

An Uncertain Impairing Traumatic Relationship within the Circle of Rejection, Anger, and Freedom: An Interpretive Phenomenological Analysis of the Subjective Burden of Caregivers of Patients with Bipolar Disorder

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Abstract

Introduction: Bipolar disorder is a huge burden for the caregivers of patients. Negative impact of living with individuals with mental disorders can be either objective or subjective. Subjective burden is more complex than the objective burden and less studied. This study aimed to investigate subjective burden through the lived experience of caregivers in their interactions with patients with bipolar disorder.

Method: This study was carried out qualitatively through the Interpretive Phenomenological Analysis (IPA) framework. A semi-structural interview was used for Iranian participants in 2020 that was conducted online via WhatsApp and Skype applications. Eight caregivers of patients with bipolar disorder were selected via targeted sampling.

Results: Three super-ordinate themes were identified: achieving an objective view of the patient (denial of bipolar disorder, accepting the existence of a problem, a paradoxical perception of the patient, making a subject-object relationship and different explanations for bipolar disorder); the cycle of rejection, anger, and freedom (rejection of patients by caregivers, patients' anger, decreased caregivers' freedom and decreased patients' freedom) and the process of psychological trauma in caregivers (emotional contagion, fusion between the patient and the caregiver, anxiety and trauma).

Conclusion: Results specified the principles of appropriate communication with patients for caregivers which can reduce subjective burden in caregivers. Future studies can benefit from this phenomenological approach in developing novel psychological interventions for caregivers of patients with bipolar disorder.

Keywords: Bipolar Disorder, Subjective Burden, Caregiver, Qualitative Study, Phenomenology

Introduction

Bipolar disorder (BD) is among the most severe and chronic mental disorders [1, 2]. Bipolar I disorder involves at least one major depressive episode and/or at least one manic episode. In contrast, bipolar II disorder involves at least one period of major depressive episode and one period of hypomania. The major depressive episode is a syndrome that, over a period of at least two weeks, causes significant changes in the patient's previous functioning and is accompanied by one of the symptoms of a depressed mood or lack of interest and pleasure. Decreased energy is the most common symptom of this episode. The mania lasts for at least a week, during which the patient has an expanded, high, or restless mood on most of those days, and is constantly engaged in goal-oriented activities or has a lot of energy. Hypomania lasts for at least four days and its symptoms are less severe than mania. [1, 3]. More than 1% of the world's population suffers from recurrent and chronic BD [1, 4].

Reviewing the global burden of various diseases found BD as one of the most impairing mental disorders [5]. Consequently, most patients with BD require one or more formal full or part-time caregivers. A family member is the main caregiver of 93% of patients with BDs [6].

Living with individuals with mental disorders and BD in specific, impose a great amount of burden on the caregivers [7-10]. The majority of studies on caregivers of bipolar patients have focused on this imposed burden. The imposed burden of a disorder consists of the problems, difficulties, and negative impact of living with individuals with mental disorders [11] and can be either objective or subjective. The subjective burden refers to the psychological consequences of taking care of patients with mental disorders such as shame, worry, anger, and mental suffering, whereas financial problems, reduced social supports, physical aggression, disruption of personal plans, and lack of time for personal care are some objective burdens caregivers might face [12-15]. Notwithstanding, two points should be noted about the studies on the imposed burden of disorders, first is the focus on the objective burden relative to the subjective burden [16], and next is the complexity of the patient-caregiver relationship that requires close attention when studying the imposed burden [17].

One example of the complexity of the relationship between caregiver and patient that creates subjective burden is mentioned in Vargas-Huicochea et al.'s study. They found that caregivers in their sample, especially the female caregivers have no intention of losing their caregiver identity and this has gradually become their main identity [18]. On the other hand, Jönsson et al. reported that family members of patients with BD find themselves alone in the experience of caregiving and constantly struggle to find meaning in their current estate of being [10]. In other words, they experience a meaningless identity, this could be in part due to the permanent uncertainty that exists when living with a bipolar patient. This uncertainty is the result of changes in signs and phases of BD. Naqvi et al. found that partners of men with BD were initially shocked and subsequently experienced uncertainty as they could not comprehend changes in their partners and acquire a comprehensive picture of them and their personalities [19]. This can make it difficult for caregivers to have an integrated view of patients.

