Human Nature Journal of Social Sciences
Vol.7, No.1 (March, 2026), Pp.78-96
ISSN(online): 2788-5240, ISSN(print): 2788-5232
DOI: https://doi.org/10.71016/hnjss/cjbbw044

Original Article https://hnpublisher.com

Exploring the Burden Experienced by Caregivers of Patients with Bipolar Disorder - A Qualitative Study

Faryal Arshad[1], **Hira Liaqat**[2]

[1]Research Scholar, Centre for Clinical Psychology, University of the Punjab, Lahore, Pakistan.
[2]Lecturer, Centre for clinical psychology, university of the Punjab, Lahore, Pakistan.
Correspondence: faryalarshad57@gmail.com[1]

ABSTRACT

Aim of the Study: The present study was conducted to explore the caregiver burden in the caregivers of bipolar disorder. The major research question that was designed for the study was "What are the perspectives of caregivers of bipolar disorder regarding the caregiver burden that they experience?"

Methodology: Qualitative research design was used in the present study to get detailed information from the caregivers. Participants were selected through a purposive sampling strategy because participants were selected according to criteria that match the research objectives. Semi-structured interviews were conducted with the caregivers of bipolar disorder. Overall, there were three male and three female caregivers in the sample. The results were analyzed using thematic analysis.

Findings: Study found that seven major themes emerged, which included the physical burden due to caregiving, the emotional challenges of caregiving, the financial burden on caregivers, the effect of patient condition on family dynamics, stigma and discrimination faced by caregivers, the risk of relapse, and acceptance among caregivers about patient illness.

Conclusion: Study concluded that caregivers of patients with bipolar disorder experience substantial burden affecting physical health, emotional well-being, financial stability, and family functioning. The unpredictable nature of bipolar disorder intensifies stress and increases risk of burnout.

Keywords: Caregivers, Bipolar Disorder, Caregiver Burden, Thematic Analysis, Themes.

Article History

Received:
December 8, 2025

Revised:
February 2, 2026

Accepted:
February 5, 2026

Online:
February 10, 2026

1. INTRODUCTION

Mental health problems significantly affect patients and their caregivers. They influence behaviour, mood, and thinking, and impair functioning at work, school, and home. In Pakistan, mental health problems are a leading cause of disability, with 29% of women and 19% of men diagnosed with mental health conditions (Gadite & Mugford, 2007). Mental illness can disturb family dynamics, social connections, workplace functioning, cognition, and may lead to suicidal ideation and health-related issues. Physical health is closely related to mental health; anxiety, stress, and depression can cause fatigue, headaches, digestion problems, and weakened immunity.

In 2019, common mental disorders worldwide included bipolar disorder (45 million), depression (264 million), dementia (50 million), and schizophrenia (20 million). Neurodevelopmental disorders include autism spectrum disorder, intellectual disability, learning disabilities, cerebral palsy, and attention deficit hyperactivity disorder.

1.1 Bipolar Disorder

Bipolar disorder is also called a manic-depressive illness. It is a chronic mood disorder which causes extreme mood swings. Mania involves high irritability, increased energy, and disturbed sleep; hypomania is less severed and does not affect functioning. Depressive episodes involve low mood, hopelessness, and suicidal ideation (Reiners et al., 2008).

Over the past 20 years, 6% of women with bipolar died by suicide, and approximately 40% engaged in self-harm. Most individuals experience depressive episodes, and substance use and anxiety disorder are associated. Onset typically occurs in late adolescence and early adulthood. Genetic factors influence 73–93% of risk. Psychosocial factors, including childhood abuse and trauma (30–50%), and neurological conditions such as traumatic brain injury, temporal lobe epilepsy, and porphyria are also associated (Maassen et al., 2018)

The cost of bipolar disorder is high. In 2009, the total cost in the United States was approximately $151 billion, including $30.7 billion in direct healthcare costs and $120.3 billion in indirect costs such as unemployment and reduced productivity (Miller et al., 2014).

1.2 Caregiver Burden

Caregivers play a vital role in patients' recovery. Informal Caregivers provide unpaid support to individuals unable to manage daily activities. They may be friends or family who help them with personal care, household chores, etc. (Sherwood et al., 2008).

Caregivers may neglect their own health. Caregiver burden is linked with increased health-risk behaviors and higher levels of somatic symptoms, depression, insomnia, stress, and social isolation (Kazemi et al., 2021).

Caregiver burden includes emotional, psychological, physical, social and financial strain. Caregivers may experience anxiety, depression, frustration, and hopelessness. They often report fatigue and health-related issues due to disrupted routines. Financial strain arises from treatment expenses and reduced professional engagement, resulting in comprised quality of life and social isolation (Perlick et al., 2008).

1.3 Caregivers Burden in the Patients of Bipolar Disorder

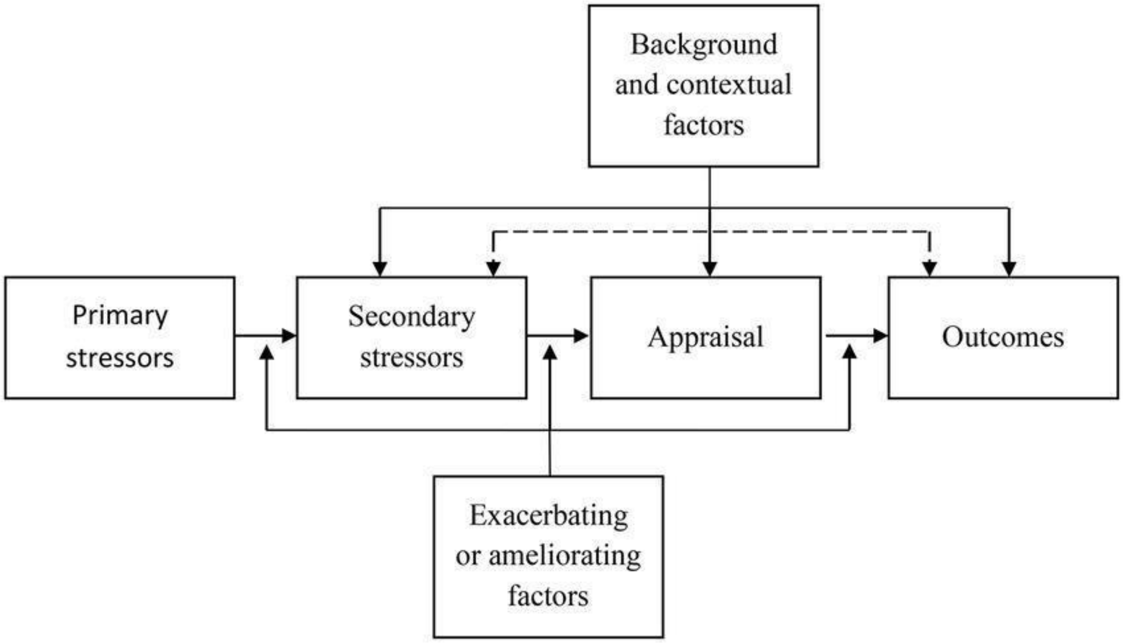
Physical burden includes disrupted routines, lack of sleep, fatigue, reduced energy, and chronic health issues such as hypertension and cardiovascular disturbances (Reiners et al., 2006).

Caregivers also experience social isolation, strained relationships, and stigma (Granik et al., 2016; Guan et al., 2023). Financial pressures related to treatment and caregiving responsibilities increase stress and anxiety (Perlick et al., 2008).

1.4 Model of Caregiver Stress and Burden

The model of caregiver stress and burden includes objective burden, subjective burden, and mediators (Montgomery et al., 1985). Objective burden refers to tangible caregiving demands. Subjective burden refers to perceived distress. Mediators such as social support and coping strategies influence the relationship between objective and subjective burden.

Figure 1: Study model



The model of caregiver stress and burden includes objective burden, subjective burden, and mediators (Montgomery et al., 1985). Objective burden refers to tangible caregiving demands. Subjective burden refers to perceived distress. Mediators such as social support and coping strategies influence the relationship between objective and subjective burden.

1.5 Significance of the Research

Previous qualitative studies on caregiver burden among the caregivers of bipolar disorder in Pakistan are very limited. A number of quantitative studies have been done, but qualitative researches are rare.

1.6 Study Objective

Exploring the caregiver burden in the caregivers of bipolar disorder through a qualitative study.

