

# Perspective of Mental Health Professionals toward Stigma and Discrimination Faced by the Caregivers of Patients with Bipolar Disorder: A Qualitative Study

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## ABSTRACT

**Aim of the Study:** The present study was conducted to explore the perspectives of mental health professionals on stigma and discrimination faced by the caregivers of patients with Bipolar Disorder.

**Methodology:** The qualitative research design was used in the present study to get detailed information on stigma and discrimination. Participants were selected through a purposive sampling strategy. In-depth and face-to-face semi-structured interviews were conducted with 6 mental health professionals practicing in government institutes of Lahore. The interviews typically lasted for about 20 minutes. The interviews were recorded and then transcribed. The results were analyzed using thematic analysis.

**Findings:** Six major themes emerged, which included; perpetrators of stigma against caregivers, forms of stigma experienced by caregivers, root causes of stigma: lack of education and superstitious beliefs, challenges faced by caregivers as a result of stigma, demographical and geographical dimensions of stigma, and proposed initiatives to overcome stigma among caregivers.

**Conclusion:** All the themes included different subthemes, explaining the perspectives of mental health professionals regarding stigma and discrimination.

**Keywords:** Stigma, Discrimination, Caregivers, Bipolar Disorder, Mental Health Professionals, Thematic Analysis.

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## Introduction

Mental health illnesses include a wide range of chronic and debilitating health conditions that adversely affect the emotional regulation, behaviour, and cognitions of a person. These conditions significantly affect the quality of life of the individuals, impairing their functioning in their everyday lives. The individual's social, occupational, and personal life is at high risk of deterioration (Manwell et al., 2015). According to the World Health Organization (WHO), mental health disorders, including anxiety, depression, bipolar, and schizophrenia are the primary cause of poor mental health and disability around the world (World Health Organization, 2019).

In Pakistan, the prevalence of mental health disorders is substantial, with around 10-16% of the population suffering from mild to moderate psychiatric illnesses. There are several factors contributing to the high prevalence rates, including unawareness in public about mental health issues, stigmatisation, discrimination, and inadequate access to mental health services.

### ***Bipolar Disorder***

Bipolar disorder is one of the most common chronic mental disorders that is characterised by significant mood swings. During the manic phase, the patient has an irritable mood, hyperactivity, insomnia, and disinherited behaviour. However, during the depressive episode, the patient experiences symptoms of low mood, lack of interest in activities, changes in appetite, changes in sleep, and suicidal ideations (Shamsaei, Mohamad Khan Kermanshahi, Vanaki, & Holtforth, 2013). The prevalence rate of bipolar disorder is almost three percent in the general population. Besides this, it is also the sixth leading cause of disability globally (Gania et al., 2019).

### ***Stigmatisation and Discrimination of Mental Illnesses***

Stigma is defined as labelling, holding stereotypes, unfair attitudes, and showing biases towards others (Coffey, 2009). People who are experiencing mental illnesses are highly stigmatised in our society. Stigmatisation is also linked to discrimination which ultimately makes the mental illness more traumatic and worse for the patients and their families. It leads to significantly high levels of distress, tension, reduced self-esteem, and compromised overall quality of life (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012).

In developing countries, the rate of stigmatisation and discrimination is much higher. Especially in South Asian countries like Pakistan, Nepal, India, Bangladesh, and African countries, the development of mental illnesses is considered a punishment from God and a sign of personal failure (Patel & Prince, 2010). In Pakistan, the stigma and discrimination that is associated with mental illnesses are highly influenced by the people's cultural and religious beliefs (Waqas et al., 2020).

### ***Stigma Faced by Caregivers of Bipolar Disorder***

Stigma does not involve only the patients but has a drastic impact on their caregivers as well. The caregivers of individuals having bipolar disorder also face significant levels of stigmatisation and discrimination from society (Evans-Lacko, London, Little, Henderson, & Thornicroft, 2010). They have to bear with the emotional and psychological challenges of adequately managing the patient. The prolonged period of caregiving results in high levels of stress, anxiety, burnout, and physical and mental health issues among caregivers as well (Rüsch, Angermeyer, & Corrigan, 2005).

### **Literature Review**

Daniel et al., (2021) conducted a cross-sectional study in three tertiary care hospitals in Peshawar, Khyber Pakhtunkhwa. It was aimed to assess the impact of mental disorders on discrimination and stigmatization among patients. Data were collected from 432 participants using a structured questionnaire. SPSS analysis revealed that 72.9% of participants experienced stigma due to mental health disorders which negatively impacted their family relationships (52%) and social skills (65.05%). Additionally, 45.6% were married, 54.19% unemployed, and 19.9% quit their jobs due to their mental condition. The study emphasised the need for interventions to decrease stigma and support the social and financial well-being of individuals with mental disorders.

Gunasekaran et al. (2022) conducted research in Singapore to assess the views of mental health professionals on stigma and recovery. They recruited 17 healthcare experts via direct email invitations and performed semi-structured interviews with them. For coding and inter-rater analysis, NVivo software was used, along with the snowball sampling technique. The data in this study were analyzed using inductive thematic analysis. Three multi-levels of stigma were created from the results. It stressed the

importance of increasing mental health literacy; eradicating misconceptions about mental illness, implementing approaches to recovery, and improving insurance options for those in need.

Latifian et al., (2023) conducted a study to examine the experience of stigma in people who are diagnosed with bipolar disorder and their families. A systematic review was conducted using six online databases. The results included four themes: stigma experienced by individuals living with bipolar disorders and their families, predictors of this stigma, consequences, and useful intervention strategies that can help in reducing this stigma.

Shamsaei et al., (2013) conducted a study aimed at understanding the experience of stigma in the caregivers of bipolar disorder in a psychiatric hospital in Iran. Data was collected through in-depth interviews and analysis was done using the "Collaizi" method. The results showed that stigma was a major concern for almost all participants. Caregivers report that they have this feeling of being stigmatized and they are the most affected. The study concluded that bipolar disorder has a worse recovery. There are also problems in accessing health services such as treatment and support, and difficulty in gaining acceptance from society.

Hanafiah and Van Bortel (2015) conducted a study in Malaysia intending to investigate the stigma and discrimination of mental illness from the perspective of mental health professionals. They conducted in-depth interviews with 15 professionals from both government and private sectors, including psychiatrists, psychologists, and counsellors. The data was analyzed using a thematic analysis approach. After the analysis, seven main themes were identified. The study concluded that stigma traps mental patients into a vicious cycle of discrimination, hence affecting their mental and emotional health. It also has a profound impact on their families, communities, and the society as a whole.

### ***Study Objective***

Exploring perspectives of mental health professionals on stigma and discrimination faced by the caregivers of patients with Bipolar Disorder.

### ***Research Question***

What are the perspectives of mental health professionals on stigma and discrimination faced by the caregivers of patients with Bipolar Disorder?

### ***Method***

#### ***Research Design***

The qualitative research design is used in the present study as it focuses on understanding how an individual perceives different events and circumstances.

#### ***Research Paradigm and Method***

The interpretivist paradigm was used in the present research. The interpretivist paradigm in qualitative research is a framework that focuses on understanding the subjective meaning of human experiences and social phenomena (Schwandt, 1994).

The research method used in the present study was phenomenology. It is an approach to qualitative research that focuses on exploring and understanding the lived experiences of individuals.

#### ***Sampling Strategy***

A purposive sampling strategy was used in the present research because a specific population was selected according to the set inclusion criteria (Strauss and Corbin, 1990).

### ***Inclusion Criteria***

- Trained mental health professionals currently working with bipolar disorder patients.
- The professionals working in either government or private mental health care settings.
- Mental health professionals with at least 2 years of practical experience.

### ***Exclusion Criteria***

- Mental health professionals who do not have working experience with bipolar patients were excluded.