Anger as a secondary emotion is characterized by tension and hostility arising from frustration, real or imagined hurt by others, or perceived injustice [20]. This emotion in addition to uncertainty, is one of the elements of complex communication between the patient and the caregiver. The feeling of being rejected by the family can lead to aggressive behavior in patients hospitalized in mental hospitals [21]. Withal, 44% of caregivers of patients with BD have been bullied and disrespected by the patients mostly during the aggressiveness and restlessness of manic episodes [6]. Furthermore, the majority of aggressive behaviors observed in mental hospitals are for patients of the bipolar spectrum with 70% tending toward their family members [22]. Therefore, the apperception of

being rejected by the family can instigate severe aggressiveness in bipolar patients. Namely, patients feel anger toward their caregivers and limit their freedom upon being rejected. Decreased perceived freedom by caregivers and patients can increase their anger towards each other [23]. Nevertheless the cycle of anger and rejection that occurs between the patient and the caregiver has been less studied.

Taking care of patients with BD can cause several interpersonal complications both in patient-caregiver and marital relationship of the caregiver [8, 9]. Due to the phasic nature of the BD, caregivers constantly experience some sort of anticipatory anxiety and are always awaiting the next active phase. They further have to deal with the symptoms of BD and the ensuing patient's impaired function between two active episodes and continually feel stressed [7]. This connection may lead to psychological trauma to caregivers.

Since the only way to understand subjective burden is to study the lived experience of caregivers [24] and due to complexities mentioned in the patient-caregiver relationship, it seems necessary to conduct qualitative studies on the lived experience of caregivers of bipolar patients, through which we can investigate the subjective burden caused by this disorder. Therefore, in this study, we intend to examine subjective burden in caregivers of patients with BD by exploring their lived experience.

Method

To serve our focus on the lived experience of participants in the present study, a phenomenological approach was adopted from the three major qualitative research methods (realism, phenomenology, and constructivism). One category of phenomenological research which relies on Heidegger's view criticizes sole phenomenology and assumes that no description is ever separated from interpretation. In addition to Epoché as a phenomenological principle in research, they also mark the role of interpretation as a hermeneutics [24, 25]. With the addition of hermeneutics to phenomenology, phenomenological research became more interpretive and less solidly based on descriptions. Nonetheless, there was still a missing link; a framework for the interpretation of the result. Smith and Shinebourne [26] utilized psychological concepts and findings as frameworks for the interpretation of phenomena and named it the Interpretive Phenomenological Analysis (IPA). This method of research on lived experience is designed and is reportedly suitable for psychological studies [27]. Accordingly, IPA was selected as the research method.

In this study, we developed a semi-structured interview to investigate the subjective burden of caregivers living with bipolar patients. We adhered to principles of interview design for interpretive phenomenological analysis [26, 27] and followed the steps of semi-structured interviews which have been used in similar studies [28-31]. Next, we took in one participant to evaluate the interview in the pilot run.

Questions and prompts in the initial version of the interview were revised based on this pilot run. Concerning

the COVID-19 pandemic and preventive instructions, the interviews were conducted online via WhatsApp and Skype. Volunteers who met the inclusion criteria were identified and provided with the consent and briefing forms. Upon receiving their consent, we proceeded with the initial questionnaire before conducting the main interview. This questionnaire examined the demographic information and psychological characteristics of the participants.

The interview session was recorded and transcribed precisely. We then studied each script several times using the principles of data analysis from interpretive phenomenological analysis [26, 27]. Using epoché and the hermeneutics circle among components and the whole, we determined the subthemes or the initial codes for each interview and employed them to find, name, and describe the main themes. These themes were then organized in order of appearance to obtain a broader meaning for each section. Subsequently, we went over each interview again to make sure all themes and subthemes are identified for all participants. Intersecting themes were clustered for all participants such that several themes were as far as possible grouped in a few clusters to form the super-ordinate themes.

The number of participants in an interpretive phenomenological analysis depends on the researcher's judgment. However, small homogeneous groups of 4 to 10 participants are recommended for Ph.D. research projects [32]. Following these guidelines we recruited 8 Iranian participants in 2020 from all over the country for this study by targeted sampling method.

With respect to the COVID-19 pandemic and preventive instructions, the interviews were conducted online via WhatsApp and Skype. We approached participants by asking psychotherapists and psychiatrists to introduce patients with BD upon their consent and also by using a poster to publicly call for eligible individuals to take part in this research. Next, caregivers of volunteers who met the inclusion criteria were invited to study. Upon affirming the inclusion criteria and their interest to continue, we first provided them with the consent and briefing forms and proceeded with the initial questionnaire before conducting the main interview.

Two main inclusion criteria to choose sample members were: the patient being diagnosed with BD by a member of the research team and the candidate participant being confirmed as the caregiver by the psychiatrist or psychotherapist in charge, the patient and the caregiver [18, 33]. Then the potential participant who was a member of the patient's family, he/she should fulfill at least three of the following criteria: can be the patient's wife/husband, father, mother, or anything equivalent to partner, has the most interaction with the patient, supports the patient financially, has accompanied the patient the most in treatment, and the patient has given his/her number to the health staff as the emergency number.

