Status of Social Support among Patients with Bipolar Mood Disorder: A Quantitative Study

By

Mahmuda Akter

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Bachelor of Science in Occupational Therapy

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Faculty of Medicine

University of Dhaka

Thesis completed by:

Mahmuda Akter
4th year, B.Sc. in Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

……
Signature

Supervisor's Name, Designation, and Signature

Md.Saddam Hossain
Assistant professor
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

……
Signature

Head of the Department's Name, Designation, and Signature

Prof. Sk. Moniruzzaman
Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

……
Signature

BOARD OF EXAMINERS

Prof. Sk. Moniruzzaman
Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343, Bangladesh.

.....
Signature

Dr. Md. Shakhaoat Hossain, PhD
Chairman & Associate Professor
Department of Public Health and Informatics
Jahangirnagar University
Savar, Dhaka-1342, Bangladesh.

.....
Signature

STATEMENT OF AUTHORSHIP

I declare that, except where explicitly referenced in the text of this thesis, no material has been published elsewhere or extracted in whole or in part from a thesis I have presented for any other degree or seminar. No other person's work has been used without proper acknowledgment in the main body of the thesis.

This thesis has not been submitted for the award of any other degree at any tertiary institution. All ethical considerations related to this study have been carefully observed and protected. Should the findings of this research be disseminated in future publications, my research supervisor will be fully involved and appropriately acknowledged, and this thesis will be credited as part of my undergraduate studies.

Mahmuda Akter

4th year, B.Sc. in Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

Centre for the Rehabilitation of the Peralysed (CRP)

Chapain, Savar, Dhaka: 1343

……

Signature

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DEDICATION

To my honorable and beloved parents & respected teachers.

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LIST OF ABBREVIATIONS

APA	American Psychological Association.
BD	Bipolar Disorder
BHPI	Bangladesh Health Professions Institute
BMD	Bipolar Mood Disorder
CBPR	Community-Based Participatory Research
CRP	Centre for the Rehabilitation of the Paralyzed
DSM	Diagnostic and Statistical Manual of Mental Disorder
IRB	Institutional Review Board
NIMH	National Institute of Mental Health
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organization

ABSTRACT

Background: Bipolar Mood Disorder (BMD) is a chronic mental health condition characterized by alternating episodes of mania and depression, which significantly affect an Person's daily functioning, social participation, and overall wellbeing. Social support from family, friends, and spouses plays a vital role in helping patients cope with the challenges of the disorder and maintain mental health. In Bangladesh, research on social support among patients with BMD is limited. Stigma, discrimination, and lack of social support often exacerbate the difficulties faced by these individuals, restricting their engagement in social, occupational, and community activities. Understanding the level and sources of social support is essential for developing culturally appropriate interventions that enhance social participation and improve mental health outcomes.

Aim: The aim of this study was to assess the level of social support among patients with Bipolar Mood Disorder and to identify key gaps in support from family, friends, and spouses, as well as the impact of stigma and loneliness on social participation.

Methods: A cross-sectional quantitative study was conducted among 106 patients diagnosed with BMD at the National Institute of Mental Health (NIMH). Data were collected through face-to-face interviews using structured questionnaires and the Multidimensional Scale of Perceived Social Support (MSPSS), which measures. **Results:** The findings showed that 6.6%(7) of participants experienced low social support, 59.4% (63) had moderate support, and 33.96% (36) reported high support. Family support was the highest, followed by support from friends and spouses.

However, stigma, loneliness, and limited peer and spousal support were identified as key gaps affecting social participation and overall wellbeing. These findings suggest

that while family provides strong support, additional interventions targeting peer and spousal support, as well as stigma reduction, are necessary to improve social inclusion and quality of life among patients with BMD.

Conclusion: The study shows that the critical role of social support in the lives of patients with Bipolar Mood Disorder. Despite moderate to high levels of family support, gaps in peer and spousal support, combined with stigma and loneliness, continue to limit social participation. These findings emphasize the need for targeted interventions, including peer-led support groups, family counseling, and community-based programs, to enhance social support, reduce stigma, and improve overall quality of life for individuals living with BMD in Bangladesh

Keywords: Bipolar Mood Disorder, Social Support, Family Support, Friends Support, Spousal Support, Mental Health, Psychosocial Factors.

