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Family-Focused Therapy for a Young Adult with Bipolar Affective Disorder and Family Dysfunction: A Case Report

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Abstract

Background: Bipolar disorder involves severe manic episodes affecting patients and families. We report a 25-year-old female with his first manic episode (YMRS = 42), marked by insomnia, grandiosity, aggression, and family conflict. Interventions: Hospitalization with mood stabilizers and antipsychotics provided partial relief (YMRS = 27). Twelve family-focused therapy (FFT) sessions over 7 weeks with the patient, parents, and spouse addressed psychoeducation, communication, and problem-solving. Outcomes: YMRS declined to 5, indicating remission. Family functioning improved on the McMaster Family Assessment Device (e.g., problem solving 2.70→2.16, communication 3.30→2.00). Expressed emotion and Family Attitude Scale scores decreased (55→22), reflecting healthier dynamics. No adverse effects beyond mild sedation occurred. At 6 months, the patient remained stable with sustained family improvements. Conclusion: Combining FFT with pharmacotherapy in acute bipolar mania, especially in family-centered cultures, enhances symptom control, adherence, and long-term outcomes.

Keywords: Bipolar disorder; Mania; Family Focused Therapy; Expressed Emotion.

Bipolar disorder is a recurrent mental illness characterized by episodes of mania and depression. Acute manic episodes often require prompt treatment with mood stabilizers and/or antipsychotic medications as first-line therapy [1]. Pharmacologic treatment is essential and typically maintained long-term due to high relapse rates in bipolar disorder [1]. However, medication alone may not address psychosocial stressors that can trigger or exacerbate episodes. Psychosocial interventions particularly those involving the patient's family are recognized as valuable adjuncts to pharmacotherapy [1]. Educating the patient's support system about the chronic nature of bipolar disorder, the risk of relapse, and strategies for early intervention is recommended to improve outcomes [1].

Family environment plays a significant role in the course of bipolar disorder. Caregivers of patients with bipolar disorder often experience high burden and stress [2]. This stress can manifest as negative interaction patterns within the family, such as high expressed emotion (hostility, criticism, over-involvement), which have been linked to worse patient outcomes. Conversely, a supportive and low-stress family environment is associated with better adherence and fewer relapses. Family-focused therapeutic approaches aim to reduce familial stress and improve communication. Evidence from multiple studies has shown that adding family-focused therapy (FFT) to standard treatment hastens recovery from mood episodes and reduces symptom severity and recurrence rates, especially in patients from high-EE (high expressed emotion) family backgrounds [3]. Despite this evidence, family-oriented interventions are not routinely implemented during acute inpatient management of mania. This case report is unique because it details the successful integration of an intensive family-focused intervention alongside standard medical treatment in the acute phase of a manic episode. It highlights how addressing family dysfunction in parallel with pharmacotherapy can lead to both clinical remission and restoration of healthy family functioning.

Patient Information and History

The index patient, Ms. R K, is a 25-year-old graduate, unemployed, single Hindu female from a lower middle socioeconomic background. She hails from rural area of Ranchi, Jharkhand, and lives in a nuclear family of four members. Her personal history suggests neglectful parenting by her father and inconsistent parenting by her mother. The family is currently in the life cycle stage VI (launching young adults). Family dynamics reveal clear and open internal and external boundaries; however, parent–child and couple subsystems function inadequately. The father is the nominal head, while the brother functions as the family's decision-maker. Chaotic decision-making occurs primarily among the brother, mother, and patient, with minimal paternal involvement. Expressive roles within the family are inadequate. Communication between the patient and father is indirect; cohesiveness and reinforcement are insufficient. Problem-solving and coping strategies are poor, and the secondary social support system is inadequate. The family ecomap indicates a strained relationship with the father and a need-based relationship with paternal aunt, uncle, and neighbors.