The exclusion criteria were as follows: caregivers who have fulfilled the diagnostic criteria for BD type 1 and 2, cyclothymia, schizophrenia, and other psychotic disorders at least once in their life.

A summary of participants' information is presented in table 1.

Table .1 Demographic and Psychological Data of Participants

No	Caregiver code	Patient code	Relationship duration (years)	Relation type	Age	Gender	Education	Birthplace	Interview time (minutes)	Caregiver history of mental disorders
1	C.1	P.1	13	Husband	37	Male	Bachelor	Mashhad	86	-
2	C.2	P.2	0.6	Fiancé	21	Female	Bachelor student	Tehran	54	Major depressive disorder
3	C.3	P.3	33	Sister	33	Female	Masters	Arak	45	Generalized anxiety disorder
4	C.4	P.4	Patient's whole life (32)	Mother	60	Female	Diploma	Varamin	26	-
5	C.5	P.5	7	Husband	32	Male	Masters	Saveh	60	-
6	C.6	P.6	Patient's whole life (31)	Mother	55	Female	Diploma	Ramsar	70	Major depressive disorder, generalized anxiety disorder
7	C.7	P.7	Patient's whole life (19)	Mother	42	Female	Masters	Shiraz	83	Marital issues, major depressive disorder
8	C.8	P.8	Patient's whole life (29)	Mother	53	Female	Masters	Tehran	80	Obsessive-compulsive disorder

Results

We can describe the experience of the participants from subjective burden as that their burden begins with the inability of forming an integrated image of the patient and yet their continual effort toward it and leads to a pattern of interaction between the

patient and the caregiver in which they reciprocally reject one another, feel anger, and resultantly limit each other's freedom. Such a pattern of communication begets psychological trauma in caregivers. These findings were presented in the form of three super-ordinate themes as explained

in the Table 2.

The relationship between research super-ordinate themes is shown in Figure 1.

1. Achieving an Objective View of the Patient

1.1. Denial of Bipolar Disorder

Most participants had noticed some issues in patients even before they were diagnosed with BD but tried to ignore and overlook them. They resisted having the mentally healthy image of the patient tarnished and denied any signs of mental disorder. "I couldn't believe it at all. His uncle said that he has the same illness as her father, this is hereditary in our family, my cousin and my mother were like that, too ... I asked him why they are labeling this child, I couldn't believe it" (C.7).

1.2. Accepting the Existence of a Problem

Over time, participants cannot deny the existing problems in the patients anymore, however, they are still unable to comprehend what the patients with BD experience. Hence, they fail to fully understand them and their own interaction with them, and instead, they experience a series of changes often inexplicable to them. "I cannot explain it at all, not even to myself. I feel he is not there; I really don't know what to call it. He is not like what he should be" (C.2).

1.3. A Paradoxical Perception of the Patient

However, when they start to understand the patient's experiences, they find them variable and conflicting. C.2 finds her impressions of P.2 entirely temporary or short-lived and retains a volatile image of him. "Sometimes I feel he is being extreme, he can be confident or say he will do something and it is just for that very moment and never actually happens". This volatile image eventually makes the participants doubt their interaction with the patient considering it emptied of any truth. "Everything is void in that period, there is nothing".

1.4. Making a Subject-object Relationship

Participants adopt different strategies to deal with this varying image. C.1 works together with her

wife to set some rules. However, by witnessing her breaking those rules, to him she becomes a rule breaker and less reliable than before "Her mind resets. That means you cannot plan for these (people), there is no adherence in their mind, no principles". Thus, they are disappointed in obtaining an integrated image of the patient and find their interaction fruitless. So he attempts to find a pattern in these variations by analyzing changes in his wife to have a more predictable and cohesive version of her in his mind. Thence, the participant takes the subjective stance and the patient becomes his/her object of awareness. "I always tell her that I know her like the back of my hand, I know you by heart, I know all about you" (C.1). Finding a descriptive pattern for the variation in BD and predicting and controlling it then becomes the common desire amongst all participants since such a pattern enables them to form an integrated image of the patient.

1.5. Different Explanations for BD

Biological explanation of patients' problems is one of the most prevalent patterns. C.5 focuses on the bodily signs of biological changes to control and prevent the relapse of manic episodes. "One of the signs is her hands getting sweaty even before the relapse happens. When I see her hands are sweating, I pay more attention to her compared to other days ... [another issue] is the sleep, she sleeps much less, or sometimes when I see that she has not been sleeping enough for several nights, I focus more on her behavior as she might be having a manic relapse, I consult with her physician to change her medicine doses". (C.5). With such management, he never comprehends his wife in her manic state, considers her constant depression as one of her characteristics and her reality regardless of her depression, that is, he recreates the reality of his wife and views it as he seeks appropriate.

