Case Report

A Casework Approach in Psycho-Social Rehabilitation of Person with Bipolar Affective Disorder

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Abstract

Objectives: The concern of mental health is affecting the psychosocial well-being of the people worldwide. Its impact can be seen on every age group, gender, and country. Mostly, the biological and social factors trigger mental health issues among individuals. Similarly, the psychiatric disorder like bipolar affective disorder, which is a multifactorial disorder causing of severe episodes of mood disorders, including depression and mania. It also triggers physiological changes and functional impairment among the patients. Mostly, the onset of the bipolar affective disorder is observed higher during late adolescence age, but sometimes it appears in children as well. Therefore, the impact of bipolar affective disorder along with physical and emotional changes during adolescent age produces worse health outcomes. Though the symptoms of bipolar affective disorder may differ over time, but lifelong recovery and treatment management become critical task for the individual. Therefore, the closed supervision and better quality of life of the person with bipolar disorder can be ensured by family members along with other available support systems. In the present study the casework approach was used to investigate and understand the various aspects of client's demography, psychological wellbeing, social environment, and genetic risk factors. This study tried to address the on-going concerns and prioritize the short-term and long term intervention plans for the overall recovery of the client. It includes various psycho-social intervention like activity scheduling, anger management techniques, psycho-education, occupational counselling, supportive therapy with family and vocational rehabilitation for the client during her hospitalization. The outcomes of the intervention were satisfactory and acknowledged by the client and family members.

Apart from the individual factors, the demand of complex societal system, competitive environment, technological advancement and service driven economies act as push factor causing poor mental health outcomes among peoples. Therefore, the availability of adequate healthcare facility, including mental health professionals and physical infrastructure, can manage the increasing demand of the people.

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Introduction

Globally, nearly 25% population experience mental health issues at some point in their lifetime [1]. Such mental health conditions can cause functional impairment and disability in patients. Globally, five to ten leading causes of disability are associated with psychiatric disorders [2]. Further, Brundtland highlighted that the rate of disability caused by psychiatric disorders is higher in high-income countries than the low-middle-income countries [3]. Similarly, the lifetime prevalence of disorders like anxiety, mood, and substance use disorder is 18.1% -36.1% [4], the global burden of mental health issues on children and adolescents is 10%-20% worldwide [5].

BPAD is the sixth leading cause of disability, adversely impacting patient's education, work, social, and family functioning [2, 6]. It can be observed as a dimensional illness fluctuating from manic to depressive symptoms. The prevalence of BPAD range between 0.4% - 0.5%, and its lifetime prevalence rate is 2.6%–7.8 % worldwide [1]. The Indian population reported a significant association between the patient's age at the onset and family history of mood disorder with the BPAD [7]. The prevalence rate of BPAD ranges between 0.51-20.78 people per thousand in India [8]. The medical management of BPAD in India is complex task especially to deal with people's magico-religious beliefs. It limits the peoples reach to the universally accepted medical interventions. Though,

the cultural competence of the health professionals can improve the treatment outcomes in terms of understanding the cultural, social, and religious concerns of the patients and family, but on the other side people's awareness of mental health treatment plays crucial role [9].

Study Process and Case Presentation

This study provides a deep insight into the various psycho-social queries, symptoms management, and community rehabilitation of the patient through Casework approach of treatment. The holistic approach of treatment including biological, psychological, social, and spiritual aspect of the client was taken into the account for better treatment outcomes. The process of client's admissions in health institution to termination of client is chronically presented (Figure 1).

Brief History of the Case

Miss J. is 31-year-old unmarried lady formally educated up to the primary level. She belongs to a lower socio-economic family background in Bihar, India. Nearly fifteen years ago, she stayed with her family and maintained everything well. Mostly, she helped her mother at home with household responsibilities. However, soon after, she became irritable and aggressive without reason leading to fiery quarrels with family members. The irritable and aggressive behavioral manifestation of Miss J. was mainly projected towards her mother only. She had multiple hospitalizations for the same queries over the last 16 years.

Intake

Measuring the met or unmet needs of the client is usually recognized during the process of intake [10]. Initially, the psychiatric team referred the client for psychosocial intervention with the client to schedule her daily routines and individual sessions to comply with medical treatment. However, soon after, the client's family members were referred to address the various concerns like psycho-education, addressing family expressed emotions, and supportive psychotherapy to reduce the caregiver's burden to ensure a better treatment outcome. After the initial screening, the intake was initiated with the client and family members for further psychosocial assessments and an intervention plan.