Quantitative assessments show dysfunction across communication, problem solving, roles, affective responsiveness, affective involvement, behavioral control, and general functioning. Moderate levels of expressed emotion, elevated affiliate stigma, and moderate criticism, hostility, or emotional over-involvement toward the patient were present, along with severe caregiver burden on the mother.

Clinical Findings

At admission, Ms. R K was alert and physically

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healthy but markedly agitated and uncooperative. Her speech was pressured, loud, and difficult to interrupt. She exhibited an expansive mood with irritability and labile affect shifting from euphoria to anger. Thought processes were racing and tangential. She expressed grandiose delusions, including claims of impending major business success without any relevant background. She denied hallucinations, but insight and judgment were severely impaired; she did not acknowledge illness. Neurological examination revealed no focal deficits; vital signs were stable.

Her Young Mania Rating Scale (YMRS) score was 42, indicating severe mania (scale 0–60, higher scores denote greater severity).

Timeline

To clarify the sequence of events in this episode of care, a timeline of key interventions and outcomes is provided:

Day 1 – Hospital Admission: The patient was admitted to the psychiatric inpatient unit with acute manic symptoms (YMRS score: 42). Standard pharmacological treatment was initiated as per hospital protocol. The family was informed about the diagnosis and initial treatment plan. They expressed significant emotional distress, feelings of helplessness, and ongoing interpersonal conflicts.

Day 16 – Family Involvement and Treatment Planning: While manic symptoms persisted, there was a slight reduction in intensity. The patient was sleeping approximately 4 hours per night with the help of medication. The treatment team met with the patient's immediate family (e.g., parent and brother). During this interaction, high levels of expressed emotion were noted, with family members critical comments about the patient's behavior. Based on the clinical status and family readiness, it was decided to initiate family focused therapy.

Day 24 Initiation of Family-Focused Therapy (FFT), Psychoeducation (Sessions 1 to 4): FFT sessions began with the patient and available family members participating (e.g., parent and brother). Conducted by a trained family therapist every alternate day, early sessions focused on psychoeducation. The family was educated about bipolar disorder emphasizing that mania is a medical condition, not a character flaw and the roles of stress and communication in relapse prevention. The patient, now calmer on medication, actively participated, though mild irritability and some manic features remained.

Week 3 – Communication Skills Training (Sessions 5 to 9): Pharmacological management continued. FFT sessions transitioned to communication enhancement. Family members practiced expressing emotions constructively, listening actively, and avoiding accusatory language. Gradually, tensions began to decrease, and the family adopted more adaptive communication strategies. The patient began gaining insight into her illness as she witnessed more empathetic and constructive family interactions.

Week 7 (Discharge), Problem-solving skills (Sessions 10-12): By the end of Week 7, a total of FFT sessions 12 had been completed. The final phase emphasized problem-solving skills. The family addressed specific issues (e.g., disagreements over the patient's career option, responsibilities or finances) through structured, therapist-guided discussions. At the time of discharge, the patient showed significant clinical improvement: sleeping 7–8 hours per night, no longer displaying agitation or grandiosity, with a YMRS score of 5, indicating remission. The family demonstrated improved understanding, reduced expressed emotion, and healthier interaction patterns. A discharge plan was created by considering typhoid at that time and the plan problem-solving skills included continuation of mood stabilizer (e.g., valproate 1000 mg twice daily), a shift from haloperidol to oral risperidone 2 mg at night, and scheduled outpatient follow-up for both psychiatric and family therapy support.

First follow-up (after a month): The patient remained manageable and reported improvement in sleep, appetite and overall biological functions. And patient had physical difficulties due to typhoid. Involvement of patient's father was started during this time. And the psycho education session was reviewed during this time. The family exhibited adequate knowledge and attitude towards illness and understand the importance of continuing the treatment.

Second follow-up (After 2 months): At the 2nd month follow-up, the patient remained in stable remission with no recurrence of manic or depressive episodes. Medication adherence was consistent, with no notable side effects. The family continued to use the communication and problem-solving techniques learned during FFT, reporting only minor disagreements an improvement from the pre-treatment baseline follow-up family assessment confirmed ongoing functional and relational improvements. The patient currently planning to pursue higher education in zoology.

