CASE REPORT

Psychosocial intervention to prevent child custody loss of a mother with bipolar affective disorder

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ABSTRACT

Background: Bipolar Affective Disorder (BPAD) is a major mental disorder.Various psychosocial issues are often found to be associated with its course and outcome. So, to demonstrate the scope, feasibility and possible outcome of the psychosocial intervention (PSI) in the case of a woman with BPAD and associated psychosocial problems, formed the background of this case report. **Assessment and Management:** The case presented here is that of 22 years old, married, female, belonging to a Sikh joint family of middle socio-economic status from a rural background of Haryana who presented with a depressive episode and was struggling to reintegrate with her child and family with various associated psychosocial problems. Through an in-depth case study using face to face interview with the patient and her family members, a psychosocial formulation was made and a plan for psychosocial intervention was carried out. As the sessions progressed, further associated issues were discussed. Consent was taken from the patient and family members for future possible reporting of this case in any journal. **Outcome:** After the psychosocial intervention, knowledge and understanding about illness and PSI was enhanced in the client and family, they actively participated in the psychosocial intervention and made positive efforts to achieve set goals; the patient restarted studies, appeared for her graduation examination and passed; all family conflicts and legal cases were resolved; the patient was successfully accepted by the husband and his family and took her back into their house. On follow-up, she reported a happy married life. **Conclusion:** The case study illustrates the nature and extent of psychosocial problems in a woman of BPAD who was struggling to reintegrate with her child and family and enhanced the understanding on some psychosocial issues associated with BPAD in a young women. It also demonstrated that psychosocial intervention plays a key role in the treatment of BPAD, especially in women.

Keywords: Women, bipolar affective disorder, psychosocial intervention

BACKGROUND

Bipolar Affective Disorder (BPAD) is a major mental disorder. It affects more than 1% of the world's population irrespective of nationality, ethnic origin, or socioeconomic status.[1]The National Mental Health Survey of India 2015-2016 reveals that the prevalence of bipolar affective disorder (BPAD) in India is 0.3%.[2] It is an episodic illness in which episodes of depression/mania/mixed/hypomania occur. During the long-term course of illness patient experience, fluctuating levels of severity of manic and depressive symptom interspersed with symptom-free (euthymic) periods.[3] In a substantial number of persons with BPAD residual symptoms may be present even during remission period.[4,5,6] After hospitalization and treatment symptoms may be recovery but functional recovery is difficult to achieve in the substantial number of persons with BPAD.[7] Many persons with BPAD experience psychosocial and occupational difficulties,[8,9] financial problems,[10] marital failure,[11,12] substance abuse,[13,14] neuropsy-

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chological deficits,[15] sexual dysfunction,[16] suicide,[17] poor quality of life,[18] legal issues,[19] poor parenting skills,[20] disability[21] and some other psychosocial problems. Person with BPAD who get married frequently experience many negative consequences in their marital life due to the illness like poor marital adjustment.[22] The situation may even be more worrisome for a married woman having BPAD who is supposed to fulfil all the cultural and moral obligations in the Indian scenario. In a society where there is a lack of awareness among people about mental disorders, it becomes difficult for a female to adjust in the family and take care of her children.

The index case report is about a mother with BPAD who was struggling to reintegrate with her child and family. It was dealt with psychosocial intervention; a psychosocial formulation was made and a psychosocial intervention was accomplished with the patient and her family members.[23] So, to demonstrate the scope, feasibility and possible outcome of the psychosocial intervention in a case of a woman with BPAD and associated psychosocial problems, formed the background of this case report. The positive outcome of this case also gave us an opportunity to critically assess the feasibility of the psychosocial intervention in a facility named "Psychosocial Intervention Clinic" which has started functioning recently in the Department of Psychiatry, Government Medical College and Hospital, Chandigarh.[23]

ASSESSMENT

Case Introduction: The case presented here is that of a 22 years old, married, female, belonging to a Sikh joint family of middle socio-economic status from a rural background of Haryana.

Source of Information: The client herself, her mother, brother and case record file were the sources of information which were reliable and adequate.

Reason for referral: For psychosocial assessment and management, particularly family intervention.

