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Original Article

The Effectiveness of Family-Focused Therapy on the Caregiver Burden of Parents with Children Diagnosed with Bipolar II Disorder

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Abstract

Background: Parents of children with bipolar II disorder often experience a substantial caregiver burden, encompassing emotional, psychological, and practical challenges. This burden can negatively affect both the parents' well-being and the overall family functioning.

Objectives: This study investigated the effectiveness of family-focused therapy in reducing caregiver burden among parents of children with bipolar II disorder.

Methods: This quasi-experimental pre-test-post-test control group study investigated the effects of family-focused therapy on caregiver burden. Thirty parents of children with bipolar II disorder, recruited from counseling services in Isfahan, Iran in 2023, were randomly assigned to either a family-focused therapy group (n = 15) receiving nine 120-minute sessions or a waiting-list control group (n = 15). All participants completed the Caregiver Burden Inventory at pre-test, post-test, and follow-up. Data were analyzed using descriptive and inferential statistics, including repeated measures ANOVA in SPSS v.26.

Results: In the family-focused therapy group, the mean caregiver burden scores showed a significant reduction from the pre-test (81.78 ± 8.63) to the post-test (54.50 ± 7.52), with partial maintenance of this reduction observed at the three-month follow-up (58.36 ± 6.63). Family-focused therapy had a statistically significant impact on caregiver burden (P <0.01), specifically on the time-related, developmental, and social burden subscales, as well as the total caregiver burden score at both post-test and follow-up assessments.

Conclusion: This study found that family-focused therapy effectively reduced caregiver burden in parents of children with bipolar II disorder. These results suggest that family-focused therapy is a valuable tool for enhancing the quality of life for caregivers.

Keywords: Family Therapy, Caregiver Burden, Parents, Bipolar Disorder

1. Background

Bipolar disorder is one of the most common psychiatric disorders, with a lifetime prevalence of approximately 3% in the general population, and is recognized as the sixth leading cause of disability worldwide.[1] This disorder is characterized by recurrent episodes of mood and activity disturbances, including periods of elevated mood and increased energy (mania) and periods of low mood and decreased energy (depression).[2,3] Bipolar II disorder is associated with episodes of hypomania, a less severe form of mania, and depression.[4] Since this disorder often begins in adolescence or early adulthood, individuals with bipolar disorder spend a significant portion of their lives experiencing its symptoms.[5]

Naturally, this disorder has a significant impact on family members of patients, and families themselves are affected by family environments related to caregiving.[6] Close family members or friends are often the primary source of support for individuals with bipolar disorder, and they assume many responsibilities in caring for the patient, including managing the variable and often unpredictable symptoms of depression and mania, as well as the high risk of suicide.[7,8] Consequently, family members experience significant emotional distress and caregiver burden, with reports indicating that between 89% and 91% of family members experience these challenges in relation to the severity of the patient's symptoms.[9]

Caregiver burden encompasses the challenges, difficulties, and negative consequences experienced by those caring for individuals with illnesses. It is typically categorized into two dimensions: objective burden,

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referring to quantifiable problems such as disruptive patient behaviors, and subjective burden, encompassing the emotional responses to these challenges.[10] Research has consistently demonstrated the substantial burden associated with caring for individuals with bipolar disorder,[11] with caregivers frequently reporting elevated levels of physical health problems and psychological distress, including depression.[12] Caregiver burden also reflects the impact of a family member's mental illness on the emotional well-being, time management, financial resources, and overall quality of life of other family members.[13] Recent studies indicate that subjective burden and/or depression can impair caregivers' ability to effectively manage caregiving demands, leading to adverse patient outcomes. Furthermore, higher levels of caregiver burden have been linked to emotion-focused coping strategies and a diminished sense of control among caregivers.[14]

Family members with high levels of psychological burden are also less likely to prioritize self-care and may suffer from negative effects on their physical health, which can weaken their resilience and preparedness to manage acute or subacute problems of patients with bipolar disorder.[15] The intensive involvement of caregivers in patient care is often associated with significant caregiver burden. These caregivers may face complex conflicts as they feel trapped, helpless, and overwhelmed. They may also feel stigmatized due to the mental illness of the person they care for.[16,17] This stigma can manifest in various ways, including internalized shame, fear of judgment from others, and social isolation. Crucially, this stigma can also act as a significant barrier to help-seeking, preventing caregivers from accessing much-needed support services, therapy, or even respite care. Therefore, it is essential to provide family caregivers with adequate information about the illness and teach them constructive coping strategies. One effective intervention in this area is family-focused therapy.[18]