CHAPTER I: INTRODUCTION

1.1 Background

Bipolar Mood Disorder (BMD) is a chronic psychiatric disorder characterized by frequent episodes of mania, hypomania, and depression, which significantly affect mood regulation, cognitive function, behaviour, interpersonal relationships, and daily functioning. Human with BMD often experience emotional instability, social withdrawal, and difficulty maintaining routines, which negatively impacts their overall quality of life (World Health Organization, 2022). Social support, defined as emotional, informational, and practical assistance received from family, friends, and significant others, plays a critical role in the psychosocial management of patients with BMD.

Bipolar mood disorder affects mood, energy, behavior, and cognitive functioning, and follows a cyclical pattern throughout the lifespan. The disorder is relatively common, affecting almost 1.3% to 1.6% of the global population. Despite its prevalence, it is associated with severe consequences: the mortality rate is two to three times higher than that of the general population, and 10–20% of individuals ultimately die by suicide. Moreover, nearly one-third attempt suicide at least once. Although both men and women are affected, rapid cycling characterized by frequent shifts between depressive and hypomanic/manic episodes is more commonly observed in women. Owing to its recurrent nature and the high risk of relapse, continuous long-term treatment is often required to help stabilize mood fluctuations and reduce the frequency of episodes (Müller-Oerlinghausen et al., 2002). According to the DSM-5, depressive episodes in bipolar disorder are marked by persistent hopelessness, loss of interest in enjoyable activities, reduced energy, impaired concentration, and suicidal ideation. In contrast, hypomanic or manic episodes are characterized by elevated mood, a decreased need for

sleep, rapid thoughts, pressured speech, increased activity, and impulsive decision-making. Diagnostic criteria require individuals to exhibit symptoms such as inflated self- esteem, reduced sleep requirement, heightened talkativeness, and increased goal-directed behavior during these elevated mood phases. On the depressive end, individuals typically present with low mood, diminished motivation, and significant disruption in social and occupational roles.

1.2 Justification of the study

Bipolar Mood Disorder (BMD) is a chronic psychiatric condition that significantly affects emotional regulation, interpersonal relationships, occupational functioning, and overall quality of life. Globally, bipolar disorder is associated with high relapse rates, functional impairment, and increased suicide risk (American Psychiatric Association, 2013; WHO, 2022). Research consistently highlights the importance of social support as a protective factor in the management of bipolar disorder. Strong emotional and practical support from family, friends, and significant others has been associated with improved treatment adherence, reduced relapse, and better psychosocial functioning (Cohen & Wills, 1985; Miklowitz, 2007).

Studies suggest that inadequate social support increases vulnerability to depressive symptoms, emotional instability, and suicidal ideation (Perlick et al., 2007). Furthermore, stigma and social isolation often limit patients' participation in social and occupational activities, thereby negatively impacting recovery outcomes (Corrigan & Watson, 2002). Family psychoeducation and supportive interpersonal environments have been shown to reduce relapse rates and enhance coping abilities (Miklowitz & Goldstein, 1997).

Despite strong international evidence, limited research has been conducted in Bangladesh regarding the level and pattern of social support among patients with

Bipolar Mood Disorder. Cultural values, family structures, stigma, and limited mental health resources in Bangladesh may significantly influence perceived social support. Without local evidence, mental health professionals cannot design culturally appropriate psychosocial interventions, family-centered programs, or community-based rehabilitation strategies.

Therefore, assessing the level of social support among Bangladeshi patients with BMD is essential to identify existing gaps and to guide clinical practice, policy development, and occupational therapy interventions aimed at improving social participation and quality of life.

1.3 Operational Definition

1.3.1 *Bipolar Mood Disorder*

Bipolar disorder, previously known as manic depression, is a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks.(I. M. Anderson et al., 2012; Vahia, 2013) If the elevated mood is severe or associated with psychosis, it is called mania; if it is less severe and does not significantly affect functioning, it is called hypomania(I. M. Anderson et al., 2012) . During mania, an individual behaves or feels abnormally energetic, happy or irritable, and they often make impulsive decisions with little regard for the consequences.

1.3.2 *Social Support*

Social support refers to the overall emotional, informational, and practical assistance an individual receives from people within their social network. For this study, social support is operationalized as the availability, frequency, and perceived adequacy of support coming from family members, spouse, friends, and significant others. It includes emotional support (care, empathy), instrumental/tangible support (help with

tasks), informational support (guidance), and companionship. The level of social support is measured using structured items, and categorized into low, moderate, or high support based on score ranges. (WHO, 2004).