1.7 Research Question

What are the perspectives of caregivers of bipolar disorder regarding the caregiver burden that they experience?

2. LITERATURE REVIEW

Nagarajan et al. (2021) examined coping and burden among caregivers of patients with major mental illness using a cross-sectional design. Results showed that over 50% of caregivers of bipolar disorder experienced moderate burden, and family atmosphere was significantly affected. Caregivers experienced similar levels of burden across major mental disorders.

Kargar et al. (2021) conducted a qualitative study using semi-structured interviews with 13 caregivers and 14 therapists. Conventional content analysis revealed that caregiver burden is multifaceted, involving individual, social, and organizational aspects. Therapists’ perspectives were considered useful for designing interventions.

Ganguly et al. (2010) conducted a longitudinal qualitative study including 305 caregivers of patients with bipolar disorder and schizophrenia. Findings showed burden affecting family functioning, interpersonal relationships, financial stability, and health. Coping strategies included compassion, hope, religious practices, and seeking support. The study highlighted the need for culturally sensitive caregiver support.

Girdhar and Patil (2023) analyzed caregiver burden in bipolar disorder and schizophrenia and its relationship with anxiety and depression. Caregivers of bipolar disorder perceived higher burden and lower quality of life, with psychological distress including anxiety, depression, social isolation, and financial issues. Limitations included cross-sectional design and small sample sizes.

Camil and Yılmaz (n.d.) analyzed perceived caregiver burden among caregivers of bipolar disorder patients selected from outpatient and inpatient clinics in Istanbul. The Caregiver Burden Inventory and statistical analyses (Mann-Whitney U test, t-test, ANOVA, Pearson correlation) were used to identify factors related to caregiver burden.

Van Der Walt and Carbonate (2019) identified caregivers' needs through qualitative interviews. Caregivers reported financial needs, emotional support, knowledge about bipolar disorder, and coping tools. The study emphasized the importance of family-focused care and support mechanisms.

Ae-Ngobese et al. (2015) explored caregiver experiences in rural Ghana using interviews and focus groups with 75 caregivers. Caregivers experienced emotional, psychological, social, and financial problems. Counselling and economic assistance were recommended.

Udoh et al. (2021) assessed psychological distress and burden among caregivers in Nigeria using GHQ-12 and Zarit Burden Interview. Results showed 51.3% mild-to-moderate burden and 34% high-to-severe burden. A high prevalence of psychological morbidity was identified.

Azman et al. (2017) examined the impact of mental illness on family caregivers in Malaysia. Caregivers reported financial strain and physical, mental, and social effects. Support groups were recommended.

Souza et al. (2017) studied 281 caregivers in Brazil using structured questionnaires and Zarit Burden Interview. Mild-to-moderate burden was associated with depression, lack of assistance, increased patient contact, and recent crises. Family therapy and psychoeducation were suggested.

Gel aye and Andualem (2022) examined quality of life among 398 caregivers in Ethiopia. Poor quality of life (47.5%) was associated with stigma, poor social support, and marital status.

Issel et al. (2016) conducted interviews and focus groups with caregivers. Themes included disruptive behavior, stigma, discrimination, lack of social support, family disruption, and financial restrictions. Acceptance and religious practice were coping mechanisms.

Azhar et al. (2010) assessed family burden, anxiety, depression, and quality of life among caregivers in Lahore using WHO-QOL Breve, Family Burden Interview Schedule, and HADS. Anxiety and depression scores were high, and family burden related to routine disruption and financial constraints.

Leng et al. (2019) studied 181 caregivers in China using MOS SF-36 and Social Support Rating Scale. Caregivers reported low quality of life associated with illness severity, care duration, financial burden, and social support.

A systematic review and meta-analysis reported caregiver burden prevalence at 31.67%, higher in hospital settings and among caregivers of individuals with psychosis (Ganguly et al., 2010).

Caregivers of individuals with severe mental illnesses experience physical, psychological, financial, and social challenges. Caregiver burden varies according to disorder severity, care setting, and social support. Caregivers of bipolar disorder and schizophrenia report higher burden, distress, and poorer quality of life. Coping strategies include social support, religious practices, and professional help. Literature highlights the need for structured caregiver support systems, particularly in non-Western countries.

3. METHOD

This section outlines research design, sampling strategy, participant characteristics, measures, procedure, ethical considerations, and data analysis.

3.1 Research Design

A qualitative research design was used to explore caregiver burden among caregivers of patients with bipolar disorder. Qualitative research focuses on gathering rich data describing experiences, beliefs, perspectives, and meanings assigned to lived experiences (Smith et al., 2009).

3.2 Research Paradigm and Method

The interpretivist paradigm was used, emphasizing subjective experiences and socially constructed reality (The SAGE Handbook of Qualitative Research, 2024). Under this paradigm, phenomenology was employed to explore lived experiences of participants and provide a detailed description of their perceptions (Tindall, 2009).

3.3 Sampling Strategy

Purposive sampling was used because participants were selected according to criteria matching the research objectives (Palinkas et al., 2013).

3.4 Inclusion Criteria

- Caregivers aged 35-70.
- Providing care for at least one year
- Able to understand Urdu.

3.5 Exclusion Criteria

- Not primary caregiver.
- Having physical disability.

3.6 Measuring Instruments

Semi-structured interviews were conducted with caregivers selected from Punjab Institute of Mental Health (PIMH). The sample comprised six caregivers (three male, three female). Interviews lasted 15–20 minutes and were audio recorded. The interview guide explored caregiver burden. An example item was: “What is the impact of caregiving on your daily life?”

3.7 Participant Characteristics

Six caregivers participated:

Participant 1: 39-year-old married male (BS CS), brother, caregiving for 25 years.

Participant 2: 70-year-old married male (middle education), father, caregiving for 6 years.

Participant 3: 30-year-old married male (F.A), husband, caregiving for 4 years.

Participant 4: 47-year-old married female (Matric), mother, caregiving for 2 years.

Participant 5: 48-year-old married female (illiterate), mother, caregiving for 5 years.

Participant 6: 50-year-old married female (illiterate), mother, caregiving for 6 years.

3.8 Data Collection

Face-to-face semi-structured interviews were conducted. Participants were informed about the purpose of the research and provided written informed consent. Interviews were audio recorded.

3.9 Ethical Considerations

Departmental approval was obtained from Centre for Clinical Psychology, University of the Punjab. Participants were informed through an information sheet and in this way written informed consent was obtained. Confidentiality, privacy, and anonymity were ensured.

3.10 Thematic Analysis

Thematic analysis was used. It involves coding significant statements and developing themes. The six steps included:

- Transcribing interviews and reading thoroughly.
- Generating keywords from significant statements.
- Grouping keywords into codes.
- Reviewing and grouping similar codes into themes.
- Analyzing relationships between keywords, codes, and themes.
- Deriving a conceptual model (Naeem et al., 2023).

3.11 Verification of Data

Validity and trustworthiness were ensured through peer review, frequent debriefing sessions, and mentor check. Themes and subthemes were reviewed by a specialist and modified accordingly. Regular meetings with the supervisor aided theme development and refinement. Themes were discussed with participants, who agreed with the emergent themes and codes.

4. RESULTS

The study explored caregiver burden among caregivers of patients with bipolar disorder. Thematic analysis identified seven main themes:

- Physical Burden due to Caregiving
- Emotional Challenges of Caregiving
- Financial Burden on Caregivers
- Effect of Patient Condition on Family Dynamics
- Stigma and Discrimination Faced by Caregivers
- Risk of Relapse
- Acceptance among Caregivers about Patient Illness

4.1 Main Theme 1: Physical Burden due to Caregiving

Caregivers of bipolar disorder report deteriorations in their physical health, including weakness and fatigue and exhaustion.

