

Compassion-Based Intervention Program for Enhancing Coping Patterns Among Family Caregivers of Patients With Bipolar Disorder

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Abstract

Introduction: Bipolar disorder is a long-term, complicated mental illness that affects not only the patient's mental health, but also their family's psychological health and coping strategies.

Objective: This study aimed to evaluate the effects of a compassion-based intervention program on coping patterns among family caregivers of patients with bipolar disorder.

Methods: From June 2023 to March 2024, a study utilizing a one-group pre- and postinterventional design evaluated 50 family caregivers of patients with bipolar disorder. The study was conducted in an outpatient clinic at the Institute of Psychiatry affiliated with Ain Shams University Hospitals, Cairo, Egypt. The program consisted of 16 consecutive sessions, each lasting approximately 45 to 60 min. Researchers used a predesigned questionnaire to collect data pre- and postintervention to assess the sociodemographic data, self-compassion scale, and coping strategies inventory.

Results: Prior to the compassion intervention program, the study found that 62% of the evaluated family caregivers had low self-compassion; however, after the compassion intervention program, a highly significant improvement was observed, with 54% having high self-compassion ($p < .01$). Likewise, in the compassion intervention program, the study revealed that 60% of the family caregivers had a high use of disengagement coping patterns; however, in the postcompassion intervention program, a highly significant improvement was observed, with 64% having a high use of engagement coping patterns ($p < .01$).

Conclusion: The Compassion-Based Intervention Program has a positive effect on enhancing coping patterns and self-compassion among family caregivers of patients with bipolar disorder. Therefore, psychiatric nurses and mental health practitioners should collaborate in designing holistic caregiver support strategies that incorporate self-compassion techniques alongside traditional therapeutic approaches.

Keywords

self-compassion, coping patterns, family caregivers, bipolar disorder

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Introduction

Bipolar disorder (BD) is one of the most complex psychiatric disorders, affecting approximately 3% of the general population over a lifetime, and ranking among the top 10 causes of disability globally. Patients with BD experience mood swings that alternate between episodes of heightened, irritability, and hyperactivity (mania) and periods of deep sadness, indifference, or hopelessness (depression) (Jain & Mitra, 2023).

In Egypt, a study of “National Survey for Mental Health in Egypt: One Year Prevalence of Common Mental Disorders—

Community Survey,” conducted by the General Secretariat of Mental Health and Addiction Treatment, revealed that 25% of

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the studied population have psychiatric illnesses, among these the prevalence of BD was 2.7% among them (Rabie et al., 2017).

The deficits associated with BD—such as cognitive, behavioral, attention, and memory impairments—can significantly hinder an individual's ability to function in occupational, social, and daily activities. As a result, individuals with BD often require continuous, high-level care and support from their families. Family caregivers play a crucial role by providing a comprehensive range of support services that address physical, psychological, spiritual, and emotional needs, ultimately promoting the wellbeing of their loved ones (Ashalata & Koujalgi, 2022).

Consequently, family caregivers often experience high levels of burden and psychological distress, which may lead them to adopt maladaptive coping mechanisms, such as social isolation, feelings of guilt, avoidance of problems, and wishful thinking. These unhealthy strategies are associated with heightened levels of anxiety and despair (Mohamed et al., 2023; Marzban et al., 2024).

Therefore, compassion-based intervention programs to enhance coping patterns and self-compassion for families caring for patients with BD are needed. Considered as a healthy type of self-to-self interaction, self-compassion treats oneself with the same compassion that one would offer to another. It involves treating oneself gently when things go wrong (Murfield et al., 2021a, 2021b; Tan et al., 2021).

Self-compassion is conceptualized as having three components, each of which has two parts: the presence of one and the negation of the other: (a) “self-kindness” (recognizing, accepting, and being nice to oneself at times of pressure and despair) rather than “self-criticism” (being judged oneself), (b) “common humanity” (understanding that one's pain and frustrations are universal and experienced by human life) rather than “isolation” (withdrawn); and (c) “mindfulness” (realizing of one's negative thoughts and feelings) rather than “over-identification” (being squelched and over-involved with the problem) (Neff, 2003a, 2003b; 2023; Lathren, 2023).