1.3.3 Patients with BMD

Patients with BMD in this study refer specifically to individuals aged 18 years and above who have been diagnosed with Bipolar I or Bipolar II Disorder by a qualified psychiatrist and who are receiving treatment, therapy, or follow-up services at the National Institute of Mental Health (NIMH). Patients must meet the inclusion criteria, provide informed consent, and be mentally stable enough at the time of data collection to participate. This operational definition ensures a reliable and clinically relevant sample population. (American Psychiatric Association, 2013).

1.3.4 Mental Health Illness

A mental disorder is a clinically significant disturbance in an individual's cognition, emotional regulation, or behaviors. It frequently comes with distress or functional impairment in key areas (WHO, 2022).

1.4 Aim of the study

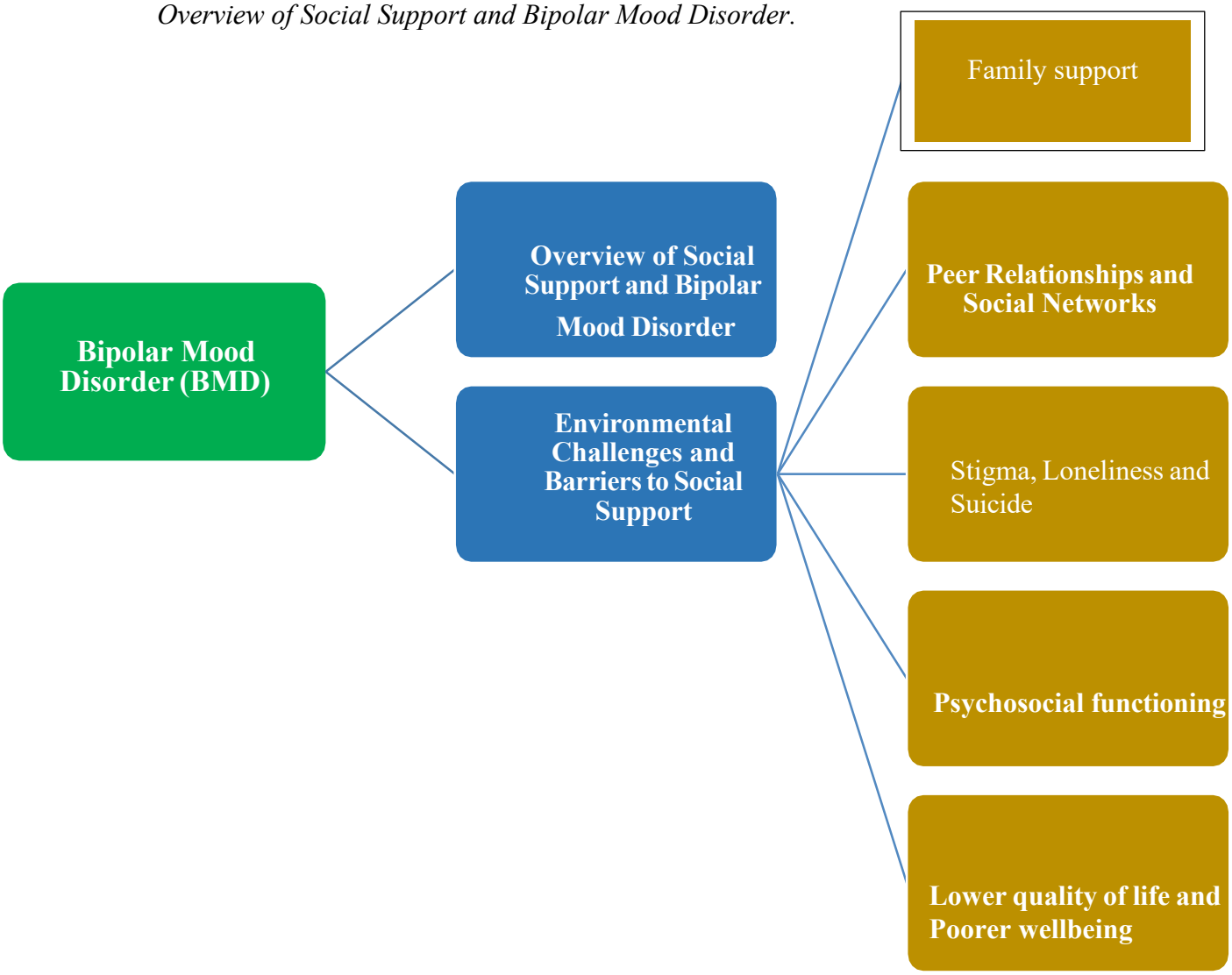
To find out the level of Social Support among patients with Bipolar Mood Disorder.

