Family involvement in Chinese immigrants with bipolar disorder in New Zealand

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Abstract

Aim To explore the dynamic between Chinese people with bipolar disorder (BD) and family functioning.

Methods Nine New Zealand Chinese with BD were interviewed. Data analysis was guided by content and thematic approaches.

Results Four themes summarised from the interviews included: (1) family members are the primary resource; (2) many facets of recovery from BD is integrally linked with caregiving; (3) quality of family relationships is associated with acceptance of the illness; and (4) perception of caregiver burden motivates self-care.

Conclusion The findings support the need for mechanism that can minimise the risk of adverse family functioning associated with BD and the need of professional involvement when working with these families.

Bipolar Disorder (BD) imposes a significant burden on personal, medical, and socio-economic aspects of living. It is acknowledged that informal caregivers who consistently support and care for those people with BD have made significant contributions to society. Without their help, the costs to the formal health care system of caring for people with BD would be considerably higher.

A study with 94 stabilised people with BD found that the absence of social support delayed recovery after an episode and low levels of social support may increase the risk of relapse. It is further argued that family support systems significantly influence the enablement of self-management. Furthermore, larger social networks and support systems may help in the experience of more positive life events, which partly contribute to a recovery status.

However, caring for an individual with disability is often burdensome and stressful. It is argued that caregivers are at risk with respect to negative health outcomes due to high levels of caregiving demands. A study conducted to assess the caregiving consequences of 260 spouses and relatives of people with depression found that caregivers frequently experienced distress and feelings of being burdened, and prevalence and frequency are related to the severity of care receivers’ symptoms.

In addition, it has been reported that fatigue, depression and anxiety in conjunction with problems related to restricted activities and financial concerns may hinder the lives of caregivers. Nevertheless, some positive aspects of caregiving have been reported by caregivers, such as increased knowledge of the illness and themselves, improved relationships with others, and gratification that comes from caregiving. Those positive effects of caregiving were considered to be associated with positive appraisal and less reliance on emotional coping.
In general, caregiver burden exists within family roles and relationships are associated with implicit or explicit obligations.\textsuperscript{13} Pinquart and Sorensen also noted that caregivers of ethnic minorities had lower socio-economic status, and were younger, less likely to have a spouse, and more likely to receive informal support. A meta-analysis study integrated the results of 116 empirical studies and suggested different effects of caregiving between ethnic minority and majority groups.\textsuperscript{14}

Ethnic minority groups tended to feel stronger filial obligations and provided more support than European caregivers. Furthermore, with the influence of traditional cultural norms, the family may have a fear of being exposed to criticism and disgrace when a family member has a mental illness.\textsuperscript{14}

The New Zealand population has become more diverse in recent years. According to the 2006 census, the Asian ethnic group accounted for 9.2\% of the total New Zealand population, the fourth largest major ethnic group in New Zealand after European, Māori and other ethnicities.\textsuperscript{15} In the Asian ethnic group, 45\% of people identified themselves as Chinese.

It has shown that 1 in 200 of the population has some form of bipolar disorder in New Zealand.\textsuperscript{16} Thirty-five percent of Asian patients who admitted to psychiatric units in Auckland received a principle diagnosis of mood disorder, which was slightly higher compared to New Zealand Maori and Pacific groups.\textsuperscript{17}

Therefore, it is important to develop an understanding of how Chinese migrant families cope with mental illness and the practical strains involved in caring for an individual with mental illness. Little research has been done into the experience of caring for an individual with a mental illness using non-English speaking cohorts, thus, it is impossible to identify the elements of coping strategies used by Chinese people. As such, further research is warranted which indicates that studying New Zealand Chinese immigrants may further help our understanding in relation to the effect of culture and ethnicity on illness management.

The aim of the present study was to explore the dynamic relationship between Chinese people with BD and their family members in New Zealand.

**Methods**

**Participants**—A total of nine participants attended individual interviews. At the interviews, research participants (4 male; 5 female) had an average age of 41 years (range = 20–56 years) with an average age at first illness episode of 30 years (range = 14–41 years). Two participants were born in New Zealand and the remainder in China - Hong Kong and mainland China.

**Procedure**—A purposive sampling method was instigated to select people who had taken care by their family members or caregivers and had years of experience in coping with BD. The interviewer (first author) initially approached relevant mental health services and organisations to identify the availability of potential participants. Subsequently, relevant case managers or support workers were approached and asked to provide information to potential participants. Semi-structured interview guidelines were developed to ensure the elicitation of responses related to study objectives in line with the issues of wellness, family, and friends.

