Cultural and Clinical Implications of Family-Based Therapy for Adolescents with Bipolar Disorder in Oyo State

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ABSTRACT: Bipolar disorder (BD) is a severe psychiatric condition characterised by extreme mood swings, including episodes of mania and depression, significantly impairing emotional, social, and economic functioning. It is particularly impactful among adolescents and young adults, with early onset contributing to chronicity and severe comorbidities. Family-based therapy (FBT) has emerged as an effective intervention in managing BD, addressing both the patient's symptoms and the family dynamics that can aggravate the condition. FBT, particularly when combined with pharmacotherapy, has been shown to reduce relapse rates, improve medication adherence, and enhance psychosocial functioning. Moreover, it can serve as a preventive strategy for at-risk youth, potentially delaying the onset of BD. This approach fosters healthier communication within families, reduces caregiver burden, and supports long-term recovery. The integration of FBT into standard BD treatment protocols, especially in regions with cultural and systemic barriers to mental health services, is crucial for improving patient outcomes and addressing the broader impacts of BD.

KEYWORDS: Bipolar disorder, mania, mood swing, family-based therapy, cultural barriers

1. INTRODUCTION

Bipolar disorder is a mental health condition characterised by rampant changes in mood. Individuals with bipolar disorder exhibit emotional highs and lows swinging for instance between excitement and hopelessness. In the opinion of Ayano (2016), Bipolar disorder (BD), also known as manic-depressive illness, is a severe psychiatric condition characterised by alternating periods of depression and mood elevation, which can manifest as mania or hypomania. For that reason, diagnosis requires at least one manic or hypomanic episode to distinguish it from unipolar depression. Ayano (2016) further divides bipolar disorder into Bipolar I, involving at least one manic episode, with or without major depressive episodes, and Bipolar II, defined by at least one hypomanic and one major depressive episode. Moreover, mania typically causes significant social or occupational dysfunction, whereas hypomania does not. The condition is highly disabling, with a global lifetime prevalence of 2.6% to 7.8%, often leading to devastating social, economic, and familial impacts. Bipolar disorder has a complex aetiology involving genetic, biochemical, psychological, and environmental factors, and early onset (typically between ages 17 and 21) contributes to its chronic nature. Effective management requires a multidisciplinary approach integrating medical, psychological, and psychosocial interventions (Duffy & Grof, 2024).

According to Zhong et al. (2024), bipolar disorder significantly impairs the physical, psychological, and social functioning of adolescents and young adults, making it a pressing public health concern. According to the Global Burden of Diseases (GBD), as cited in Zhong et al. (2024), bipolar disorder affects 2.4% of the global population, with a high burden among individuals aged 10–24 years. From 1990 to 2019, the incidence of bipolar disorder in this age group rose from 79.21 to 84.97 per 100,000, with the most pronounced increase in those aged 20–24 years and in regions like Southern Latin America and Greenland. Despite being a leading cause of disability and associated with high risks of substance abuse, hospitalisations, and suicide, only about 56.1% of affected youth receive mental health services. The disorder's early onset often leads to severe comorbidities, poorer quality of life, and heightened functional impairment, emphasising the need for tailored mental health strategies and policies that address the unique needs of this vulnerable population.

Varghese et al. (2020) stated that family-based therapy integrates the cultural significance of family as a core support system in addressing mental health issues. Although informal family involvement has long been a part of therapeutic practices, formalised family therapy emerged decades later. This modality stresses that mental illness affects not just the individual but the entire family, often leading to "courtesy stigma," where family members also face societal stigma. Moreover, family therapy aims to educate families about mental illnesses, develop coping strategies, and address dysfunctional patterns to foster healthier dynamics. Techniques range from psycho-education and counselling to systemic approaches that identify interaction patterns and avoid assigning blame. Challenges for therapists include managing family dynamics, avoiding bias, and engaging all members in therapy. The ultimate goal is to enhance communication, resolve conflicts, and strengthen familial resilience, making it a vital part of psychiatric care.