Individual Assessment

The individual assessment is a process of gaining every detail of a person's life events, especially in mental

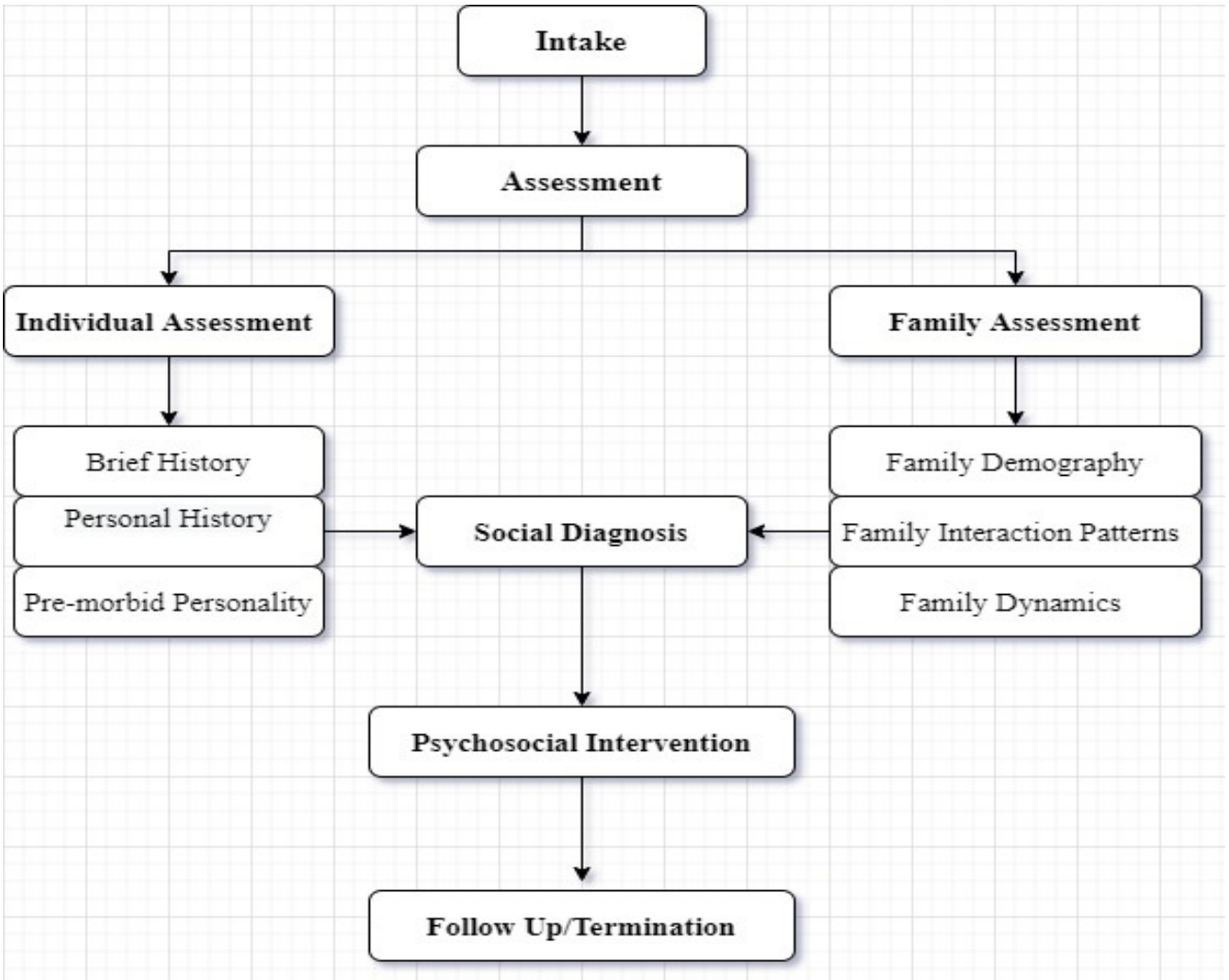

Figure 1. Working model for the Casework approach

health settings. It may include personal history, pre-morbid personality, and a brief history of the client's psychiatric illness. Further, this information can be used to conceptualize the working strategies for the client. These strategies include short-term and long-term goals for the client's mental health recovery.