4.1.1 Physical Weakness due to Caregiving

The participant M.N. reported that he has been experiencing a lot of deterioration in his physical health because of the caregiving of the patient. He reported that he has also been seeking medical treatment. His verbatim was

بس کچھ نہیں رہ گیا میری اپ تصویریں دیکھیں اج سے 10 سال پہلے کی اپ نہیں پہچانیں گے میں اب شوگر کا پیشنٹ ہوں یہ میری انکھیں اس وقت مجھے 15 فیصد نظر ارہا ہے باقی سب کچھ ختم ہو چکا ہے ابھی ساتھ میرا علاج بھی چل رہا ہے

The participant A.P reported that the dual burden of physical weakness and caregiving responsibilities creates mental and physical exhaustion that makes it very tough for her to manage her daughter along with her own health issues. Her verbatim is:

جسمانی طور پر میں پہلے سے ہی کمزور ہوں میری ٹانگوں میں درد رہتا ہے میرے گردے کا بھی مسئلہ ہے تو ویسے ہی میں بہت
کمزور ہوں پھر اس کی یہ حالت اف یہ سب بہت مشکل ہوتا ہے سنبھالنا میرے لیے مجھ سے یہ بالکل نہیں سنبھلتی

The participant G.N reported that she is completely occupied by household responsibilities, including caring for four children and two patients so in between all these

responsibilities, her physical health is suffering as she is getting old so it becomes difficult for her to manage all the household now. Her verbatim is:

اب گھر میں میری بس ہو گئی ہے عمر کے لحاظ سے بھی دو مریض ہیں اور چار بچے اپ خود ہی سوچیں ان کو سنبھالتے
سنبھالتے میری کیا حالت ہوگی

4.1.2 Fatigue and Exhaustion

The participant U.N. reported a distressing change in his physical health. He also said that he had never felt this tired before, and now there is a significant change in his physical health. His verbatim is:

مجھے اب بہت زیادہ تھکاوٹ محسوس ہوتی ہے پہلے ایسا نہیں ہوتا تھا مگر اب بہت تھک جاتا ہوں ان سب چیزوں کے ساتھ

The participant S.A reported that at times he used to feel angry before, but now his physical condition has worsened after excessive caregiving to the patient. He mentioned that he feels as if he has no energy in his body. His verbatim was;

پہلے تو اس کی ان حرکتوں کی وجہ سے مجھے بھی بہت غصہ اتا تھا بعد میں ایسے لگتا جیسے میرے اندر اب ہمت ہی نہیں ہے تو
میں چپ کر جاتی ہوں

‘‘The participant K.K also reported physical exhaustion and weakness in his body. His verbatim was;

میں اس کے ساتھ ابھی بڑا تھک سا جاتا ہوں مجھ میں بیٹری تو نہیں لگی ہوئی نا انسان ہوں بہت تھک جاتا ہوں

4.2 Main Theme 2: Emotional Challenges of Caregiving

Caregivers reported stress, frustration, hopelessness, resentment, and difficulty managing aggression.

4.2.1 Stress and Frustration

The participant M.N. reported that the patient says such words that are unbearable and harsh for a normal person. So, he avoids sitting with the patient. His verbatim was;

ہم خود اسے اوائڈ کرتے ہیں جب یہ میری اور اپنی امی کے ساتھ باتیں کرتا ہے تو بہت فضول بولتا ہے یہ خود تو پاگل ہے ہمیں بھی
پاگل کر دے گا بس اس کو اوائڈ کرتے ہیں ایک گھنٹہ بڑی مشکل سے میں اس کے ساتھ بیٹھتا ہوں کیونکہ یہ ہائپر ہو کے ایسی باتیں
کرتا ہے جو پھر میں نہیں برداشت کر پاتا اب ایسے یہ ہائپر ہوتا ہے تو اگلے کو بھی ہائپر ہونا پڑتا ہے

The participant A.P reported that the patient does not listen to them and does not take her medicines, which makes them stressed and frustrated at times, and often scold her for that her verbatim was;

میں اسے صرف میڈیسن کی وجہ سے ڈانٹ دیتی ہوں کیونکہ یہ بات بالکل نہیں سنتی ہم نے ہر طریقہ اپنایا مگر یہ نہیں سنتی بہت
تنگ کرتی ہے

The participant G.N reported that she feels hopeless and crying. This shows the participant is emotionally distressed, and her emotional burden is so heavy that she is thinking of self-harm and suicide, she does not know what to do with her life. Her verbatim was;

میں اپنے بیٹے کی حالت دیکھ کر ایسے ہو گئی تھی کہ کیا بتاؤں رونے اور ٹینشن لینے کے سوا میرے پاس اور کیا ہی ہے اب

The participant U.N. reported that he tries to handle the patient with care, despite feeling angry or exhausted. His verbatim was;

میں اب بہت کنٹرول کرتا ہوں غصہ مجھے بھی اتا ہے مگر میں کوشش کرتا ہوں کہ اسے پیار سے سمجھاؤں جب یہ ہائپر ہوتی ہے تو

The participant S.A. reported that she sometimes feels angry and exhausted, but when she looks at her child, she develops a sense of empathy, remains quiet, and controls her anger. Her verbatim was;

پہلے تو بہت غصہ اتا ہے جب یہ ایسی حرکتیں کرتی ہے تو پھر اس کی طرف دیکھتی ہوں تو چپ کر جاتی ہوں ترس اتا ہے

The participant K.K reported that initially, when he used to feel stressed, he used to beat the patient as well. but now the participant is used to it and remains quiet during such kind of stressful situations, His verbatim was;

شروع شروع میں میں بھی اسے مارتا تھا چڑ جاتا تھا میں اب 25 سال کا ایکسپیرینس ہو گیا ہے عادت ہو گئی ہے تو اب میں بھی خاموش ہو جاتا ہوں

4.2.2 *Resentment and Hatred towards Caregivers*

The participant A.P reported that the patient considers her as her enemy. His verbatim was;

یہ مجھ سے بہت زیادہ نفرت کرتی ہے اس کے دل میں میرے لیے بہت نفرت ہے کیونکہ میں اسے میڈیسن کھلاتی ہوں اور یہ مجھے اپنا دشمن سمجھتی ہے

The participant K.K reported the patient considers him as his biggest enemy and villain of his life. His verbatim was;

یہ مجھے اپنا بہت بڑا دشمن سمجھتا ہے اس کی نظر میں میں اس کی زندگی کا ولن ہوں

4.2.3 *Feelings of Hopelessness*

The participant M.N. displayed a sense of hopelessness over the improvement of the patient's condition, stating that he has gained acceptance that the situation will prevail for the rest of their life, the participant also feels emotional distress after looking at the patient himself and his kids. His verbatim was;

پریشان تو بہت ہے بیٹا اس کی وجہ سے پریشانی تو نہیں نکل سکتی نا اب ختم نہیں ہو سکتی میں تو اس کو دو دن نہ دیکھوں تو میرا گزارا نہیں ہوتا چھوٹے چھوٹے بچے ہیں اس کے

The participant A.P showed a sense of hopelessness, stating that she has no time for herself because of the burden of responsibilities on her shoulders. She mentioned that she single-handedly has to look after the patient and her child and manage the rest of the house chores. His verbatim was;

میرے پاس اپنے لیے اب بختی کہاں ہے اس کو اور اس کے بچوں کو میں نے سنبھالنا ہوتا ہے اور اوپر سے میرے اپنے سو مسئلے ہیں

The participant G.N mentioned that their entire business had collapsed. He displayed a sense of hopelessness and disappointment, stating that life was just passing by. The patient's condition has worsened to the extent that he himself is unable to manage his everyday tasks placing all the burden over his parents. Her verbatim was;

میں اور میرے میاں کرتے تھے سارے کام ہم دونوں نے سنبھالا ہوا تھا میرے بیٹے کا سارا کاروبار خراب ہو گیا چھوٹے چھوٹے بچے ہیں اس کے کہاں وقت ہے اب اپنے لیے بس زندگی گزر رہی ہے

The participant U.N. reported that he has to manage everything all alone, from household to managing all the social tasks. he has to look after his parents and the patient(wife) he mentioned that he has no time for himself. He also showed hopelessness, stating that life is full of sacrifice, and he has no other options. His verbatim was;

مشکل ہوتا ہے یہ سب کچھ گھر بھی دیکھنا والدہ کو بھی دیکھنا والد صاحب کو بھی دیکھنا اور اوپر سے اس کی یہ حالت انسان کو زندگی میں سیکریفائس کرنا پڑتا ہے اپنے لیے تو بالکل ٹائم ہی نہیں ہے اب

The participant S.A reported high levels of distress, worry and dissatisfaction with her life, her verbatim showed that she is extremely discontent with her life, and the hopelessness has increased to such an extent that she has started praying for her death. She wishes that her life should end because of the unbearable challenges and the problems that seem to have no solution. Her verbatim was;

میں تو اتنی پریشان ہوں نا کہ اللہ سے دعا کرتی ہوں یا اللہ مجھے موت دے دے جیسی میری زندگی گزر رہی ہے اداسی ہوتی ہے مجھے بہت زیادہ یقین کرے کل نماز پڑھ رہی تھی اور میں اتنا روئی ہوں کہ میری حالت خراب ہو گئی تھی اس وجہ سے

The participant K.K reported the disturbances in his social life. He also feels anxious and has a disturbed sleeping pattern he feels as if his life has stopped processing and he has no time for himself.