Stratton (2016) explained that family therapy is a therapeutic approach that emphasises the interconnectedness of individuals within their family systems. Unlike traditional therapies that focus on individuals, family therapy addresses psychological difficulties by mobilising the strengths and resources of family relationships. This holistic approach has proven effective across a wide range of conditions, including mental health disorders, substance abuse, and chronic illnesses. Research as stated by Stratton (2016) consistently highlights the efficacy of family therapy in treating over 72 conditions, showing clinical effectiveness and cost efficiency. Its unique strength lies in its ability to foster long-term improvements by involving families as active participants in the healing process. This collaborative framework is particularly impactful in contexts where individual treatments have failed, offering an alternative that reduces relapse rates and enhances overall well-being. Furthermore, family therapy holds the potential for addressing broader societal mental health challenges, particularly in underfunded areas like child mental health, where early intervention can significantly alter life trajectories. It is against the background above that this study sought to explore the cultural and clinical implications of family-based therapy for adolescents with bipolar disorder in Oyo State.

2. LITERATURE REVIEW

2.1 Bipolar Disorder among Adolescents

Diler & Birmaher (2019) stated that bipolar disorder (BD) in adolescents is now widely recognised as a serious psychiatric condition marked by episodic mood disturbances ranging from manic or hypomanic episodes to major depressive episodes. Its subtypes include BD-I (mania with or without depression), BD-II (hypomania with major depression), cyclothymic disorder, and BD-OS (subthreshold mood episodes). BD in youth often presents with rapid mood shifts, and mixed symptoms and can be easily mistaken for other psychiatric disorders, complicating diagnosis and treatment. It significantly impairs psychosocial functioning, leading to academic, behavioural, and interpersonal difficulties, as well as increased risks for substance abuse, psychosis, and suicide. Epidemiological studies indicate a global prevalence of 1.8% in youth, with higher adolescent rates. Despite concerns about over diagnosis, BD remains underdiagnosed in many young patients, delaying treatment for years. Early and accurate diagnosis is crucial to mitigating its profound impact on long-term development and reducing associated healthcare costs and morbidity.

According to Jain (2020) bipolar disorder in adolescents presents unique challenges in diagnosis and management due to fluctuating mood episodes that range from severe mania or hypomania to debilitating depression. Adolescents may initially be misdiagnosed with major depressive disorder (MDD) because bipolar depression lacks distinctive features and may appear similar to unipolar depression. Furthermore, symptoms such as extreme mood swings, lack of sleep, impulsivity, and suicidal ideation make accurate diagnosis difficult, often leading to delayed treatment. More so, adolescents with Bipolar I experience full manic episodes that severely impair functioning and may require hospitalisation, while those with Bipolar II exhibit milder hypomania alongside depressive episodes. Goes (2023), noted that co-occurring conditions like anxiety or Attention-deficit/hyperactivity disorder (ADHD) further

complicate early diagnosis. Rapid cycling, characterised by four or more mood episodes per year, is particularly concerning in teens, requiring immediate intervention. Effective treatment involves a combination of mood stabilisers, antipsychotics, and psychosocial therapies, but balancing efficacy with side effects, such as weight gain or emotional blunting, is especially difficult in this age group. The lack of comprehensive understanding of bipolar disorder's pathophysiology, particularly its genetic and neurochemical underpinnings, adds to the complexity of tailoring long-term, preventative care for adolescents (Abrams, 2020).

An empirical review of literature on Bipolar Disorders (BDs) stresses their chronic nature, significant impact on disability-adjusted life years (DALY), and historical under-research, particularly in regions like Sub-Saharan Africa and Nigeria. Jindong et al. (2023) conducted a mixed-method design that quantitatively analysed public knowledge of BDs among 575 participants using one-way ANOVA, revealing low awareness across demographics, especially among youth and older adults. However, knowledge was higher among participants aged 25–44 and part-time workers. Furthermore, the authors qualitatively explored the lived experiences of 15 participants, including patients, clinicians, and caregivers, revealing perceptions of genetic and psychosocial causes and highlighting cultural and religious barriers to treatment uptake despite the availability of psychotropic medications and psychotherapy. The findings emphasise the need for culturally adapted psychosocial interventions in Nigeria to improve BD awareness and treatment acceptance.