Family-focused therapy involves sessions that provide families with psychological education about bipolar disorder, communication skills training, and problem-solving techniques.[19] The primary goal of this therapy is to help families better understand bipolar disorder so they can actively participate in the treatment process.[18] This therapy involves providing psychoeducational information, enhancing communication skills, and problem-solving methods to help patients and families better understand the nature of the illness, its causes, progression, consequences, and treatment options.[20] The overall goal of this therapy is to improve family functioning, attitudes, and coping strategies that may be disrupted by bipolar disorder.[21]

Several family-based psychosocial interventions have demonstrated their effectiveness in helping patients with bipolar disorder and their caregivers.[22,23] In one study, Reinares et al.[24] reported that caregivers who participated in family education programs experienced a reduction in the number of relapse episodes and an increase in the duration of remission. Additionally, Perlick et al.[25] observed significant improvements in patients' symptoms and a decrease in caregivers' high-risk behaviors after 12 to 15 sessions of educational and cognitive-behavioral interventions. Furthermore, their symptoms of depression and stress decreased. Other studies have shown that poor family functioning, especially in the context of severe mental disorders, is associated with lower psychological functioning in patients with bipolar disorder.[26,27]

Bipolar II disorder is a complex mental health condition that significantly impacts both individuals and their families. While pharmacological interventions are often employed, there is a growing need for effective psychosocial interventions to address the emotional and practical challenges faced by caregivers. Family-focused therapy, a promising approach that involves the entire family in the treatment process, has shown potential in improving outcomes for individuals with various mental health conditions. However, its efficacy in reducing caregiver burden among parents of children with bipolar II disorder remains understudied. This research aims to fill this gap by investigating the impact of family-focused therapy on alleviating caregiver burden, thereby enhancing the overall well-being of both the affected child and their caregivers.

2. Objectives

The purpose of this research was to investigate the efficacy of family-focused therapy in reducing caregiver burden among parents of children diagnosed with bipolar II disorder.

3. Methods

This study employed a quasi-experimental pre-test-post-test design with a control group. The population comprised parents of children diagnosed with bipolar II disorder who sought counseling services in Isfahan, Iran, in 2023. A purposive sample of 30 parents was randomly assigned to either a family-focused therapy group or a control group. A power analysis (G*Power) determined that a sample size of 30 would provide sufficient power (0.95) to detect a statistically significant difference ($\alpha = 0.05$). The intervention group received nine 120-minute sessions of family-focused therapy, while the control group remained on a waiting list and received no intervention during the study period. The therapy was delivered by the first author with a degree in specialized training in family-focused therapy. Table 1 outlines the content of the family-focused therapy sessions. To ensure unbiased assignment of participants to either the family-focused therapy group or the control group, a random number table was utilized. First, each participant was assigned a

unique identification number from 1 to 30. Then, a random number table was used to select numbers, with each corresponding to a specific participant. The first 15 numbers selected were assigned to the family-focused therapy group, and the remaining 15 participants were assigned to the control group. To be included in the study, participants were required to meet the following criteria: both parents attended therapy sessions, at least one year had elapsed since the child's diagnosis, no prior similar interventions had been received, informed consent was provided, and the child had a confirmed diagnosis of bipolar II disorder. Exclusion criteria included missing more than two sessions, failing to complete assignments, incomplete questionnaires, and parental separation or divorce. All participants completed the Caregiver Burden Inventory (CBI) at three time points: prior to the commencement of the therapy sessions (pre-test), immediately following the completion of the nine therapy sessions (post-test), and three months after the post-test assessment (follow-up).