### **Measuring Instruments**

#### ***Demographic Sheet***

**Table 1:** *Table Showing Demographics of Participants*

<b>Participants</b>	<b>Age</b>	<b>Gender</b>	<b>Education</b>	<b>Experience</b>	<b>Patient Count</b>
Participant 1	24	F	MS Clinical Psychology	2.5 years	10
Participant 2	45	F	MS Clinical Psychology	10 years	10-15
Participant 3	45	F	PhD Scholar	20 years	15
Participant 4	31	M	PhD Scholar	6 years	10
Participant 5	29	F	MS Clinical Psychology	4 years	20
Participant 6	33	M	MD Psychiatry	7 years	40-45

### ***Semi-Structured Interviews***

In-depth and face-to-face semi-structured interviews were conducted with 6 mental health professionals who were practicing in government institutes of Lahore. The sample comprised 4 female clinical psychologists, 1 male psychologist, and 1 male psychiatrist. The interviews typically lasted for about 20 minutes. The interview guide was made which comprised different questions to explore a range of domains related to stigma and discrimination among caregivers.

Example items included;

- “How does stigma and discrimination affect the caregivers of individuals having bipolar disorder?”
- “Can you describe different forms of stigma that caregivers of bipolar disorder face in their everyday life?”
- “What is the impact of stigma on the mental health of caregivers of bipolar disorder?”
- “From a mental health professional’s perspective, what strategies do you recommend to help the caregivers in coping with stigmatization?”

## **Participant Characteristics**

### ***Participant 1***

H.I was a 24-year-old female. She had completed her master's in Clinical psychology and was working as a clinical psychologist at a government institute. She had professional experience of 2.5 years. On average, she attended 10 patients daily.

### ***Participant 2***

T.A was a 45-year-old female clinical psychologist. She had completed her master's in Clinical psychology. She had professional experience of 10 years. On average, she used to attend between 10-15 patients daily.

### ***Participant 3***

N.A was a 45-year-old female. She was a PhD scholar in Clinical psychology. She had been working as a clinical psychologist at a government institute for almost 20 years. On average, she attended 15 patients daily. She had an extensive experience with bipolar patients and their caregivers. She had also done various research on Schizophrenia and Bipolar Disorder. She reported that she had treated thousands of psychosis patients.

### ***Participant 4***

Y.O was a 31-year-old male. He was a PhD scholar. He was working as a clinical psychologist at a government institute for 6 years. On average, he used to attend to 10 patients daily.

### ***Participant 5***

S.A was a 29-year-old female clinical psychologist, working in clinical settings for 4 years, She had done her masters in Clinical Psychology. She used to attend to 20 patients daily.

### ***Participant 6***

S.H was a 33 years old male psychiatrist. He had done his Doctor of Medicine (M.D.) in psychiatry. He had an experience of about 7 years and he used to attend 40-45 patients daily in OPD and ward.

## ***Data Collection***

The present study utilized face-to-face, semi-structured interviews with the participants. After thoroughly reviewing the literature and having discussions with the research supervisor, the researcher formulated an interview guide. The interview guide was also reviewed by a senior psychologist. The suggestions of the senior psychologist were taken into consideration, and the interview guide was finalized. Then, the participants were approached through a purposive sampling strategy. The participants were informed of this research's purpose, and their written informed consent was obtained before the interview. Then, one-on-one interviews were conducted with each participant, and they were audio-recorded to explore the experiences and perspectives of the participants in detail.

## ***Ethical Considerations***

- Before conducting the current study, departmental approval from the Centre for Clinical Psychology, University of the Punjab, was obtained.
- The participants were informed beforehand of the aim of the research through the information sheet.
- Written informed consent was obtained (before the study) from the participants.
- An adequate level of confidentiality of the research data was ensured at each level of the research.
- Privacy and anonymity of individuals and organizations participating in the research was ensured.

## ***Thematic Analysis***

Thematic Analysis was used in the present research. The Systematic thematic analysis consists of six below-mentioned steps (Naeem et al, 2023).

1. Transcriptions and familiarization with the interviews
2. Selection of appropriate keywords
3. Coding (Assigning short phrases/codes)
4. Developing themes
5. Understanding the data through interpretation of keywords, codes, and themes
6. Formulation of a Conceptual Model

After transcribing the interviews, the researcher read them thoroughly to become familiar with the data. In the next step, manual data coding was carried out. Short phrases and codes were assigned, and patterns in the codes were identified. These patterns are called themes, which are the repetitive patterns of ideas, feelings, and thoughts that we identify from our data set.

## ***Verification of Data***

In qualitative research, it is used to ensure the reliability and validity of data.

## ***Mentor Review***

In order to establish the internal validity and credibility of the research, data was reviewed by a professional. The suggestions of the professional regarding the themes and subthemes were considered, and adequate changes were made according to the professionals' instructions.

## ***Frequent Debriefing Sessions***

Frequent debriefing sessions were conducted between the supervisor and the researcher. It was beneficial in the current study as it helped in the development of ideas which further helped in creating themes.

## ***Results***

**Table 2:** *Themes of the Study.*

Statements/Quotations	Keywords	Codes	Themes
"زیادہ تر سٹگما اور ڈسکرمنیشن خاندان اور قریبی رشتہ داروں سے آتا ہے۔"	Predominant Stigmatisation from Family Members	Stigmatisation from Family and Close Relatives	Perpetrators of Stigma Against Caregivers
سب سے زیادہ سٹگما فیملی کی طرف سے ہی آتا ہے۔			
گھروالے تانے دے رہے ہوتے ہیں اور caregivers کو بار بار کہتے ہیں کہ اسے کہیں چھوڑ کر آجاؤ۔	Family Pressure for Institutionalization		
اس کے گھر والوں کو یہی ڈر تھا کہ جب ہم واپس جائیں گے تو سارے رشتہ دار پوچھیں گے کہ اسے کیا مسئلہ ہوا ہے، تو	Fear of questioning from relatives		

ہم انہیں کیا جواب دیں گے			
ایکسٹینڈڈ فیملی جو ہوتی ہے جیسے، خالہ، مامو، چاچا، تایا، کزنز، اس طرح کے جو لوگ ہیں یا جو ان کے ان لاز ہیں، وہ لوگ زیادہ سٹگمٹائز کرتے ہیں۔	Stigmatisation from extended family		
پڑوسی یہی سمجھتے ہیں کہ یہ سب گھر والوں کو ایسا مسئلہ ہے	Neighbors' generalisation of Illness to the family		
پڑوسی خود بخود گھر والوں سے دور بھاگ جاتے ہیں	Stigma driven social distancing by neighbours		
گھر والوں کو یہ ایک مشکل ہوتی ہے کہ وہ مریضوں کے محلے میں جھگڑے نیٹاتے رہتے ہیں	Family resolving Patients' Fights with Neighbors	Neighbourhood stigma and its impact	
گھر سے باہر نکلے گا تو پڑوسی اپنے بچوں کو خوف سے چھپا دیتے ہیں کہ وہ پاگل باہر نکل آیا ہے	Neighbors Hiding Children Due to Fear of Patient		
محلے سے ہمیں شکایتیں آرہی ہیں، نوٹسز آنا شروع ہو گئے ہیں کہ گھر خالی کرو	Complaints and Relocation Notices from neighbourhood		
کچھ ہیلتھ کیئر پروفیشنلز ہی یہ سمجھتے ہیں کہ ان لوگوں نے کبھی ٹھیک نہیں ہونا	Healthcare Professionals' Perception of Untreatability	Stigmatisation of caregivers from Healthcare sector	
سائیکو تھیراپی پر اتنی امپورٹنس نہیں دی جاتی۔ وہ یہیں سمجھتے ہیں کہ ان کا علاج صرف دوائیوں سے ممکن ہے	Emphasis on Medication Over Psychotherapy		
تھیراپسٹ کی موٹیویشن لو ہو جاتی ہے اس طرح کے مریضوں کے ساتھ کام کرنے سے	Therapist's Low Motivation towards bipolar patients		
تھیراپسٹ بھی بایاسڈ ہو جاتے ہیں کہ اچھا اس نے تو امپروو نہیں ہونا ہے، اس کے اندر تو امپروومنٹ نہیں آئی ہے میں اس کی بجائے کسی ایسے پیشینٹ کے اندر اپنی انرجی انویسٹ کروں جس کے اندر بہتری	Psychiatrists' Biasness		