Self-compassion interventions integrate multiple psychological theories, providing a holistic approach to enhancing mental and emotional wellbeing. By incorporating elements from cognitive behavioral theory, mindfulness-based theory, attachment theory, and humanistic theory, these interventions help mitigate psychopathology by reducing automatic negative thinking, improving emotional regulation, and fostering greater adaptability in the face of challenges. Each theoretical framework reinforces different aspects of self-compassion, highlighting its versatility and effectiveness across various psychological domains (Neff & Germer, 2022; Murfield et al., 2021a, 2021b).

In addition, self-compassion interventions are increasingly being applied across various disciplines, including nursing science, mental health (therapists and counselors), education (teachers and students), sports psychology (athletes and

coaches), and workplace environments (Finlay-Jones et al., 2023; Cormier et al., 2023). By integrating these interventions into different fields, individuals can develop healthier coping strategies, manage stress more effectively, foster resilience, and enhance both performance and overall wellbeing (Charitidou, 2024; Zhang & Fathi, 2024).

So, it is important as a part of psychiatric/mental health nurses to provide family caregivers with compassion-based program education and practices to help them navigate the emotional and physical challenges of caregiving by integrating self-compassion skills of self-kindness, mindfulness, and a sense of shared humanity into their daily lives (Travis et al., 2024). This intervention helps caregivers develop healthier relationships with themselves, increase self-awareness, promote life satisfaction, lower anxiety and depression, less use of dysfunctional coping patterns, more compassionate caregiving, and more resilience against burn-out (Ewert et al., 2021; Hughes et al., 2021).

Therefore, this study aimed to implement a compassion-based intervention program to enhance coping patterns and self-compassion among family caregivers of patients with bipolar.

Review of Literature

Tan et al. (2021) conducted a cross-sectional study involving 107 informal caregivers with diagnosed mental illnesses, who completed an online questionnaire. The study employed several assessment tools, including the COPE scale, General Benefit Finding Scale (GBFS), Self-Compassion Scale-Short Form (SCS-SF), Psychological Well-Being Scale (PWBS-B), and Hospital Anxiety and Depression Scale (HADS). The findings indicated that higher levels of self-compassion were positively associated with greater psychological wellbeing among caregivers. This association was partly explained by the caregivers' increased use of problem-focused coping strategies, suggesting that self-compassion plays a crucial role in enhancing emotional resilience in caregiving settings.

In a similar study, Hansen et al. (2021) conducted a randomized clinical trial across two community settings in Denmark, enrolling 161 caregivers. Participants were randomly assigned (1:1) to either an 8-week Compassion Cultivation Training (CCT) course or a control group. The study used the Depression, Anxiety, and Stress Scale (DASS) to measure outcomes at baseline, postintervention, and at 3- and 6-month follow ups. Results revealed that caregivers who completed the CCT program experienced significant reductions in depression, anxiety, and stress, with these benefits maintained at the 6-month follow up, demonstrating the long-term efficacy of compassion-based interventions.

Xu et al. (2020) conducted a convenience sample study with 208 Chinese family caregivers of cancer patients receiving treatment at a hospital in Tianjin City. Their findings showed that caregiving burden was strongly linked to higher levels of depression. However, hierarchical multiple

regression analysis indicated that self-compassion significantly mitigated the negative impact of caregiver burden on depression, suggesting that fostering self-compassion can serve as a protective factor against emotional distress in caregiving environments.

Similarly, Lloyd et al. (2019) conducted a cross-sectional survey with 73 informal caregivers of individuals diagnosed with dementia. Their results indicated that higher levels of self-compassion were associated with lower caregiver burden, which was partially explained by caregivers' reduced reliance on dysfunctional coping strategies. These findings further support the growing evidence that self-compassion enhances psychological resilience among caregivers by promoting healthier coping mechanisms and reducing emotional strain.