Brief History

In 2003, the family approached the medical institution when Miss J. complained of assaultive behavior, grandiose ideas, poor self-care, disturbed sleep, and poor social and occupational functioning for the last two months. She was diagnosed with Bipolar Affective Disorder (BPAD) - a current episode of mania as per the diagnostic guidelines of the International Classification of Diseases-10 [11]. After-clinical intervention, she was discharged from in-patient care, but her frequency of hospitalization increased due to multiple relapses triggered by poor drug adherence and psychosocial causes. She had history of non-compliance with medical treatment in the past as well.

Lastly, in April 2017, she was again brought by her mother to the psychiatric emergency ward of the hospital with insidious onset and a current episode of mania. She was found symptomatic for the last one month with complaints of abusive, assaultive, irritable behavior, increased speech, over-familiarity, and religiosities. Additionally, she was also found over-demanding for money, wondering tendency, impaired social and occupational functioning, and decreased sleep and appetite. Therefore, based on the initial screening and past medical records, she was clinically diagnosed with BPAD - Mania without Psychotic Symptoms. And case was referred to the psychiatric social worker for further psycho-social assessment and intervention plans.

Personal History

The birth and early development of Miss J. were normal as other children. It was home-based full-time normal delivery without any medical complications. She achieved developmental milestones normally. The childhood behavior of Miss J. was normal. She has not reported any history of behavioral and conduct disorders or major physical illness during her childhood days. She started schooling at the age of six and studied up to sixth standard with average scholastic performance. She attained menarche at the age of 14 years and has regular periods now. She never reported any emotional disturbance concerning the menstrual cycle. Miss J. attains puberty at the age of sixteen. She gained sex education or information through peer group discussions at eighteen. According to family members, she never had a relationship with anyone.

Further, Miss J. was somewhat skilled in tailoring, but she did not take it as a profession. Occupationally, she never worked under any organized or unorganized organization. Despite this, she used to engage herself in household work.

Pre-Morbid Personality

The attitude of Miss J. towards others in the family or social milieu was appropriate and culturally accepted. She was friendly, emotional, and able to trust, develop, and sustain relationships with other people. Her attitude toward herself was positive and productive. Pre-Morbidly, she was satisfied with her household work, family life, and social environment. She was able to bounce back in healthy ways from the achievements and failures of life. She believes that her positive attitude can overcome all her life difficulties and challenges.

Additionally, Miss J. was an emotionally stable personality without a history of mood swings and traumatic life experiences. She was lively and expressed her emotions effectively. She never reported special dreams or fantasy life that bothered her during her childhood. She was religious and god-fearing; therefore, she uses "Nawaz" daily and often visits the mosque with her parents.

Family Assessment

The family assessment is all about gaining member's structural and functional status as a single unit. It includes multiple members directly related to each other through emotional ties, financial needs, roles, responsibilities, etc. In this case, family assessment tried to explore the various factors contributing directly or indirectly to the poor mental health outcomes of the client, including demographic characteristics of the members, family interaction patterns, and family dynamics.

Family Demography

Miss J. was a third-born child from non-consanguineous marriage [12]. Currently, staying with a joint family, including parents, elder brother, sister-in-law, and four kids, in the Bengaluru city. Her father is 69 years old and formally not educated. Additionally, he had a query diagnosis of BPAD and has never been on medical treatment. Mostly, she spends time with her mother, who is sixty-five years old illiterate lady and housewife by profession. The mother has chronic medical conditions like Hyper Tension. She was the only member taking care of the client and managing the household responsibilities. Even though she was supportive and encouraged children to do their work effectively, still, she was observed as critical, especially towards the client.

The client's 47-year-old elder sibling is educated up to the seventh standard and works in a garment factory. He is married and has four kids. However, he is submissive by nature but shares a close bond with Miss J. The last family member is a thirty-seven-year-old sister-in-law who is educated up to the sixth standard and works as a housewife. She had the authority to make essential household decisions, including financial matters. She was concerned and protective toward the client.

Family Interaction Patterns

Families play a crucial role in the recovery process of a person with mental health issues because they act as the primary source of care and protection [13]. Now, it depends upon the nature of the family's interaction patterns. In the case of Miss J., interaction with her parents was minimal and need-based only. On the other hand, the parent's interaction with children was laden with criticism, negative remarks, and need-based without warmth in the relationship. The mother appeared over-involved and occasionally dominating in the family. Meanwhile, the elder brother takes the majority of the family decisions and imposes them on family members. Thus, the absence of democratic decision-making in the family occasionally leads to family conflicts. On the other hand, the sibling interaction was adequate, and they could support each other emotionally. Even though the elder brother shares love, affection, and care, he still occasionally found critical toward the client due to her mood swings or behavioral changes.