Chief Complaints (as on 5th April 2018):

- sadness of mood
- loss of interest
- reduced interaction

(For 2 and half months)

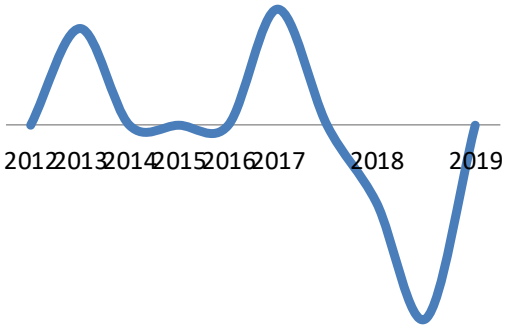
- suicidal attempt – once on 4th April 2018

It was a postpartum case with an insidious onset, episodic course and precipitated by strained inter-personal relationship (IPR) with in-laws

Brief Clinical History: The patient was apparently well before January 2018 with medication and was on regular follow-up with GMCH. Though, she was married and pregnant (nine months), she was living with her parents, and she was worried about the future of her child and her own life. On 11th January 2018, she delivered a baby boy (it was a full-term normal vaginal delivery with no prenatal or postnatal problem) but she was sad and worried for the same reasons which continued to persist all the time and became pervasive. Subsequently, she lost interest in all the actives and her interaction with others reduced significantly. She was not even able to take care of the child which was taken care of by her mother. On follow up on 1st February, 2018, suicidal thoughts were also found; her biological functions (sleep and appetite) were disturbed and socio-occupational functions had a remarkable impairment. By the end of February 2018, her husband took her to his house reluctantly; though they (in-laws) were not taking care of her during the pregnancy and did not participate in any ceremonies etc. There (at her in-laws place) she was not feeling comfortable as they would 'be very critical towards her, would keep taunting about her mental illness and even discussing to get her divorced. Since the husband was fully dependent on his parents and had minimal say on such issues; he did not give any support either for child-rearing or for dealing with inter personal issues that started between the patient and her in-laws immediately after marriage. Her ongoing problems (psychopathology) worsened. In-laws called a Panchayat on the issue of her mental illness and divorce was discussed where she could not defend herself alone (they were not informed before marriage about her mental illness). She was sent alone (on the last week of March 2018) without the baby citing that, as she is suffering from mental illness so she will not be able to take care of the baby. She was very much distressed and wanted her baby back. Despite her repetitive request, they did not give the baby to her. Later the husband filed a divorce case, though the patient didn't want that. These issues led to increased stress and in

turn further worsening of the psychopathology (depressive cognitions) occurred. After a week or so she attempted suicide (4thMarch, 2018) by lying down on railway track. On 6th April 2018, she was admitted to GMCH, Psychiatry ward with a diagnosis of bipolar affective disorder, current episode severe depression without psychotic features (F 31.4).[24] During the hospitalization, neither husband nor in-laws turned up. Her younger brother was very much caring and supportive towards her along with her parents. On 25th April 2018, she got discharged with improvement in psychopathology and she has been on regular follow-up in the OPD and PSI clinic (since 6th September, 2018).

Past History:



- June-Aug 2013: At the age 16 years, 1stmanic episode occurred following successfully treated typhoid fever without any past or family history of psychiatric illness or associated psychosocial stressors.[25] She was admitted at some mental health facility at Karnal, Haryana from 27th July to 23rd August, 2013.
- May 2017: 2nd manic episode occurred and it was the first contact with GMCH, Department of Psychiatry. (15th May, 2017) following which she was treated as an inpatient (28thMay to 12th July, 2017) and improved.

She was doing well, doing her graduation studies (B.A), when her marriage was arranged for 26thFebruary, 2017 (at a village in the Kaithal District of Haryana). On the 2nd day of her marriage there was a reception party. On that occasion, she acted out on the DJ, was cheerful, would show-off and boasts a lot. This could be explained on the basis of her psychopathology and she may have had either overvalued idea[26] or residual symptoms[4],[5],[6] or both.

The situation was embarrassing for the in-laws and they came to know about her past episode of mental illness about which they were not informed. After this inter-personal relationship (IPR) issues started with the in-laws and husband.

Though, she got pregnant but started living alone in a Paying Guest facility (March-May 2017). She was also pursuing her studies in a private college near Jalandhar and had minimal interaction with husband and in-laws

Family History: Nil contributory; there is no major medical or psychiatric history in the family.

