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Research Paper

The Ripple Effects on the Immediate Surroundings of Patients with Untreatable Mental Health Disorders

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ABSTRACT

The paper aims onto understanding the ripple effects on the immediate surroundings of patients with untreatable mental health disorders. This paper focuses on the lingering effects in society because of untreatable mental health disorders on the patient as well as on their immediate surroundings narrowing it down to patients with schizophrenia and bipolar disorders. There has been a lot of awareness regarding mental health issues, but there are still undiagnosed and untreatable mental health disorders that affect the patient and their surroundings. My research focuses on the ripple effect they have on society as a whole. Starting from the first circle of the ripple. The patient, his family, their social beings, relatives and friends, and then the extended society. The abnormal psychology that deals with psychological disorders in humans can be divided into three parts: the disorders that are diagnosable and treatable for example General Anxiety Disorder and Depression, and the disorders that are diagnosable but untreatable for example Schizophrenia and Bipolar Disorder and the disorders of that are neither diagnosable nor treatable hence remain unknown to us at this point of time. The present research is nearly negligible in the last category but abundant in the first two. In today's time, there have been several suggested cures for untreatable disorders but none seem sufficient or completely successful for now. Although there is a lot of research on other aspects of these disorders the emotional aspect or the notion of expressed emotions seems to be fairly low. There is not much talk about the sufferings of those who take care of these patients and more importantly their suppressed emotions due to the expectation of always being sympathetic towards the ones with disorders. Exists a treatment for schizophrenia and bipolar disorder yet? Most likely not. But even if there is no known cure for many diseases, people can nevertheless live normal lives without being constrained by their symptoms. To begin with, first I would like to explain what schizophrenia and bipolar disorders are and then move forward to their effect on the patient and his/her family and social beings, and then move forward to the main objective of understanding the effect on society. The methodology that was adopted for the research was the interview method with open-ended questions with the family and social circle of patients with schizophrenia and bipolar disorder. The questions were focused on an emotional approach that was specifically formed keeping in mind the empathetic angle of the interviewees.

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DSM-5 specifies more than 70 types of mental disorders of which 7 are classified as major psychological disorders or mental disorders named:

1. Anxiety Disorders.
2. Mood Disorders.
3. Psychotic Disorders.
4. Eating Disorders.
5. Personality Disorders.
6. Dementia.
7. Autism.

Out of these disorders, surely many are there in the world but remain unknown to the humankind at this moment. When a person is cured of a disease, it signifies that it is permanently gone. Some diseases, such as Alzheimer's, cannot be treated. Once a person develops Alzheimer's, they will always have it. However, even chronic conditions like Alzheimer's can be managed. People can live long and healthy lives if they routinely take their prescriptions and alter their lifestyles. They can be treated with these drugs and way of life modifications. The same applies to mental diseases. Although there is no known cure for some mental illnesses, many efficient treatments exist. Mentally ill individuals can recover and lead long, healthy lives.

The difference between some treatable disorders and untreatable ones lies in the advancement of the sciences. Some decades ago, we didn't have a cure for disorders like anxiety but now patients with anxiety trust the field of psychology to treat them. So we might have some cures later but in the 21st century, a lot of mental disorders remain incurable. This research paper aims on talking about two such disorders common yet uncommon in masses: schizophrenia and bipolar disorder.

Schizophrenia is identified as a type of psychotic disorder according to DSM-5 and bipolar as a mood disorder. Both disorders can occur at any age but can be typically diagnosed in the early teens or twenties.

Schizophrenia

Schizophrenia is a disorder that involves distortions in thinking, perception, emotions, language, sense of self, and behavior which are traits of psychosis, including schizophrenia. A psychotic episode can cause hallucinations and delusions in the individual experiencing it. Symptoms may include the patient perceiving voices or hearing other individuals talking about him or her even when that is not the reality. Additionally, the individual might experience sadness, irritability, or a sense of constant surveillance. The individual may have trouble falling asleep, talk to himself or herself, and act violently.

Bipolar

Bipolar Disorder can be understood as a mood disease having two extremes – a depressed phase ("low") and a manic phase ("high") – which is known as bipolar disorder, formerly known as manic depressive illness. The severity varies, and mild cases may seem typical for years. There are many different symptoms; a person may be either manic or predominantly depressive. A person is most likely healthy and able to operate between bouts.

Symptoms of the depressive phase include feeling gloomy and hopeless all the time, being lethargic, and even having suicidal thoughts. When manic, a person exhibits excessive elation, is more irritable, needs less sleep, develops lofty plans, and may act rashly in ways that could be dangerous.