Table 1. Summary of Family-Focused Therapy Sessions

Sessions	Content
First	Introductions, rapport building, outlining objectives, session number, rules, administering pre-test.
Second	Member goals, bipolar II disorder explanation, reducing negative emotions, exploring positive expectations.
Third	Reciprocal impact of bipolar member and family, addressing family concerns, expressing attitudes/feelings, correcting negative attitudes/feelings, focusing on family strengths, examining each member's role.
Fourth	Reciprocal impact of bipolar member and family, addressing family concerns, expressing attitudes/feelings, correcting negative attitudes/feelings, focusing on family strengths, examining each member's role.
Fifth and sixth	Practicing active listening and effective communication, teaching contingency contracting (establishing a contract, identifying desired behavior, determining rewards), teaching modeling (teaching specific behaviors, practice, feedback).
Seventh and eighth	Practicing contingency contracting and modeling, teaching negotiation (expressing feelings, interests, desires, proposing solutions, reaching agreement), teaching problem-solving (defining the problem, setting goals, brainstorming solutions, testing solutions, evaluating outcomes).
Ninth	Reviewing constructive changes, maintaining/consolidating changes, summarizing sessions, member feedback, administering post-test, concluding therapy.

3.1. Ethical Considerations

Given the potential vulnerability of caregivers experiencing significant burden, particular attention was paid to ensuring their well-being throughout the study. Informed consent was obtained with careful attention to ensuring participants understood the information provided. Participants were informed about the availability of respite services and were provided with contact information for local support organizations. During the data collection process, researchers were sensitive to signs of distress and offered breaks or the option to discontinue participation if needed.

3.2. Measure

The Caregiver Burden Inventory (CBI) was developed by Novak and Guest in 1989.[28] This questionnaire consists of 24 items and five subscales: time-related caregiver burden (items 1-5), developmental caregiver burden (items 6-10), physical caregiver burden (items 11-14), social caregiver burden (items 15-19), and emotional caregiver burden (items 20-24). Responses are rated on a 5-point Likert scale ranging from "strongly disagree" (score 1) to "strongly agree" (score 5). The total score of the questionnaire ranges from 24 to 120. Scores between 24 and 39 indicate mild caregiver burden, 40 to 71 indicate moderate caregiver burden, and 72 to 120 indicate severe caregiver burden. The validity of the CBI was confirmed in a study by Abbasi et al.[29] through content and face validity. The reliability of the subscales was reported with Cronbach's alpha ranging from 0.69 to 0.87, and the Cronbach's alpha for the entire questionnaire was 0.80.

3.3. Statistical Analysis

Data were analyzed using SPSS version 26. Descriptive statistics, including means and standard deviations, were calculated to summarize the data. Repeated measures analysis of variance (ANOVA) was used to examine the effects of the family-focused therapy on the outcome variables over time.

4. Results

A total of 30 parents of children with bipolar II disorder were recruited for this study and randomly assigned to either a family-focused therapy group (n = 15) or a control group (n = 15). The mean age of mothers in the therapy group was 40.03 years (SD = 3.70), and in the control group, it was 41.12 years (SD = 5.61). The mean age of fathers in the therapy group was 43.86 years (SD = 4.10), and in the control group, it was 48.38 years (SD = 6.87). Table 2 presents the mean scores and standard deviations for the caregiver burden components and total caregiver burden at the pre-test, post-test, and follow-up stages.

Shapiro-Wilk tests were conducted to assess the normality of data for each caregiver burden component and the total caregiver burden score at the pre-test, post-test, and follow-up stages. The results confirmed the

normality assumption. Levene's test was used to verify the homogeneity of variances between groups, and the assumption was met.

A repeated measures ANOVA was conducted to examine the effects of family-focused therapy on caregiver burden. Significant main effects of the group were found for time-related (F = 62.35, *P*<0.001), developmental (F = 24.01, *P*<0.001), physical (F = 22.32, *P*<0.001), social (F = 38.09, *P*<0.001), and emotional (F = 8.32, *P* = 0.006) caregiver burden, as well as the total caregiver burden score (F = 85.63, *P*<0.001). Additionally, a significant main effect of time was observed for all caregiver burden components and the total score (*P*<0.001). These findings indicate that family-focused therapy significantly reduced caregiver burden across various dimensions (Table 3).

