support is given to the caregivers, they will be able to provide necessary care and support for the patients, which can result in a good prognosis for the patients and thereby relieve the burden on the caregivers.

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