Since schizophrenia was identified by Dr. Emile Kraepelin in 1887 as a mental illness but with a different name “dementia praecox”, many pieces of research have proved that there is no complete cure for the disorder. Although many pieces of research in the 21st century have proved that it cannot be cured but can be controlled with medications and proper treatments. An article written by Peter J. Weiden, MD, Director, of the Psychosis Program, at the University of Illinois at Chicago Medical Center, Chicago, Illinois, is a Professor of Psychiatry, at the Center for Cognitive Medicine, and Department of Medicine. "Is Recovery Achievable in Schizophrenia?" made headlines in many newspapers. The reason for it was that there has never been much talk on the cure and complete treatment of schizophrenia until his article,

When it comes to schizophrenia, in his article, Dr. Weiden focuses on the word recovery rather than cure. Psychotic illnesses, particularly schizophrenia, have always been thought to be chronic, incurable diseases with little chance of cure. Although that point of view has since shifted, there is still disagreement on the exact definition of recovery. Schizophrenia is a psychotic disease that might not appear to be as common as other mental health disorders but is very much concerning for the patient and the family. It can hamper the complete social lives of the people suffering from it. The patients might suffer from hallucinations and have problems making out the difference between the real world and their world. People tend to lose touch with reality in extreme cases. Schizophrenia varies in severity from individual to person. Sometimes the patients are reported to have experienced a single psychotic episode in their lives, while some patients have been observed to have multiple episodes over the course of their lifetimes with having and leading very regular lives in between those episodes. Others might gradually experience worse functioning with little improvement in between fully developed psychotic episodes. In cycles referred to as relapses and remissions, schizophrenia symptoms appear to deteriorate and recover.

Patients with schizophrenia are paranoid, they always have a feeling that someone or something will harm them and nothing is trustable or real except the voices in their heads or the hallucinations. Research has shown the most common symptom of schizophrenia is keeping windows and doors closed to protect themselves and their loved ones from anything. For the majority of us, the term "schizophrenia" conjures thoughts of a person with an untidy appearance, messy hair, and ripped clothing; a person who lacks self-control and exhibits unpredictable and violent conduct; or a person who talks with UFOs or behaves possessed. People with schizophrenia have been portrayed in movies as eccentric geniuses or violent, violent people who should spend the rest of their life locked up in a mental institution.

In India, a person with schizophrenia is typically portrayed as an out-of-control psychopath who is dangerous to both himself and everyone around him. According to doctors, the way this condition is portrayed in the media is inaccurate. Many studies like those published by the National Alliance on mental illness with real stories of people who are or did suffer from schizophrenia express how was their journey and what helped them which eliminates the kind of image media has portrayed in front of us. The actual cause of it remains unknown

but what is hinted through years of research by various psychiatrists, psychologists, and doctors like Dr. Kripal Singh who gave out his research in 1958 that some abnormal damage in neurotransmitters during pregnancy or genes the development of the brain can be held responsible until the exact reasons are found.

Talking about Bipolar disorder, history dates back to the 3rd and 4th centuries. The first people to ever talk about bipolar disorder were Hippocrates, often called "the father of medicines" and Aretaeus of Cappadocia, a Greek physician in the 1st century. Their explanations were somewhat similar hinting at two extreme ends. A lot of psychiatrists and physicians came in between and explained bipolar disorder with various names. In the 1950s DSM-1 classified bipolar disorder but in a different way from how we know it today. In the latest revised DSM-5 edition, bipolar disorder is classified into seven types:

1. Bipolar I disorder
2. Bipolar II disorder
3. Cyclothymic disorder
4. Substance/medication-induced bipolar and related disorder
5. Bipolar and related disorder due to another medical condition
6. Other specified bipolar and related disorders
7. Unspecified bipolar and related disorder

The causes of bipolar disorder are unknown and remain still unclear what causes bipolar disorder specifically. Bipolar disorder often begins in adolescence or throughout the teenage years. Most persons with bipolar disorder suffer for a very long time before seeking help because they are ignorant about the disorder.

Hormonal imbalance, genetics, severe trauma brought on by tragic events, drug or alcohol misuse, and others may be risk factors. Other conditions like acute depression with psychosis or schizophrenia can co-occur with bipolar disorder.

According to Narayana Health, a low-cost Indian healthcare service provider "Between 0.5 and 21 per 1000 Indians experience bipolar disorder each year, and symptoms commonly appear between 20 and 30 years old. Over the course of a lifetime, men have more manic episodes and more depressed ones in women." Which shows how common it is in India.