Figure 2 shows the variations of this super-ordinate theme.

Table 2. Themes and Super-ordinate Themes

Super-ordinate themes	Themes
Achieving an objective view of the patient	Denial of BD
	Accepting the existence of a problem
	A paradoxical perception of the patient
	Making a subject-object relationship
	Different explanations for BD
The circle of rejection, anger, and freedom	Rejection of patients by caregivers
	Patients' anger
	Decreased caregivers' freedom
	Decreased patients' freedom
The process of psychological trauma in caregivers	Emotional contagion
	Fusion between the patient and the caregiver
	Anxiety and trauma

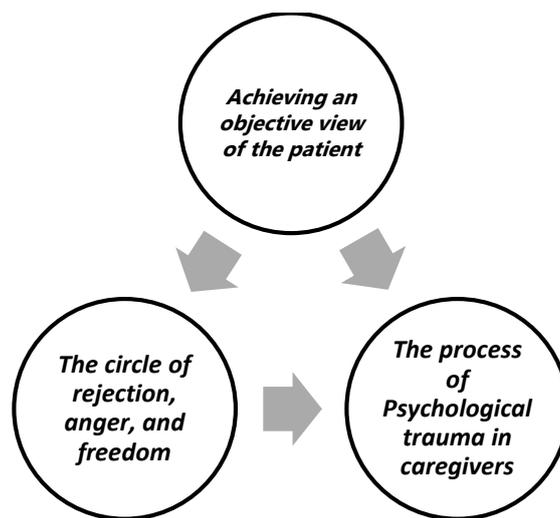


Figure 1. Relationship between research super-ordinate themes.



Figure 2. The process of achieving an objective view of the patient in the participants.

2. Circle of Rejection, Anger, and Freedom

2.1. Rejection of Patients by Caregivers

There are many fluctuations in the relationship between the patient and the caregiver during the active phases of BD. The underlying reasons could be mapped in a cycle from rejection to freedom; sometimes patients feel that their caregivers have rejected them. "Since her kids are very troublesome, I feel burdened when she visits us at home. When I asked her not to stay for the night at least, she got extremely upset with me for asking that" (C.3). One of the reasons for being rejected by the caregivers is the patient's inattentiveness to rules and regulations. "One with a broken arm is unable to wash dishes or cook. But you can in no way justify this for a mentally sick person, especially with BD, especially when she crosses the red lines" (C.1). C.1 interpreted these violations that accrued during mania as the patient's method of bothering him. "She knew she could hurt me through that point, she went as far as she could". To protect himself and prevent intensified mania, C.1 gradually starts to neglect the patient. "If you see her doing something immoral or irrational, you can just ignore it indifferently". The patient can interpret this reaction as a form of rejection.

2.2. Patients' Anger

The patients view the caregivers' rejection as their means of showing anger and in response, they express their anger toward caregivers and reject them. P.7 feels rejected by her family and experience a world

overwhelmed by anger and power enforced on her as she enters the manic episode. "She messaged me saying that she wants to leave the house because her brother and I threatened her. She said that you beat me, you broke my shoulder when no such thing ever happened" (C.7). To confront the anger she feels against herself, P.7 takes her complaints to external sources of power such as police.

2.3. Decreased Freedom of Caregivers

Patients resist any kind of restriction during manic episodes. For C.5, her wife's mania comes together with neglecting the rules of spending and staying home. "She went out shopping every day. For example, once I gave her my credit card and she spent 500 Tomans in one day, while this was not what she normally does ... She used to stay in a coffee shop for a long time, she never used to stay out late, but in the manic phase she would go there and stay until 12 or 1 a.m.". Therefore, the perceived freedom of patients shifts from healthy to pathological in the caregiver's eyes. "At first, he makes some good decisions, later, decisions above what he is ... he has a lot of fictional thoughts, I will do this and do that" (C.6). The increased freedom of patients results in restrained freedom of caregivers. "He has some bizarre expectations and demands and wants me to accompany him in doing them. Sometimes I really feel suffocated" (C.2). In face of the increased freedom of patients during mania, C.8 attempts to limit her son P.8. "Always (saying) don't go, don't do that, calm down, I am already exhausted". Efforts that remain fruitless make the caregivers see the patient's

behaviors as power abuse and aggression intended toward them.