CHAPTER II: LITERATURE REVIEW

This literature review chapter overviews the findings of a few articles about the status social support among patient with Bipolar Mood Disorder. This chapter discussed the evidence for Family support, Peer relationships and networks, Stigma, Loneliness and suicide, Psycho social functioning, Lower quality of life and poorer wellbeing. This chapter summarized to provide a clear overview.

Figure 2.1

Overview of Social Support and Bipolar Mood Disorder.



2.1Overview of Social Support and Bipolar Mood Disorder

Social support is a key protective factor for people living with Bipolar Mood Disorder (BMD). It helps stabilize mood, supports regular medication use, and reduces the risk of relapse. Support from family, spouses, friends, and the wider community offers emotional comfort, practical help, and a sense of belonging. Together, these factors make it easier for individuals to cope with stress and manage daily life. (Johnson et al., 2000)

Research consistently shows that people with stronger social support report fewer depressive symptoms, greater resilience, and a better overall quality of life. Johnson et al. (2018) found that interpersonal support improves psychosocial functioning, while Sajatovic et al. (2020) reported that adequate support is linked to significantly lower symptom severity. Overall, social support plays a direct and central role in promoting better clinical outcomes and long-term stability in BMD.

2.2 Environmental Challenges and Barriers to Social Support

Despite its importance, many people with BMD face environmental barriers that limit their access to consistent social support. Stigma is one of the most significant obstacles. It can lead individuals to hide their symptoms, avoid disclosing their diagnosis, and withdraw from relationships.(WHO, 2022, Corrigan, Druss, & Perlick, 2014; Stuart, 2006).

Limited mental health awareness among families and communities often leads to misunderstanding of mood episodes and unpredictable behaviour. As a result, empathy and support may be reduced at precisely the times they are most needed. Practical challenges such as financial strain, lack of transportation, and caregiver burden also make it harder to access services and maintain supportive relationships over time. (WHO, 2022, Awad & Voruganti, 2008, Fadden, Bebbington, & Kuipers, 1987).

Corrigan and Watson (2007) note that stigma can severely restrict social interaction, while Perlick et al. (2016) highlight how ongoing logistical and financial stressors can weaken long-term family support. In addition, cultural norms that discourage open discussion of mental illness can further isolate individuals. Together, these barriers make it difficult for people with BMD to maintain stable emotional and practical support networks.

2.2.1Family Support

Family support is central to the clinical stability and emotional wellbeing of individuals with BMD. Families can provide reassurance during depressive episodes, help with monitoring and regulating behaviour during manic phases, and encourage regular medication use and follow-up care. (Miklowitz, 2008; Reinares, Colom, Martínez-Arán, & Vieta, 2004; WHO, 2022).

Evidence shows that strong family involvement reduces relapse, strengthens coping skills, and fosters resilience. Reinares et al. (2016) found that family-focused psychoeducation significantly decreases recurrence rates in bipolar patients. Similarly, Miklowitz (2014) showed that positive family communication, lower expressed emotion, and supportive interactions are closely associated with better treatment outcomes.

In this way, family support acts as a protective buffer against stress and illness-related challenges. It promotes long-term stability and improves the person's ability to manage BMD in everyday life.

2.2.2 Peer Relationships and Social Networks

People with BMD often find it difficult to maintain stable peer relationships because of mood swings, impulsive behavior, and emotional instability. However, when peer relationships are strong, they can have a powerful positive impact. Supportive friends

and broader social networks can improve self-esteem, encourage healthier behaviour, and reduce feelings of loneliness and social exclusion.

Studies show that individuals with richer social networks tend to experience lower symptom severity and better functional outcomes. A systematic review by Samamé (2013) and a meta-analysis by Bora et al. (2016) indicate that impairments in social cognition such as difficulty understanding others' emotions or intentions can interfere with forming and maintaining friendships. Strengthening peer relationships and social skills can therefore play an important role in improving social integration, daily functioning, and overall recovery in BMD.

2.2.3 Stigma, Loneliness, and Suicidal Risk

Stigma is one of the most powerful barriers to recovery for people living with bipolar disorder. Public stigma, stigma within families, and internalized self-stigma all contribute to social withdrawal and deep feelings of loneliness. This emotional isolation is strongly associated with suicidal thoughts and behaviours.