Hypothesis 1: The compassion-based intervention program will enhance coping patterns and self-compassion among family caregivers of patients with BD.

Methods

Design

From June 2023 to March 2024, a quasi-experimental design was used in this study (one group pretest–post-test).

Study Setting

The study was conducted in the outpatient clinics of the Institute of Psychiatry affiliated with the Ain Shams University Hospitals. The Institute of Psychiatry is located in Eastern Cairo and serves both urban and rural areas, including those around Greater Cairo. The institute consists of two parts; the first part is inpatient departments divided into 3 units for the management of various psychiatric disorders and substance abuse patients. The second part comprises outpatient clinics that include an adolescent clinic, pediatric clinic, psychiatric clinic, and psychosexual clinic for 4 days per week. It provides services for approximately 30 to 50 patients per day suffering from a variety of disorders such as BD, schizophrenia, mood disorder, anxiety disorder, obsessive-compulsive disorder, and other different types of psychiatric disorders.

Study Subjects

The purposive sample included 50 family caregivers of patients with BD attending specialized outpatient clinics in the previously mentioned study setting.

Inclusion Criteria

Patients were over 18 years old, diagnosed with BD at least 1 year ago, of both sexes, and without comorbid psychiatric

disorders. The inclusion criteria for family caregivers of patients with BD were family members who had given direct care to the patient for at least 1 year, both sexes, who at least read and write, and willingness to participate in the study.

Sample Size

The sample size was calculated using data from Barakat and Ibrahim (2020). With 95% statistical power, the grade of assuredness (1-Alpha Error) was 95%, alpha 0.05, beta 0.1, and the mean of the brief symptom inventory pre-intervention (mean (SD) = 179.34 (19.75)) compared with postintervention 123.42 (15.582), $p < .05$, an effect size of 0.51 was estimated. The final sample size included 50 family caregivers. The participants were recruited according to the inclusion criteria mentioned in the study. The researcher explained the objectives and aims of the study to the participating family caregivers and informed them that they were allowed to choose to participate or not in the study and given the right to withdraw at any time from the study without giving reasons.

Using the Kane SP. The Sample Size Calculator, a test that compares two means, was used to determine the sample size. Rosner (2011) developed the ClinCalc.

$$n = \left(\frac{Z_{1-\alpha/2} + Z_{1-\beta}}{ES} \right)^2$$

Tools of Data Collection

Data were collected using the following tools: the researcher translated these tools from English into Arabic and rendered the same English formats to bilingual experts for further verification of the translation of the Arabic formats, which were then translated back into the original language by other bilingual experts.

Tool I: The interview questionnaire was designed by the researcher in Arabic and consisted of the following parts. The first part contained data about the sociodemographic characteristics of family caregivers, including age, sex, level of education, occupation, monthly income, relationship to the patient, and others. The second part included the sociodemographic data of patients with BD: age, sex, education, marital status, employment, commitment to employment, and others. The third part included the patient's health history regarding BD, onset of symptoms, onset of treatment, and type of treatment, such as electroconvulsive therapy.

Tool II: Self-Compassion Scale (SCS): It was developed by Neff (2003a, 2003b) to measure typical actions towards the self during arduous times. It involved 26 items distributed to six subscales including Self-Kindness including (5) items, as opposed to Self-Judgment, which includes (5) items, Common Humanity includes (4) items, as opposed to Isolation, which includes (4) items, and Mindfulness includes (4) items as opposed to Over-identification including (4)

items. The items on the subscales of self-kindness, common humanity, and mindfulness on the Likert scale were almost never = 1, rarely = 2, sometimes = 3, often = 4, and almost always = 5. The items in the opposing subscales (self-judgment, isolation, and over-identification) were reversed in scoring, in which almost never = 5, rare = 4, sometimes = 3, often = 2, and always = 1. The total score was classified as low self-compassion if the sum was less than 65, moderate self-compassion if the score ranged from 65 to 90, and high self-compassion if the score ranged from 91 to 130.