Diagnostic Assessment

The diagnosis of bipolar disorder, current episode mania was made based on ICD-10 criteria, given the distinct period of abnormally elevated mood and increased activity lasting over one week with classical manic symptoms (insomnia, grandiosity, talkativeness, flight of ideas, distractibility, impulsivity) causing severe social impairment and requiring hospitalization. The presence of transient psychotic features (grandiose delusions) further confirmed it as a manic episode rather than hypomania.

Other potential diagnoses were carefully considered and ruled out. Schizoaffective disorder was considered given the psychotic features, but the temporal alignment of delusions strictly with mood elevation (and their resolution with mood stabilization) favored bipolar mania with psychotic features. There was no concurrent depressive symptomatology to suggest a mixed episode at that time. Hence, the primary diagnosis remained bipolar mania.

Psychiatric rating scales were used to track both the patient's clinical status and family dynamics throughout treatment. The Young Mania Rating Scale (YMRS) showed a marked reduction in manic symptoms, from 42 at baseline to 5 post-intervention, indicating substantial clinical improvement. Family functioning was assessed using the Family Assessment Device (FAD) [4], which revealed significant dysfunction across all domains at baseline, with scores exceeding clinical cutoffs (e.g., problem solving 2.70, communication 3.30, affective involvement 4.00). Following intervention, all FAD domain scores improved substantially and fell within normal limits (e.g., problem solving 2.16, communication 2.00, affective involvement 2.10), reflecting healthier family interactions. The Level of Expressed Emotion (LEE) [5] scale also showed marked decreases in perceived lack of emotional support, irritability, intrusiveness, and criticism (baseline scores 38, 22, 25, and 12; post-intervention 18, 11, 11, and 7, respectively), indicating an improved emotional climate. Similarly, the Family Attitude Scale (FAS) [6] total score declined significantly from 55 to 22, underscoring positive shifts in family attitudes. Collectively, these results highlight meaningful improvements in both the patient's symptom severity and the family environment, emphasizing the effectiveness of the integrated therapeutic intervention.

Therapeutic Intervention

Family-Focused Therapy (FFT): The cornerstone of this case's intervention was the integration of an intensive family-focused therapy program concurrent with medical treatment. The FFT was conducted by a clinical psychologist trained in family therapy, with sessions held in the hospital setting. Following the evidence-based FFT model [3], the intervention comprised three core components:

Psychoeducation: The therapist provided comprehensive education about bipolar disorder to the patient and family. They learned about the nature of the illness, typical symptoms of mania and depression, the expected course, and the role of genetic and environmental factors. The family was taught that stress and interpersonal conflict can precipitate mood episodes, and conversely, that a supportive family environment can improve outcomes. This knowledge helped reframe the family's understanding: for example, the patient's father moved from seeing the manic behavior as "intentional misbehavior" to recognizing it as symptoms of an illness. The family was also educated about the medications, their side effects, and the importance of adherence, which empowered them to support the patient's treatment.

Communication Enhancement Training: Given the longstanding communication problems in the family, a major part of therapy was dedicated to enhancing healthy communication. The therapist coached family members in skills such as active listening, using "I" statements to express feelings (instead of blame), and taking turns speaking without interruption. Through role-playing exercises, the family practiced de-escalating techniques for instance, if a conversation grew heated, they learned to call a brief "time-out" and resume discussion when calmer. The patient learned to articulate his feelings (e.g., frustration or needs) in a respectful manner, rather than through angry outbursts. Over several sessions, the family's communication style visibly shifted: the frequency of yelling and critical remarks decreased, and members showed improved empathy towards each other's perspectives.