Tidemalm et al. (2014) reported that suicide risk is notably higher among individuals with bipolar disorder who perceive low levels of social support. Yıldız et al. (2020) likewise found that loneliness and negative social interactions predict suicidal behaviour even during periods of remission. Stigma can also discourage people from seeking treatment, reduce their confidence in managing the illness, and undermine hope for the future. Together, these factors create a cycle of emotional vulnerability that significantly increases the risk of self-harm and suicide.

2.2.4 Psychosocial Functioning

Psychosocial functioning refers to a person's ability to carry out everyday activities, maintain relationships, work or study effectively, and cope with stress. In BMD, episodes of mania and depression can disrupt cognition, emotional regulation, and

behaviour. These difficulties often persist between episodes, leading to impaired functioning even when individuals are considered clinically stable.

Research suggests that poor social support, negative social experiences, and difficulties in social cognition are all associated with worse psychosocial outcomes. Martinez-Arán et al. (2004) found that social cognition and emotional processing are key predictors of functional recovery. Johnson et al. (2018) also reported that individuals with low levels of interpersonal support tend to have poorer social adjustment and reduced role functioning. Thus, psychosocial functioning in BMD is closely tied to the presence of stable support networks and the ability to regulate emotions effectively.

2.2.5 Lower Quality of Life and Wellbeing

Quality of life in bipolar disorder is often lower than in the general population. This is influenced by the chronic nature of the illness, frequent relapses, medication side effects, stigma, and unstable social support. Weak family and peer support, high levels of loneliness, and recurrent mood episodes all contribute to reduced emotional, social, and physical wellbeing.

Michalak et al. (2005) reported that even during remission, many individuals with BMD experience significant impairments in life satisfaction and overall wellbeing. Szentagotai-Tătar et al. (2019) found that social support is a strong predictor of higher quality of life, while low support is associated with poorer outcomes.

CHAPTER III: METHODS & METERIALS

3.1 Study Questions, Aim and Objectives

3.1.1 Study Question

What is the level of social support received from family, friends, and spouse among patients with bipolar mood disorder**?**

3.1.2 Aim

To find out the level of Social Support among patients with Bipolar Mood Disorder.

3.1.3 Objectives

- To find the level of social support (Family,Friends,Spouse) among the patients.
- To assess the associated factors of Social Support.
- To find the sociodemographic information.

3.2. Study Design

3.2.1 Study Method

In this study, the researcher used a quantitative research method because it helps Measure occurrences through numbers and calculations through numbers and calculations. Quantitative studies focus on aspects like frequency and quantity by testing objective theories and examining the relationships between variables. The data, presented in numerical form, can then be analyzed using statistical methods (John W. Creswell & J. David Creswell, 2018).

3.3.2 Study Approach

Cross-sectional studies are observational studies that analyze data from a population at a single point in time. They are often used to measure the prevalence of health outcomes, understand determinants of health, and describe features of a population.

Unlike other types of observational studies, cross-sectional studies do not follow individuals up over time. They are usually inexpensive and easy to conduct. They are useful for establishing preliminary evidence in planning a future advanced study.

By using this design, the study will be able to explore the prevalence of social support among patients with bipolar mood disorder and the variations in its effects, depending on factors such as the source of support, the severity of the disorder, and demographic variables (Creswell, 2014).

3.3 Study Setting and Period

3.3.1 Study Setting

The National Institute of Mental Health (NIMH) in Bangladesh is a leading government hospital and Research center for mental health care. Located in Dhaka, it provides specialized treatment for psychiatric Disorders, including bipolar disorder, schizophrenia and depression. NIMH also conducts research, training, and education for mental health professionals. It plays a crucial role in improving mental health services in Bangladesh.

3.3.2 Study Period

This research was conducted from June 2025 to December 2025**.**

3.4.1 Study Participant Study Population

The person who are clinically diagnosed with Bipolar Mood Disorder.

3*.4.2 Sampling Techniques*

Purposive sampling technique was used to select the participants for this study. In this method, individuals are intentionally chosen based on the researcher's judgment and specific characteristics relevant to the study objectives. For this research, only clinically diagnosed patients with bipolar mood disorder who met the inclusion criteria were

selected. This approach ensured that the sample consisted of participants who could provide accurate and meaningful information related to their level of social support.