Tool II: Coping Strategies Inventory (CSI): It was developed by Tobin et al. (1984) and adapted by the researcher to assess the thoughts and behaviors of individuals used to deal with the internal or external that are required by a specific stressful event. The CSI contains 72 items, and the final total of items after the researcher adaptation is 26. Based on the original scale, the tool is classified into 14 subscales, with a descending ranking of the two main tertiary subscales (engagement coping and disengagement coping).

The items in the engagement coping subscales (problem-solving, cognitive restructuring, emotional expression, and seeking social support) are rated on a three-point Likert scale, where always = 3, sometimes = 2, and rare = 1, except for item No.3 in emotional expression, which was reversed in score. The items in the disengagement coping subscales (problem avoidance, wishful thinking, self-criticism, and social withdrawal) were reversed in scoring in which rare = 3, sometimes = 2, and always = 1. The total scores were classified as low-use engagement coping if summing from 14 to 30.8 or high-use engagement from 30.9 to 42. Low-use disengagement coping if summing from 12 to 26.4, or high-use disengagement from 26.5 to 36.

Tool Validity and Reliability

Validation of the Scales

The content validity of the tools was reviewed by five experts from the Psychiatric/Mental Health Nursing Department, Faculty of Nursing, Ain Shams University, Cairo, Egypt. These experts, comprising professors and assistant professors from different academic ranks, assessed the tools for face and content validity. Their evaluation focused on clarity, comprehensiveness, accuracy, relevance, and the extent to which the tools elicited the intended information.

Reliability

The internal reliability of the data collection tools was assessed using Cronbach's alpha, yielding the following results: the Self-Compassion Scale had a reliability coefficient of 0.870, indicating good reliability, while the Coping Strategies Inventory had a reliability coefficient of 0.923, indicating excellent reliability.

Fieldwork

The process of data collection and implementation of the program took 10 months, starting at the beginning of June 2023 and was completed by the end of March 2024. Fifty family caregivers were selected based on the previously mentioned inclusion criteria from the study settings. The program was conducted in the following phases:

(A) Assessment and planning phase (pre)

Family caregivers who fulfilled the study criteria were chosen, and the researchers conducted interviews to determine their needs and study materials. After the family caregivers informed them of their goals, permission and informed consent were obtained from them. The assessment phase lasted approximately 2 months. Data were gathered twice a week on Wednesdays and Thursdays during the morning shift. The sessions of the compassion-based intervention program were created to meet the needs of the participants.

(B) Implementation phase

Family caregivers were divided into nine groups, and the number in each group ranged from five to six family caregivers. The compassion-based intervention program was applied to the study subjects in 16 consecutive sessions aimed at enhancing coping patterns and self-compassion among study subjects, and each session took about 45 to 60 min according to the caregiver's understanding and attention span.

The Training Program's Content. Session (1): Essential knowledge was provided to all caregivers, including basic facts regarding BD, such as its definition, risk factors, symptoms, and care management. Session (2, 3, and 4) each caregiver was familiarized with the practical skills involved in enhancing patient adherence to the treatment plan, techniques to reduce the patient's relapse, techniques for dealing with a spouse with BD, and some methods to help the patient during episodes. In session (5), each caregiver was acquainted with essential knowledge about the meaning of coping patterns and different coping patterns. In sessions (6, 7, 8, 9, and 10) each caregiver was acquainted with knowledge and skills, including meaning, benefits, and steps of relaxation techniques (meditation, breathing exercises, and gradual muscle relaxation), anger management, time management, and problem-solving techniques. In session (11), each caregiver was familiarized with the meaning, components, and benefits of self-compassion. In sessions (12, 13, 14, 15, and 16) each caregiver was familiarized with practical skills involving daily compassion affirmations, self-acceptance techniques, replacing negative thoughts and emotions with positive ones, positive self-talking, lifestyle modifications, ideas for self-care activities, and mindfulness exercises.