2.4. Decreased Freedom of Patients

Contrariwise, patients find the caregivers limiting their freedom during mania and view them as aggressors who want them depressed. "He says that it sounds like you wish I am always depressed" (C.6). During the depression as well, participants gradually stop cooperating with the patients and

no more understand them and thence tend to limit their freedom and become hostile towards them. "I understand her, I don't say anything to her, I let her sleep. But sometimes when I can't tolerate more, I drag her to the bathroom forcefully, to take a shower, she doesn't care about her hygiene then, at the end, I force her" (C.4).

The variations of this super-ordinate theme is presented in Figure 3.

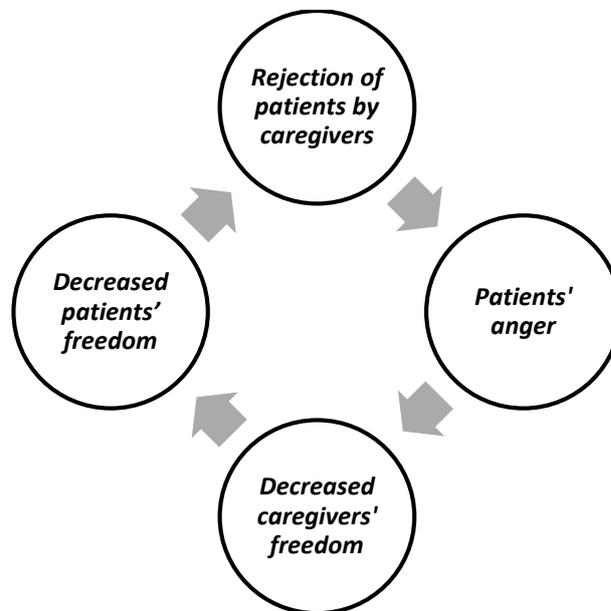


Figure 3. The process of the circle of rejection, anger, and freedom.

3. Process of Psychological Trauma in Caregivers

3.1. Emotional Contagion

The former two super-ordinate themes are eventually accompanied by this theme. The uncertainty around the patient and the caregiver's endless efforts toward making the patients relatively more deterministic along with the ups and downs of their relationship within the cycle of rejection, anger, and excessive limitation or freedom ultimately engender psychological trauma in participants. Having mood swings aligned with the active phases of BD in patients is one of the most prevalent traumas among participants. "(Along with P.2 changes) I as well experience these ups and downs" (C.2). Similarly, C.4 feels unhappy as depression commences in her child. "I think to me that such a young girl is just sleeping, doing nothing, she always wants to sleep and asks us not to bother her (in a regretful tone)". This contagious influence of the patient's mood is also evident in the manic phase. "(When P.4 is in the manic episode) I am very delighted; I thank God for she is jolly" (C.4).

3.2. Fusion between the Patient and Caregiver

One factor contributing to this emotional contagion is the fusion between the patient and the caregiver that makes delimitation between the two impossible. "She tells me everything. She is not the kind of girl to have secrets or keep them away from me, whatever happens, she tells me" (C.4).

The presence of family issues leads to a stronger fusion between the patient and participants. C.4, C.7, and C.6 had husbands who were absent in

major events of their lives or if present, suffered from mental disorders themselves. Under such circumstances, the patient and the caregiver turn into the other's haven and the fusion strengthens. Furthermore, besides looking after the patients with BD, participants are also burdened by the absence of the father or psychological problems of him and other family members. C.6 has another son with a history of drug abuse and marital problems. The aggregating burden of nursing three people at the same time incapacitates her to give P.6 sufficient care which worsens his problems and adds up to the burden she has to deal with. "I have fallen sick myself too because of these three. I should go somewhere to calm down and then come back. Sometimes I become less cooperative, P.6 is not tolerant, he becomes edgy and it instigates his illness".

3.3. Anxiety and Trauma

Participants sometimes experience panic and anxiety during the patient's manic episodes as they tend to take challenges and adventures that seem too dangerous to caregivers despite looking safe to the patients. "He went to the desert and slept there alone and didn't tell us at all, we thought he has gone to his father's village, but when we asked after him, they had no news of him, we were scared to death when he called us a few days later telling where he is" (C.8).

The variations of this super-ordinate theme is presented in Figure 4.

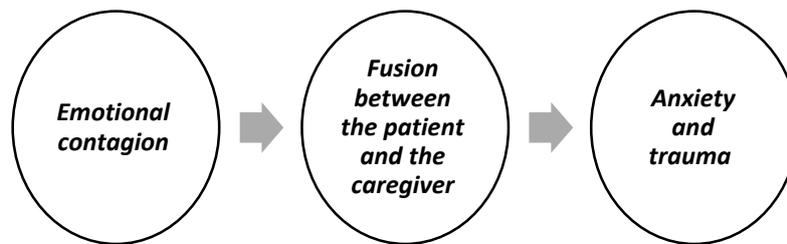


Figure 4. The process of psychological trauma in caregivers.