Problem-Solving Skills: In the later phase of FFT, therapy focused on collaboratively solving practical problems that had been fueling conflict. One key issue was the disagreement between the patient and his father about the family business operations. The therapist guided the family to define this problem clearly and brainstorm potential solutions together. They agreed on a structured plan where the patient, once stable, would handle a smaller, manageable aspect of the business under supervision, rather than taking on the entire responsibility that had overwhelmed him before. Another issue addressed was the distribution of household chores and caregiving for the patient's infant child, which had been a source of tension between the patient's wife and parents. Through negotiation moderated by the therapist, the family created a schedule to share responsibilities, reducing stress on any single member. By actively solving such problems, the family not only resolved immediate conflicts but also gained confidence in tackling future challenges collaboratively.

The FFT was delivered over a relatively short period (approximately 8 weeks) given the inpatient setting, which is consistent with some inpatient family intervention models reported in literature [2]. All participating family members attended the majority of sessions, demonstrating good engagement. The therapeutic alliance was strengthened as the family observed the patient improving; they became more invested in the process, seeing how their own interactions could positively influence his recovery. There were no drop-outs or major interruptions in the therapy. The patient occasionally showed mild irritability during sessions, especially early on, but as his insight improved, he became an active participant. By the end of the 12 sessions, both patient and family had

developed a set of communication and problem-solving tools and had a written relapse prevention plan (including early warning signs of mania to watch for, and family strategies to encourage treatment or stress reduction should those signs appear).

Outcomes

Clinical Outcome: The outcome of this combined intervention was very favorable. By the time of discharge after four weeks, the patient's manic symptoms were essentially in remission. His YMRS score had dropped to 5, which falls in the normal range (for context, a YMRS score below ~10 is often considered euthymic or minimally symptomatic). He no longer exhibited delusions or aggressive behavior, his mood was stable, and he had regained full insight, acknowledging that he had experienced a manic episode and needed ongoing treatment. The patient's sleep and appetite were restored to normal patterns. He was not experiencing depressive symptoms either. He was deemed fit to resume some of his work and family duties with appropriate support and monitoring.

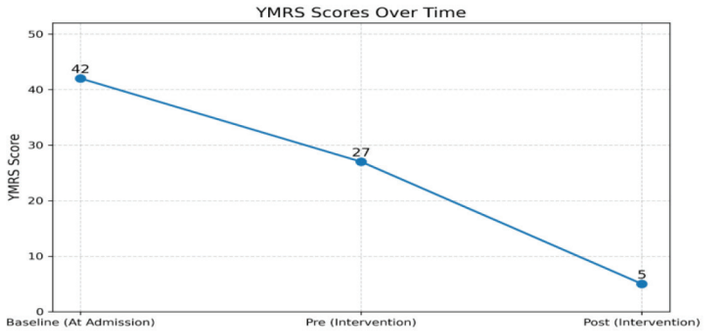

Figure 1. Temporal Trends in YMRS Scores During the Course of Intervention

Figure 1. Young Mania Rating Scale (YMRS) scores over time. This line plot illustrates the reduction of manic symptom severity from severe mania at baseline (score = 42), to partial improvement before intervention (score = 27), and remission after intervention (score = 5).

Family Intervention Outcome: Parallel to the patient's clinical improvement, the family's functioning showed marked improvement as a result of therapy. This was evidenced both qualitatively and quantitatively. Family members reported a significant reduction in day-to-day conflicts. They described the household atmosphere as "much calmer" and more cooperative than before.

Figure 2. Changes in family assessment scores from baseline (pre-intervention) to post-intervention. (A) McMaster Family Assessment Device subdomain scores across Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavioral Control, and General Functioning. Baseline scores (blue bars) exceeded clinical cut-offs (green bars), indicating family dysfunction. Post-intervention scores (orange bars) decreased below cut-offs, demonstrating significant improvement in family functioning following therapy. (B) Level of Expressed Emotion (LEE) subdomain scores showing reductions in Perceived Lack of Emotional Support, Irritability, Intrusiveness, and Criticism from baseline (red bars) to post-intervention (blue bars), reflecting an improved emotional environment within families. (C) Family Attitude Scale (FAS) total scores depicting a significant decline from baseline to post-intervention, indicating enhanced family attitudes after therapeutic intervention.