Figure 2 Family of Origin

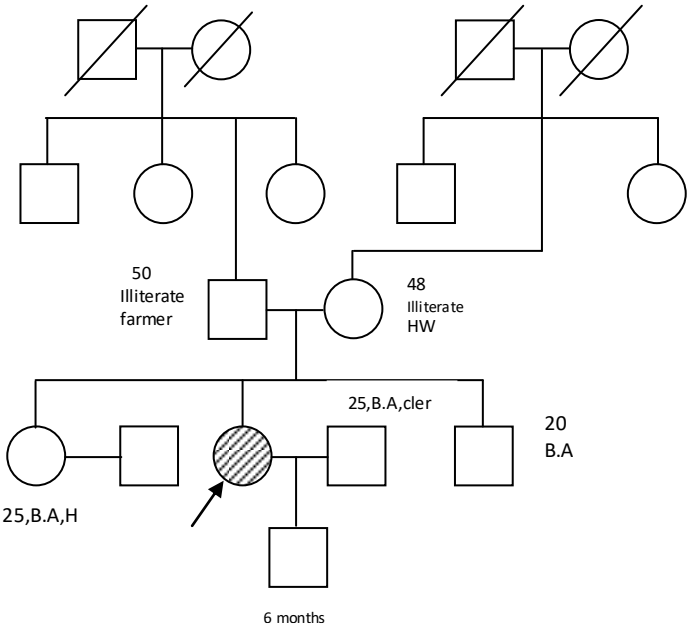
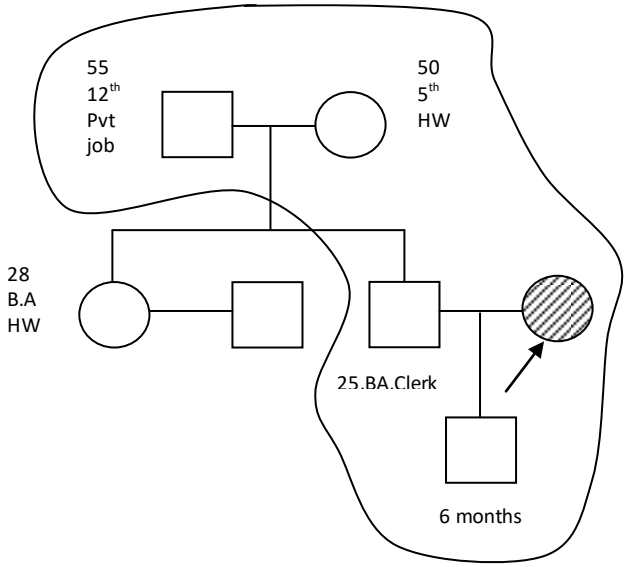


Figure 3 Family of Procreation



Personal History:

- **Birth and early developmental history:** Patient was born out of a non-consanguineous marriage and was full-term normal vaginal delivery with no prenatal or postnatal problem. Normal milestones. No neurotic traits reported.
- **Educational history:** Patient had started studying at age of 5, was an average in studies, passed 10thin 2013, passed 12th in 2015, did graduation (B.A. with Katha Bachak) which she continued (after intervention) through correspondence.
- **Occupational history:** Patient never had any salaried job. She was doing households works apart from her studies.
- **Sexual and marital history:** Patient had attained menarche at the age of 14 years, would have regular normal cycles with no complications. She gained sexual knowledge from peer groups. No history of premarital or extramarital affairs or sexual contact orabuse was reported. The patient was married and having a son of 6 months.
- **Alcohol and Drug History:** No History of any substance Abuse
- **Premorbid personality-** The patient was extrovert in nature. She was more interested in religious activity likes religious songs, poetry, *path* etc. The patient had a good peer relationship. Overall, the patient had a well balanced premorbid personality.

Psychosocial Formulation: Index patient 22 years old female, 12th pass, married, belonging to a Sikh joint family of middle socioeconomic status from a rural background of Haryana; presented with a depressive episode (April 2018) characterized by sadness of mood, loss of interest, reduced interaction and suicidal attempt with a past history of two manic episodes (June 2013, May 2017) and nil contributory family and personal history.

Social and family analysis revealed that the patient belongs (family of origin) to a religious family. It was found that knowledge and understanding about illness and associated psychosocial issues in the client and family were very less; they were having very blurred ideas about how to deal with the situation. Patient's socio-occupational functions were grossly impaired (discontinued study). High level of family burden was found.

The entire family was finding it difficult to cope up with the situation and brother's education, job and marriage planning was kept on hold; parents were preoccupied with the situation and complete time and energy of the family members were consumed in finding support from the community, Gurudwara, panchayat etc; there were repetitive meetings etc.