The trustworthiness of the data of the present study was evaluated by Lincoln and Guba's criteria [34]. Transferability of the research was conducted by providing details (full description of the participants, details of the research method, providing a sample of interview questions and examples of participants' statements). Extensive interaction was made with data and participants to achieve credibility: high variance of age, gender, type of relationship with participants and participants' place of birth, search for conflicting evidence, and multiple review of participants. Finally, the interviews were recorded, fully transcribed and reviewed by one's co-researchers to achieve dependability and conformability.

Discussion

The results of the present study showed that the subjective burden of BD for caregivers can be found in three research super-ordinate themes. According to current findings, caregivers are unable to obtain an integrated image of the patients due to the corresponding discrepancy between the active phases of BD in patients and hence intend to reduce this uncertainty. The possibility of disambiguating the patient lowers according to the type of interaction between the two since they alternately reject and show anger toward each other and limit the other's freedom. Such a cycle can induce several traumas in participants: from mood disorders to communicational and physical problems that at times go beyond the patient-caregiver relationship and contaminate the whole family.

Consistent with these findings some other researchers indicated that caregivers or individuals who live with bipolar patients have trouble achieving a stable integrated image of participants [10, 18, 19] that is because the participants' desire for certainty and stability is not in consonance with the human nature [35] and on top of that, the active phases of BD lead to incessant changes in patients. In the face of such uncertainty, participants initially inclined towards denial which is then preserved by the patients' avoidance during depressive and sometimes manic episodes. However, with the presence of conflicting desires and behaviors in patients, denial of changes becomes no more possible for the participants. Subsequently, they adopt different strategies such as setting rules to make the patient more predictable. Rules that are after all broken either actively during the manic phase or passively during the depression. Through such an interaction, participants lose hope in understanding and communicating with the patients, and instead, they tend to view patients as objects from a subjective stance with the aim of obtaining a

possibly stable image of them via objectification. They subsequently resort to deterministic explanations and yet come to realize that each of these explanations fails in one way or another to describe and formulate the patient. Therefore, objectifying the patients as well cannot help the participants achieve a stable image of patients. Finally, it should be noted that participants' desire to achieve an integrated image of the patient is not only due to the characteristics of BD, but also the psychological characteristics of caregivers. For example, C.8's history of obsessive-compulsive disorder makes it harder for her to tolerate ambiguity than other caregivers.

The second super-ordinate theme in the current study indicated the volatile interaction between the patient and caregiver during the active phases of BD. These findings are relatively consistent with some investigations [6, 21, 22]. The quality of change in the extend of patient-caregiver interaction can be explained by a cycle in which patients experience anger and rejection from the caregivers' side and as a result have their freedom reduced. Through this process that is evident during the depression, participants experience more freedom. The process is however reversed in mania so that the patients take the powerful stance and anger toward and reject the participants and further limit their freedom increasing their own freedom. Under such circumstances, participants limit the patients in order to impede their excessive freedom starting another round of the aforementioned cycle. This is in partial agreement with Vargas-Huicochea et al.'s study [18] but demonstrates a cycle in which power is not exclusive to the caregiver and rather swaps between the patient and caregiver.

These two super-ordinate themes inevitably give rise to traumas in participants as are revealed in the third super-ordinate theme. This result supports the findings of some investigations [7-9, 36, 37]. Third super-ordinate theme specifically showed that participants experience various psychological traumas that have their roots in their relationship with the patients. Caregivers experience uncertainty about their relationship with patients, which can reduce their relationship with patients, on the other hand this reduction in relationship is experienced by patients as rejection and anger, and they consider their limitation as the desire of caregivers. Therefore, patients also become angry with caregivers and the relationship between them becomes more harmful over time.

One limitation of the current study is that we did not differentiate between types of BD, patients' and caregivers' gender, and the type of family relationship to investigate the subjective burden of caregivers of bipolar patients. Another limitation of the present study was the

corona pandemic, which prevented face-to-face interviews. Individual interviewing was the last limitation of the present study. Due to these limitations, it is suggested that future research on the subjective burden of caregivers of patients with BD use focus group interviews according to the gender of patients and caregivers, the type of their relationship and type of BD.