According to the most recent National Mental Health Survey (2015-2016) done by NIMHANS, 0.5% of Indians currently have schizophrenia, and 1.4% have lived with it their entire lives. Recent studies also show that 3 in 1000 individuals suffer from schizophrenia in India but it goes untreated due to a lack of awareness and the stigmas surrounding mental disorders. The family members of the patients often end up believing ghostly stories about the victims and instead of giving them proper treatment, the victims are made to go through harsh religious practices due to the false beliefs of their families.

The effect on the patient's immediate surroundings is severe as they have just two choices either to invalidate the patient completely or make him/her suffer or listen to the patient and let their thinking and belief affect them slowly and steadily. Most Indian families do the first, but some who are educated enough to take mental health seriously and get help for patients suffer passively.

This study reviews the effects on the patient's immediate well beings and how their disorder and the life the patients lead affects the personal life of their family and friends as well. Many types of research have shown that people with these kinds of disorders are very unpredictable and their behavior cannot be judged or pre-understood, their reactions to certain things and situations can be very different in different scenarios and the immediate people have to be ready for everything which affects their mental health as well since there is too much pressure on them to tackle certain situations. This study reviews the mental and emotional pressure that the family of the patient deals with.

LITERATURE REVIEW

Studies have shown that the immediate family members of individuals with untreatable mental health disorders often experience a range of negative consequences, including increased stress and anxiety, depression, and financial burden. Family members may also struggle to understand the patient's condition and find it challenging to provide support.
In addition, friends and community members may also be impacted by the presence of an untreatable mental health disorder. For example, the stigma associated with mental illness can lead to social isolation and discrimination, which can further exacerbate the patient's condition and those of their immediate surroundings.

METHODOLOGY

Method

The study elucidates contributing information to the body of knowledge already known. A research project's methodology is indeed the entire set of steps taken by the researcher to ensure that the research is as scientific and valid as feasible. It is thought to be the basis of the research. Any research's success is based on the approach taken, the technique for gathering data, and the analysis. The methodology chosen and the measures/techniques employed for data gathering and analysis must serve as the foundation for all research. This chapter goes into detail about the numerous processes that the researcher took to carry out the study, such as the participant selection, the method employed, the data gathering techniques, the statistical analysis applied, etc.

This research will be a qualitative study, utilizing in-depth interviews with a purposive sample of individuals who have a family member or close friend with an untreatable mental health disorder. The interview questions will be designed to elicit information about the participants' experiences, including the ways in which the individual's disorder has affected their own mental health, relationships, and daily life.

Data analysis will be conducted using a thematic analysis approach, in which the researcher will identify and examine common themes that emerge from the interview data.

Participant Demographic Details

Total Number of Participants: 5
Gender:
Age:

Relationship with the patient:

Method

Qualitative Approach

For this work, a qualitative approach was adopted as the research strategy. To explain and clarify various findings, the research process entails practical effort in the acquisition of facts that can support, contradict, or challenge theories. Inductive research gathers information on a particular topic of study using a method known as induction, and the investigator subsequently develops various conceptions and theories from this information. In comparison to a quantitative approach, which is more structured, larger in scope, and more numerically based, a qualitative approach was assumed to be more pertinent to this research since this allowed for a greater capacity to gain more depth and meaning based on an individual's experience, along with their beliefs and feelings.

Interview

For this study, semi-structured interviews were used. as these gave the liberty to participants more versatility, scope, and hence the opportunity to learn more knowledge by allowing the participants to elaborate. Views the interview as the most appropriate approach to study complex and sensitive areas as the interviewer has the opportunity to prepare a participant before asking a question. Semi-structured interviews allow participants to respond to questions more on their terms than formalized interviews permit, but still provide a good comparability structure over that of the focused interview. Because every interview is distinct and the caliber of the responses from various interviews can vary greatly, so can the interaction between the interviewer and the participant. Additionally, the expertise, abilities, and dedication of the interviewer have an impact on the quality of the data produced. Additionally, there is a chance of researcher bias. Additionally, obtaining trustworthy data on the research topic can be challenging if few individuals are participating, as opposed to the quantitative technique, which typically involves more participants and can, therefore, yield more conclusive and trustworthy results.

Procedure

The period of data collection was September and October. Interviews were recorded on the phone recorder, and they were all accurately transcribed. None of the subjects were known by the researcher beforehand; instead, a reputable clinical psychologist in Delhi who is a third party known to the researcher recruited every participant. The counselor first provided all participants with information about the interview and presented information about the research before obtaining their consent. Some participants opted to have interviews performed in their homes because it made them feel more secure and encouraged them to talk more easily and candidly about the research topic. Additionally, several of them opted to conduct the interview in the clinic where they accompanied the patient for sessions.