آ سکتی ہے			
وہ لیول اف کیئر اور اٹینشن پرووائڈ نہیں کی جا رہی جو شاید ایک ایسے پیشنت کو پرووائڈ کی جا رہی ہوتی ہے جس کے اندر ریکوری کے چانسز زیادہ ہوتے ہیں	Lack of care and attention towards patients		
سوسائٹی میں لوگ ہی سمجھتے ہیں کہ گھر والوں نے کچھ ایسا کیا ہے جس کی وجہ سے اس کی یہ حالت ہو گئی ہے	Societal Blame on Family for Patient's Condition	Caregivers' Experience of Social Stigma	Forms of Stigma Experienced by Caregivers
لوگ یہ کہتے ہیں کہ اگر مریض ٹھیک نہیں ہو رہا تو اس کا مطلب ہے کہ فیملی اس کا خیال نہیں رکھتی	Assumed Family Neglect		
لوگ کہتے ہیں کہ اگر اس خاندان میں ایک شخص کو ذہنی مسئلہ ہے تو اس کا مطلب ہے کہ خاندان کے سب افراد کو ہی ذہنی مسائل کا سامنا کرنا ہوگا	Society's assumption of Mental Illness across the family		
ایک سٹگما والدین میں ہوتا ہے کہ شاید ان کی وجہ سے ایسا ہو رہا ہے	Parents Blaming Themselves for the Illness	Self-Stigma experienced by caregivers	
اگر بچی بیمار ہوئی ہے تو یہ سمجھتے ہیں کہ ماں کی وجہ سے ہوئی ہے	Blaming Mother for Daughter's Illness		
یا انہوں نے خود کوئی ایسا کام کیا ہے، یعنی گھر والوں کے اعمال غلط تھے، جس کی وجہ سے یہ بیماری ہوئی ہے، زیادہ تر کیر گیور ایسا ہی سوچتے ہیں	Beliefs that Patient's Illness is Punishment for Family's Sins		
ہماری پاپولیشن میں مینٹل ہیلتھ لٹریسی بہت ہی کم ہے	Low Mental Health Literacy in society	Hindrances to Effective Care Due to Caregiver lack of awareness and Education on Bipolar Disorder	Root Causes of Stigma: Lack of Education and Superstitious Beliefs
ہمارے ہاں زیادہ تر لوگوں کو ہائے پولر ڈس آرڈر کا پتہ ہی نہیں ہوتا	Unawareness About Bipolar Disorder		
پیشنت کو علاج کے لیے لے کر نہیں آتے، اس کو وہ کیئر نہیں دی جاتی جس کی اس کو ضرورت ہوتی ہے	Neglect of Necessary Care and Treatment by the caregivers for patients		
تو وہ مار پیٹ والا جو رو بہ ہے یہ فیملی کی طرف سے آ رہا ہوتا ہے، لیک اف	Violent Behavior from the family towards the		



اویرنس کی وجہ سے ان کو یہ پتہ ہی نہیں ہوتا کہ یہ ایک ذہنی مسئلہ ہے	patient		
تھوڑا سا مسٹریٹ بھی کرتے ہیں فیملی والے کئی دفعہ بہت زیادہ مسٹریٹ کرتے ہیں، مارتے ہیں	Family Mistreatment and Violence Towards Patients		
وہ مدد حاصل کرنا چاہتے تھے لیکن وہ خود کو دو قطبی کی دیکھ بھال کرنے والے کے طور پر لیبل نہیں لگانا چاہتے تھے۔	Avoiding Caregiver Label While Seeking Help		
ہیلپ بھی سیک کرنا چاہ رہے ہوتے ہیں لیکن ساتھ ہی اپنے آپ کو ہائی لائٹ بھی نہیں کرنا چاہ رہے ہوتے کیوں کہ میٹل ہیلتھ کے بارے میں ایک سٹگما اٹیچ ہو جاتا ہے	Seeking Help Without Identifying as a Bipolar Caregiver		
کوئی جادو یا علم ہو گیا ہے	Caregivers and society's belief in black magic	Superstitious beliefs and spiritual healing practices	
کسی نے کوئی کالا جادو کروا دیا ہے			
یا جنات کا کوئی اثر ہے	Belief of caregivers in Jinn Possession		
پہلے سارے بابا، پیر، فقیر، دم درود کروا کر ہی ہمارے پاس مریض کو لے کر آتے ہیں	Preference for Spiritual Healers Before Medical Help		
مریض کو اس حال میں دیکھ کر ان کو تکلیف ہوتی ہے	Distress among caregivers over patient's condition	Emotional and psychological strain among caregivers	Challenges Faced by Caregivers as a result of stigma
کیئر ویورز کافی پریشانی کا شکار رہتے ہیں			
آہستہ آہستہ کیئر گیورز تھک جاتے ہیں اور مریضوں کو ان اداروں میں داخل کروا کر چلے جاتے ہیں	Exhaustion and difficulty handling the burden of caregiving		
جذباتی مسائل بہت آ جاتے ہیں آٹومیٹکلی جیسے کہ ڈپریس رہتے ہیں، کام میں دل نہیں لگتا روتے ہیں	Depression and crying among caregivers		
دیکھ بھال کرنے والوں کی سوشل لائف بالکل ختم ہو جاتی ہے	Disrupted Social Life for Caregivers	Social Isolation and Family Avoidance	

لوگ گھر والوں سے کٹ آف ہو جاتے ہیں ان سے دور بھاگ جاتے ہیں	Caregivers' isolation from their family	among caregivers	
گھر والے بھی باہر جانے سے گریز کرتے ہیں اور لوگوں سے نہیں ملتے	Family members avoid socialising		
رورل ایریاز میں ڈیفینٹلی سٹگما زیادہ ہے کیونکہ وہاں کے لوگ جو ہیں ان میں اوپرنس نہیں ہے	High Stigma in Rural Areas	Geographical Variations in Stigma and Discrimination	Demographical and Geographical dimensions of stigma
اربن ایریاز میں سپرچول ہیلنگ بھی کم ہے اور لوگوں میں اوپرنس بھی کافی زیادہ ہے تو سٹگما بھی کمپیئرٹولی کم ہے	Lower Stigma in Urban Areas Due to Awareness		
پنجاب میں کیوں کہ ایجوکیشن ریٹ زیادہ ہے اور بیکورڈ ایریاز جہاں ایجوکیشن کم ہے وہاں یہ چیز زیادہ ہے جیسے کہ بلوچستان وغیرہ	Higher Stigma in Less Educated Areas Like Balochistan	Cultural and Provincial Variations in Stigma	
آپ پختون کلچر میں چلے جائیں یا کے پی کے والی ہیلٹ یا بلوچستان وہاں سٹگما زیادہ ہے	Higher Stigma in Pashtun Culture and Balochistan		
انہیں یہ بتاتے ہیں کہ یہ کوئی کالا علم یا جادو نہیں ہے اور نہ ہی کوئی جنات کا اثر ہے بلکہ یہ بیماری ہے اور اس بیماری کے بارے میں انہیں آگاہی دی جاتی ہے	Educating caregivers about mental illness	Psychoeducation and Public Awareness Initiatives	Proposed Initiatives to overcome stigma among caregivers
مل کر لوگوں کو ذہنی مسائل کے بارے میں بتا سکتے ہیں آگاہی دے سکتے ہیں	Raising Awareness About Mental Illnesses among public		
شارٹ ڈاکومنٹریز بنا کر لوگوں کو دکھائیں، ریپلیکیٹ کر لیں اسی چیز کو یہاں پر تو اس سے کافی فائدہ ہوگا، اپنی لینگویج کے اکارڈنگ	Making short documentaries to psychoeducate people		

### Main Theme 1: Perpetrators of Stigma against Caregivers

Perpetrators are defined as the different individuals, networks, and institutions who are involved in stigmatising and discriminating the caregivers of bipolar disorder. All the participants reported that there are various types of perpetrators of stigma. So, this pattern was classified into the central theme of “perpetrators of stigma against caregivers.”