Moreover, the stressful family environment and negative interaction patterns are associated with poor psychosocial health outcomes among people with mental illness [14]. Similar interaction patterns can be observed in the family of Miss J., leading to worsening the symptoms and poor recovery process of the client.

Family Dynamics

It is an essential component of the family assessment as it provides an accurate portrayal of the family structure and the functional status of members. The smooth functioning of the family depends upon various factors like clear boundaries and subsystems, better communication and reinforcement, and clear role and responsibilities. These factors are discussed in the following section.

Family Development Stage, Boundaries and Subsystem

Miss J's family was in the eighth stage of the family development stage, i.e., the aging Family [15], Both the children were above thirty and married, except Miss J. The family had clear and open boundaries allowing sub-systems to carry out their functions without undue interference. However, the marital sub-system and parent-child sub-system was present in the family but not evenly shaped. Throughout the treatment process of Miss J., the members of every sub-system appeared to be over-involved with each other. Therefore, the failure of the sub-system, like the marital sub-system, leads to poor social and academic functioning along with other internalizing and externalizing problems [16], for Miss J.

Leadership Pattern, Role Structure, and Functioning

The client's brother was the nominal and functional leader of the family. He took the final authority to exercise his decisions even after partial discussion with other members. On the other hand, the father was missing from the family affair, whereas the mother was over-involved in the client's care. The brother took all the family decisions, like what household articles needed to buy, in an autocratic manner. The remaining household members accept his decision without any complaint.

Even though the effective role is seen as an essential function of the family [17], but in the case of Miss J., the definition of family roles was not clear enough as bother had to perform multiple roles. It includes fulfilling the family's financial needs, managing the client's medical consultation and expenses, workplace responsibility, and other family engagements. He was over-burdened with multiple roles and responsibilities. The role allocation and depiction were primarily unspoken in the family. Thus, family members could not decisively perform their specific roles. Similarly, the role expectations and performance were not addressed adequately in the family, resulting in poor family functioning. However, the family members put efforts into managing household tasks timely, but sometimes the client's health condition adversely affects their role performance.

Communication and Reinforcement

Direct communication was present in the family but not clear enough to deliver the message. The frequent expression of negative expressed emotion elevates the high level of noise in the family. They often project their anger or aggression toward each other, which depicts compromised verbal and non-verbal communication of the members, primarily due to negative expressed emotions. However, the client's brother gives verbal feedback to the members, especially those who have not performed well in their respective roles or household tasks. Mostly, family members used to criticize the client's behavior and her complaints about multiple things.

On the other side, the reinforcement technique can lead to positive health outcomes with other medical and psychotherapeutic interventions, especially for those with mental health issues [18]. However, the family poorly understood the implication of reinforcement in the treatment process. They hardly gave positive reinforcement like verbal appraisals and material gifts to the members. Thus, considering the importance of reinforcement techniques in the treatment process can enhance the recovery outcomes of the client.

Cohesiveness and Family Rituals

The family had enmeshed cohesiveness as its members get severely affected by each other's problems. Their reciprocal warmth and affection lead them to become emotionally over-involved. Moreover, all members were at the same level of proximity in every instance. Additionally, the family strictly follows rituals, including religious practice, visiting worship places regularly, and prayers as a daily routine.

Adaptive Patterns and Social Support System

The problem-solving ability and coping management strategies were not enough to resolve all the quarries of the family members. However, the members cooperate and support each other in financial, physical, and emotional matters with mutual satisfaction and pride in each other's achievements. But, in various aspects, they have scarce resources, including insufficient financial resources. The family had only earning member, i.e., bother, who is the primary source of the family income. After recognizing the mental health issues of the client and her father, the primary support system became weaker.

On the other hand, the family lacks secondary sources of support, while treating institutions of Miss J. was the only tertiary support system available to the family. The availability of support systems play a considerable role in mental health recovery, especially among females, older adults, and patient [19]. Thus, it is required to strengthen the client's support system through networking and liaise with other support groups or voluntary organizations.

Social Analysis and Diagnosis

Miss J's social analysis brought her up in an atmosphere where she was not getting adequate warmth and positive encouragement from her family. She had to face social stigma and exclusion on various occasions. Her mother was dominating and critical on various grounds. Meanwhile, her brother was over-burdened with multiple roles and responsibilities to fulfill family requirements. He had to perform multiple roles, including financial role, decision-maker, workplace management, and taking care of and protecting the family members. Therefore, he found an autocratic in his decision-making most of the time. Further, the family's high communication gap and noise levels often resulted in quarrels, disagreements, and weak emotional bonds among the members. Family lacks in use of reinforcement techniques, especially positive reinforcement for good conduct.