میری سماجی زندگی ضائع ہو گئی ہے مجھے سکون نہیں ہوتا اب رات کو نیند بھی نہیں اتی اپنے لیے اب وقت ہی نہیں ہے ایسا لگتا ہے جیسے زندگی رک سی گئی ہے

4.2.4 Bearing with the Aggressive and Violent Behavior of the Patient

The participant M.N. reported that the patient had beaten him and his wife many times when he was in a manic episode, he also reported that their family has to tolerate his threatening behavior a lot. His verbatim was;

بہت مشکل ہوتا ہے اب اس کے ساتھ اس نے مجھے بھی کئی دفعہ بہت مارا ہے اور اپنی ماں کو بھی اسے ٹانکے بھی لگی ہوئی ہیں دو کسی دن پیچکس لے کر ایا اور کہتا ہے اب تم لوگ مجھ سے بچ کر دکھاؤ ایسی حرکتیں

The participant A.P reported that the patient considers her as her enemy and has also beaten her many times. Her verbatim was;

میں اس سے میڈیسن کھلاتی ہوں تو یہ مجھے اپنا دشمن سمجھتی ہے اور کہی دفعہ مجھے مارا بھی ہے اور بہت زیادہ گالیاں نکالتی ہے

The participant G.N reported that once the patient had slapped his brother-in-law. And often fights with his father and uses abusive language to him her verbatim was;

یہ اپنے ابو کا گربان پکڑتا ہے اور اس کو بہت گالیاں نکالتا ہے اس نے اپنے سالے کو تھپڑ بھی مارا تھا اور مجھے بھی بہت گالیاں دیتا ہے

The participant S.A reported that the patient becomes extremely aggressive and threatens the family with knife or sharp objects, The patient has also broken mobile phones in manic episodes.

چھوری پکڑ لیتی ہے یہ چاہے جس مرضی کو لگے موبائل توڑ دیتی ہے پچھلے دنوں اس نے ٹیبل توڑا تھا اس طرح کی حرکتیں کرتی رہتی ہے

The participant K.K also reported that he faces harsh and violent behavior from the patient. He has beaten the participant many times when he becomes aggressive. His verbatim was;

جب وہ ایگریسو ہو جاتا ہے تو مکے مارنا شروع کرتا ہے اس نے کئی دفعہ مجھے مارا بھی ہے

4.3 Main Theme 3: Financial Burden on Caregivers

Caregivers reported financial strain due to treatment expenses and reduced professional functioning.

4.3.1 Challenges faced by Caregivers in Professional Lives

The participant M.N. reported that he faces significant life challenges and a downfall in his personal and professional life due to caregiving. These statements show the emotional burden of balancing his son's responsibilities with financial needs and personal ambitions. The participant compares his past professional status and achievements to his current situation. His verbatim was;

مین مسئلہ یہی ہے تبھی تو اج کچھ کر نہیں پا رہا ہوں زندگی میں اگر اس کے ساتھ یہ مسئلہ نہ ہوتا تو میں کوئی کام وغیرہ ڈھونڈ لیتا اب اس کا خیال رکھوں یا کام کی تلاش میں نکل جاؤں میں انجینیئر تھا 1994 سے 2010 تک اب دیکھو میں اپنی ڈاؤنسٹ پوزیشن پر ہوں

The participant G.N. reported her role in their family business. She showed her active contribution to it initially, but now, due to her health issues and other responsibilities, she is unable to play her role in it, which shows a sense of helplessness and frustration. her verbatim is:

بیٹا ہمارا چکن کا کاروبار تھا اور میں خود اپنے بیٹے کی مدد کرتی تھی اس میں چار پانچ گھنٹے لگا کر اب ان ساری ذمہ داریوں کی وجہ سے میں وہ نہیں کر پاتی ہوں میں نے اپنے شوہر اور اپنے بیٹے کو کہا اب مجھ سے نہیں ہوتا یہ سب کچھ میں ایک ساتھ اتنی ذمہ داریاں نہیں سنبھال سکتی تھک گئی ہوں میری اپنی صحت اب ٹھیک نہیں رہتی

The participant U.N. reported that he is experiencing difficulties in managing his professional duties along with his caregiving responsibilities. His verbatim is:

بہت مشکل ہوتا ہے یہ سب کچھ اپ کو ہر چیز دیکھنی پڑتی ہے اب دیکھیں ان کی ذمہ داریاں اور پھر میری اپنی جاب دونوں کو ساتھ لے کر چلنا میرے لیے بہت مشکل ہوتا ہے

The participant K.K reported that he has been experiencing problems in his personal and professional life because of the violent and aggressive behavior of the patient. The patient often engages in fights and other immoral activities that directly disrupt the everyday functioning of the caregiver. His verbatim was;

بہت مشکل ہوتا ہے اس کے ساتھ اپنی ذاتی زندگی کو دیکھنا میری پروفیشنل لائف بہت زیادہ متاثر ہوئی ہے کام پر چلا جاتا ہوں تو اس کی یہ حالت ہو جاتی ہے پھر بھاگ کر واپس انا پڑتا ہے کبھی کبھی یہ پولیس کے چکر میں پڑ جاتا ہے تو سب کچھ میں نے ہی دیکھنا ہوتا

4.3.2 Difficulty in Managing Finances of Patients

The participant M.N. highlighted his financial burden. He not only has to look after the patient's expenses but also manages and fulfils the needs of the patient's family, including his wife and 3 children. His verbatim was;

اس کے تین بچے ہیں ایک بیٹا دو بیٹیاں ایک 40 دن کا ہے اس کے اخراجات ہیں اج کل مائیں دودھ پلاتی ہیں نہیں فیڈر استعمال کرتی ہیں اس کے لیے الیکٹرک پمپ ہزاروں خرچے ہوتے ہیں بیٹا مشکل ہو جاتا ہے بہت

The participant G.N reported that she was initially getting the patient treated from a private mental facility, but since the financial burden has been beyond her capacity, the patient has now been shifted to a government mental health institute. His verbatim is:

میں اس کا پرائیویٹ علاج کرواتی تھی ہارون رشید سے اب افورڈ نہیں کر سکتی ہے اسی لیے اس کو بھی میں اب یہاں لاتی ہوں

The participant U.N. reported that he all alone manages the expenses of the patients. His verbatim is;

سب کچھ میں کرتا ہوں میں کوشش کرتا ہوں کسی طرح اس کی نیڈز پوری کر سکوں گزارا ہو ہی جاتا ہے

The participant S.A reported that the family has only a single earning member. the whole needs of the family are dependent on his income. The family feels pressured because of the medication and treatment costs of the patient. Her verbatim was:

پاپا اس کے پہلے ہی ٹھیک نہیں ہیں گھر میں ایک کمانے والا ہے اس کے بھی 40 ہزار تنخواہ اس سے کیا ہی ہوگاا پھر اس کے علاج میں بھی اتنا خرچہ ہوا سی ایم ایچ سے میں نے کروایا ان کی میڈیسن کی فیس یہ سب کچھ نہیں ہوتا بجٹ میں پورا

The participant K.K reported that he alone has to bear all the expenses of the patient. His verbatim was:

اس کا سارا خرچہ میں اٹھاتا ہوں کوشش کرتا ہوں کہ پورے ہو جائیں بس گزارا ہو ہی جاتا ہے تھوڑا بہت

4.4 Main Theme 4: Effect of Patient Condition on Family Dynamics

Caregivers reported disturbed home atmosphere and disruption of routine functioning.