Quantitative evaluation of family functioning and emotional climate at the 7-week post-intervention point demonstrated substantial improvements across multiple standardized measures. The McMaster Family Assessment Device (FAD) [4] revealed marked reductions in all seven subdomains compared to baseline: Problem Solving improved from 2.70 to 2.16, Communication from 3.30 to 2.00, Roles from 2.60 to 1.80, Affective Responsiveness from 2.50 to 2.20, Affective Involvement (the most impaired domain) from 4.00 to 2.10, Behavioral Control from 2.60 to 1.50, and General Functioning from 2.25 to 1.80. All post-intervention scores fell within normal clinical limits, indicating a shift from dysfunctional to healthier family dynamics.

Similarly, the Level of Expressed Emotion (LEE) [5] scale showed significant decreases in perceived negative emotional expressions within the family. Scores for Perceived Lack of Emotional Support decreased from 38 to 18, Irritability from 22 to 11, Intrusiveness from 25 to 11, and Criticism from 12 to 7, reflecting an overall improved emotional environment and reduced familial stress.

The Family Attitude Scale (FAS) [6] total score also decreased notably from 55 at baseline to 22 post-interventions, underscoring positive changes in family attitudes and relational patterns.

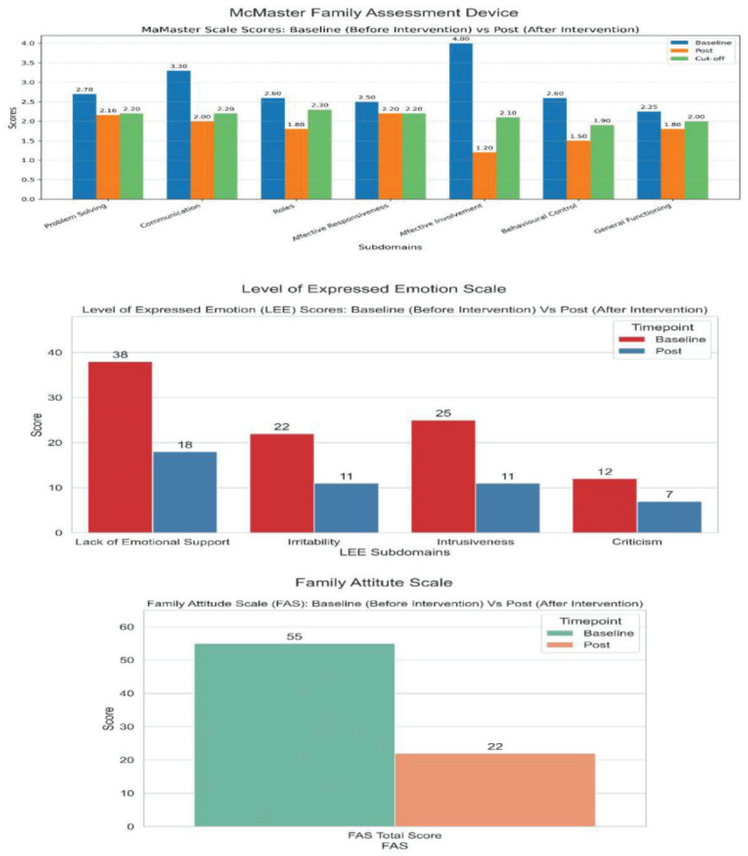

Figure 2. FFT-Related Reductions in Family Dysfunction, Negative Expressed Emotion, and Critical Attitudes

Concurrently, the patient's clinical status improved as evidenced by a marked decline in the Young Mania Rating Scale (YMRS) scores over time (from 42 at baseline to 5 post-intervention), indicating symptomatic remission.