A study by Dade Matthews et al. (2024) explores the prevalence and correlates of depressive disorders among adolescents in secondary schools in Abeokuta, Nigeria, emphasising the substantial mental health burden in this population. Conducted in two phases, the study involved systematic random sampling and comprehensive interviews using validated tools like MINI-KID, Rosenberg's Self-Esteem Scale, and Family-APGAR. Results showed a 12-month prevalence of major depression at 11.3% and dysthymia at 1.4%, with notable risk factors including female gender, bullying, difficulty in peer relationships, sexual abuse, and family dysfunction. Multivariate regression highlighted the strong association of these factors with depressive disorders, with bullying [OR = 7.96, p = 0.004] and sexual abuse [OR = 8.1, p = 0.01] showing particularly high odds. These findings emphasise the critical need for targeted interventions addressing these risk factors to mitigate adolescent depression and its associated risks, such as suicide, in Nigeria.

2.2 Understanding Family Therapy

According to Kahn et al. (2004) families and friends play a crucial role in supporting individuals with bipolar disorder (BD) by fostering a stable and understanding environment. Education is essential; loved ones should become well-informed about BD's causes, symptoms, and treatments, enabling them to recognise early warning signs of manic or depressive episodes. Additionally, open communication about treatment plans and relapse prevention strategies helps maintain consistency in care. Encouraging adherence to treatment, including medication and therapy, while avoiding substances like alcohol or drugs, is vital.

Walker (1995) expressed that family-Based therapy (FBT) applies systems theory principles to address the interconnectedness of family members in shaping individual behaviours. This therapeutic approach recognises that individual issues often reflect broader family dynamics, communication patterns, and relational structures. Emerging in the 1950s, FBT evolved from dissatisfaction with individual psychoanalysis, emphasising group interactions as a source of healing. For instance, techniques like Structural Family Therapy focus on reshaping family hierarchies to create functional dynamics, while Strategic Family Therapy explores problem-solving strategies and systemic interactions during life transitions. Systemic Family Therapy emphasises non-blaming, neutral intervention to alter family communication rules, and Brief Solution-Focused Therapy encourages families to identify and build upon existing strengths and exceptions to problems. Social workers employ these models to engage families holistically, promote lasting change, and empower members through practical solutions and collaborative goal-setting.

Bobek et al. (2024) posited that family-based therapy draws from the principles of Systemic Family Therapy (SFT), a proven approach for addressing adolescent behavioural issues by focusing on family dynamics. Despite its effectiveness, it has faced challenges in widespread adoption due to the intensive training and resources required for implementation. To address this, a core competencies framework has been developed, emphasizing two key categories: Systemic Stance and Systemic Skills. Systemic Stance involves attitudes like collaboration, nonjudgmental curiosity, respect for complexity, and maintaining a relational focus. Systemic Skills focus on practical techniques, including systemic assessment, relational cycle construction, problem formulation, and goal setting. Borek et al. (2024) believed by integrating these competencies, family-based therapy aims to empower families, promote relational balance, and address complex family interactions. This framework not only simplifies SFT for routine care but also enhances its accessibility, fostering better outcomes for adolescents through collaborative family engagement.

Jiménez et al. (2019) conducted a study involving 41 adolescents and their parents evaluating structural strategic family therapy's impact on adolescent behaviour, parental practices, and family cohesion through pre-test and post-test assessments. Results indicated significant reductions in adolescents' internalising and externalising problems, alongside improvements in family cohesion, parenting satisfaction, and the adoption of healthier parenting practices. Notably, an interaction between parenting alliance and gender revealed more favourable outcomes for mothers. These findings stress the efficacy of structural-strategic family therapy in enhancing family functioning and addressing adolescent mental health challenges.