(C) Evaluation phase

The post-test was collected from the studied family caregivers following the implementation of the compassion-based intervention program using the previously mentioned study tools to evaluate the effectiveness of the program on improving family caregivers' coping patterns and self-compassion.

Data Analysis

After being entered into SPSS version 22, the study data were coded in preparation for analysis. The data were reviewed for mistakes and outliers before analysis. Standard deviation and mean were used as suitable metrics to explain the quantitative data. The chi-square test was used to investigate the differences between categorical variables. A *p*-value of $<.05$. used to indicate statistical significance, while a *p*-value of $<.01$ **indicated highly significant data.

Results

Table 1 the sociodemographic characteristics show that the mean age of the studied family caregivers was 46.14 ± 3.65 years, and 46% of their ages ranged from $36 \leq 50$ years. Also, 74% of them were female and 80% of them were married. Regarding the educational level, 50% of them were in intermediate education and 52% of them were mothers. Regarding the family caregivers' occupation, it was found that 62% of them were not working and 84% of them had insufficient monthly income. Furthermore, about 76% of the studied caregivers were residing in urban areas and 78% of them did not suffer from any chronic disease.

Table 2 the health history regarding BD shows that in 52% of the studied patients, the onset of the disease ranged from $8 \leq 10$ years, with a mean of 8.16 ± 1.03 . Also, 50% of them began treatment ranged from $8 \leq 10$ years, with a mean of 8.75 ± 1.08 . As regards types of treatment, 100% of them were taking pharmacological treatment, 90% of them received electroconvulsive therapy and 46% of them underwent psychotherapy. Concerning the daily activity, 76% of them needed assistance in carrying out the activities of daily living. Moreover, in 66% of them, the number of hospital admissions ranged from $4 \leq 6$, with a mean of 5.78 ± 0.84 and in 60% of them the current episodes were mania.

Figure (1) shows that 62% of the studied family caregivers had low self-compassion before implementation of the compassion-based intervention program, compared to 54% of them having high self-compassion postimplementation of the program. Therefore, there were statistically significant differences in the levels of self-compassion among the studied family caregivers pre- and postimplementation of the compassion-based intervention program ($X^2 = 17.362, p < .01$).

Figure 2 shows that 60% of the studied family caregivers had a high use of disengagement coping patterns before implementation of the compassion-based intervention

Table 1. Characteristics of the Studied Family Caregivers (n = 50).

Items	n (%)
Age	
20 \leq 35	8 (16.0)
36 \leq 50	23 (46.0)
>50	19 (38.0)
Mean \pm SD	46.14 \pm 3.65
Sex	13 (26.0)
Male	37 (74.0)
Female	
Relation to patient	
Father	10 (20.0)
Mother	26 (52.0)
Bother	1 (2.0)
Sister	6 (12.0)
Husband	2 (4.0)
Wife	5 (10.0)
Marital status	
Single	3 (6.0)
Married	40 (80.0)
Widowed	3 (6.0)
Divorced	4 (8.0)
Residence	
Rural	12 (24.0)
Urban	38 (76.0)
Educational level	
Primary education	14 (28.0)
Intermediate education	25 (50.0)
University education	11 (22.0)
Occupation	
Work	19 (38.0)
Not work	31 (62.0)
Monthly income	
Sufficient	8 (16.0)
Insufficient	42 (84.0)
Suffer from any chronic diseases	
Yes	11 (22.0)
No	39 (78.0)
If yes type of chronic diseases n = 11	
Diabetes	7 (63.6)
Hypertension	4 (36.4)
Heart disease	0

program, compared to 64% of them having a high use of engagement coping patterns after implementation of the program. Therefore, there were highly statistically significant differences in the levels of coping patterns (engagement and disengagement) among the studied family caregivers between pre- and after the postimplementation of the compassion-based intervention program ($X^2 = 12.214$ at $p < .01$).