4.4.1 Disturbed Home Atmosphere

The participant M.N. reported one of the incidents of the patient's disruptive behavior that significantly disturbed their home atmosphere. he mentioned that the patient had beaten his wife out of his aggression. his verbatim was;

اس نے اپنی بیوی کو بلایا کمرے میں دروازہ بند کیا اور اس کو مارنا شروع کر دیا اور چھوڑ ہی نہیں رہا تھا بیچاری کو اتنا مارا

The participant A.P reported that there is an increase in tension and fights at their home, mainly because of the patient she shared one such incident where the patient's brother became so violent that he wanted to kill the patient. She reported that such fights have become more frequent in their home, hence disturbing the overall home atmosphere. Her verbatim was;

بس اب گھر میں لڑائی جھگڑے زیادہ ہوتے ہیں اس دن اس کا بھائی اس کو قتل کرنے والا تھا گلے میں رسی باندھ کے میں نے چھڑوا دیا یہ رات کو چھت پر جا کر لڑکوں سے باتیں کرتی ہے وہ اس کے بھائی کو پتہ چل گیا تھا قسم سے بہت پریشانی چلتی رہتی ہے گھر میں لڑائی جھگڑے ہوتے رہتے

The participant G.N reported that she has to manage everything single-handedly because of the disturbed family environment the patient’s wife has also been diagnosed with epilepsy. So, the participant has to look after the patient and his wife as well as handle their children. Her verbatim was:

بہت مشکل ہوتا ہے بیٹا گھر کے ساری چیزوں کو سنبھالنا میرے گھر کا ماحول بالکل بگڑ سا گیا ہے ساری ذمہ داریاں اب مجھ پر ہے چھوٹے چھوٹے بچے ہیں ان کو اکیڈمی لے کے جانا خاوند کا خیال رکھنا اس بیٹے کا خیال رکھنا اس کی بیوی وہ بھی بیمار ہے اس کا بے خیال رکھنا بس اب کیا بتاؤں گھر کا ماحول بگڑ گیا ہے

The participant U.N. reported that because of the patient's anger outburst, the family atmosphere remains disturbed. Especially if the patient becomes violent and aggressive in front of relatives it becomes more problematic his verbatim was:

ظاہری بات ہے بولنا ہوتا ہے کبھی بہت غصہ اتا ہے اور اس کی طبیعت خراب ہو جاتی ہے تو گھر والوں کے سامنے بہت کچھ بول دیتی ہے جس کی وجہ سے گھر کا ماحول خراب ہو جاتا ہے

The participant S.A reported the tension in their family atmosphere. Because of the patient's aggressive behavior, she has also been beaten by the family, especially by her father. Her verbatim was;

ذاتی زندگی پر اثر بہت زیادہ ہو جاتی ہے مار کٹائی بھی بہت ہوتی ہے اب اس کے پاپا بھی اس کی بہت مار کٹائی کرتے ہیں

The participant K.K reported that his own marital life has been greatly influenced because of the patient's condition. His own wife has left the house and has filed for a divorced. His verbatim was;

زندگی ختم ہو گئی ہے میری اب بیوی بھی چھوڑ کر چلی گئی اس کو میں نے بہت سمجھایا مگر وہ کہتی ہے کہ اب میں نے کاغذ بھی بنوا لیے ہیں یہ میرا اخری فیصلہ ہے

4.5 Main Theme 5: Stigma and Discrimination faced by Caregivers

Caregivers experienced social stigma and withdrawal, leading to isolation.

4.5.1 Social Stigma

The participant M.N. reported that he is refraining from his relatives because he does not want them to know the disturbed home environment. He mentioned that he does not even call up his relatives for help or when in need. he does not want them to know about the patient's current condition. her verbatim was;

گھر والے جو ہیں وہ اوائڈ کر رہے ہیں رشتہ داروں کو یہ پتہ نہ چلے کہ اس کی یہ حالت ہے اور ہم اس کو کس طرح سے ہسپتال لے کے جاتے ہیں باندھ کر مجھے یہ ساری چیزیں دیکھ کر رونا بھی اتا ہے لیکن کیا کروں پھر وہ باتیں کریں گے اس لیے ان کو بتاتے ہی نہیں ہ

The participant A.P reported that she has completely isolated herself from society including her relatives neighbors and in-laws. She doesn’t even attend weddings or family gatherings. The main reason behind this social isolation is the fear of judgment from society. Her verbatim was;

بیٹا اس نے ہمیں محلے میں ایسا کر دیا ہے کہ ہم نہ اب کسی کے گھر اتے ہیں نہ جاتے ہیں شرمندگی کے باعث اس کی یہ گالی نکالنے والی عادت سے ہم بہت پریشان ہیں کہیں اؤ جاؤ تو لوگ 10 سوال کرتے ہیں پھر بدنامی ہماری ہی ہوتی ہے میرے سسرالی بھی اب باتیں کرنے لگی ہیں ان کو موقع چاہیے ہوتا ہے میرے اوپر بولنے کا میں اب خاندان کی شادیوں میں بھی نہیں جاتی ہوں کہ کہیں میری بدنامی نہ ہو

The participant G.N reported that people especially business partners have distanced themselves and terminated their work agreements with them, they have this hidden fear that the participant is not mentally sane to work with. They also labelled the patient as (pagal) She also reported that she had also been bearing up negative judgments of the people pointed out at the patient. She mentioned that her image has been upside down in society because of the patient’s condition. Her verbatim was;

اس کی اس بیماری کی وجہ سے کاروبار میں بہت نقصان ہوا ہے لوگوں نے ہمارے ساتھ لین دین ختم کر دیا ہے یہ کہہ کر کے یہ دماغی مریض ہیں ہمارے پیسے بھی لے ڈوبے گا بیٹا ان سب سے ایک چیز پتہ چل گیا ہے کہ انسان کی عزت اس طرح نہیں رہتی جس طرح پہلے تھی اپنا ہماری اور نہ ہمارے بیٹے کی وہ عزت رہی ہے کہیں جاؤ تو لوگ کہتے ہیں دیکھو بیچاری ادھر گئی بیچاری ادھر گئی

The participant U.N. reported refraining from going anywhere. He believes it is better to stay inside and avoid the harsh words of others. He also mentioned that he usually tries to keep the patient away from others because she gets aggressive and irritated easily. His verbatim was;

ہم کہیں اس کو لے کر اب اتے جاتے بھی نہیں ہیں لوگ نہیں سمجھتے ہیں نا کہ اس کی طبیعت خراب ہے اب اس کو پروپر علاج کروا کر ہی میں گاؤں واپس جاؤں گی کیونکہ اس حالت میں اسے کہے لے کے جاؤ تو ان بن ہو جاتی ہے پھر مسئلے ہوتے ہیں اور لوگ برا بھلا کہنا شروع کردیتے ہیں

The participant S.A reported that she has a fear of shame. She does not take the patient outside as she thinks she will misbehave in front of others, bringing disgrace to the family. Her verbatim was;

اسے کہیں لے کر جاؤ تو ڈر سا لگتا ہے میرے دل میں یہ خیال اتا ہے کہ کہیں لوگوں کے سامنے یہ ایسا کچھ بول نہ دے کہ شرمندگی اٹھانی پڑے یا ہمارے ساتھ بدتمیزی نہ کر لیں

The participant K.K mentioned that he avoids taking the patient alongside with him. He reported that the participant often becomes aggressive, losing control over his tongue. his words become so harsh that the participant eventually becomes uncomfortable and shameful in front of others, seeking their apologies. His verbatim was;

میں اسے لے کر کہیں جا کر بہت زیادہ انکمفرٹیبل ہو جاتا ہوں کہ یہ اپنی زبان سلپ نہ کر دے کیونکہ یہ اکثر ایسا کرتا ہے اور پھر لوگوں کے سامنے شرمندہ ہو کر معافیاں مانگنی پڑتی ہے

4.5.2 Self-Stigma

The participant M.N. blames himself, stating that they might have done a wrongful act that resulted the patient’s current condition. His verbatim was:

یہ پوزیشن نہیں تھی اس کی ہم سے کوئی غلطی ہوئی ہوگی انسان ہے ہم تب ہی اج میرا بیٹا اس حال میں ہے

4.6 Main Theme 6: High Risks of Relapse

Caregivers highlighted medication adherence and fear of relapse.