2.3 Cultural Context of Adolescent Mental Health in Oyo State

Ogundare (2020) stated that cultural beliefs significantly shape the understanding, expression, and treatment of mental health conditions. The culture influences how individuals recognise and communicate symptoms, cope with psychological challenges, and seek help. In many Nigerian communities (including communities in Oyo state, mental health issues are often attributed to spiritual or supernatural causes, leading individuals to seek traditional healing practices instead of formal psychiatric care. This cultural perspective can affect the diagnosis and treatment of mental health disorders, with symptoms often expressed through somatic complaints or interpersonal difficulties rather than emotional distress. Furthermore, the interpretation of mental health conditions is deeply rooted in cultural norms that define what is considered "normal" or "abnormal"behaviour, making it crucial for clinicians to consider cultural contexts to avoid misdiagnosis and ensure effective treatment. The shift towards incorporating cultural competence in mental health care, such as the Diagnostic and Statistical Manual (DSM-V's) inclusion of a Cultural Formulation Interview, acknowledges the diversity in the presentation of mental disorders and the need for culturally sensitive approaches to enhance the accuracy of diagnosis and improve patient outcomes.

According to Labinjo et al. (2020) cultural beliefs surrounding mental health in Nigeria (Oyo state included) are deeply rooted in traditional and spiritual perspectives, often attributing mental disorders to supernatural causes such as spiritual attacks, possession by evil spirits, or punishment from God. Consequently, traditional and spiritual healers are commonly sought as the first line of treatment, particularly in rural areas and among older populations. Urban residents and those with higher education are more likely to acknowledge psychological and drug-related causes, reflecting a growing awareness of medical explanations. Despite this, stigma remains pervasive, with individuals with mental disorders often labeled as "dangerous" or "mad" and facing social exclusion, limited job opportunities, and marriage stigma. While medical professionals generally favour psychological and biological explanations, traditional beliefs persist among some primary healthcare workers, highlighting a complex interplay of modern and traditional views on mental health in Oyo State.

Similarly, cultural beliefs about mental health conditions are often linked to spiritual curses or divine punishment, attributing mental illness to offenses against gods or others, rather than biological or psychological factors.

Traditional healers are typically the first point of care due to their deep-rooted cultural relevance, proximity, and affordability, offering herbal remedies and spiritual interventions. Western mental healthcare is often secondary, and perceived as less effective for culturally specific or "mysterious" illnesses. Furthermore, significant stigma surrounds mental health conditions viewed as hereditary taboos that hinder help-seeking and isolate sufferers, reinforcing reliance on traditional rulers over stigmatised psychiatric services (Jidong et al., 2021).

Bisi et al. (2022) expressed that mental illness in Nigeria is deeply influenced by cultural, spiritual, and societal beliefs, often viewed through metaphysical frameworks involving demonic possession, witchcraft, curses, or ancestral punishment. Among the Yoruba, for instance, mental illness is exemplified by the culturally specific condition Ode-Ori**,** observed in the Oke-Ogun region of Oyo State, characterised by hallucinations, agitation, mutism, and erratic behaviour, especially during the transition from puberty to adulthood. Such conditions are perceived as spiritual afflictions triggered by unprepared participation in traditional rites, leading many to seek help from spiritual or religious healers before considering biomedical treatment. Despite the prevalence of indigenous healing, mental illness remains stigmatised, with terms like "madness" reinforcing social exclusion. However, blending traditional remedies with modern psychiatric care is common, reflecting a belief in the interconnectedness of mental, physical, and spiritual health.

2.4 Clinical Implications of Family-based Therapy for Bipolar Disorder

Reinares (2016) conducted a systematic review of evidence-based studies up to March 2015 highlighting the efficacy of adjunctive family therapy in improving illness outcomes for both youth and adult patients, with notable reductions in relapse rates, enhanced medication adherence, and improved psychosocial functioning. It was discovered that family interventions alleviate caregiver stress, improving their coping mechanisms and overall well-being. However, variability in study methodologies, sample characteristics, and intervention designs suggests the need for tailored therapeutic approaches that address the specific needs of patients and their families. This stresses the importance of incorporating structured family interventions into standard bipolar disorder treatment protocols to enhance both patient and caregiver outcomes.