Table 3 was a strong statistically positive correlation between self-compassion and engagement coping patterns among family caregivers, in which $r = .652$ at $p = 0.000^{**}$. While, there was a strong statistically negative correlation between self-compassion and disengagement coping patterns among family caregivers, in which $r = -.701$ at $p = 0.000^{**}$ in the postimplementation stages of the compassion-based intervention program.

Table 2. Health History Regarding Bipolar Disorder of the Studied Patients (n = 50).

Items	No. (%)
Onset of the disease	
1 ≤ 4 years	5 (10.0)
5 ≤ 7 years	9 (18.0)
8 ≤ 10 years	26 (52.0)
More than 10 years	10 (20.0)
Mean ± SD	8.16 ± 1.03
Beginning of treatment	
1 ≤ 4 years	3 (6.0)
5 ≤ 7 years	12 (24.0)
8 ≤ 10 years	25 (50.0)
More than 10 years	10 (20.0)
Mean ± SD	8.75 ± 1.08
*Types of treatment	
Pharmacological treatment	50 (100.0)
Electroconvulsive therapy	45 (90.0)
Psychotherapy	23 (46.0)
Daily activities	
Independent	8 (16.0)
Need assistant	38 (76.0)
Dependent	4 (8.0)
Number of hospital admissions	
1 ≤ 3	2 (4.0)
4 ≤ 6	33 (66.0)
7 ≤ 10	15 (30.0)
Mean ± SD	5.78 ± 0.84
Current episodes	
Depression	20 (40.0)
Mania	30 (60.0)

Discussion

The study found a highly statistically significant difference in the total self-compassion levels of family caregivers before and after the implementation of the compassion-based intervention program. The results showed that, before participating in the compassion-based intervention program, more than three-fifths of the studied family caregivers had a low level of self-compassion. However, after the program, more than half demonstrated high levels of self-compassion. This result may be due to the program providing family caregivers with the necessary knowledge and skills about the importance and components of self-compassion and how to practice self-compassion thinking and behavior techniques.

These findings align with those of Noei et al. (2022), who reported a significant increase in self-compassion scores post-intervention, highlighting its positive impact on caregivers. Similarly, a study by Hansen et al. (2021) found that increased self-compassion following the intervention was associated with reductions in depression, anxiety, and stress among caregivers of individuals with mental illness.

These findings align with the concept of coaching with compassion in caregivers' coaching, as discussed by D'Agostino et al. (2023). Additionally, Murfield et al.

(2021a, 2021b) emphasized the importance of implementing mindfulness- and compassion-based interventions to support family caregivers in managing their responsibilities more effectively.

The present study illustrated that there was a highly statistically significant difference in the total levels of coping patterns (engagement and disengagement) among the studied family caregivers between pre- and after the implementation of the compassion-based intervention program. This means that the studied family caregivers submitted higher responses in the engagement coping pattern subscales in contrast to the disengagement coping pattern subscales after implementing the compassion-based intervention program. This may be due to the introduction of cognitive restructuring skills, problem-solving techniques, emotional expression, and how to seek a social support system during times of stress; these subscales are part of the engagement coping patterns. In addition, the family caregivers during the program asked about their engagement coping skills and how to implement them as part of their daily lives. Moreover, the researcher gave some real situations with examples that helped the studied family caregivers improve their positive coping skills throughout the program.

This result was supported by a study conducted by Zhai et al. (2023), which showed that digital health interventions notably improved problem-solving skills and engagement among family caregivers, highlighting the beneficial effects of the intervention on caregivers' capabilities. This result was in agreement with a study performed by Zhou et al. (2020) in Hong Kong, which reported that the psycho-educational group showed significant improvements in problem-focused coping skills compared with the control group across three time points (pretest, post-test, and 3-month follow up). In addition, Quinn et al. (2023) identified specific therapist behaviors in emotionally focused family therapy that resulted in successful openness events, thereby improving emotional engagement and expression among family caregivers. Moreover, this result was supported by a study by Abbaslou et al. (2023), which highlighted the importance of effective coping strategies in reducing the perceived burden among caregivers of patients with chronic psychiatric disorders such as BD.