### ***Stigmatisation from Family and Close Relatives***

Alarming, almost all the participants reported that the most frequent perpetrators were “family and close relatives.” They are often seen as passing judgemental remarks and holding strange attitudes and beliefs.

The participant H.I reported that close relatives often stigmatize the caregivers with their harsh words. They usually isolate and cut off from them, not inviting them to family gatherings. Her verbatim was;

زیادہ تر سٹگما اور ڈسکریمنیشن فیملی اور کلوز ریلیٹوز کی طرف سے ہوتا ہے۔ زیادہ تر ڈسٹریس انہی کی طرف سے دیا جاتا ہے، یا محلے والوں کی طرف سے۔ لیکن یہ ڈیپنڈ کرتا ہے کہ آپ کے خاندان کے لوگ کس طرح کے ہیں

Further she also said,

گھر والے طعنے دے رہے ہوتے ہیں اور کینر گیورز کو بار بار کہتے ہیں کہ اسے کہیں چھوڑ کر آ جاؤ

The participant Y.O also reported that relatives stigmatize and discriminate the caregivers of bipolar disorder. He also shared an example from his experience where the caregivers were facing stigma and discrimination from their close relatives. His verbatim was;

زیادہ تر یہ رشتہ داروں کی طرف سے ہے، جیسے میرا ایک پیشنٹ تھا، اسے سویر بائے پولر تھا جس کی وجہ سے اس کے اندر سوسائٹل ٹنڈن سبز کافی زیادہ تھی، اور اسی لیے اسے ایڈمٹ بھی کیا ہوا تھا۔ اس کے گھر والوں کو یہی ڈر تھا کہ جب ہم واپس جائیں گے تو سارے رشتے دار ہم سے پوچھیں گے کہ اسے کیا مسئلہ ہوا □ ہے تو ہم انہیں کیا جواب دیں گے

The participant S.A. reported that caregivers and patients mostly face stigma and discrimination primarily from their uncles, aunts, cousins, and in-laws. Her verbatim was;

جو فیملی میں... ایکسٹینڈڈ فیملی ہوتی ہے... امیڈیٹ فیملی تو شاید کینر پرووائڈ کر رہی ہوتی ہے لیکن جو اس کی ایکسٹینڈڈ فیملی ہوتی ہے، خالہ، مامو، چچا، تایا، کزن، اس طرح کے جو لوگ ہیں یا ان کے ان لاز ہیں، وہ لوگ زیادہ سٹگمائز کرتے ہیں

### ***Neighbourhood Stigma and its Impact***

According to most participants, neighbours usually harbour stigmatizing attitudes and discriminatory behaviours. They distance themselves from the caregivers of bipolar disorder, avoiding socializing with them as they have a fear of acquiring the mental illness from the patient. This leads to social isolation among the caregivers.

The participant H.I reported that neighbours are also the perpetrators of stigma and discrimination. Her verbatim was;

نیریز یہ سمجھتے ہیں کہ سب گھر والوں کو ایسا مسئلہ ہے تو وہ خود بخود ان سے دور بھاگ جاتے ہیں اور اس کے علاوہ فیملی ممیزز بھی باہر جانے سے گریز کرتے ہیں اور لوگوں سے نہیں ملتے کہ میں باہر لوگوں سے کیا کہوں گا کہ میری بیٹی کو کیا مسئلہ ہے، لوگ یہیں کہیں گے کہ تمہارا بیٹا پاگل ہے۔ تو اس ڈر کی وجہ سے وہ ملنا جلنا بالکل بند کر دیتے ہیں اور گیٹ ٹوگیدرز پر بھی نہیں جاتے □

The participant T.A reported that the family faces harsh treatment from the neighbours and at times, the family is pressured to leave their home and relocate to a different area. Her verbatim was;

ان مریضوں کی محلے میں لڑائیاں بہت زیادہ ہوتی ہیں مریض ہر جگہ لڑ کر آ جاتا ہے زیادہ تر میل پیشنٹس جو ہوتے ہیں وہ بیرائڈ ہوتے ہیں وہ محلے میں کسی نہ کسی سے لڑ کر آتے ہیں، غصیلے بہت زیادہ ہوتے ہیں، □ تو گھر والوں کو یہ ایک مشکل ہوتی ہے کہ وہ ان کے جھگڑے نیٹاتے رہتے ہیں

She also added;

گھر والوں کو وہ جگہ چھوڑنی پڑتی ہے۔ یہ بھی میں نے دیکھا ہے کہ ان کو وہ جگہ، وہ علاقہ، وہ محلہ چھوڑنا پڑتا ہے؛ صرف اور صرف پیشنٹ کی وجہ سے □

The participant Y.O reported that the neighbors stigmatize the patient and the caregivers because of the fear that they develop from the violent actions of the patient. His verbatim was;

□ مریض گھر سے باہر نکلے گا تو نیبرز اپنے بچوں کو چھپا دیں گے کہ یہ باہر نکل آیا ہے

He further added;

جیسے میرے پاس ایک پیشینت آیا تھا اور اس کے کینر گورز یہی کہہ رہے تھے کہ اسے ایڈمٹ کر لیں کیونکہ □ اس کی وجہ سے محلے سے ہمیں شکایتیں آ رہی ہیں، نوٹس آنا شروع ہو گئے ہیں

### ***Stigmatisation of Caregivers from the Healthcare Sector***

Health-related alliances include different people who are working in the healthcare sector, e.g., physical health providers, mental health professionals, nurses, hospital staff, etc. Caregivers of bipolar disorder are often not taken seriously by the medical staff. Maltreatment of their patient in front of their eyes, blame, judgment, limited access to services, and stigmatising policies, are some ways in which they face stigmatisation and discrimination from the health sector (Stengler-Wenzke et al., 2004).

The participant H.I reported that most healthcare professionals hold biased views toward the caregivers of bipolar disorder. Her verbatim was;

عموما جب پیشینتس ہمارے پاس آتے ہیں تو ایسا ہوتا ہے کہ فیملی ایڈمٹ کروا کر بھاگ جاتی ہے۔ تو جب فیملی ہمارے پاس آتی ہے تو ہم یہی سمجھتے ہیں کہ یا تو فیملی بڑھا چڑھا کر مسئلے کو بتا رہی ہے؛ کیونکہ شاید وہ ایڈمٹ کروا کر جانا چاہ رہے ہیں اور اپنی جان چھڑوانا چاہ رہے ہیں یا یہ لوگ مریض کا خیال نہیں رکھنا □ چاہتے تو اور اس سے اکتا گئے ہیں

The participant N.A reported that mental health professionals sometimes hold this belief that such patients are incurable and untreatable. So, they do not invest time and resources in the treatment process. Her verbatim was;

ہمارے ہاں مینٹل ہیلتھ پروفیشن میں بھی ہر قسم کے لوگ ہیں کچھ ہیلتھ کیئر پروفیشنلز ہی یہ سمجھتے ہیں کہ ان لوگوں نے کبھی ٹھیک نہیں ہونا۔ سائیکائٹرسٹ یہ سمجھتے ہیں کہ اس کا علاج صرف دوائیوں سے ممکن ہے۔ سائیکوتھیراپی پر اتنی امپورٹنٹس نہیں دی جاتی وہ یہی سمجھتے ہیں کہ ان کا علاج صرف دوائیوں میں □ ہے اور مریض نے ساری عمر دوائیاں ہی کھانی ہیں

### **Main Theme 2: Forms of Stigma Experienced by Caregivers**

The participants reported that there are various types of stigma. So, this pattern was organized under the central theme of “Forms of Stigma Experienced by Caregivers.”

#### ***Caregivers' Experience of Social Stigma***

Social Stigma refers to the separation, stereotyping, disapproval, discrimination, ignorance, prejudice, and status loss that individuals face from other members of society (Corrigan & Miller, 2004).