Notably, the family belongs to the lower social-economic status in society. Their social support system was weak and not capable enough to accommodate their various concerns, including emotional and financial needs. Similarly, the family lacks secure secondary and tertiary support as well. It makes them highly vulnerable, especially when two family members have a mental illness. Overall, the current status of the family and the client's mental illness is putting an additional emotional and financial burden on the family.

Therefore, Miss J. falls under multiple categories of social diagnosis as per the ICD-10, including problem-related to employment and unemployment (Z54), social inclusion and rejection (Z60.4), inadequate family support (Z63.2), family history of mental illness, and other behavioral disorder (Z81.8) and personal history of non-compliance with medical treatment (Z91.1) (Figure 2) [20].

Psychosocial Intervention

Psychosocial interventions have a crucial role in treating mental health disorders like bipolar affective disorders. It prevents relapses and reduces the client's dependence on hospitalization. The interventions like psycho-education and cognitive-behavioral therapy have better outcomes with a medicated client [21]. Therefore, the psychosocial consultant needs to identify and formulate the working intervention strategies for the short-term and long-term

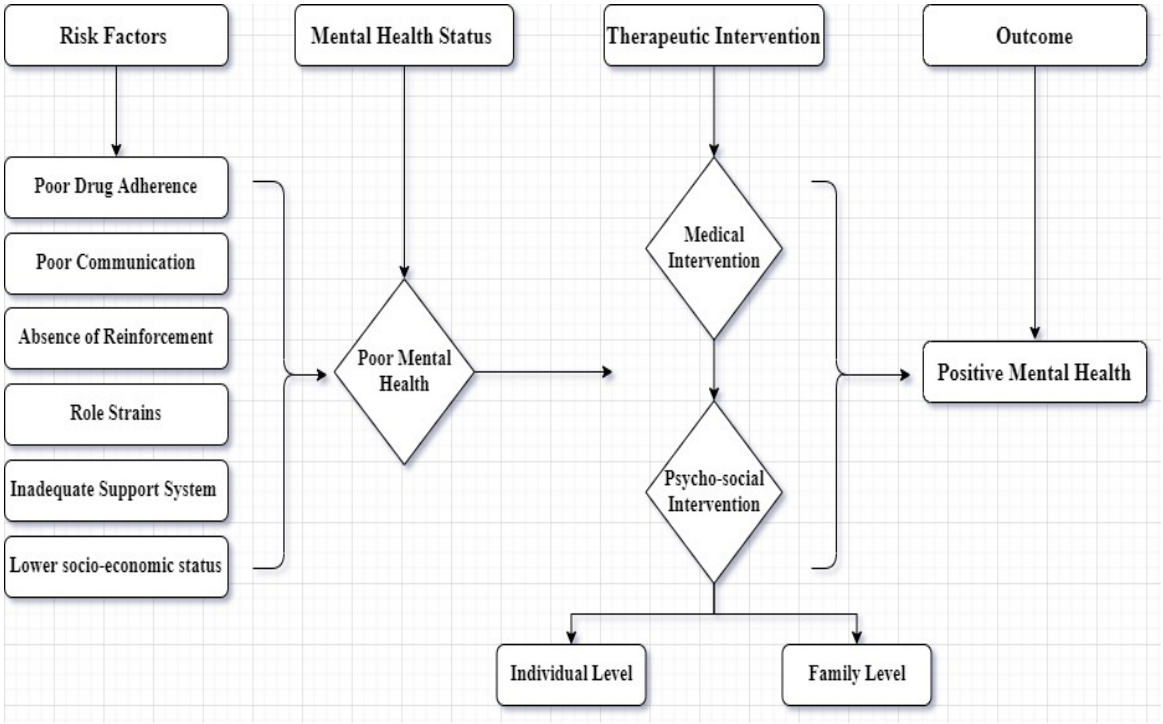

Figure 2. Role of therapeutic interventions in mental health recovery and risk factors.

requirements of the client. Though this process may be tiring, as a consultant has to investigate every minute detail of the client's history, and based on assessment, the intervention plan can be conceptualized to ensure the client's short-term and long-term recovery goals. The details of individual and family intervention used in this case are as follow:

Individual Level

The individual session was started with the client to gain better insight into the cause of the current episode of illness. The psychiatric social worker (PSW) notes the client's complaints and allows her to vent her emotional concerns during the session. He tries to identify the possible stressors in the family triggering the current episode and maintains a record of all sessions for further reference. Miss J. was trained in various domains like dealing with emotional disturbances and household issues via making choices and healthy coping strategies in the sessions. The detail of individual interventions is given below;

Psycho-Education

The psycho-education is a universally accepted therapeutic intervention that enhances the client's understanding of the mental illness. It has shown a positive impact on treating mental health disorders [22]. Therefore, the client was educated on various domains of psychiatric illness, such as the nature of the mental illness, etiological factors, the stress vulnerability model, prognosis factors, drug adherence, relapses, and the role of regular follow-up processes. The emphasis was primarily placed on the client's symptoms as they are part of the illness and cannot be controlled until clinical intervention. Additionally, the role of long-term medical treatment in a conducive atmosphere and recognizing early signs of the symptoms was discussed with the client. During the treatment, it was revealed that the client was not complying with medication regularly. Thus, the role of regular medication or drug adherence was discussed and described how it ensures better recovery outcomes from the illness.

Activity scheduling to gain social-rhythm

Mostly, clients spend their time lying down on the bed and sleeping for long hours of the day. Therefore, it was necessary to reframe daily routine and engage her in various activities. The PSW involves the client in preparing an activity schedule based on the "Mastery and Pleasure" principle [23, 24]. This technique helps the client to recognize all those activities primarily related to her experience of mastery and pleasure. During the in-patient care the client was suggested to visits the Department of Psychiatric Rehabilitation Services for tailoring training and take part in other activities within the hospital ward, including managing personal hygiene, ward exercise, yoga training, etc. Additionally, the staff nurses and PSW managed the supervision of the client's daily activities. Over time, these activities were re-scheduled and improvised as per the client's treatment requirement.

Anger Management

Though anger is not a core symptom of BPAD, but sometimes mood fluctuation may trigger aggression among individuals. Ballester et al. stated that individuals with an acute episode of BPAD could exhibit more anger than others [25]. Knowing the cause and consequences of anger for individuals and family members is necessary. It helps them to plan accordingly and reduce the possibilities of anger and related consequences. Similarly, Miss J. was often observed angry with her family members in various instances in this case. Therefore, anger-provoking situations were identified during counselling sessions, and she was trained to practice various anger management techniques. It includes practical exercises like "walk away from the person causing anger, close the eyes and count one to ten forward and backward, take a deep breath and give self-suggestion like relax or calm down. Finally, write down the angry experiences, read and re-read them, and think calmly. She was trained to indicate upset or disappointment whenever she got angry with someone.

Occupational Counselling

It helps people develop work habits and accelerate their recovery from mental issues. Therefore, before the termination of the case, a few occupational counseling sessions were conducted with Miss J. and her family. The importance of occupational engagement was explained and how it will reduce the relapses during the mental illness. Additionally, the emphasis was given on the significance of regular work habits and being functional. For Miss J., the area of tailoring, which she preferred to do earlier and skilled somewhat, was highlighted and discussed with the client and family for her functional rehabilitation.

Family Level

It includes the therapeutic intervention being carried out with the client's family members to explore the possible factors within the family and societal environment causing the current episode of illness and affecting the overall recovery process of the client. During the session, the PSW allows the family members to share their concerns and challenges regarding managing the client's illness. During the sessions, multiple issues were observed in the family leading to poor health outcomes among the client. It includes poor knowledge of the illness, negatively expressed emotions, and problems related to medication supervision. The detail of family interventions is given below:

Psycho-Education

The various studies have highlighted that family psycho-education is an effective intervention model for the individual's mental health recovery, including bipolar affective disorders. The mode of family education could be workshops, group psycho-education, or client-family psycho-education to address their concerns like high

expressed emotions, caregiver burden, and treatment supervision [26]. During the session, the family was educated on the nature and possible causes of the illness, symptomology, and available treatment. It also encloses family expectations and removes the blaming or criticality in the family. Additionally, the family was informed that the client's current behavior is a part of her illness. The following key concerns were addressed during the family session.

Reducing the Expressed Emotions:

The likelihood of relapses in a person with bipolar affective disorder is higher due to the high expressed emotions of the family, especially from the parents. Globally, females face more parental criticism than males. Additionally, a girl's parents pass more critical commenting in adolescent age than the childhood onset of bipolar affective disorder. On the other hand, their expressed emotions toward boys are just the opposite [27].