3.4.3 Inclusion Criteria

- Patients aged 12–65 years diagnosed with bipolar mood disorder
- Individuals receiving mental health treatment for at least six months.
- Currently receiving treatment or follow-up.

3.4.4 Exclusion Criteria

- Patients with severe cognitive impairments prevent participation in the survey.
- Individuals unwilling to provide informed consent.

3.4.5 Sample Size

$$n = \frac{Z^2 p(1-p)}{d^2}$$

$$n = \frac{(1.96)^2 0.50(1-0.5)}{(0.05)^2}$$

$$n = 384$$

Here,

n= sample size

z= the standard normal deviate usually set at 1.96; 95% confidence interval.

p= the investigator did not know the prevalence rate so the prevalence is 50% (0.5)

q=(1-p)=0.5; proportion in the target population not having the particular **.**

3.5 Ethical Consideration

3.5.1 Ethical Approval from IRB

- Ethical clearance will be sought from the Institutional Review Board (IRB) of the Bangladesh Health Professions Institute (BHPI) through the Department of Occupational Therapy.
- Permission will be obtained from relevant authorities within mental health organizations and clinics to recruit participants for the study.
- All participants will be informed about the aim and objectives of the study.

3.5.2 Informed Consent

- An Information Sheet was provided explaining the study.
- A Consent Form was given to the participants.

3.5.3 Withdrawal Form

Withdrawal form is a document that describes the procedure and conditions of withdrawal participation. By using this form, the participant can voluntarily withdraw participation from the research.

3.5.3 Unequal Relationships

There had been no prior relationship between the participants and the student researcher. To avoid any unequal dynamics with individuals he was already acquainted with in another capacity and to prevent any form of bias, the student researcher deliberately refrained from selecting participants from within his institute, including those he already knew or had a prior relationship with.

3.5.4 Risk and Beneficence

The participants did not involve any risk and did not get any beneficence participants the study.

3.5.5 Power Relationship

The researcher maintained a neutral role throughout the study. Participation was fully voluntary, and no pressure or influence was exerted on any participant. All respondents were treated with equal respect and autonomy to ensure that no power imbalance affected the data collection process.

3.5.6 Confidentiality

All participant information will be kept confidential. No personal identifying details will be published in any reports. A unique code will be assigned to each participant to ensure anonymity during data analysis. Only the research team will have access to identifying information, and data will be stored securely on a password-protected computer system. All hard copies of the data will be stored in locked filing cabinets to ensure privacy and security.

3.6 Data Collection Process

3.6.1 Participant Recruitment Process

Contact the patients who have bipolar mood disorder and their caregivers. First, the student researcher communicated with the responsible psychiatrist and occupational therapist at NIMH. The researcher then observed patients diagnosed with Bipolar Mood Disorder and selected individuals who met the inclusion and exclusion criteria. After introducing the study to the participants and providing them with information, the student researcher contacted them either by phone or in person to obtain verbal consent and schedule the interviews. The researcher then visited the pre-scheduled location and conducted the interviews as planned.

3.6.2 Data Collection Method

The data was gathered face to face interviews by both the researcher and trained interviewers. During this process, the interviewers followed a specific sequence when

collecting the data. It was essential to preserve the order of the questionnaire to avoid potential bias that could have arisen if questions were answered out of sequence (Kielhofner, 2017). Given the wide geographic spread, it was not feasible to reach all participants in a short timeframe for data collection. Additionally, in-person visits would have been costly for the student researcher. Face-to-face interviews allow for the student researcher. Face-to-face interviews allow for detailed responses, observation of non-verbal cues, and immediate clarification of questions.

3.6.3 Data Collection Instrument

A structured questionnaire will be used, incorporating the Multidimensional Scale of Perceived Social Support (MSPSS) to assess the level of social support among BMD patients. Additionally, demographic data will be collected to analyze correlations between social support and other relevant factors.

Demographic Variables

The demographic section of the questionnaire includes the following:

- Age
- Gender
- Marital status
- Educational level
- Employment status
- Duration of bipolar mood disorder diagnosis
- Family structure and living arrangements

Survey Questionnaire

The MSPSS, a widely validated instrument, is used to assess three dimensions of social support: support from family, friends, and significant others. Additional questions related to the availability of formal and informal support networks will be included.

The questionnaire will be reviewed and pre-tested for cultural relevance and clarity.