The participant H.I reported that the blaming from society can serve as a stigmatization towards the caregivers. People in society, especially relatives and neighbours, usually misplace the blame on the family and attribute the causes of bipolar disorder to the actions or failures of their caregivers, such as poor care, neglect, or lack of control. Her verbatim was;

سوسائٹی میں لوگ یہی سمجھتے ہیں کہ گھر والوں نے کچھ ایسا کیا ہے جس کی وجہ سے مریض کی یہ حالت ہو گئی ہے، فیملی کی طرف سے کوئی نہ کوئی سٹریس ملا تھا یا فیملی نے کوئی ایسی ڈیمانڈ کی تھی۔ اس کے علاوہ اگر مریض ٹھیک نہیں ہو رہا تو اس کا مطلب ہے کہ گھر والے خیال نہیں رکھتے اور یہ بھی کہ اگر اس خاندان میں ایک شخص کو ذہنی مسئلہ ہے تو اس کا مطلب ہے کہ خاندان کے سب افراد کو ہی ذہنی مسائل کا □ سامنا کرنا پڑے گا

### ***Self-Stigma Experienced by Caregivers***

Self-stigma, or internalized stigma, occurs when individuals with mental illness or their caregivers internalize negative societal beliefs, biases, and stereotypes about mental health conditions (Perlick et al., 2011). This process leads them to apply these stigmatizing views to themselves and because of it, they develop feelings of shame and guilt among them (Livingston & Boyd, 2010).

The participant N.A reported that parents mostly face self-stigma. Her verbatim was;

ایک سٹگما والدین میں ہوتا ہے کہ شاید ان کی وجہ سے ایسا ہو رہا ہے۔ ایسا ہوتا ہے کہ اگر بچی بیمار ہوئی ہے تو یہ کہنا کہ ماں کی وجہ سے ہوئی ہے۔ وہ ان کو ایک کلنک فیل کرنا پڑتا ہے یا یہ سوچنا کہ یہ ان کے گناہوں کی سزا مل رہی ہے؛ تو یہ سب کچھ فیس کرنا پڑتا ہے

The participant Y.O also reported that families usually develop the feeling of self-stigma and blame themselves for their loved one's condition. His verbatim was;

یا انہوں نے کوئی ایسے کام کیے ہیں؛ یعنی گھر والوں کے اعمال جو تھے وہ غلط تھے، جس کی وجہ سے یہ بیماری ہوئی ہے۔ زیادہ تر گھر والے یہی سوچ رہے ہوتے ہیں

### ***Main Theme 3: Root Causes of Stigma: Lack of Education and Superstitious Beliefs***

Participants identified various causes contributing to stigma, which were categorized under the central theme of "Root Causes of Stigma: Lack of Education and Superstitious Beliefs." Within this theme, two distinct subthemes emerged; hindrances to effective care due to caregivers' lack of awareness and education on bipolar disorder and superstitious beliefs and spiritual healing practices.

#### ***Hindrances to Effective Care Due to Caregiver Lack of Awareness and Education on Bipolar Disorder***

Lack of education and awareness about mental health can contribute significantly to stigmatization towards caregivers of individuals with bipolar disorder. Because of insufficient mental health literacy, people often develop negative attitudes and discriminatory behaviours towards caregivers (Pescosolido, Martin, Lang, & Olafsdottir, 2008).

The participant H.I reported that the mental health literacy in our society is inadequate. The majority of people do not have an insight into mental illness; especially bipolar disorder. Her verbatim was;

ہماری پاپولیشن میں مینٹل ہیلتھ لٹریسی بہت کم ہے اور اگر ہے بھی تو بس ڈپریشن کی ہی ہے کیونکہ ہم نے نام سنا ہوا ہے تو ہمیں لگتا ہے کہ ہر کسی کو ڈپریشن ہے۔ تو جب بائے پولر کے سمٹمز ہوتے ہیں تو عام طور پر یہی کہا جاتا ہے کہ یہ تو پاگل ہے اور ہمارے ہاں زیادہ تر لوگوں کو بائے پولر ڈس آرڈر کا پتہ ہی نہیں ہے

#### ***Superstitious Beliefs and Spiritual Healing Practices***

Caregivers who are inclined towards spiritual healing practices attribute mental health conditions such as bipolar disorder to spiritual or moral failings rather than considering it as a medical or psychological illness (Jackson et al., 2022).

The participant H.I reported that people have an inclination towards spiritual healing practices. They mostly believe that the illness is incurable as it is caused by supernatural entities such as Jinns (spirits or demons) and practices like jadoo (witchcraft or black magic). Her verbatim was;

یہی سمجھا جاتا ہے کہ مریض اب تاحیات ایسے ہی رہے گا۔ جس کی وجہ سے گھر والے امیدیں چھوڑ دیتے ہیں۔ گھر والے یہی سوچتے ہیں کہ ان لوگوں نے اب ٹھیک نہیں ہونا، یہ لاعلاج بیماری ہے۔ کوئی علم ہو گیا ہے یا کسی نے کوئی کالا جادو کروا دیا ہے یا جنات کا کوئی اثر ہے پہلے سارے بابا، پیر، فقیر، دم، درود کروا کر ہی ہمارے پاس مریض کو علاج کے لیے لے کر آتے ہیں

The participants T.A reported that the caregivers seek medical help only as a last option. Her verbatim was;

سٹر سے اسی فیصد جو کینر گیورز ہوتے ہیں وہ کہیں نہ کہیں سے ساری طرف سے گھوم کر آئے ہوئے ہوتے ہیں۔ یعنی کہ پہلے وہ پیروں، فقیروں، دم، درود، سپرچول ہیلنگ، اس سب سے گزر کر آئے ہوئے ہوتے ہیں اور جب بیماری شدت اختیار کر جاتی ہے تو مریض کو ہمارے پاس لے کر آتے ہیں □

#### **Main Theme 4: Challenges Faced by Caregivers as a Result of Stigma**

The participants highlighted various impacts of stigma on the caregivers of bipolar disorder patients. So, this pattern was classified into the central theme of "Challenges Faced by Caregivers as a Result of Stigma." It included codes of emotional and psychological strain among caregivers, and social isolation and family avoidance among caregivers.

##### ***Emotional and Psychological Strain among Caregivers***

Stigmatization and discrimination can also have profound effects on the emotional and mental health of caregivers of individuals with bipolar disorder. It leads to a heightened level of emotional distress, isolation, anxiety, shame, guilt, depression, and feelings of helplessness among the caregivers (Yanos, Roe, & Lysaker, 2010) (Hatzenbuehler, Phelan, & Link, 2013).

The participant H.I reported that the caregivers go through a huge emotional turmoil when they see that their close one is suffering from bipolar disorder. It negatively affects their mental and emotional health. Her verbatim was;

کوئی فیملی ممبر جو اچانک اس طرح ہو جائے اور وہ مریض اب خود کا خیال بھی نہیں رکھ پا رہا تو ظاہر سی بات ہے کہ گھر والوں کے لیے مشکل ہوتا ہے۔ مریض کو اس حال میں دیکھ کر انہیں تکلیف ہوتی ہے کہ یہ ایسے ہی گندی حالت میں پڑا رہتا ہے، پہلے جیسے خود کا خیال نہیں رکھ پا رہا، کپڑے گندے پہنے ہوئے □ ہیں، میری بات پر توجہ نہیں دے رہا، جس کی وجہ سے کینر گیورز کافی پریشانی کا شکار رہتے ہیں

##### ***Social Isolation and Family Avoidance among Caregivers***

Stigmatization and discrimination strain the relationships of caregivers with their families, relatives, and colleagues. They experience social withdrawal and isolation, which reduces their social interactions and support networks (Reavley & Jorm, 2011). Besides this, the disrupted social relationships of the caregivers also lead to caregiver burnout and diminished quality of life (Perlick et al., 2007).