Figures 1 and 2 respectively illustrate the decline in YMRS scores and the post-intervention reductions across the FAD, LEE, and FAS scales. These parallel improvements highlight the reciprocal relationship between enhanced family functioning and patient recovery, supporting the efficacy of the combined therapeutic approach.

No significant adverse events occurred during the course of this case. The patient did experience mild side effects from medication (sedation and tremor as mentioned) but these were manageable and resolved with adjustments. The family therapy process at times brought up emotional discussions, which occasionally caused distress during sessions, but with therapist support these moments were constructively handled and ultimately led to catharsis and resolutions. The patient and family maintained a high level of engagement throughout, which likely contributed to the positive outcome.

Discussion

This case illustrates the powerful impact that addressing family dynamics can have on the outcome of a severe bipolar manic episode. Typically, the acute management of mania focuses on rapid tranquilization and pharmacological stabilization, which is indeed crucial [1]. In this patient's case, standard medications were necessary to control the most severe manic symptoms. However, the addition of an intensive family-focused therapeutic approach was pivotal in achieving full remission and in healing the psychosocial environment to which the patient returned. The simultaneous improvement in the patient's YMRS scores and the family's FAD scores is notable as the patient's clinical state improved, so did the family's functioning, suggesting a reciprocal benefit.

Comparison with Literature: The approach and outcome in this case are consistent with findings in the literature that emphasize the role of family factors in bipolar disorder outcomes. High levels of familial expressed emotion (criticism, hostility, over-involvement) have been associated with higher relapse rates and poorer recovery in bipolar disorder, as well as

other psychiatric illnesses [2]. By directly intervening to reduce expressed emotion and improve communication, it is possible to alter the course of illness. In fact, family-focused therapy (FFT) is a well-established evidence-based adjunct for bipolar disorder management. Miklowitz and Chung (2016) have demonstrated across multiple studies that patients with bipolar disorder who receive FFT (in conjunction with medication) have longer times to relapse and fewer symptomatic days compared to those who receive standard care or brief psychoeducation [3]. Notably, those studies show FFT's benefits are most pronounced in families that initially have high conflict or high expressed emotion [3]. Our case aligns with this: the family in question had significant dysfunction and stress at baseline, creating a fertile ground for FFT to make a meaningful difference.

There is also precedent for delivering family interventions even during the acute phase of illness. Padmavathi et al. (2021) reported on two cases in India where structured FFT (12 sessions over 3-4 weeks) was implemented for inpatients with bipolar mania, resulting in reduced caregiver expressed emotion and improved patient outcomes [2]. Those reports, like our case, suggest that engaging families early, even while the patient is hospitalized can be feasible and beneficial. Early family involvement can set the stage for better outpatient support and adherence. It's important to note that in cultures where familial ties are strong and family members are the primary caregivers (such as in this case's context), integrating them into the treatment process is not only appropriate but arguably necessary. Doing so leverages an existing support system to bolster the patient's recovery.

Clinical Significance: The outcome of this case underscores several important clinical lessons. First, it highlights that pharmacotherapy, while essential, may not be sufficient on its own for optimal recovery in bipolar mania when significant psychosocial stressors are present. The patient might have eventually stabilized on medication alone, but the concurrent resolution of family conflict likely accelerated his improvement and certainly provided a healthier environment to maintain stability post-discharge. This suggests that clinicians should assess the family climate in cases of severe mental illness; where dysfunction or high stress is identified, a referral to family therapy or inclusion of family in the treatment plan can substantially improve outcomes.

Second, this case demonstrates that family-focused interventions can be successfully carried out in an acute inpatient setting. Inpatient psychiatry often prioritizes crisis management and medication adjustment, with limited time for psychotherapy. However, as shown here, even a relatively brief course of intensive family therapy (12 sessions) was achievable and effective within a one-month admission. This challenges the notion that therapy must wait until the patient is fully stable; instead, therapy (especially involving family education and support) can be intertwined with medical treatment from early on. Key to success was the collaboration of a multidisciplinary team, psychiatrists, psychologists, psychiatric social workers and nursing staff, who all supported the idea of family involvement and coordinated the scheduling of sessions amid the patient's other treatments.