4.6.1 Significance of Medications

The participant M.N. reported the patient is fine as long as he takes his medication. However, he displays a lack of medication adherence which ultimately makes his condition worse. His verbatim was;

یہ دوائی کھاتا رہے تو ٹھیک رہتا ہے نہ کھائیں تو پھر وہی حالت ہو جاتی ہے میرے سامنے کہتا ہے لاؤ دوائی میں کھا لیتا ہوں لیکن سائیڈ میں جا کے تھوک دیتا ہے اس طرح بہت تنگ کرتا ہے یہ

The participant A.P reported that the patient tenses them over medication. She does not take her medication easily, which triggers the symptoms. When she is taking the medicines, she remains fine, does her chores, and looks after the children as well. Her verbatim was;

یہ بہت زیادہ ضد کرتی ہے اور پریشان کرتی ہے میڈیسن چھوڑ دیتی ہے تو اس کو پرابلم ہو جاتا ہے اگر کھا لیتی ہے تو پھر ٹھیک رہتی ہے جیسے ہی دوائیاں نہیں کھاتی اس کی طبیعت بہت زیادہ خراب ہوتی ہے مگر دوائی لیتی ہے تو ٹھیک رہتی ہےاور اپنے بچے کو بھی سنبھالتی ہے

4.6.2 *Lack of Medication Adherence*

The participant G.N reported that the patient felt fine while on medication. However, when he stopped taking his medicines, he had a relapse. His verbatim was;

اللہ کا شکر ہے انہوں نے ٹیکے وغیرہ پہلی دفعہ لگوائیں پھر اہستہ اہستہ میڈیسن سکھاتے کھاتے تین مہینوں کے اندر بالکل ٹھیک ہو گیا دوبارہ اٹیک ہوا اس کو اسی مہینے میں اگست کے جب اس نے میڈیسن چھوڑ دی

The participant U.N. reported that the patient gets disturbed when there is a gap or change in her medications. His verbatim was;

میڈیسنز بند ہوتی ہیں یا یا چینج ہوتی ہیں تو مسئلہ ہو جاتا ہے کافی ڈسٹربنس ہوتہ ہے

The participant S.A. reported that the doctor changed the medicines. Initially, the patient was recovering, but after some time, her condition deteriorated which resulted in a relapse.

میڈیسن چینج کر دی ڈاکٹر نے تو اس کا مسئلہ اور زیادہ ہو گیا شروع میں تو ٹھیک تھی مگر پھر اس نے دکھا دیا کہ یہ چیز کیا ہے

4.7 *Main Theme 7: Acceptance among Caregivers about Patient Illness*

Caregivers showed acceptance despite distress.

4.7.1 *Acceptance of Illness*

The participant M.N. reported that the patient became aggressive mainly because of his illness, it's not in his hand. His verbatim was;

اس کی تو غلطی بھی نہیں ہے کہ یہ ہائپر ہو جاتا ہے یہ اس کے ساتھ مسئلہ ہے اس میں اس کی کیا ہی غلطی

“The participant A.P reported that he is used to the patient’s behavior now, and has gained acceptance of her condition. His verbatim was;

میرے ساتھ بہت ضد کرتی ہے اور مجھے گالیاں نکالتی ہے مجھے دکھ بھی ہوتا ہے مگر خیر اب عادت ہو گئی ہے میں سمجھتا ہوں کہ اس میں اس کی کوئی غلطی نہیں یہ بیمار ہے

The participant G.N reported that although the patient gets aggressive and hyper, that is mainly of his illness. They have gained an insight and acceptance that he is unwell. His verbatim was;

ہمیں پتہ ہے ہمارا بیٹا ہمارے پاؤں چومتا تھا لیکن اب اس کی بس کی بات نہیں یہ بیمار ہے اس لیے ہائپر ہو جاتا ہے

The participant U.N reported that he feels that the patient is not responsible for his actions. It’s happening mainly because of his illness. His verbatim was;

حالانکہ ان کی غلطی بھی نہیں ہے مجھے پتہ ہے میرے گھر والوں کو پتہ ہے یہ بیمار ہے

5. DISCUSSION

The first main theme, physical burden due to caregiving, comprises two subthemes: physical weakness due to caregiving and fatigue and exhaustion. The physical burden due to caregiving is consistent with the previous findings showing that caregivers of bipolar disorder experience higher levels of physical health problems as compared to non-caregivers. In the present research, the physical burden experienced by caregivers was visible, showing that the physical health of caregivers of bipolar disorder experiences a huge toll because of the increased responsibilities of their caregiving. It can be supported from the literature that caregivers of individuals diagnosed with mental illness have less room for themselves. They often neglect and overlook their physical health (Perlick et al., 2001).

The first subtheme of physical burden is Physical Weakness due to caregiving. The caregivers reported that they experience physical deterioration, including lack of energy, reduced stamina to handle patients, vision loss, headaches, and body pain. This can be supported by the previous literature showing that the caregivers of bipolar disorder often experience higher levels of physical weakness in their bodies, making them more prone to physical ailments and aches in their bodies. Caregivers also report increased muscle pain and body tension, which ultimately worsens their physical conditions (Gupta et al., 2015).

Fatigue and Exhaustion are the second subthemes of physical burden. The caregivers reported a significant change in their physical health after excessive caregiving to patients, and they feel physically and emotionally exhausted and tired. It can be supported by literature showing that caregivers experience chronic stress and tension, which leads to physical exhaustion and fatigue due to the demanding nature of bipolar patients. Besides this, they also do not get adequate levels of rest, which further intensifies the fatigue symptoms. Fatigue can be physical or mental, causing significant damage in either of its forms (Schulz et al., 2008).

The second main theme is the Emotional challenges of caregiving, which include four subthemes: stress and frustration, Resentment and hatred towards the caregiver, Feeling of Hopelessness and bearing up with the Aggression and violence of the patient. In the present research, the caregivers of bipolar experienced many emotional challenges while caregiving due to the nature of the illness. These challenges have a large impact on their mental health and overall well-being. This can be supported by previous literature showing that caregivers of bipolar disorder often experience high levels of anxiety, stress and emotional distress, which is related to the severity of the patient's illness (Perlick et al., 2004).

The first subtheme is stress and frustration, and the caregivers reported that they also feel stressed and frustrated because the patient sometimes says words that are unbearable and harsh for a normal person. Still, they try to control their anger and remain quiet. When the patient is in a manic episode and becomes aggressive, it also frustrates the caregiver. This can be supported by previous literature showing that Caregivers also have to deal with the patient's emotional outbursts, irritability and fluctuating moods. These interactions can lead to emotional exhaustion, stress and feelings of frustration.

The second subtheme is Resentment and hatred towards caregivers, where the caregivers reported that the patients consider the caregiver as their enemy and used to beat and scold them. They think the caregivers are their biggest enemy and displace their anger on the caregiver. This has an adverse impact on the emotional well-being of caregivers, causing them to develop feelings of emotional instability and helplessness. This can be supported by the previous literature showing that caregivers of bipolar disorder often experience high levels of resentment and hatred, which cause them to be emotionally distressed. These emotions are linked with the high levels of burden and the effect of caregiving on their personal lives (Chen et al., 2004).

The feeling of hopelessness is the third subtheme of the Emotional challenges of caregiving. In this study, the caregivers showed a sense of hopelessness, stating that they have no time for themselves because of the huge burden of the patient's responsibilities on their shoulders. The caregivers show extreme discontent with their lives. Previous literature validates this, as continuous management and giving care lead to feelings of hopelessness because caregivers may not see any end to their responsibilities (Grunfeld et al., 2004).

The fourth subtheme is bearing up with the Aggression and violence of the patient. The caregivers reported that they have to tolerate the threatening and violent behaviour of the patients. When the patients are in a manic episode, they become extremely aggressive and start abusing their family. They also show physical aggression and hatred towards the caregivers. This is validated by the previous literature, showing that the caregivers experience high levels of anxiety and emotional distress because of the recurrent physical and verbal aggression due to the bipolar patient's mental condition. They also face physical harm, which develops a sense of fear and anxiety in the caregivers (Steele et al., 2010).

The third main theme is the financial burden on caregivers, which comprises two subthemes: challenges faced by caregivers in professional life and Difficulties in Managing Patient Finances. In this study, the caregivers experience significant challenges in their professional lives. They reported that they are experiencing difficulties in managing their professional lives along with their caregiving responsibilities

This can be supported by previous literature that an individual faces significant problems at the workplace due to the caregiver burden. there is a decrease in work hours and job performance and an increase in absenteeism, directly affecting the caregiver's professional life (Gaugler et al., 2000).