The participant H.I reported that the social life of caregivers suffers a lot. Her verbatim was;

دیکھ بھال کرنے والوں کی سماجی زندگی بالکل ختم ہو جاتی ہے کیونکہ لوگ یہی سمجھتے ہیں کہ ضرور گھر والوں نے اس کے ساتھ برا سلوک کیا ہے اور گھر والوں کے اندر کوئی خرابی تھی تو گھر والوں سے کٹ آف ہو جاتے ہیں وہ یہ بھی سمجھتے ہیں کہ سب گھر والوں کو ہی ایسا مسئلہ ہے تو لوگ خود بخود ان سے دور بھاگ جاتے ہیں اور اس کے علاوہ فیملی ممبرز بھی باہر جانے سے گریز کرتے ہیں

#### **Main Theme 5: Demographical and Geographical Dimensions of Stigma**

Participants reported that stigma varies across demographic regions and cultures. Thus, it was categorized under the theme of "Demographical and Geographical dimensions of stigma."

##### ***Geographical Variations in Stigma and Discrimination***

Stigma faced by caregivers of individuals with bipolar disorder varies significantly between rural and urban areas. In rural and close-knit community settings, the caregivers have limited access to mental health services.

Participant T.A reported that stigmatization is more prevalent in rural areas due to lower levels of education. Her verbatim was;

رورل ایریاز میں ڈیفینٹلی سٹگما زیادہ ہے کیونکہ وہاں کے لوگ جو ہیں ان میں اوپرنس زیادہ نہیں ہے، ارین ایریا کے جو لوگ ہیں ان میں کافی حد تک اوپرنس ہوتی ہے تو یہ فرق آ جاتا ہے۔ رورل ایریاز میں اوپرنس نہیں ہوتی تو پہلے وہ سپیریچول ہیلنگ کی طرف جاتے ہیں۔ جب وہ ہمارے پاس آتے ہیں تو بیماری بہت ہی

زیادہ کرونگ ہو چکی ہوتی ہے، ٹریٹمنٹ کافی مشکل ہو چکا ہوتا ہے، مطلب مسئلہ بہت پرانا ہو چکا ہوتا ہے  
تو یہ فرق ہے

### ***Cultural and Provincial Variations in Stigma***

The experience of stigma faced by caregivers of individuals with bipolar disorder varies across provinces of Pakistan. The main reason behind this variation is cultural, social, and economic differences. In more rural or conservative provinces, caregivers face more stigmatization because of the lack of awareness and stronger adherence to traditional beliefs and inclination towards spiritual healing practices.

The participant H.I reported that stigmatization is more often in provinces like Balochistan, mainly because of the lack of education and awareness. Her verbatim was;

پنجاب میں کیوں کے تعلیم زیادہ ہے اور بیکورڈ ایریاز جہاں تعلیم کم ہے وہاں یہ چیز زیادہ ہے جیسے کہ یہ  
□ بلوچستان وغیرہ

The participant S.H reported that there exists a huge difference in discrimination and stigma faced by the people of Balochistan, KPK as compared to Punjab. Given the lower literacy rates in Balochistan and KPK, stigma tends to be more in these regions. His verbatim was;

اب پختون کلچر میں چلے جائیں یا کے پی کے والی بیلٹ میں یا بلوچستان وہاں سٹگما زیادہ ہے۔ ان سے آپ یہ  
انڈرسٹینڈنگ ایکسپیکٹ نہیں کریں گے جو کہ آپ یہاں ایک پنجابی پنجاب میں رہنے والے سے ایکسپیکٹ کریں  
گے بہت زیادہ فرق نہیں ہوگا لیکن کچھ فرق ہوگا۔ اس فرق کا تعلق کلچرل بیک گراؤنڈ سے بھی ہے۔ اب جیسے  
پنجابی کلچر میں ڈپریشن، انزائٹی فورن سے برش آف کر دیتے ہیں کہ اپنے اندر ہمت پیدا کرو، موٹیویشن لاؤ۔  
جو دوسرے کلچر سے ہیں ان میں اپروچ تھوڑی ڈفرنٹ ہے۔ کچھ کلچرز میں تھوڑی سی ایگریسو اپروچ بھی  
ہے۔ تو کلچرل ڈفرنسز ایگزسٹ کرتے ہیں

### **Main Theme 6: Proposed Initiatives to Overcome Stigma among Caregivers**

Different participants suggested initiatives and practices that can help to reduce stigmatization and discrimination among the caregivers of bipolar disorder. So, these insights were classified under the central theme of “Proposed Initiatives to Overcome Stigma among Caregivers.”

#### ***Psychoeducation and Public Awareness***

Improving mental health education and fostering supportive environments are essential to addressing these issues of stigmatization and discrimination and reducing stigma towards caregivers of individuals with bipolar disorder (Corrigan et al., 2012).

The participant H.I highlighted the significance of psycho-education. She has mentioned the psycho-education strategies that they are using at present to reduce the stigmatization faced by caregivers. Her verbatim was;

ہمارے یہاں ایمرجنسی میں سپیشل فیملی کونسلنگ یونٹ ہے کہ جب کینر گوز جب مریض کو لے کر آتے ہیں  
تو ظاہر سی بات ہے کہ وہ پریشان ہوتے ہیں تو ہم وہاں ان کی پریشانی کو کم کرنے کی کوشش کرتے ہیں اور  
انہیں یہ بتاتے ہیں کہ یہ کوئی کالا علم یا جادو نہیں ہے اور نہ ہی جنات کا کوئی اثر ہے بلکہ یہ بیماری ہے اور  
□ اس بیماری کے بارے میں انہیں آگاہی دی جاتی ہے

The participant T.A mentioned that we can create awareness among the public by holding different workshops and seminars. This is a collective effort of psychiatrists, psychologists, and social workers. Her verbatim was;

مینٹل ہیلتھ پروفیشنل اپنے قریبی علاقوں میں تو جا ہی سکتے ہیں جیسے کہ لاہور کے جو رورل ایریاز ہیں ان  
میں جا کر ٹیم کی صورت میں ڈیوائڈ ہو جائیں، کلیکٹیو ایفرٹ ہے یہ۔ اس کے لیے ایمپیشن اور جذبے کی  
ضرورت ہے... اس کے لیے طریقہ یہی ہے کہ ہم ان دا فارم آف ٹیم جس میں ایک سوشل ورکر ایک  
سائیکالوجسٹ اور ایک سائیکائٹرسٹ ہو یہ ڈیفینٹلی ٹیم کے ممبرز ہیں اور مل کے لوگوں کو مینٹل انس کے  
□ بارے میں بتا سکتے ہیں ان کو اوپرنس دے سکتے ہیں