Table 2. Means and Standard Deviations (SD) of Research Variables

Variables	Groups	Pre-test	Post-test	Follow-up
		Mean ± SD	Mean ± SD	Mean ± SD
Time-related caregiver burden	Family-focused therapy group	14.64 ± 2.31	7.71 ± 1.73	8.64 ± 1.91
	Control group	14.44 ± 2.50	13.87 ± 2.31	14.31 ± 2.49
Developmental caregiver burden	Family-focused therapy group	18.86 ± 2.38	11.84 ± 1.99	13.43 ± 2.34
	Control group	19.13 ± 2.42	18.82 ± 2.19	19.43 ± 2.68
Physical caregiver burden	Family-focused therapy group	14.14 ± 1.61	10.43 ± 2.68	9.50 ± 2.62
	Control group	14.31 ± 1.92	14.56 ± 2.16	14.69 ± 2.38
Social caregiver burden	Family-focused therapy group	18.21 ± 2.86	11.14 ± 2.35	12.57 ± 2.68
	Control group	19.94 ± 2.84	19.44 ± 2.72	19.13 ± 2.87
Emotional caregiver burden	Family-focused therapy group	16.93 ± 2.41	13.36 ± 2.84	14.21 ± 2.12
	Control group	17.56 ± 2.19	17.50 ± 1.93	17.19 ± 2.56
Caregiver burden (total)	Family-focused therapy group	81.78 ± 8.63	54.50 ± 7.52	58.36 ± 6.63
	Control group	85.37 ± 6.36	84.19 ± 6.55	84.75 ± 6.71

Table 3. Repeated-Measures ANOVA Results

Variables	Source	MS	F	P	η_p^2
Time-related caregiver burden	Time	342.88	21.11	0.001	0.53
	Group	290.29	62.35	0.001	0.60
Developmental caregiver burden	Time	526.67	30.24	0.001	0.59
	Group	97.35	24.01	0.001	0.36
Physical caregiver burden	Time	288.73	19.95	0.001	0.48
	Group	122.18	22.32	0.001	0.35
Social caregiver burden	Time	719.78	35.86	0.001	0.63
	Group	229.18	38.09	0.001	0.48
Emotional caregiver burden	Time	151.45	13.10	0.001	0.38
	Group	32.71	8.32	0.006	0.17
Caregiver burden (total)	Time	9379.66	66.08	0.001	0.76
	Group	3459.28	85.63	0.001	0.67

Figure 1 illustrates the trajectory of caregiver burden over time for both the family-focused therapy and control groups. At baseline (pre-test), both groups exhibited relatively high levels of caregiver burden, with the family-focused therapy group demonstrating slightly lower initial levels compared to the control group. The family-focused therapy group experienced a substantial reduction in caregiver burden from pre-test to post-test. This decrease was maintained at the follow-up assessment, highlighting the long-term efficacy of the family-focused therapy. In contrast, the control group exhibited only a modest reduction in caregiver burden. Overall, the figure underscores the effectiveness of family-focused therapy in significantly alleviating caregiver burden among parents of children with bipolar II disorder.

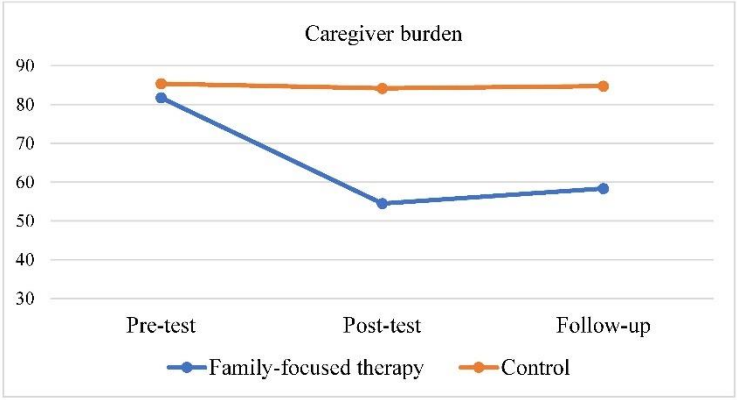

Figure 1. Changes in Caregiver Burden Scores in Family-Focused Therapy and Control Groups.

5. Discussion

The present study aimed to investigate the effectiveness of family-focused therapy on the caregiver burden of parents with children diagnosed with bipolar II disorder. The findings indicated that family-focused therapy had a significant impact on caregiver burden in families with a member diagnosed with bipolar II disorder. It emerged as an effective approach for reducing caregiver burden in such families. Consistent with these results, Lee et al.[30] confirmed that family-centered interventions led to a decrease in caregivers' emotional distress and fostered positive interactions among family members. Furthermore, Perlick et al.[31] reported higher efficacy of family-focused therapy in reducing caregiver burden and stress. Padmavathi et al.[32] highlighted the effectiveness of family-focused therapy in improving quality of life and reducing negative emotions within families.