Regarding disengagement coping patterns, the subscales of the studied family caregivers obtained lower responses in problem avoidance, wishful thinking, self-criticism, and social withdrawal after implementing the compassion-based intervention program. This may be due to the researcher throughout the program educating family caregivers about the negative consequences of using self-blame, problem avoidance, wishful thinking, and social withdrawal in dealing with problems of caring, burden, and frustration as reported by the family caregivers. In addition, the engagement coping skills practiced during the program helped and supported family caregivers during stressful life events and associated stressful feelings.

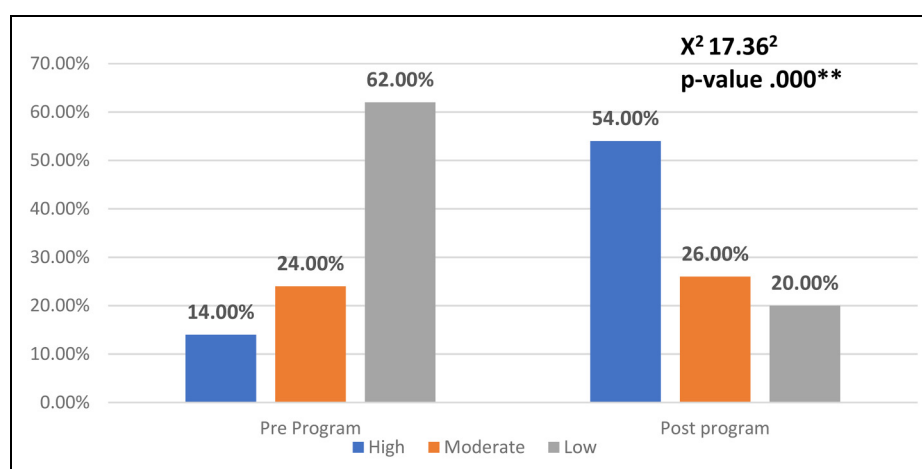


Figure 1. Self-compassion among family caregivers at pre- and postintervention (n = 50).

*Significant at $p < .05$. **Highly significant at $p < .01$. Not significant at $p > .05$.

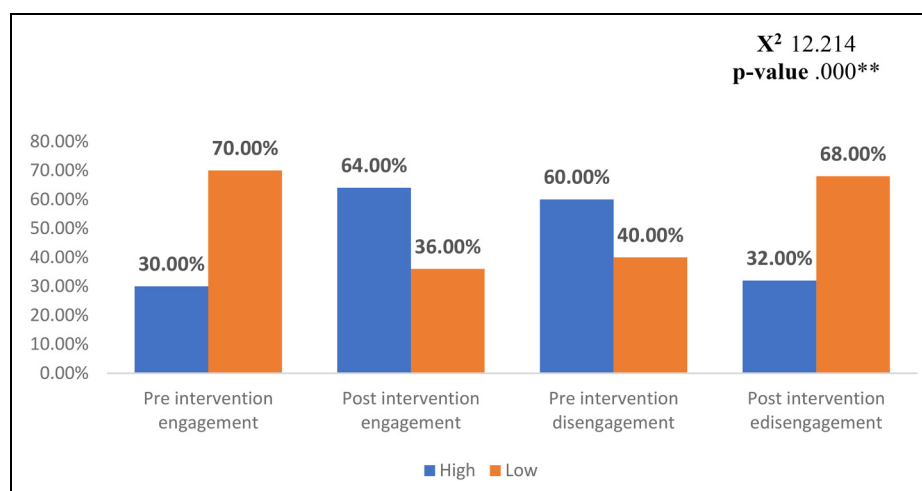


Figure 2. Coping patterns among family caregivers at pre- and postintervention (n = 50).

*Significant at $p < 0.05$. **Highly significant at $p < .01$. Not significant at $p > .05$.

Table 3. Correlation Between Study Variables at Postintervention (n = 50).

Items	Self-Compassion	Engagement Coping
Caregivers' engagement coping	r .652 p .000**	
Caregivers' disengagement coping	r -.701 p .000**	-.724 .000**

(**) Statistically significant at $p < .01$. r=Pearson correlation.