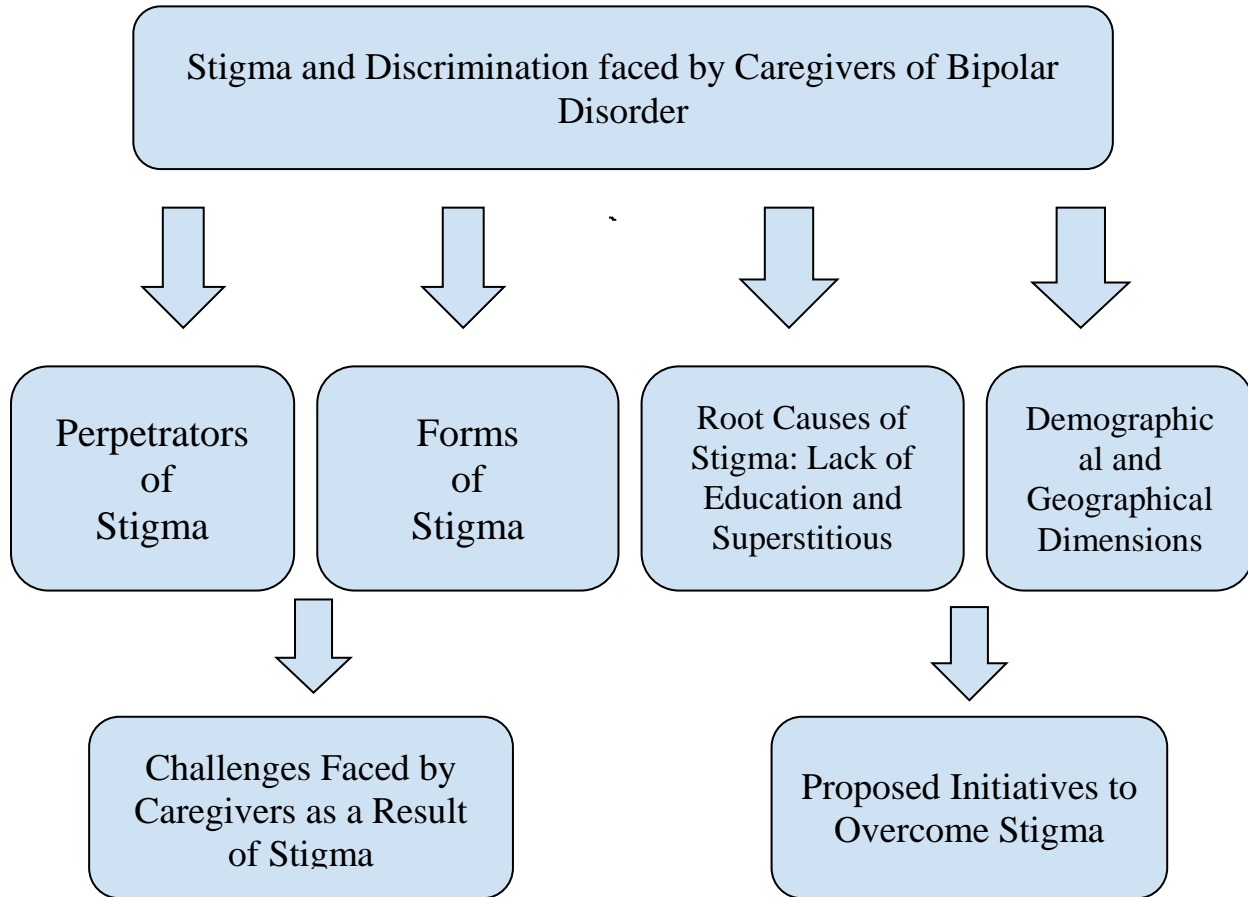
The participant S.H. reported the significance of psychoeducation programs by mentioning NHS projects. His verbatim was;

میرا خیال ہے انگلینڈ میں این ایچ ایس نے ایک پروگرام شروع کیا تھا اس میں انہوں نے چھوٹی چھوٹی ڈاکومنٹریز بنائی تھی ذہنی مسائل کے اوپر جس میں وہ مختلف لوگوں کو ایجوکیٹ کرتے تھے اور اس کا مقصد یہی تھا کہ اسٹگما کو ریموو کر سکے اور ذہنی مسائل کے بارے میں لوگوں کو آگاہی دی جا سکے۔ تو میرے خیال میں اگر فی الحال ایک سٹیٹ لیول پہ اسی انیشیٹیو کو کاپی پیسٹ کر لیں، چھوٹی چھوٹی ڈاکومنٹریز بنا کر لوگوں کو دکھائیں، اسی چیز کو ریپلیکیٹ کر لیں، اپنی زبان کے مطابق تو اس سے کافی فائدہ ہوگا □

## Summary of Findings

The findings of the present research unfolded six main themes. The verbatim of the participants supported all the themes. Caregivers face significant levels of stigmatisation from their family, relatives, neighbours, and the public. This stigmatisation and discrimination adversely affect their social life, leading to social isolation and social withdrawal. They also experience high levels of distress, tension, reduced self-esteem, and compromised overall quality of life, which affects their psychological well-being. The results also show that there are demographic and geographical variations in stigma, with stigma being more prevalent in rural areas. Different initiatives were also proposed to help caregivers deal with stigma and discrimination in their day-to-day lives.

**Figure 1: Conceptual Model**





## Discussion

The first main theme, perpetrators of stigma against caregivers, comprised of three subthemes. It is consistent with the previous findings as the perpetrators of stigma and discrimination against caregivers of patients with bipolar disorder come from various sectors. These commonly include the general public, healthcare professionals, and even families.

The first subtheme is stigmatisation from family and close relatives. Within the families, caregivers of bipolar disorder often face blame and criticism from their close ones. The caregivers are blamed for the condition of the patient. This type of intra-family stigmatisation and discrimination leads to significant levels of emotional distress among the caregivers.

The second subtheme is neighbourhood stigma and its impact. The people from the neighbourhood often harbour misconceptions and prejudices about bipolar disorder. These misconceptions not only affect the lives of patients who are suffering from the disorder but also extend to those who are associated with bipolar patients, such as their caregivers. Stigmatisation from the neighbourhood is manifested in different ways resulting in rejection and discriminatory behaviours towards the caregivers (Perlick et al., 2007).

The third subtheme is the stigmatisation of caregivers in the healthcare sector. Despite being in the field of mental health, some healthcare professionals may also be involved in the stigmatisation and discrimination of the caregivers of bipolar disorder. The previous literature also validates this subtheme. It has been indicated that healthcare professionals, including psychiatrists and psychologists, often blame and judge the caregivers (Reavley & Jorm, 2011).

The second theme identified was the forms of stigma experienced by caregivers. It included two subthemes and is consistent with the previous findings. In addition, their neighbours, friends, and relatives socially isolate them (Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2005).

The first subtheme was caregivers' experience of social stigma. The findings of the present research stated that caregivers face a lot of social stigma from society. Individuals in society, particularly family members and neighbours, frequently lay the responsibility for the patient's condition to the caregivers. Because of this high social stigma, caregivers are also forced to change their residence and move to somewhere else. It is supported by the literature that such kinds of rejection, ostracization, discriminatory behaviours, harsh attitudes and negative judgments make caregivers feel unwelcome and isolated (Perlick et al., 2007). Literature also indicates that people in Asian countries experience high levels of social stigma. Because of this, they are less likely to seek professional help for mental issues as they have the fear of being called "weak" or "crazy" (Reavley & Jorm, 2011).

The second subtheme identified from the research was self-stigma experienced by caregivers. The results showed that caregivers started to believe that the patient's condition and misery were their fault. As a result of this self-blame, they experience high levels of depression, anxiety, and despair. Also, caregivers in Asian cultures experience higher levels of depressive symptoms because of this self-stigma.

The third theme identified from the research findings was the root causes of stigma: lack of education and superstitious beliefs. The first subtheme was hindrances to effective care due to caregivers' lack of awareness and education on bipolar disorder. It was found out that the caregivers face stigma from society, and because of this lack of understanding, they do not seek medical help.

The second subtheme was superstitious beliefs and spiritual healing practices. Caregivers of bipolar disorder have a deep inclination towards spiritual healing practices. They mostly believe that the illness is incurable as it is brought on by supernatural entities such as Jinns (spirits or demons) and practices like jadoo (witchcraft or black magic). It is supported by the previous literature in which it was highlighted that in most Asian communities, mental disorders, especially bipolar disorder, are seen as a manifestation of possession by spirits (Corrigan & Miller, 2004).

The fourth theme was the challenges faced by caregivers as a result of stigma. The first subtheme was emotional and psychological strain among caregivers. It was reported that when the caretakers come to know that their loved one has bipolar disorder, they experience extreme mental distress, which negatively impacts their emotional and mental well-being. It is validated from the literature that the emotional toll of caregiving, along with the experiences of social stigma, creates feelings of sadness and depression among caregivers.

The second subtheme was social isolation and family avoidance among caregivers. It was evident from the findings that the social lives of caregivers of bipolar disorder social lives are severely hampered. Asian caregivers of bipolar disorder experience rejection from their society due to their negative image of mental illness. This widespread social stigma makes social isolation worse because the neighbours and close relatives ignore or mock caregivers (Reavley & Jorm, 2011).

The fifth theme was the demographical and geographical dimensions of stigma. Within this classification, the first subtheme was geographical variations in stigma and discrimination. Because of the lower levels of education in rural areas, stigmatization is more common there. There's also a strong tendency in these areas for spiritual healing. As a result, many caregivers prefer to wait until the patient's condition becomes intolerable before seeking medical attention.