In the case of Miss J., her mother was observed as emotionally over-involved, critical, and occasionally hostile. Her critical remarks and over-involvement often led to emotional distress in the client. These negative expressed emotions were found as triggering factors for the violent and aggressive behaviour of the client. Thus, initial sessions were focused on addressing the expressed emotions and explaining how it contributes to the poor prognosis of the illness. Furthermore, the mother was suggested to exercise positive regard and warmth instead of the negative expressed emotion to ensure the positive mental health recovery of the client.

Addressing negative emotions and enlisting family co-operation in the treatment plan:

During the session, the family's negative emotions and guilt feelings were addressed, and PSW validated their concerns about being alone in this situation. Further, the treatment plan was discussed with family members, including explaining the pharmacological treatment, role of psychosocial intervention, and cost analysis for the past treatment. The family members were expected to co-operation in line with the treatment plan and must strengthen the client's participation in various activities.

Enhancing the ability of the family to monitor the disorder:

The family members were educated on various aspects of "disorder monitoring" like recognizing early warning symptoms, supervision of medical compliances, and side effects. They were also educated on how to respond during a client's relapse.

Brief supportive psychotherapy with client's mother:

Managing the psychiatric symptoms and related stress is challenging task for both client and family. It can burden family financially and emotionally. Similarly, in the case of Miss J., her mother had stress burnout syndrome due to multiple role performance in the family. Her role majorly includes the management of client's illness and behavioral issues. Even after the detailed psycho-education of the family the brief supportive psychotherapy was given to the mother. It helps mother to reduce her emotional disturbances and distress level via using technique like empathetic listening, reassurance, instilling hope, giving advice and suggestions. Additionally, she was allowed ventilating her feelings, fears, anxieties, and enabling them to choose appropriate ways to deal with it.

Vocational rehabilitation services

These services assist individuals with disability to achieve employment. The disabilities caused by psychiatric disorder challenges the mental and functional capacities of the individual. It limits their reach to variety of the employment opportunities. Therefore, the vocational rehabilitation is perceived as substantial process that facilitates the working condition for the willing and potentially able individuals with a disability. In present case, the implication of vocational rehabilitation and necessity in the client's recovery process was discussed with the family member. Additionally, few vocational rehabilitation centers were recommended in their native areas for their reference and further action [28].

Outcome of intervention

The working approach of the casework technique in "Bio-Psycho-Socio-Spiritual" modal of treatment leads remarkable outcomes in the case of Miss J. It includes both medical and psycho-social intervention as the key strategy ensuing considerable changes among client's mental health outcomes. Post intervention, the client was observed more confident and positive toward her future concerned. She admitted that she can feel substantial improvement in her psychosocial functioning and able to sustain at home.

Additionally, the family members were able to recognize the positive changes and acknowledged sixty to seventy percent improvement in the client's health condition. They planned to engage her in the tailoring work at garment factory for the vocational rehabilitation. The overall session improved the collective consciousness of family members on various aspects like nature of the client's illness, treatment approach and causes of poor prognosis factors. It also includes the role of the family environment and express emotion in the treatment process. Altogether family bonding and relationship were improved enough to manage family issues and challenges in constructive manner.

Follow-up and Termination

The psychiatric social worker was kept in touch with the client's family and ensures the drug adherence and regular follow-ups in the hospital. The initial follow-up was scheduled once a month for next three months. During this

period client's behavior was observed cordial with family members and able to follow instruction being given by mother. Soon after, based on re-evaluation of the client's psycho-social functioning her follow-up was re-scheduled by the treating team as once in every three months for the next one year. The overall health condition of the client was positive and recovering well with the medication and other intervention.

Conclusion

Though the mental health issues can affect anyone, still there are plenty of factors that may forecast the recovery outcomes. It includes adequate health infrastructure, specialized care units, availability of trained health professionals, and treatment approach of the family. The developed nation had enough mental health professions to provide specialized services to their citizens, still low-middle-income countries are lacking in this field. The mental health recovery also depends upon the ratio of health professional and population of the countries. Therefore, the country like India needs to train more mental health professional to ensure the better treatment outcomes among the psychiatricpatients.