The interviews took place in a venue nominated by the participants that was most convenient for them. All of these procedures complied with the requirements set by the Northern X Regional Ethics Committee. Prompt questions included: “Could you describe what’s going on in your life when you’re feeling well?” “How do friends, family and co-workers affect your ability to stay well?” “How do you know it is the right time to start using self-management strategies?” The exact patterning of questions varied across the interviews depending on the participants’ response to each question.
Data analysis—The audio tapes were transcribed immediately after the interviews to improve the quality of transcription and maximise accuracy in terms of the context of the conversation. Four face-to-face or telephone follow-up interviews were conducted with participants to verify the accuracy of the general themes that emerged from the first round of interviews. The questions in the follow-up interviews were developed specifically for participants in relation to a preliminary analysis of the initial interview. Furthermore, the interviewer double checked the accuracy of the general themes that emerged from the initial interview with participants and then coded the responses.

Data analysis focused on identifying content themes and patterns in the notes, which were checked against audio commentaries and notes from the interviews. Incorporating the approach developed by Ulin, Robinson and Tolley, the interviewer first read through the scripts to gain a sense of the data, then coded emerging themes. After which each thematic area was carefully considered in more detail and finally the information was reduced to its essential constituent ideas.

Results

The four main themes summarised from the qualitative interviews included:

1. Family members are the primary resource;
2. Many facets of recovery from BD is integrally linked with caregiving;
3. Quality of family relationships is associated with acceptance of the illness; and

Family members are the primary resource—According to the participants, stigma attached to mental illness often comes from friends. As a result, they only feel safe to disclose their illness to family members and relatives.

“I did not tell my friends but my relatives.”

“I go out with my father having lunch and tell him what’s going on. I don’t have many close friends. Friends can share your joy but can’t help you too much.”

“I don’t want to tell my friend. Even I am too sick to drive, I would call ambulance rather than asking them.”

Help-seeking was reported by people with mental illness as one of the main coping strategies. Chinese people with psychological problems tend to seek support from their families and friends rather than professional help. All nine participants in the current study mentioned that family support was considered as the most important resource to them, although a few of them mentioned other types of social support, such as friendships, peer, or professional support. Family members were approached first when the participants had problems in their daily life or experienced episodes.

“The most important person is my sister. She is always my support. She tried to understand my illness and helped me mentally and physically. She is sort of my psychological counsellor.”

Supportive family relationships provided opportunities for the participants to experience positive social events, such as leisure activities, sports, and dining out.

“Talking to my family about my feelings and thoughts, they encourage me to be active and not stay at home. They discuss my illness which makes me feel cared for and supported.”

Many facets of recovery from BD is integrally linked with caregiving—Chinese participants strongly emphasised the importance of family involvement in their recovery. According to the participants, they could not experience ‘a good recovery’ without their families’ support. Their families played a significant role in their
An individual’s decision is greatly affected by family members who have influential power. For example, one participant disclosed a desire for doing more work but was advised by her mother to stay at home and rest. “I wanted to work, but my mum thought that I needed to have more rest and work might get me stressed”.

Quality of family relationships is associated with acceptance of the illness—Given the importance of family support, having interpersonal conflicts with family members was considered to be the main source of daily stress by half of the sample. However, for many participants, BD created an unavoidable impact on their family relationships and it was not easy for family members to accept their conditions.

Some participants reported that they have experienced serious conflicts with family members due to their illness. For example, a female participant reported that she could not cope with any family disagreement when she experienced manic episode.

“At the beginning, it was really difficult for my husband and me. Because I was so mad that time. I ran away from home several times and he had to search for me. He drove around Auckland. I knew he was angry and so for while, our relationship went badly. We were in the same house and he would not say a word to me.”

Knowledge of the illness and treatment is considered to be critical to acceptance of the disorder. According to the participants, family acceptance of their illness was positively related to knowledge of their condition and acceptance in turn affected family relationships and the support they have received.

“After the psychiatrist talked to him, my husband started to understand what happened to me and our relationship improved a lot.”

“Sometimes I feel that I am not as good as others, my son would say that I am no different from others, except I have to take pills once a night.”