The second subtheme was cultural and provincial variations in stigma. The results reported that the stigma and discrimination experienced by the people of Balochistan and KPK varied significantly from those of Punjab. Balochistan and KPK have lower literacy rates than other regions; hence, stigma is typically higher there. Literature supports the idea that the stigmatisation that caregivers experience is worse in the regions of KPK and Balochistan. This is due to the limited access to mental health services.

The sixth theme was proposed initiatives to overcome stigma among caregivers. The subtheme was psychoeducation and public awareness initiatives. Different strategies and policies were suggested to create awareness among the public by holding various workshops and seminars. Psychoeducation can dispel myths, lessen anxiety, and increase empathy by delivering factual knowledge and promoting understanding.

### ***Limitations and Suggestions***

- All the participants included were practising in urban mental health facilities.
- Future research should include other groups in the health system, such as patients, caregivers, and policymakers.
- Investigating participants from rural areas can also prove beneficial.

### ***Future Implications***

- The research explored the stigma experienced by caregivers of bipolar disorder. It will help tailor mental health support programmes and coping strategies for stigma and discrimination.
- The research also highlighted the very pressing need for improvement of the mental health sector to help reduce the stigmatisation of caregivers from their side.

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## Conflict of Interest


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## References

- Chadda, R. K. (2014). Caring for the family caregivers of persons with mental illness. *Indian Journal of Psychiatry*, 56(3), 221. <https://doi.org/10.4103/0019-5545.140616>
- Coffey, M. (2009). Shunned: Discrimination against People with Mental Illness. *Journal of Psychiatric and Mental Health Nursing*, 16(1), 108–109. <https://doi.org/10.1111/j.1365-2850.2008.01283.x>
- Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, 13(6), 537–548. <https://doi.org/10.1080/09638230400017004>
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), 37–70. <https://doi.org/10.1177/1529100614531398>
- Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the Public Stigma of Mental Illness: A Meta-Analysis of Outcome Studies. *Psychiatric Services*, 63(10), 963–973. <https://doi.org/10.1176/appi.ps.201100529>
- Daniel, F., Ghani, N., Ali, S., & Suliman, M. (2021). Impact of Mental Disorders in terms of Discrimination and Stigmatization: A Cross-Sectional Study in Peshawar, Khyber Pakhtunkhwa. *Journal of Saidu Medical College Swat*. <https://doi.org/10.52206/jsmc.2021.11.2.96-102>
- Evans-Lacko, S., London, J., Little, K., Henderson, C., & Thornicroft, G. (2010). Evaluation of a brief anti-stigma campaign in Cambridge: do short-term campaigns work? *BMC Public Health*, 10(1). <https://doi.org/10.1186/1471-2458-10-339>
- Gania, A., Kaur, H., Grover, S., Khan, A., Suhaff, A., Baidya, K., & Damathia, P. (2019). Caregiver burden in the families of the patients suffering from bipolar affective disorder. *British Journal of Medical Practitioners*, 12(1), a006. <https://doi.org/10.52206/jsmc.2021.11>
- Gunasekaran, S., Tan, G. T. H., Shahwan, S., Goh, C. M. J., Ong, W. J., & Subramaniam, M. (2022). The perspectives of healthcare professionals in mental health settings on stigma and recovery - A qualitative inquiry. *BMC Health Services Research*, 22(1). <https://doi.org/10.1186/s12913-022-08248-z>
- Hanafiah, A. N., & Van Bortel, T. (2015). A qualitative exploration of the perspectives of mental health professionals on stigma and discrimination of mental illness in Malaysia. *International Journal of Mental Health Systems*, 9(1). <https://doi.org/10.1186/s13033-015-0002-1>

- Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, 103(5), 813–821. <https://doi.org/10.2105/ajph.2012.301069>
- Latifian, M., Abdi, K., Raheb, G., Islam, S. M. S., & Alikhani, R. (2023). Stigma in people living with bipolar disorder and their families: a systematic review. *International Journal of Bipolar Disorders*, 11(1). <https://doi.org/10.1186/s40345-023-00290-y>
- Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71(12), 2150–2161. <https://doi.org/10.1016/j.socscimed.2010.09.030>
- Magliano, L., Fiorillo, A., De Rosa, C., Malangone, C., & Maj, M. (2005). Family burden in long-term diseases: a comparative study in schizophrenia vs. physical disorders. *Social Science & Medicine*, 61(2), 313–322. <https://doi.org/10.1016/j.socscimed.2004.11.064>
- Manwell, L. A., Barbic, S. P., Roberts, K., Durisko, Z., Lee, C., Ware, E., & McKenzie, K. (2015). What is mental health? Evidence towards a new definition from a mixed methods multidisciplinary international survey. *BMJ Open*, 5(6), e007079. <https://doi.org/10.1136/bmjopen-2014-007079>
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative Research: A Guide to Design and Implementation* (4th ed.). San Francisco, CA: Jossey-Bass.
- Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *BMJ*, 328(7443), 794. <https://doi.org/10.1136/bmj.328.7443.794>
- Naeem, M., Ozuem, W., Howell, K., & Ranfagni, S. (2023). A Step-by-Step process of thematic analysis to develop a conceptual model in qualitative research. *International Journal of Qualitative Methods*, 22. <https://doi.org/10.1177/16094069231205789>
- Perlick, D. A., Miklowitz, D. J., Link, B. G., Struening, E., Kaczynski, R., Gonzalez, J., Manning, L. N., Wolff, N., & Rosenheck, R. A. (2007). Perceived stigma and depression among caregivers of patients with bipolar disorder. *The British Journal of Psychiatry*, 190(6), 535–536. <https://doi.org/10.1192/bjp.bp.105.020826>
- Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A Framework Integrating Normative Influences on Stigma (FINIS). *Social Science & Medicine*, 67(3), 431–440. <https://doi.org/10.1016/j.socscimed.2008.03.018>
- Phelan, J. C., Bromet, E. J., & Link, B. G. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin*, 24(1), 115–126. <https://doi.org/10.1093/oxfordjournals.schbul.a033304>
- Reavley, N. J., & Jorm, A. F. (2011). Stigmatizing Attitudes towards People with Mental Disorders: Findings from an Australian National Survey of Mental Health Literacy and Stigma. *Australian & New Zealand Journal of Psychiatry*, 45(12), 1086–1093. <https://doi.org/10.3109/00048674.2011.621061>
- Richard-Lepouriel, H., Aubry, J., & Favre, S. (2021). Is Coping with Stigma by Association Role-Specific for Different Family Members? A Qualitative Study with Bipolar Disorder Patients' Relatives. *Community Mental Health Journal*, 58(1), 179–192. <https://doi.org/10.1007/s10597-021-00809-6>
- Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, 20(8), 529–539. <https://doi.org/10.1016/j.eurpsy.2005.04.004>

- Schwandt, T. A. (1994). "Constructivist, Interpretivist Approaches to Human Inquiry." In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 118-137). Thousand Oaks, CA: Sage.
- Shamsaei, F., Mohamad Khan Kermanshahi, S., Vanaki, Z., & Holtforth, M. G. (2013). Family Caregiving in Bipolar disorder: Experiences of Stigma. *Iranian journal of psychiatry*, 8(4), 188–194. [https://doi.org/10.1016/s0140-6736\(07\)61263](https://doi.org/10.1016/s0140-6736(07)61263)
- Waqas, A., Malik, S., Fida, A., Abbas, N., Mian, N., Miryala, S., Amray, A. N., Shah, Z., & Naveed, S. (2020). Interventions to Reduce Stigma Related to Mental Illnesses in Educational Institutes: a Systematic Review. *Psychiatric Quarterly*, 91(3), 887–903. <https://doi.org/10.1007/s11126-020-09751-4>
- World Health Organization: WHO. (2019, December 19). Mental health. Retrieved from <https://www.who.int/health-topics/mental-health#:~:text=In%202019%2C%20970%20million%20people,at%20school%20and%20at%20work.>
- Yanos, P. T., Roe, D., & Lysaker, P. H. (2010). The Impact of Illness Identity on Recovery from Severe Mental Illness. *American Journal of Psychiatric Rehabilitation*, 13(2), 73–93. <https://doi.org/10.1080/15487761003756860>