The second subtheme is the difficulty in managing patients' finances. The caregivers highlighted the financial burden that makes it difficult for them to manage the medication cost and other additional expenses related to the patient. They also have to financially support the patient's family, including their wives and children, so they are further burdened. This can be supported by the previous literature showing that the caregivers of bipolar disorder are usually under heavy turmoil because of the financial constraints related to the patient's condition. They face burdens especially in the manic phase of patients, due to poor financial management and the high cost of the patient's treatment and medications (Cloutier et al., 2018).

The fourth main theme of the study is the effect of patient conditions on family dynamics, which includes a subtheme of disturbed home atmosphere. Due to the disruptive behaviour of the patients, there is a significant disturbance in the family dynamic. When patients with bipolar disorder are in manic episodes, they become aggressive and disturb their overall home atmosphere and their relationship with other family members. They say words that are unbearable and harsh for a normal person. This can be supported by the previous literature showing that due to the fluctuating moods and aggressive behaviour of patients with bipolar disorder, the home environment is always tense and disturbed. The family member also experiences stress and worries about the patient's condition. Due to the patient's condition, conflicts and miscommunication may arise within the family (Perlick et al., 2008).

The subtheme of the effect of patient conditions on family dynamics is a disturbed home atmosphere. The caregivers reported that the family environment remained disturbed due to the patient's anger outbursts which disturbed their routines and daily activities. The marital lives of caregivers are also disturbed, and there are greater marital conflicts because of the caregiving. This can be supported by the previous literature showing that the family of a bipolar patient suffers a lot emotionally due to the nature of the illness, and there is an increased level of anxiety, stress and conflicts within the family, which also leads to significantly affecting the caregiver's marital relationship (Dore & Romans, 2001).

The fifth main theme of the study, **S**tigma and Discrimination faced by Caregivers, comprises two subthemes: social stigma and self-stigma. Caregivers of individuals with bipolar disorder often face stigma and discrimination from society. Society judges and labels them frequently, leading to rejection and social isolation, which highly affect their social contact, mental health and overall well-being. This can be supported by the previous literature showing that Caregivers of bipolar disorder may face social rejection from friends, relatives, and colleagues who do not understand the nature of the illness. This may leads to social isolation and a lack of social support. The study showed that stigma and discrimination lead to high levels of emotional distress and social isolation among caregivers of bipolar disorder (Perlick et al., 2001).

The first subtheme of stigma and discrimination is social stigma, where the caregivers reported that they refrain from their relatives and do not want them to know about the patient's condition due to the fear of judgment from society. They have also reported avoiding going out or to family gatherings and completely isolating themselves from society, including their relatives and neighbours. The main reason behind this social isolation is the fear of judgment from society. The caregivers stated that their image has been upside down in society because of the patient’s condition. The previous literature supports this, showing that society often holds negative judgments about mentally ill patients. They perceived that individuals with bipolar disorder are dangerous and unstable. Hearing such kinds of negative remarks and judgments about the patient from the communities makes the caregivers feel unwelcomed and isolated, hence intensifying the effects of social stigma and negatively impacting their mental health (Struening et al., 2001).

The second subtheme of discrimination and stigma faced by caregivers is self-stigma, where the caregivers blame themselves that they might have done something wrong that resulted the patient's current condition. They develop these feelings of shame and guilt, considering them as the reason behind illness. This subtheme of social stigma is consistent with the literature that caregivers might blame themselves for the condition of their loved ones. They feel responsible for the failures in managing the patient's illness which often leads to the feeling of shame and guilt in them (Veltman et al., 2002).

The sixth main theme is the High Risks of Relapse, which consists of two subthemes Significance of Medications and Lack of Medication Adherence. The caregivers of bipolar disorder reported that the patients have a high chance of relapse. the theme is consistent with the literature, such that patients with bipolar are at high risk of relapse, which significantly impacts the patient's lives and the process of caregiving. Each episode of relapse can significantly affect the burden on caregivers, which may develop feelings of frustration, and hopelessness in them (Post et al., 2011).

The first subtheme of the risk of relapse is the Significance of Medications. The caregivers reported that the patients are fine if they take medication. However, if they display a lack of medication adherence, it ultimately makes their condition worse. They stated that the patients tense the caregivers over medications and do not take their medicines easily, which triggers their symptoms and ultimately leads to relapse. This can be supported by the previous literature showing that Medications play a significant role in the management of bipolar disorder, influencing both the quality of life for caregivers and their patients and the course of illness. Continuously use of medicine maintains long-term stability and prevents relapse.

The second subtheme is the Lack of Medication Adherence. They reported that the patient gets disturbed and deteriorates when there is a gap or change in their medications, but their condition remains stable when they take their medication properly. As reported by (Sajatovic et al., 2006), lack of medication adherence in patients with bipolar disorder is a severe problem with significant consequences, which include a high risk of relapse, symptoms worsening and high levels of burden in caregivers.

The seventh main theme is Acceptance among Caregivers of Patient Illness, which includes a subtheme of Acceptance of Illness. In this study, the caregivers have insight into the illness and accept its nature. This can supported by previous literature showing that acceptance of the illness among caregivers of patients with bipolar disorder is helpful in building up their ability to cope with both the condition of the patient and their disturbances. This further leads to better-coping strategies, improved relationship with the patient, emotional stability and decreased caregiver burden (Perlick et al., 2007).

Acceptance of the illness is the only subtheme of Acceptance among Caregivers of Patient Illness. The results of the research revealed that the caregivers of bipolar disorder gain acceptance towards the patient's illness The caregivers reported that the patients are not responsible for their actions, it is happening because of their illness. the existing literature can support this showing that Acceptance of illness in caregivers encourages them to manage the patient's symptoms proactively and implement preventive measures. This reduces the severity of the illness and overall better management of the disorder (Reinares et al., 2008).

5.2 Implications

Mental health services should incorporate caregiver-focused interventions, including counselling, psychoeducation, and support groups. Developing structured support systems may help reduce caregiver burden and improve quality of life.

6. CONCLUSION

Study concluded that caregivers of patients with bipolar disorder experience substantial burden affecting physical health, emotional well-being, financial stability, and family functioning. The unpredictable nature of bipolar disorder intensifies stress and increases risk of burnout. Addressing caregiver burden through counselling, psychoeducation, and support systems is essential to ensure caregiver well-being.

Acknowledgements

None.

Conflict of Interest

Authors declared NO conflict of interest.

Funding Source

The authors received NO funding to conduct this study.

ORCID iDs

Faryal Arshad[1] https://orcid.org/0009-0000-5892-5864
Hira Liaqat[2] https://orcid.org/0000-0002-5262-6684

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Azman, A., Singh, P. S. J., & Sulaiman, J. (2017). The mentally ill and their impact on family caregivers: A qualitative case study. *International Social Work*, *62*(1), 461–471. https://doi.org/10.1177/0020872817731146

Cloutier, M., Greene, M., Guerin, A., Touya, M., & Wu, E. (2018). The economic burden of bipolar I disorder in the United States in 2015. *Journal of Affective Disorders*, *226*, 45–51. https://doi.org/10.1016/j.jad.2017.09.011

Dore, G., & Romans, S. E. (2001). Impact of bipolar affective disorder on family and partners. *Journal of Affective Disorders*, *67*(1–3), 147–158. https://doi.org/10.1000-5

Gadit, A. A. M., & Mugford, G. (2007). Prevalence of depression among households in three capital cities of Pakistan: Need to revise the mental health policy. *PloS One*, *2*(2), e209. https://doi.org/10.1371/journal.pone.0000209

Ganguly, K. K., Chadda, R. K., & Singh, T. B. (2010). Caregiver burden and coping in schizophrenia and bipolar disorder: A qualitative study. *American Journal of Psychiatric Rehabilitation*, *13*(2), 126–142. https://doi.org/10.1080/154009

Gelaye, H., & Andualem, A. (2022). Quality of life and associated factors among family caregivers of individuals with psychiatric illness at DRH, South Wollo, Ethiopia, 2020. *Scientific Reports*, *12*(1). https://doi.org/10.1038/s41598-022-22015-4

Girdhar, A., & Patil, R. (2023). Caregivers' burden in patients with bipolar disorder and schizophrenia and its relationship with anxiety and depression in caregivers: A narrative review. *Curēus*. https://doi.org/10.7759/cureus.47497