References

1. Swaroopachary RS, Kalasapati LK, Reddy CM. Caregiver Burden in Bipolar Affective Disorder. The International Journal of Indian Psychology 2019; 7: 1130-136.
2. Mathers, CD. History of global burden of disease assessment at the World Health Organization. Archives of Public Health 2020; 78: 11-13.
3. Brundtland, GH. Mental health in the 21st century. Bulletin of the world Health Organization 2000; 78: 411-411.
4. Kessler RC, Aguilar-Gaxiola S, Alonso J, Chatterji S, Lee S, et al. The global burden of mental disorders: an update from the WHO World Mental Health (WMH) surveys. Epidemiology and Psychiatric Sciences 2009; 18:123-33.
5. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, et al. Child and adolescent mental health worldwide: evidence for action. The Lancet 2011; 378: 98011515-1525.
6. Lopez AD, Murray CC. The global burden of disease, 1990–2020. Nature medicine 1998: 4: 111241-1243.
7. Soni A, Singh P, Kumar S, Shah R, Batra L, et al. Role of age at onset in the clinical presentation of bipolar disorder in Indian population. Industrial psychiatry journal 2021; 30: 141–46.
8. Narayanan D, Jith A, Bansal R. Nonadherence in bipolar disorder patients: A 14-year retrospective study. Indian Journal of Psychiatry 2020; 62: 3290.
9. Swihart DL, Yarrarapu SNS, Martin RL. Cultural religious competence in clinical practice; 2018.
10. Scherz FH. Intake: Concept and process. Social Casework 1952; 33(6), 233-240.
11. World Health Organization. The ICD-10 classification of mental and behavioural disorders. World Health Organization; 1993.
12. Arner L. Consanguineous marriages in the American population (No. 5633). New York: Columbia University Press, Longmans, Green, agents; London: PS King; 1908.
13. Agneessens F, Waege H, Lievens J. Diversity in social support by role relations: A typology. Social networks 2006; 28: 4427-441.
14. Newsom JT, Rook KS, Nishishiba M, Sorkin DH, Mahan TL. Understanding the relative importance of positive and negative social exchanges: Examining specific domains and appraisals. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences 2005; 60: 6P304-P312.
15. Duvall EM. Family development. J. P. Lippincott; 1957.
16. Zimet DM, Jacob T. Influences of marital conflict on child adjustment: Review of theory and research. Clinical Child and Family Psychology Review 2001; 4: 4319-335.
17. Peterson R, Green S. Families First-Keys to Successful Family Functioning. Family Roles; 2009.
18. Rimmerman A, Finn H, Schnee J, Klein I. Token reinforcement in the psychosocial rehabilitation of individuals with chronic mental illness: is it effective over time? International Journal of Rehabilitation Research 1991; 14: 2123-130.
19. Harandi TF, Taghinasab MM, Nayeri TD. The correlation of social support with mental health: A meta-analysis. Electronic physician 2017; 9: 95212–5222.
20. World Health Organization. International classification of diseases (ICD-11); 2016. http://www.who.int/classifications/icd/en/.
21. Vieta E, Colom F. Psychological interventions in bipolar disorder: From wishful thinking to an evidence-based approach. Acta Psychiatrica Scandinavica 2004; 110: 34-38.
22. Prost E, Hopman WM, Musisi S, Okello ES. The role of psycho-education in improving outcome at a general hospital psychiatry clinic in Uganda: original. African Journal of Psychiatry 2013; 16: 4264-270.
23. Hendrick I. Work and the pleasure principle. The Psychoanalytic Quarterly 1943; 12: 3311-329.

24. Furukawa TA, Imai H, Horikoshi M, Shimodera S, Hiroe T, et al. Behavioral activation: Is it the expectation or achievement, of mastery or pleasure that contributes to improvement in depression? Journal of affective disorders 2018: 238, 336-341.
25. Ballester J, Goldstein T, Goldstein B, Obreja M, Axelson D, et al. Is bipolar disorder specifically associated with aggression? Bipolar disorders 2012; 14: 3283–290.
26. Fristad MA, Gavazzi SM, Mackinaw-Koons B. Family psychoeducation: an adjunctive intervention for children with bipolar disorder. Biological Psychiatry 2003; 53: 111000-1008.
27. Coville AL, Miklowitz DJ, Taylor DO, Low KG. Correlates of high expressed emotion attitudes among parents of bipolar adolescents. Journal of clinical psychology 2008; 64: 4438-449.
28. Frank AO, Sawney P. Vocational rehabilitation. Journal of the Royal Society of Medicine 2003; 96: 11522–524.

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