These research findings suggest that family-focused therapy is one of the most effective approaches for reducing caregiver burden in families with a member diagnosed with bipolar II disorder. Family-focused therapy, by emphasizing psychoeducation and enhancing communication skills, improves families' ability to manage the behaviors and symptoms associated with the illness. Family-focused therapy enhances caregivers' ability to manage stressful situations by increasing their understanding of the disease cycle and teaching coping strategies. Additionally, family-focused therapy reduces caregivers' psychological distress by providing emotional support and a safe space.[31]

Caring for an individual with bipolar disorder within a family setting necessitates careful planning, and family members must acquire the necessary skills and competencies to provide adequate care.[6] To achieve this goal, families need appropriate training on how to communicate with the patient, administer medications, and manage the symptoms and behaviors associated with the illness. Family education has been shown to reduce relapse rates and create a supportive and nurturing environment for both the patient and family members.[32] Providing psychosocial skills training to family members of individuals with mental illness is a core component of family-based interventions. This training reduces relapse rates, hospitalization frequency, and enhances adherence to medication regimens.[20] Another significant benefit of family-focused therapy is the extensive emotional support it provides to caregivers. Lee et al.[30] demonstrated that creating a safe environment for expressing feelings and receiving professional guidance reduces caregivers' emotional stress and enhances their ability to provide more effective care.

Integrating family-focused therapy into standard care can be achieved through several strategies. First, mental health professionals should be trained in family-focused therapy techniques and encouraged to offer it as a routine part of treatment for individuals with bipolar disorder and their families. This could involve incorporating family-focused therapy modules into existing outpatient programs, community mental health centers, or inpatient settings. Second, public awareness campaigns can be implemented to educate families about the benefits of family-focused therapy and how to access these services. Finally, insurance providers and healthcare systems should recognize family-focused therapy as an evidence-based practice and ensure its reimbursement, making it more accessible to families in need.

This study, limited to parents in Isfahan, Iran, may not generalize to diverse populations, underscoring the need for future research investigating its efficacy across diverse contexts. The reliance on self-report data may have introduced social desirability bias, highlighting the value of mixed-methods approaches, including qualitative data, for future studies. Furthermore, the cross-sectional design precludes causal inferences, necessitating longitudinal studies to investigate long-term effects and temporal relationships. Finally, the study's exclusive focus on parental well-being warrants future research examining broader outcomes, such as family functioning and child well-being.

6. Conclusion

The findings of this study provide strong evidence for the efficacy of family-focused therapy in alleviating caregiver burden among parents of children with bipolar II disorder. The family-focused therapy demonstrated significant reductions in various aspects of caregiver burden, including time-related, developmental, and social burdens. These results highlight the potential of family-focused therapy as a valuable tool for improving the quality of life for caregivers of individuals with bipolar disorder. These findings have important implications for clinical practice and mental health policy. Clinicians should be trained in family-focused therapy and encouraged to offer it to families affected by bipolar II disorder. Healthcare systems should consider implementing policies that support the provision of family-focused therapy and ensure its accessibility to families in need. Future research may explore the long-term impact of family-focused therapy on caregiver burden and consider tailoring the intervention to the specific needs of families affected by bipolar II disorder. Additionally, investigating the mechanisms underlying the therapeutic effects of family-focused therapy could provide further insights into its effectiveness.

Author Contributions

Authors contributed equally to this work.

Conflict of Interest Disclosures

All authors declared that they have no conflict of interest.

Research Highlights

What Is Already Known?

Bipolar II disorder is a complex mental health condition that can significantly impact both the individual and their family. Caregivers of individuals with bipolar II disorder often experience a high level of burden, which can negatively affect their mental and physical health.

What Does This Study Add?

This study contributes to the literature by demonstrating the effectiveness of family-focused therapy in alleviating caregiver burden among parents of children with bipolar II disorder. The findings show that this therapy significantly improves various aspects of caregiver burden, including time-related, developmental, and social challenges. The study provides empirical support for family-focused therapy as a valuable intervention to enhance caregivers' quality of life.

Ethical Approval

The study was approved by the Ethical Committee of Islamic Azad University- Sanandaj Branch (code: IR.IAU.SDJ.REC.1402.090).

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