Granek, L., Danan, E., Bersudsky, Y., & Osher, Y. (2016). Living with bipolar disorder: The impact on patients, spouses, and their marital relationships. *Bipolar Disorders*, *18*(2), 217–229. https://doi.org/10.1002/ajcp.12698

Guan, Z., Poon, A. W. C., & Zwi, A. (2023). Social isolation and loneliness in family caregivers of people with severe mental illness: A scoping review. *American Journal of Community Psychology*, *72*(3–4), 443–463. https://doi.org/10.1002/ajcp.12698

Iseselo, M. K., Kajula, L., & Yahya-Malima, K. I. (2016). The psychosocial problems of families caring for relatives with mental illnesses and their coping strategies: A qualitative urban-based study in Dar es Salaam, Tanzania. *BMC Psychiatry*, *16*(1). https://doi.org/10.1186/s12888-016-0857-Y

Kargar, M., Faghihi, S. A., & Nazari, M. (2021). Care burden dimensions of informal caregivers having patients with bipolar disorder (challenges and alternatives) (qualitative study). *Journal of Education and Health Promotion*, *10*(1), 282. https://doi.org/10.4103/jehp.jehp_943_20

Leng, A., Xu, C., Nicholas, S., Nicholas, J., & Wang, J. (2019). Quality of life in caregivers of a family member with serious mental illness: Evidence from China. *Archives of Psychiatric Nursing*, *33*(1), 23–29. https://doi.org/10.1016/j.apnu.2018.08.010

Liu, T., Hsiao, R. C., Chou, W., & Yen, C. (2023). Hopelessness in caregivers of children with attention-deficit/hyperactivity disorder: Associations with depression and anxiety and multidimensional related factors. *Journal of the Formosan Medical Association*, *122*(11), 1158–1164. https://doi.org/10.1016/j.jfma.2023.05.011

McCrone, P., Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hoult, J., McKenzie, N., Thompson, M., & Bebbington, P. (2009). Economic evaluation of a crisis resolution service: A randomized controlled trial. *Epidemiologia e Psichiatria Sociale*, *18*(1), 54–58. https://doi.org/10.1017/S1121189X00001469

Miklowitz, D. J., & Johnson, S. L. (2009). Social and familial factors in the course of bipolar disorder: Basic processes and relevant interventions. *Clinical Psychology: Science and Practice*, *16*(2), 281–296. https://doi.org/10.1111/j.1468-2850.2009.01166.x

Montgomery, R. J. V., Gonyea, J. G., & Hooyman, N. R. (1985). Caregiving and the experience of subjective and objective burden. *Family Relations*, *34*(1), 19–26. https://doi.org/10.1002/ajcp.12698

Nagarajan, P., Thakur, V., & Rajkumar, R. (2021). Coping and burden among caregivers of patients with major mental illness. *Indian Journal of Social Psychiatry*, *0*(0), 0. https://doi.org/10.4103/ijsp.ijsp_160_20

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2013). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Perlick, D., Rosenheck, R. R., Clarkin, J. F., Sirey, J. A., Raue, P., Greenfield, S., & Struening, E. (1999). Burden experienced by caregivers of persons with bipolar affective disorder. *British Journal of Psychiatry*, *175*(1), 56–62. https://doi.org/10.1192/bjp.175.1.56

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: Adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric Services*, *52*(12), 1627–1632. https://doi.org/10.1176/appi.ps.52.12.1627

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Maciejewski, P. K., Sirey, J., Struening, E., & Link, B. G. (2004). Impact of family burden and affective response on clinical outcome among patients with bipolar disorder. *Psychiatric Services*, *55*(9), 1029–1035. https://doi.org/10.1176/appi.ps.55.9.1029

Perlick, D. A., Rosenheck, R. A., Miklowitz, D. J., Chessick, C., Wolff, N., Kaczynski, R., Ostacher, M., Patel, J., & Desai, R. (2007). Prevalence and correlates of burden among caregivers of patients with bipolar disorder enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder. *Bipolar Disorders*, *9*(3), 262–273. https://doi.org/10.1111/j.1399-5618.2007.00365.x

Perlick, D. A., Hohenstein, J. M., Clarkin, J. F., Kaczynski, R., & Rosenheck, R. A. (2007). Use of mental health and primary care services by caregivers of patients with bipolar disorder: A preliminary study. *Bipolar Disorders*, *7*(2), 126–135. https://doi.org/10.1002/ajcp.12698

Perlick, D. A., Rosenheck, R. A., Miklowitz, D. J., Kaczynski, R., Link, B., Ketter, T., Wisniewski, S., Wolff, N., Sachs, G., & STEP-BD Family Experience Collaborative Study Group. (2008). Caregiver burden and health in bipolar disorder: A cluster analytic approach. *The Journal of Nervous and Mental Disease*, *196*(6), 484–491. https://doi.org/10.1097/NMD.0b013e3181773927

Post, R. M., Leverich, G. S., Altshuler, L. L., Frye, M. A., Suppes, T., Keck, P. E., McElroy, S. L., Nolen, W. A., Kupka, R., Grunze, H., Walden, J., & Rowe, M. (2011). Differential clinical characteristics, medication usage, and treatment response of bipolar disorder in the US versus the Netherlands and Germany. *International Clinical Psychopharmacology*, *26*(2), 96–106. https://doi.org/10.1097/YIC.0b013e19

Reinares, M., Colom, F., Sánchez-Moreno, J., Torrent, C., Martínez-Arán, A., Comes, M., Goikolea, J. M., Benabarre, A., Salamero, M., & Vieta, E. (2008). Impact of caregiver group psychoeducation on the course and outcome of bipolar patients in remission: A randomized controlled trial. *Bipolar Disorders*, *10*(4), 511–519. https://doi.org/10.1111/j.1399-5618.2008.00588.x

Sajatovic, M., Bauer, M. S., Kilbourne, A. M., Vertrees, J. E., & Williford, W. (2006). Self-reported medication treatment adherence among veterans with bipolar disorder. *Psychiatric Services*, *57*(1), 56–62. https://doi.org/10.1176/appi.ps.57.1.56

Schulz, R., & Sherwood, P. R. (2008). Physical and mental health effects of family caregiving. *The American Journal of Nursing*, *108*(9), 23–27. https://doi.org/10.1097/01.NAJ.0000336406.45248.4C

Souza, A. L. R., Guimarães, R. A., De Araújo Vilela, D., De Assis, R. M., De Almeida Cavalcante Oliveira, L. M., Souza, M. R., Nogueira, D. J., & Barbosa, M. A. (2017). Factors associated with the burden of family caregivers of patients with mental disorders: A cross-sectional study. *BMC Psychiatry*, *17*(1). https://doi.org/10.1186/s12888-017-1501-1

Steele, A., Maruyama, N., & Galynker, I. (2010). Psychiatric symptoms in caregivers of patients with bipolar disorder: A review. *Journal of Affective Disorders*, *121*(1–2), 10–21. https://doi.org/10.1016/j.jad.2009.04.020

Struening, E. L., Perlick, D. A., Link, B. G., Hellman, F., Herman, D., & Sirey, J. A. (2001). Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services*, *52*(12), 1633–1638. https://doi.org/10.1176/appi.ps.52.12.1633

Udoh, E. E., Omorere, D. E., Sunday, O., Osasu, O. S., & Amoo, B. A. (2021). Psychological distress and burden of care among family caregivers of patients with mental illness in a neuropsychiatric outpatient clinic in Nigeria. *PloS One*, *16*(5), e0250309. https://doi.org/10.1371/journal.pone.0250309

Van Der Walt, I. A., & Carbonatto, C. L. (2019). The needs of caregivers of bipolar patients. *Social Work*, *55*(1). https://doi.org/10.15270/55-1-695

Velligan, D. I., Weiden, P. J., Sajatovic, M., Scott, J., Carpenter, D., Ross, R., Docherty, J. P. (2009). The expert consensus guideline series: Adherence problems in patients with serious and persistent mental illness. *The Journal of Clinical Psychiatry*, *70*(Suppl 4), 1–48.

Yu, Y., Hu, J., Efird, J. T., & McCoy, T. P. (2013). Social support, coping strategies and health-related quality of life among primary caregivers of stroke survivors in China. *Journal of Clinical Nursing*, *22*(15–16), 2160–2171. https://doi.org/10.1111/jocn.12251