In the family of procreation, most of the domains were having pathology e.g. leadership, decision making, role, communication, adaptive pattern, cohesiveness, reinforcement practices. Lack of knowledge and stigma associated with mental illness in the family was found.

Following working diagnosis was made:

F31.4 - Bipolar affective disorder, current episode severe depression without psychotic features with
Z63.0 - Problems in relationship with spouse or partner,
Z63.1 - Problems in relationship with in-laws,
Z65.3 - Problems related to other legal circumstances (child custody or support proceedings).

Screening Tool for Assessment of Psychosocial Problems (STAPP)[28] score was 16on pre-intervention that means moderate, requiring urgent intervention in various areas as shown in table 1.

Table 1 Psychosocial Problems

Areas of Psychosocial Problems	Score	
	Pre	Post
Knowledge/Awareness	1	0
Medication/Treatment Compliance	1	0
Availability of financial resources	0	0
Social support	1	0
Expressed Emotion	0	0
Emotional/Physical/sexual abuse	3	2
Legal issues	3	0
Conflicts include property & marital discord	3	2
Employment	2	1
Accommodation	0	0
Stigma	1	0
ADL	1	1
Total score	16	6

INTERVENTION

Goals of the intervention:

- ✓ To stabilise and maintain the therapeutic alliance
- ✓ To engender and sustain hope in the client
- ✓ To enhance the knowledge and understanding about illness and associated psychosocial issues in the client and family
- ✓ To reduce the family burden and to bring back and maintain normalcy in the client's and family life
- ✓ To utilize the resources and support system available in the family
- ✓ To support the client and collaborate with the family to deal with the high expressed emotion and strained IPR with in-laws
- ✓ To encourage to restart the client's study (SOF improvement)
- ✓ To contact the client's in-law's and explore the conflict resolutions and also to address the family stigma
- ✓ To integrate the mother with the child or to integrate the family

The psychosocial intervention was initiated during inpatient service (during the last episode) along with medication and psychological services which were later extended on OPD basis (in the current episode). Initially, a weekly session lasting around 45 minutes, then fortnightly and subsequently monthly were held. The individual sessions were held with the patient, mother of the patient, brother of the patient and her husband. Sessions were conducted jointly with the mother, brother and husband of the patient too.

Interventions consisted of:

- ✓ Rapport Building
- ✓ Supportive casework techniques
- ✓ Psychoeducation
- ✓ Problem-solving techniques
- ✓ Family Intervention based on family focused approach[27]
- ✓ Legal aid/counselling
- ✓ Active monitoring

Process notes:

- *Building a worker-client relationship:* It was achieved through active listening to all the rational as well as irrational talk of the patient. Some of the concerns reported were genuine viz. growing child by a single parent, future concern etc.
- *Psychoeducation:* Once the client's trust was gained, psychoeducation was initiated. The symptoms of 'mania' and 'depression' with a specific illustration of the patient's behaviour. i.e. pervasive and persistent sadness, loss of interest, hopelessness, suicidality etc. were taught.

The role of biochemicals in the brain and its influence the patient's mood and the subsequent need for continuous medication and interventions were emphasized.

- *Supportive casework techniques*were utilized continuously to help patients deal with distressing emotions, to reinforce pre-existing strengths and promote adaptive coping with the illness and related psychosocial issues.
- *Problem-solving techniques*were focused on generating, applying and evaluating solutions to identified problems emerged with illness and IPR issues with the husband and in-lows.
- *Family Intervention:* Psychoeducation was the main intervention which was similar as explained above with specific emphases to client's case, her premorbid personality and nature of the illness (residual symptoms) which contributed on starting of the problem in IPR. Following this education, the importance of the whole family's involvement in the patient's care and intervention to ensue in future was also explained.
- *Intervention with the husband:* Lack of knowledge and stigma associated with MI was addressed and how to cope with its symptoms was a major component of psychoeducation. The family-focused approach was adapted to restore a healthy and supportive relationship and healthy home environment. Other members from the in-laws family could not be engaged in the intervention despite sincere efforts.
- *Legal aid counselling:* The patient was suggested (by every source) that she must take legal help against the in-laws and fight for the taking custody of her child. Since she has a significant level of impairments due to the current episode of illness and they have hidden the fact of MI which could be a negative point in legal action. So, she was persuaded consistently to

concentrate on treatment and restart study. Since the child is with his grandmother and father so he will survive and grow up but if she will take legal action during the illness phase it might go ageist her.