A series of questions in the general format of an interview schedule were asked during a semi-structured interview, but the order of the questions varied from participant to participant. To assist the researcher with the structure and flow of the interview, a schedule for the interviews was created in preparation. Regarding their overall experience, their relationship with the patient, and the patient's journey as well, each participant had a somewhat different set of questions. Except for a few closed questions about information, such as why the problems they experience are so intimately tied to the patient, the questions were mostly open-ended. The open-ended question " How much does their disorder affects or have affected your life?" from the interview schedule is an illustration.

The open-ended questions gave the participant more freedom to express their opinions and feelings (especially when delicate subjects were being covered) and to go into greater depth about the research topic. The researcher tried to speak in a way that each of the participants in the interview could understand and find relevant. As a result, thank yous were given to the interview subjects afterward.

Data Analysis

Following transcription, the data was encoded, analyzed, interpreted, and confirmed. The process of transcription enabled the researcher to learn more about the subject by repeatedly reading and listening to the transcribed interviews. Data coding began after all of the data had been completely transcribed. The applied codes—keywords used to classify or organize text—were regarded as a crucial component of qualitative research. The data were then sorted into themes and sub-themes that emerged during the coding cycle after being processed, categorized, and arranged. The topics that arose were given a distinct code in accordance. The data analysis involved noting any similarities and differences in the data and any repeating patterns. The last step in the process was data verification, which entails rechecking transcripts and codes to ensure that understanding was genuine. This step allowed the researcher to confirm or change any initial hypotheses that they had already reached.

RESULT AND DISCUSSION

The findings from the interview procedure and the following analysis of the data are presented in this chapter, which will rely on the major themes. How a family viewed schizophrenia-related symptoms frequently formed the basis of the family's response. Families noted that negative symptomatology, such as loss of energy, lack of purposeful activity, and generalized unresponsiveness, were the most unpleasant symptoms displayed by the relative with schizophrenia and bipolar.

Additionally, because the attention is frequently on the relative who has schizophrenia and its aftereffects, parents, spouses, and siblings sometimes find themselves unable to address their own personal or family developmental needs. Parents and siblings frequently avoid inviting guests to the home because they are ashamed of the sick person's symptoms and behavior.

Families with youngsters who have been diagnosed with schizophrenia may never adequately bring out a young adult in society. The person with schizophrenia and bipolar are frequently seen negatively in a culture that honors grit, independence, and self-initiative. Negative symptoms like apathy or the urge to depend on family or society are frequently interpreted as laziness or an inability to study or work effectively.

The results of the study showed that the immediate surroundings of patients with bipolar and schizophrenia disorders experience significant ripple effects. Family members reported high levels of stress, anxiety, and depression, as well as financial strain, due to the demands of caring for their loved one with a mental health disorder. Participants also reported feelings of helplessness and frustration, as they struggled to understand the unpredictable and often debilitating symptoms of their loved one's condition.

The findings also indicated that friends and community members of individuals with bipolar and schizophrenia disorders faced their own set of challenges. Participants reported

experiences of stigma and discrimination, which led to social isolation and a sense of shame and embarrassment. This stigma and isolation, in turn, further compounded the difficulties faced by the individual with the mental health disorder and their immediate surroundings.

One of the key themes that emerged from the data was the lack of resources and support available for families and communities affected by bipolar and schizophrenia disorders. Participants reported feeling overwhelmed and unsupported, and many expressed the need for more accessible and comprehensive support services. This highlights the importance of addressing the needs of those affected by mental health disorders and the critical role that support services can play in improving the well-being of both the individual with the disorder and their immediate surroundings.

DISCUSSION

The findings of this study add to the growing body of literature on the impacts of bipolar and schizophrenia disorders on the immediate surroundings of the affected individuals. The results highlight the need for more support and resources for families and communities affected by these disorders, as they struggle to cope with the often devastating effects of mental illness on their loved ones and themselves.

The results also demonstrate the ongoing challenges faced by individuals with bipolar and schizophrenia disorders in the face of stigma and discrimination. This underscores the need for greater public education and awareness around mental health disorders, in order to dispel myths and reduce stigma and discrimination.

In conclusion, this study sheds light on the significant ripple effects of bipolar and schizophrenia disorders on the immediate surroundings of the affected individuals. The findings emphasize the need for more resources and support for families and communities, as well as the importance of addressing the stigma and discrimination associated with mental illness. These findings have implications for the development of support services and interventions for those affected by bipolar and schizophrenia disorders and can inform the efforts of healthcare providers, policymakers, and advocacy organizations working to improve the lives of individuals and their families impacted by these disorders.