Perception of caregiving burden motivates self-care—BD is a severe and recurrent disorder, which requires ongoing treatment and management. The participants acknowledged that looking after people with a mental illness was a tiring process and that it was essential to take some responsibility to care for themselves in order to reduce the burden of caregiving.

“My husband, he looks after me so well, but the experience is tiring for him at those moments. I think this is the same for others as well, he is willing to support me, maybe 100% but I try to help him support me, as I do not just totally depend on him. Each person only has that much patience, if he used all of his patience that would be a disaster.”

For people with younger children, they felt a great pressure to remain well in order to fulfil their parental roles. Two participants were solo mothers and they believed that the nature of frequent recurrence of BD had a dramatic negative impact on their parental function.

“When I am sick, I could not look after my son. I could not cook for him and he did not eat properly. That’s why he often complained about joint pain, which may be related to poor nutrition. I hope there is possibility to treat it.”
“I am afraid that I would hit my kids when I was mad. I knew that I would make mistakes and say something terribly hurtful.”

**Discussion**

The present study used qualitative approach to explore the dynamic between Chinese people with bipolar disorder (BD) and family functioning. The findings of the present study showed that the concept of family, developed from traditional Chinese culture, was the fundamental element influencing the participants’ recovery.

The current findings supported the general argument that family is central to the prevention and management of stressful situations and emphasised the importance of family involved in illness management.

In terms of the Chinese family in New Zealand, family care incurs multiple aspects of illness management, such as learning and understanding of the person’s condition, medication supervision, detecting early warning signs and coping with episodes. Also, Chinese family decisions have a critical impact on a family member’s decisions about recovery processes. Therefore, it may become an issue when someone receives little family support or family members have a lack of knowledge in illness management.

The present study indicates a potential risk for Chinese people not having family support and there is a need to provide extra help to them that is accessible according to their cultural needs.

The traditional concept of the ‘person’ in China is duty-oriented including responsibility to the whole family, community and country. However, because of illness, the person is seen to have low capability and responsibility is thus attached to the family and society.

The findings in this study suggest that Chinese immigrants with BD still have a strong sense of responsibility to family despite their illness. This may be linked to their traditional Confucian heritage, which is evolving with the advent of modern Chinese society and these changes affect the notion of responsibility to family. Nonetheless, the current study indicated that many participants and their families still had a strong a sense of family obligation linked to the need for the family to rally around those members experiencing adversity.

Furthermore, the current findings highlight the need for improving the understanding of mental illness in relation to Chinese people, families and their community, given the great involvement of family members in individuals’ recovery. The present study found stigma and misunderstandings related to BD in the Chinese community. The reasons for this may be attributed by inadequate linguistic support amongst mainstream professionals, a lack of culturally competent practitioners, and poor community awareness of mental health issues.

It is essential to improve family members’ understanding of BD and its treatment. This is consistent with other UK-based studies who investigated the process of life adjustment in response to migration and found that inadequate linguistic support hindered dealings with mainstream professionals. These studies also found a dearth of culturally competent practitioners and poor community awareness of mental health issues resulting in poor the information being communicated to Chinese people with mental illness and their caregivers.
Moreover, previous studies have shown that children of parents with BD are at risk of mental health problems.\textsuperscript{27–29} The current study findings support the need for mechanisms that can minimise the risk of adverse family functioning associated with BD and the need of professional involvement when working with these families, for example, family-focused psychoeducation. Previous studies have shown the positive outcomes can be acquired through expertly administered and culturally appropriate family therapy processes.\textsuperscript{4,19}

It is worth noting some of the limitations of this study. Firstly, the qualitative analysis is based on a relatively small sample and is not intended to be representative of the larger Chinese population in New Zealand. In particular, New Zealand Chinese are from a heterogeneous group which has a varied and geographically diverse immigration history. For example, the New Zealand Chinese population is composed of both native and foreign-born individuals who come from mainland China, Taiwan, Hong Kong, Singapore and other areas.

Diversity exists among New Zealand Chinese which makes it difficult to draw definite conclusions or generalise any findings about the entire New Zealand Chinese population. Nevertheless, the use of a small sample from the community setting allowed the researchers to develop an in-depth understanding of the data, which assisted in their understanding of the complexities of New Zealand Chinese as is relevant to the issue of BD. Furthermore, the current findings lay the groundwork for future cross-cultural research of associations between family involvement and treatment outcome.

\textbf{Competing interests:} Nil.

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