3.6.4 Field Note

Field notes were systematically maintained by the researcher throughout the data collection process. These notes captured important observations related to the physical environment, participant behavior, and contextual elements that could indirectly influence the study. Recording such information helped the researcher maintain awareness of situational factors, ensure consistency in the administration of the questionnaire, and support interpretation of the data during analysis. Field notes also served as supplementary documentation that enhanced the transparency of the research procedures.

3.6.5 Reflective Diary

A reflective diary was kept by the researcher as part of the self-monitoring and reflexive process. This diary included the researcher's personal reflections on the research experience, observations about challenges faced during data collection, decisions taken in the field, and reflections on potential biases. Maintaining a reflective diary allowed the researcher to remain mindful of her own perspectives and reactions, promoting greater objectivity and reducing the risk of personal bias influencing the research. It also supported continuous improvement of the research procedure by helping identify areas that required adjustment.

3.6.6 Non-participant

During the data collection phase, the researcher maintained a non-participant role. This means the researcher did not take part in any activities of the participants and did not attempt to influence their responses in any way. The researcher's presence was limited to providing instructions, clarifying questions when needed, and collecting the completed questionnaires. Maintaining a non-participant position ensured that the

participants' responses remained natural, voluntary, and free from researcher influence. This approach helped preserve the integrity and authenticity of the data.

3.7 Data Management and Analysis

All collected questionnaires were checked for completeness before data entry. Data were coded systematically, entered into SPSS, and stored securely with restricted access to maintain confidentiality. Data cleaning procedures were followed to identify missing values or entry errors. Both descriptive and inferential statistical analyses were conducted based on the objectives of the study. Descriptive statistics such as mean, standard deviation, frequency, and percentage were used to describe the level of social support. Inferential tests were applied where appropriate to examine associations between variables. The overall management process ensured accuracy, reliability, and ethical handling of the data.

3.8 Quality Control and Quality Assurance

Quality control and quality assurance were maintained at every stage of the research to ensure the credibility and reliability of the study findings. The data collection process followed standardized procedures, and participants were provided with clear and consistent instructions. A validated and widely used instrument (MSPSS scale) was utilized to ensure measurement reliability.

CHAPTER IV: RESULTS

This chapter represents the findings of the study. The chapter contains the study findings in tables and figures focusing on the socio demographic information, the overall level of Social support of spouse, family ,friends and factors associated with social support. A total of 106 respondents participated.

4.1 Sociodemographic information

Table 4. 1

Sociodemographic characteristic.

Variable	Category	Frequency(n=106)	Percentage (%)
Age	≤ 25 Years	55	51.9
	>25 Years	51	48.1
	Median=25 IQR= 18.75-30 Minimum=12 years, Maximum=65 years		
Gender	Male	53	50.0
	Female	53	50.0
Living	Rural	61	57.5
	Urban	45	42.5
Marital status	Unmarried	57	53.8
	Married	45	42.5
	Divorced	4	3.8
Educational qualification	Primary	42	39.6
	Secondary	36	34.0
	Higher secondary	17	16.0
	Graduate	11	10.4
Monthly income	≤ 10000 BDT	58	54.7
	>10000 BDT	48	45.3
Family types	Nuclear family	85	80.2
	Joint family	21	19.2
Caregiver	Parents	82	77.4
	Siblings	17	16.0
	Friends	7	6.6

Table -1 showed that the sociodemographic characteristics of individuals with Bipolar Mood Disorder (BMD) total of 106 participants in the study. Minimum age 12 years and maximum age 65 years. Their ages ranged from 12 to 65 years, with most (55.7%) belonging to the 21–40 years age group. Gender distribution was equal, with 50% males and 50% females. More than half of the respondents (57.5%) lived in rural areas, while (42.5%) lived in urban settings. Regarding marital status, (53.8%) were unmarried, (42.5%) were married, and 3.8% were divorced. Educational levels varied, with most completing primary (39.6%) or secondary (34%) education. The majority (66%) % belonged to the 3001–50,000 TK monthly income group, indicating middle-income status. Most participants (80.2%) came from nuclear families, and the primary caregivers were mostly parents (77.4%), followed by siblings (16%) and friends (6.6%).

4.2 Treatment-related information

Table 4. 2

Medical related information.