Third, from a family medicine and holistic care perspective, the case reinforces the principle that treating a patient often means treating the family. Family dysfunction not only may contribute to the initial onset of illness (as a stressor) but can also impede recovery or precipitate relapse if left unaddressed. By improving the family's ability to function and cope, we indirectly but powerfully improved the patient's prognosis. This is highly relevant for family practitioners and primary care providers who manage chronic illnesses: engaging the family and addressing their needs can be as important as the direct patient care. In our case, the family members themselves benefitted, they reported reduced stress and better mental health after therapy. One could argue that, in effect, the intervention prevented a potential "secondary victim" scenario where family members could develop depression or burnout due to the strain of caregiving.

Limitations: As a single case report, we must be cautious in generalizing these findings. Not every patient with mania will have the same family structure or willingness of family members to participate in therapy. In this case, the family was ultimately open to learning and change, which might not hold true in all situations (some families might be disengaged or have conflicts too entrenched to resolve quickly). Additionally, the improvements observed were the result of a combination of treatments, we cannot definitively parse out the relative contributions of medication versus FFT in achieving remission. It is likely the synergy of both was needed. Another limitation is the short follow-up period reported; while six months is encouraging, bipolar disorder is lifelong, and whether the family's improved functioning and patient's stability will persist over years remains an open question. Ongoing support and booster sessions may be required to maintain gains. Lastly, this report relied on the FAD and YMRS as outcome measures, which are adequate for clinical use, but more granular assessments (like measuring expressed emotion or caregiver burden with specific scales) were not done due to resource constraints. Future reports or studies could enrich these findings by including those measures.

Recommendations: For clinicians managing similar cases, early assessment of the family environment is recommended. If high stress or miscommunication is apparent, involving a family therapist or conducting family meetings can be extremely beneficial. Education should be provided to families about the nature

of bipolar disorder and how their interactions can positively or negatively influence the patient's illness course [1]. Establishing a partnership with the family can improve treatment adherence (as the family can encourage the patient to follow medical advice) and provide the patient with a stronger safety net after discharge. From a healthcare systems perspective, incorporating family interventions into standard care for severe mental illness could improve overall outcomes and reduce relapse-related readmissions. This case also suggests that even in resource-limited settings, short-term focused family interventions are doable; training staff in basic family therapy techniques may yield high returns in patient improvement.

In conclusion, this case report demonstrates that comprehensive care for bipolar mania should extend beyond the patient to the family unit. By following the CARE guidelines and presenting a thorough, patient-centered narrative, we highlight that successful management of a psychiatric illness can require treating the psychosocial context in which that illness unfolds. The primary take-away lesson is that addressing and improving family dysfunction through therapy can be a critical component in achieving and sustaining remission in bipolar disorder. Clinicians are encouraged to consider the family as both a potential contributing factor to illness and a powerful ally in recovery.

Patient Perspective

The patient and her family were given the opportunity to share their perspective on the treatment process and outcomes. The patient expressed that initially, during her manic state, she did not believe she was ill and felt frustrated by the hospitalization. She noted that learning about bipolar disorder made her feel more empowered to manage it, and she was grateful that her family "understands me better now" instead of just arguing with her.

Overall, the family agreed that the intervention not only helped the patient get better but also taught them skills that improved their overall family harmony. They expressed commitment to continue using these skills and to seek help early if symptoms recur. Their perspective underlines that the collaborative approach was a positive experience that strengthened the family bond in the face of illness.

Informed Consent

The patient described in this report provided written informed consent for publication of the case details. Identifying information has been altered or omitted to protect patient confidentiality, in accordance with CARE guidelines.

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