When interviewing the family members, some similar and certain dissimilar findings were discovered. The similar things faced by the family members of the patients are explained below:

Constant Worry

The patients' family members had constant worry like a continuous ticking clock in their heads regarding the patient throughout the day. As they could not trust anybody other than family or any environment around them so they have to be constantly around them which sometimes feel like a never-ending job with mental fatigue for them.

"mai kahin jaa nahi sakti bina yeh soche ki mere bete kaa kya routine hai aajka" said Partticipant X's mother during her interview.

She also discussed that her entire routine depends on her son's which is different each day. Even if she has to go out to buy groceries, she has to first think about what is her son doing, how long she will be gone, and who will be there for him till the time she comes. So constant thoughts and worries regarding daily activities and general chores affect her mind.

"I always have to be around her if I am not, I feel something terrible will happen," said Participant Y's husband when discussing his wife's condition during hallucinating phases. He said that the mental pressure is so much that I end up feeling guilty if in certain situations I have to leave her alone even if it is for half an hour.

The participants discussed that they always had the thought of worry at the back of their minds regarding the patient if for some reason they are not around them.

Lack of Social Life

Because of the unpredictable behavior of the patient, the social life of the immediate family members completely diminishes in the course of the patient's illness years. They said they stopped going out and hanging with friends and family initially as they thought the patient needed them more and gradually the days of not being socially active turned into weeks, months and years. It was discovered that only on rare occasions do they leave home for elongated.

The social life of the immediate caregivers as the mother in the case of participant X and the husband in the case of participant Y has slowly diminished and has been restricted to hospitals and their workplaces only. This also caused a sense of frustration in their minds as giving away their life because of someone else's illness doesn't seem fair at a point to them.

Expressed Emotions

Brown gave this concept in 1950. Expressed emotions refer to those feelings and emotions that the family members of the patients express or can express in situations that lead to relapse in Schizophrenic patients. There are 5 components of expressed emotions namely;

1. Critical Comments: saying something rude or harmful to the patients
2. Warmth: how the patients are made to feel in a conversation. If the family members are empathetic towards them or not. Reflecting on listening plays an important role here.
3. Overprotection: being overprotective of the patient and the disease and not letting them adapt to their schedule according to them.
4. Hostility: caregivers' attitude towards the patient.
5. Positive Regards: verbal and non-verbal reinforcements for small tasks that they are doing.

In most of the patient's cases, it was seen the expressed emotions played a very crucial role in their adapting to their life as participant X lived for a year in a rehabilitation center and after coming back his mother tried her best and with high expressed emotions and her warmth, hostility and positive regards the patient was okay in adapting to his life at home.

High-expressed emotion (HEE) families are characterized as hostile, critical, and overly emotional, whereas low-expressed-emotion (LEE) families are characterized as positive, empathetic, calm, and respectful with low levels of emotion. Families with HEE frequently think that the patient can somehow control the symptoms.

Warmth, which was once thought to be a characteristic of LEE, has been found to be an unreliable variable of EE because high levels of warmth (which are positive) are accompanied by emotional over-involvement, while low levels of warmth are accompanied

by an increase in critical comments. Emotional over-involvement and criticism are both variables in HEE (which is negative).

The levels of expressed emotions varied from time to time and according to the situations and scenarios of the caregiver.

CONCLUSION

The aim of this study was to understand the ripple effects on the immediate surroundings of patients with untreatable mental health disorders. The previous chapters looked at the concerns and issues that the caregivers of Schizophrenic and Bipolar patients face in general and how it impacts their physical and mental health. In summary, Schizophrenia and Bipolar are very serious mental illnesses that combine the worst aspects of both acute and chronic conditions. Even when taking the recommended medication regularly, people with this illness have terrifying and puzzling symptoms that may or may not be helped by antipsychotic medication.

The patients' families bear a heavy burden and receive scant information about the disease and how to deal with their mentally ill relatives. The care load, fear, and humiliation over sickness signs and symptoms, uncertainty about the prognosis, lack of social support, and stigma are among the reactions of the family to having a family member with schizophrenia or bipolar.

The bizarre new ideas or behaviors of their family members, as well as their diminished energy, lack of drive, or discontinuance of routine activities, terrify and perplex family members. Relationships within the family and between siblings are put under a lot of stress because of schizophrenia symptoms.

In my opinion and according to my research findings I feel the families require advice and direction since they frequently do not know how to react to these changes in a family member who has schizophrenia.

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Conflict of Interest
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