Miklowitz (2016) stated that family-focused therapy (FFT) has emerged as a pivotal evidence-based intervention for individuals with bipolar disorder (BD) and their caregivers, offering significant clinical benefits when combined with pharmacotherapy following an illness episode. Spanning over 30 years of research and supported by eight randomised controlled trials, FFT has been shown to accelerate recovery, reduce recurrence rates, and lower symptom severity in both adult and adolescent populations compared to briefer psychoeducational interventions. The therapy incorporates psychoeducation, communication enhancement training, and problem-solving skills, targeting both patients and family dynamics. Notably, FFT is particularly effective in families with high-expressed emotions, where it mitigates negative interactions that can exacerbate BD symptoms. Recent advancements explore FFT as a preventive strategy for youth at risk for BD, while neuroimaging studies are investigating the neural mechanisms underlying its efficacy. Moreover, efforts to implement FFT in community mental health settings are expanding access, highlighting its growing relevance in routine clinical practice.

Miklowitz, (2007) stated that family-based therapy has significant clinical implications for the management of bipolar disorder (BD). As a recurrent and debilitating condition, BD is influenced by psychosocial stressors, including high expressed-emotion (EE) environments within families, characterised by criticism, hostility, or over-involvement. Research indicates that high EE attitudes are linked to caregiver illness attributions and bidirectional caregiver-patient interactions, contributing to relapse vulnerability. According to O'Brien et al. (2014) and Simoneau et al. (1999), adolescents or young adults at risk for psychosis and adult patients with BD both demonstrated higher improvements in family communication during interaction tasks before and after FFT than adolescents or young adults receiving a brief psycho-educational treatment. In addition, Miklowitz, (2007) mentioned that FFT,

combined with pharmacotherapy, is proven to delay relapses and reduce symptom severity in both adults and adolescents over 1 to 2 years, highlighting its role as a critical adjunctive treatment. Beyond symptom management, FFT is being explored for its preventative potential in at-risk youth, potentially delaying the initial onset of BD. These findings suggest that integrating FFT into standard care models not only enhances relapse prevention but also improves family communication, reduces caregiver burden, and stabilises long-term outcomes. Thus, FFT represents a vital psychosocial intervention that complements pharmacological strategies, promoting more comprehensive, sustainable care for individuals with BD.

3. CONCLUSION

Bipolar disorder (BD) is a chronic psychiatric condition with profound social, emotional, and economic impacts, particularly among adolescents and young adults. High expressed emotion (EE) environments, characterised by critical and hostile family dynamics, are linked to increased relapse rates and symptom severity. Family-based therapies, especially Family-Based Therapy (FBT), have proven effective in mitigating these challenges by addressing both patient symptoms and family dynamics. Research demonstrates that FBT when combined with pharmacotherapy, reduces relapse rates, improves medication adherence, and enhances psychosocial functioning in both adults and adolescents. Additionally, FBT shows promise as a preventive intervention for at-risk youth, potentially delaying the onset of BD. By fostering healthier communication and reducing caregiver burden, FBT offers a holistic, sustainable approach to BD management, making it a crucial complement to pharmacological treatments in routine clinical practice. These findings highlight the necessity of integrating family-based interventions into standard BD care, particularly in regions with cultural and systemic barriers to mental health services.

4. RECOMMENDATIONS

This paper provides the following recommendations based on the conclusions of this study:

1. Counsellors in Oyo State should integrate Family-based Therapy (FFT) into standard BD treatment due to its proven improvement of patient outcomes and prevention of relapses
2. Counsellors should provide psychoeducation for families to reduce highly expressed-emotion environments and improve communication.
3. Counsellors should expand access to FBT in community mental health settings to ensure more individuals benefit from this effective therapy.
4. Counsellors should incorporate FBT as a preventive strategy for at-risk youth to delay the onset of bipolar disorder especially in culturally biased communities.
5. Counsellors should address caregiver burden through family therapy, offering support and enhancing coping mechanisms.

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