Conclusion

Our findings indicate that caregivers within family and people who live with patients with BD have a substantial role in the treatment of patients as they can influence both aggravation and alleviation of this disorder. On the other hand, they themselves carry a huge and complex subjective burden. Therefore, it is important to develop appropriate psychological interventions to address these caregivers. With current findings in mind, the primary principles of such an intervention could include an emphasis on the acceptance of uncertainty within the world and additional uncertainty in patients with BD, unfolding the communicational cycle based on components of rejection, rage, and freedom between the patient and caregiver and finally interventions to address psychological traumas of caregivers through formulation and rehearsal of individualized coping strategies.

Conflict of Interest

The authors declare that they have no conflicts of interest and no financial benefits from this study.

Ethical Approval

All ethical considerations were applied in this study. Our research received ethics approvals from Shahid Beheshti University, Iran. After reviewing the briefing forms, the participants signed the consent form for conducting and publishing the research.

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References

- Carvalho AF, Firth J, Vieta E. Bipolar disorder. *New England Journal of Medicine*. 2020;383(1):58-66. <https://doi.org/10.1056/NEJMr1906193>.
- Miklowitz DJ, Efthimiou O, Furukawa TA, Scott J, McLaren R, Geddes JR, et al. Adjunctive Psychotherapy for Bipolar Disorder: A Systematic Review and Component Network Meta-analysis. *JAMA Psychiatry*. 2021;78(2):141-50. <https://doi.org/10.1001/jamapsychiatry.2020.2993>.
- Association AP. *Diagnostic and Statistical Manual of Mental Disorders (5TH ED)*. Arlington, VA: American Psychiatric Publishing; 2013.
- Newman CF. Bipolar disorder: American Psychological Association; 2021. <https://doi.org/10.1037/0000219-007>.
- Ferrari AJ, Stockings E, Khoo JP, Erskine HE, Degenhardt L, Vos T, et al. The prevalence and burden of bipolar disorder: findings from the Global Burden of Disease Study 2013. *Bipolar disorders*. 2016;18(5):440-50. <https://doi.org/10.1111/bdi.12423>.
- Dore G, Romans SE. Impact of bipolar affective disorder on family and partners. *Journal of affective disorders*. 2001;67(1-3):147-58. [https://doi.org/10.1016/S0165-0327\(01\)00450-5](https://doi.org/10.1016/S0165-0327(01)00450-5).
- Pompili M, Harnic D, Gonda X, Forte A, Dominici G, Innamorati M, et al. Impact of living with bipolar patients: Making sense of caregivers' burden. *World Journal of Psychiatry*. 2014;4(1):1. <https://doi.org/10.5498/wjp.v4.i1.1>.
- Bessonova L, Ogden K, Doane MJ, O'Sullivan AK, Tohen M. The economic burden of bipolar disorder in the United States: a systematic literature review. *Clinicoeconomics and Outcomes Research: CEOR*. 2020;12:481. <https://doi.org/10.2147/CEOR.S259338>.
- Von Kardorff E, Soltaninejad A, Kamali M, Eslami Shahrabaki M. Family caregiver burden in mental illnesses: The case of affective disorders and schizophrenia—a qualitative exploratory study. *Nordic journal of psychiatry*. 2016;70(4):248-54. <https://doi.org/10.3109/08039488.2015.1084372>.
- Jönsson PD, Skärsäter I, Wijk H, Danielson E. Experience of living with a family member with bipolar disorder. *International Journal of Mental Health Nursing*. 2011;20(1):29-37. <https://doi.org/10.1111/j.1447-0349.2010.00704.x>.
- Zarit SH, Reever KE, Bach-Peterson J. Relatives of the impaired elderly: correlates of feelings of burden. *The gerontologist*. 1980;20(6):649-55. <https://doi.org/10.1093/geront/20.6.649>.
- Siddiqui S, Khalid J. Determining the caregivers' burden in caregivers of patients with mental illness. *Pakistan journal of medical sciences*. 2019;35(5):1329. <https://doi.org/10.12669/pjms.35.5.720>.
- Pshuk NG, Stukan LV, Kaminska AO. Introducing system of psychotherapeutic interventions for family caregivers of patients with endogenous mental disorders. *Wiadomosci Lekarskie (Warsaw, Poland: 1960)*. 2018;71(5):980-5. PMID: 30176626.
- Caqueo-Urizar A, Urzúa A, Jamett PR, Irrazaval M. Objective and subjective burden in relatives of patients with schizophrenia and its influence on care relationships in Chile. *Psychiatry research*. 2016;237:361-5. <https://doi.org/10.1016/j.psychres.2016.01.013>.
- İnanlı İ, Çalışkan AM, Tanrıku AB, Çiftci E, Yıldız MÇ, Yaşar SA, et al. Affective temperaments in caregiver of patients with bipolar disorder and their relation to caregiver burden. *Journal of Affective Disorders*. 2020;262:189-95. <https://doi.org/10.1016/j.jad.2019.10.028>.
- Ogilvie AD, Morant N, Goodwin GM. The burden on informal caregivers of people with bipolar disorder. *Bipolar disorders*. 2005;7:25-32. <https://doi.org/10.1111/j.1399-5618.2005.00191.x>.
- Poulin MJ, Brown SL, Ubel PA, Smith DM, Jankovic A, Langa KM. Does a helping hand mean a heavy heart? Helping behavior and well-being among spouse caregivers. *Psychology and aging*. 2010;25(1):108. <https://doi.org/10.1037/a0018064>.
- Vargas-Huicochea I, Berenzon S, Rascón ML, Ramos L. A bittersweet relationship: What does it mean to be the caregiver of a patient with bipolar disorder? *International Journal of Social Psychiatry*. 2018;64(3):207-16. <https://doi.org/10.1177/0020764018758124>.
- Naqvi TF, Dasti R, Khan N. Emotional journey of wives of spouses diagnosed with bipolar I disorder: moving from vicissitude towards reconciliation. *International Journal of Qualitative Studies on Health and Well-being*. 2021;16(1):1946926. <https://doi.org/10.1080/17482631.2021.1946926>.
- Dollar JM, Calkins SD. The development of anger. *Handbook of emotional development*: Springer; 2019. p. 199-225.
- Cipriano A, Claes L, Gandhi A, Cella S, Cotrufo P. Does anger expression mediate the relationship between parental rejection and direct and indirect forms of non-suicidal self-injury? *Journal of Child and Family Studies*. 2020;29(12):3575-85. <https://doi.org/10.1007/s10826-020-01844-9>.
- Raveendranathan D, Chandra PS, Chaturvedi SK. Violence among psychiatric inpatients: a victim's perspective. *East Asian archives of psychiatry*. 2012;22(4):141-5. <https://search.informit.org/doi/10.3316/informit.038106982237895>.
- Goldberg SG. Narratives of bipolar disorder: Tensions in definitional thresholds. *The Humanistic Psychologist*. 2019;47(4):359. <https://doi.org/10.1037/hum0000131>.
- Willig C. *EBOOK: introducing qualitative research in psychology*: McGraw-hill education (UK); 2013.
- Parker I. Criteria for qualitative research in psychology. *Qualitative research in psychology*. 2004;1(2):95-106. <https://doi.org/10.1191/1478088704qp0100a>.
- Smith JA, Shinebourne P. Interpretative phenomenological analysis: American Psychological Association; 2012.