- The family was also persuaded to be patient and take step by pre-planned actions without much expense on lawyer etc. Writing a letter to them (in-laws), requesting repetitively to engage in the patient's treatment process, convincing her objectionable behaviours were due to her illness, taking help form community and Gurudwara committee for the justice and not to accept divorce purposed and be present formally and genuinely in the court hearing (all these were followed and worked well)
- Active monitoring was done throughout the intervention period.

OUTCOME

After the psychosocial intervention:

- Knowledge and understanding about illness and PSI was enhanced in the client and family
- The patient and the family actively participated in the psychosocial intervention and made positive affords to achieve set goals
- The patient restarted studies, appeared for her graduation examination and passed
- All family conflicts and legal cases were resolved
- The patient was successfully accepted by the husband and his family and took her back into their house
- On follow-up, she reported a happy married life. Though, need-based support was provided as and when the need arose.
- Reduction in the STAPP[28] score (6) confirmed significant improvements in various areas of PSI table 1.

DISCUSSION

Though psychosocial interventions played a pivotal role in the index case pharmacotherapy, psychological service, in-patient and other services too have an equally important role. The details of pharmacotherapy and psychotherapy are not discussed here. Like for example, cognitive behaviour therapy focused on recognizing and changing maladaptive thoughts and behaviours to reduce negative emotions and facilitate psychological adjustment was not done by any of the authors. It has been an established fact that psychosocial interventions along with pharmacotherapy have a better outcome than either one alone.[29]

"Psychosocial interventions for mental health and substance use disorders are interpersonal or informational activities, techniques, or strategies that target biological, behavioural, cognitive, emotional, interpersonal, social, or environmental factors intending to improve health functioning and well-being"[30] which is practised not only by a mental health professional but also at times by paraprofessionals, caregivers and laypersons but her it has been discussed under the framework of Psychiatric Social Work intervention[31, 32] involving a multidisciplinary team in a tertiary care mental health centre.

Section 13 of Hindu Marriage Act specifies grounds for divorce. In sub-section (1) (iii) of Section 13, mental illness is accepted as a ground for divorce under certain circumstances. The sub-section states that divorce is permissible if someone "has been incurable of unsound mind or has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with the respondent." Section 13(1) has an "Explanation", which states:"(a) the expression 'mental disorder' means mental illness, arrested or incomplete development of the mind, psychopathic disorder or any other disorder or disability of the mind and includes schizophrenia; (b) the expression 'psychopathic disorder' means a persistent disorder or disability of mind (whether or not including sub-normality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the other party, and whether or not it requires or is susceptible to medical treatment."[33] Further under sub-section 1(b) of Section 12 of HMA, "a marriage is "voidable" and "maybe annulled by a decree of nullity…if…the marriage is in contravention of the condition specified in clause (ii) of Section 5." Thus, mental illness may form the ground for annulment of a marriage. Sub-section 1(c) of Section 12 allows for the annulment of a marriage if "the consent of the petitioner . . . was obtained by force, or by fraud as to the nature of the

ceremony or as to any material fact or circumstance concerning the respondent. "Under this provision, petitioners may claim that the concealment of mental illness prior to marriage is a "material fact" and hence, seek annulment of the marriage on the ground of fraud."[33] In the index case the fact of having an episode of mental illness was concealed and there were occasions when the patient had shown such behaviours which can be considered 'seriously irresponsible conduct' as per the Hindu Marriage Act and the Special Marriage Act, 1954 which can be a ground for divorce.[34] So the strategy to deal with the patient's problematic situation through psychosocial intervention proved to be fruitful and brought the best possible outcome in the given circumstances.

In the index case life events (marriage and child custody loss) along with various psychosocial factors e.g. strained IPR, lack of social support had a major role in the illness. The evidence suggest that outcomes can be poor with only medication, psychosocial variables appear to be important antecedents of episodes for example life events[35] expressed emotion[36] play a powerful role in relapse and the life events effect is not protected by medication.[37] Besides, the psychosocial consequences of this disorder, such as disability, are severe.[38]It has been estimated that psychosocial factors may contribute 25-30% to the outcome variance in bipolar disorder. So, psychosocial factors, as well as the quality of life (QOL) and cost of care can be improved by integrating psychosocial treatments with the widely used drug regimens.[39] Such interventions have been employed by a psychiatric social worker which has a better outcome.[32] Here too we were able to achieve a fair degree of success.

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