This result was consistent with that reported by Thomas et al. (2019). This study showed a notable enhancement in problem-focused disengagement among family caregivers following the intervention, suggesting a positive influence on fostering active coping strategies. The results also showed

an inverse correlation between burden and problem-focused coping strategies and a direct correlation between burden and disengagement coping strategies. Similarly, Kumar et al. (2023) emphasized the effectiveness of programs such as Interpersonal and Social Rhythm Therapy (IPSRT) and family focused therapy in enhancing disengagement coping skills, reducing caregiver burden, and increasing knowledge of the illness. This result is supported by a study conducted by Ashalata and Koujalgi (2022). This study found that the Barcelona family focused psycho-education intervention significantly reduced emotionally focused disengagement among caregivers of individuals with bipolar affective disorder, fostering emotional connectedness and engagement.

As regards the correlation between the studied variables in the postcompassion-based intervention program, the present study revealed that there were strong positive correlations

between self-compassion and engagement coping patterns as well as there was strong negative correlations between self-compassion and disengagement coping patterns. This means that the higher the use of self-compassion thoughts and behaviors among family caregivers, the more the acquisition of engagement coping skills is, contrary to disengagement coping.

This result was supported by a study conducted by Murfield et al. (2021a, 2021b). The study found statistically significant positive correlations between engagement coping and self-compassion among family caregivers of older adults, thus supporting the validity of the Compassionate Engagement and Action Scale. This result parallels Lloyd et al. (2019), who found a statistically significant negative correlation between caregivers' disengagement and their engagement in coping with their total self-compassion. This result is also supported by a study conducted by Tan et al. (2021). These results show that caregivers high in self-compassion have a greater tendency to utilize problem-focused coping strategies, which, at least partly, leads to increased psychological wellbeing.

Limitations

A limited number of studies have addressed similar compassion-based interventions for family caregivers of patients with BD. The quasi-experimental one-group pre-post-test design lacked a control group, which may have introduced potential biases and limited the ability to attribute changes solely to the intervention. In addition, the study utilized a small purposive sample of 50 family caregivers, limiting the generalizability of the findings to larger populations or diverse healthcare settings. This study focused on immediate pre- and postintervention changes, without long-term follow up, to assess the sustainability of improvements in coping patterns and self-compassion.

Challenges in maintaining participant engagement were noted, as some family caregivers initially enrolled in the program dropped out before completion, which could have influenced the consistency of the results. In addition, reliance on self-reported measures for assessing self-compassion and coping patterns may introduce social desirability or recall biases.

Implications for Practice

The findings emphasize the importance of implementing periodic reinforcement sessions that integrate compassion-based intervention programs into routine caregiver support initiatives to improve coping patterns and self-compassion, thereby enhancing the overall caregiving experience and generating policies that promote caregiver education and mental health support programs in outpatient clinics and community health settings. Moreover, larger randomized-controlled trials with diverse samples are recommended to validate the efficacy of the intervention and inform evidence-based practice.

Conclusion

Based on the findings of the current study, researchers can conclude that the implementation of a compassion-based intervention program had a positive effect on enhancing coping patterns and self-compassion among family caregivers of patients with BD. For further studies, a larger randomized controlled trial is recommended to validate the current findings, provide more conclusive evidence on the efficacy of the intervention, and guide future interventions.

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Statements and Declarations

Ethical Considerations

The Scientific and Ethical Committee of the Nursing Faculty of Ain Shams University granted ethical permission (approved number 24.02.225). The family caregivers participating in the study gave their written agreement after the researcher made clear the purpose of the study to them. Data confidentiality and anonymity were guaranteed and upheld. Family caregivers were advised that they may choose to participate in the study or not, and that they could leave at any moment. The researcher also made it clear that all data collected would be utilized for both the family caregivers' benefit and scientific research.

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Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement

The corresponding author can provide the data from this study upon request.

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