27. Nizza IE, Farr J, Smith JA. Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology*. 2021;18(3):369-86. <https://doi.org/10.1080/14780887.2020.1854404>.
28. Baruch E, Pistrang N, Barker C. 'Between a rock and a hard place': family members' experiences of supporting a relative with bipolar disorder. *Social psychiatry and psychiatric epidemiology*. 2018;53(10):1123-31. <https://doi.org/10.1007/s00127-018-1560-8>
29. Robinson S. The experience of depression among black and minority ethnic women in the United Kingdom: An interpretative phenomenological study. 2016.
30. Iacovou SL. The impact of active service on the intimate relationships of ex-servicemen: an existential-phenomenological study. 2016.
31. Maragou E. Raising awareness of clinical practice from an existential perspective with clients affected by cancer. 2015.
32. Noon EJ. Interpretive phenomenological analysis: An appropriate methodology for educational research. *Journal of Perspectives in Applied Academic Practice*. 2018;6(1).
33. Pollak CP, Perlick D. Sleep problems and institutionalization of the elderly. *Topics in geriatrics*. 1991;4(4):204-10. <https://doi.org/10.1177/089198879100400405>.
34. Grove SK, Gray JR. *Understanding nursing research e-book: Building an evidence-based practice*: Elsevier Health Sciences; 2018.
35. Yalom ID. *Existential psychotherapy*: Hachette UK; 2020.
36. Fekih-Romdhane F, Ben Ali S, Ghazouani N, Tira S, Cheour M. Burden in Tunisian family caregivers of older patients with schizophrenia spectrum and bipolar disorders; associations with depression, anxiety, stress, and quality of life. *Clinical Gerontologist*. 2020;43(5):545-57. <https://doi.org/10.1080/07317115.2020.1728600>.
37. Perlick DA, Berk L, Kaczynski R, Gonzalez J, Link B, Dixon L, et al. Caregiver burden as a predictor of depression among family and friends who provide care for persons with bipolar disorder. *Bipolar disorders*. 2016;18(2):183-91. <https://doi.org/10.1111/bdi.12379>.