Variable	Category	Frequency(n=106)	Percentage (%)
Family history of mental illness	Yes	33	31.1
	No	73	68.9
currently taking any kind of medication	Yes	100	94.3
	No	6	5.7
under the regular follow up treatment	Yes	74	69.8
	No	32	30.2
Duration of treatment	1-365 days	57	53.8
	366-2555 days	38	35.8
	2556-7000 days	11	10.4
For how long have you been taking medication for Bipolar Mood Disorder	1-365 days	10	12.5
	366-2555 days	56	52.8
	2556-7000 days	41	38.7
Are you regularly taking your prescribed medication	Yes	103	97.2
	No	3	2.8
Do you feel isolated or lonely in your daily life	Always	13	12.3
	Often	76	71.7
	sometimes	17	16.0
Do you feel comfortable discussing your mental health with others	Yes with everyone	62	58.5
	Only with close family/ friend	10	9.4
	Only with professionals	6	5.7
	Not at all	28	26.4
Do you receive any financial support from others for your treatment	Yes	9	8.4
	No	97	91.5

Table - 2 shows that most of the participants were actively engaged in treatment, as (94.3%) were taking prescribed medication and (69.8%) maintained regular follow-up treatment. About (31.1%) reported a family history of mental illness, while the majority had no such background. The duration of treatment varied widely: (53.8%) % had been receiving treatment for (1–365) days, (35.8%) for (366–2555) days, and (10.4%) for more than 2556 days. A similar pattern was observed in the duration of taking medication for bipolar disorder, with more than half (52.8%) taking medication for several years. Medication adherence was very high, with (97.2%) regularly taking their prescribed medicines. Feelings of isolation were common, as most participants (71.7%) reported often feeling lonely. Regarding mental health disclosure, (58.5%) felt comfortable discussing their condition openly, while (26.4%) were not comfortable sharing at all. Only (8.4%) received financial support for treatment, indicating that most participants managed treatment expenses independent.

4.3 Frequency distribution of Social Support across the Spouse domain among patients with Bipolar Mood Disorder

Table 4.3

Levels of Social Support Across the Spouse Domain Among Patients with Bipolar Mood Disorder.

Specific partner or spouse support	very strongly disagree % (n)	strongly disagree % (n)	Mildly disagree % (n)	Neutral % (n)	Mildly agree % (n)	Strongly agree % (n)	very strongly agree % (n)
There is a special person who is around when i am in need	38.7 (41)	5.7 (6)	4.7 (5)	.9 (1)	11.9 (12)	1.9 (2)	36.8 (39)
There is a special person with whom I can share my joys and sorrows	41.5 (44)	5.7 (6)	5.7 (6)	.9 (1)	9.4 (10)	2.8 (3)	34.0(36)
I have a special person who is a real source of comfort to me	42.5 (45)	3.8(4)	3.8 (4)	6.6 (7)	8.5 (9)	3.8 (4)	31.1 (33)
There is special person in my life who cares about my feelings	41.5(44)	5.7 (6)	3.8 (4)	5.7 (6)	7.5(8)	2.8 (3)	33.0 (33)

The Table - 4.3 shows that a large proportion of participants reported very low perceived support from their significant others. Highest percentage repeatedly appeared in the Very strongly disagree category (38.7 to 42.5%) %. This indicates that many participants do not have a reliable or supportive significant person in their lives. Only a small proportion selected positive agreement categories such as Mildly agree, Strongly agree or Very strongly agree .For example, agreement responses for emotional comfort, care, and companionship ranged between (30–36%), showing that although some participants do receive support, the majority lack consistent emotional support from a special person. Overall, the spouse support domain demonstrates low perceived support, indicating weak or absent intimate relationships for many respondents.

Table 4.4

Levels of Social Support Across the Family Domain Among Patients with Bipolar Mood Disorder.

Family support	**very strongly disagree % (n)**	**strongly disagree % (n)**	**Mildly disagree % (n)**	**Neutral % (n)**	**Mildly agree % (n)**	**Strongly agree % (n)**	**very strongly agree % (n)**
My family really tries to help me	2.8(3)	0 (0)	0 (0)	0 (0)	4.7(5)	3.8 (4)	88.7 (94)
I get the emotional help and support I need from my family	.9 (1)	0 (0)	0 (0)	.9 (0)	6.6 (7)	4.7 (5)	86.8 (92)
I can talk about my problems with my family	2.8 (3)	.9 (1)	1.9 (2)	0 (0)	2.8 (3)	6.6 (7)	84.9 (90)
My family is willing to help me make decisions	4.7 (5)	1.9 (2)	.9 (1)	0 (0)	2.8 (3)	1.9 (2)	87.7 (93)

The table -4.4 shows that family is the strongest source of support among participants. A substantial proportion of participants selected agreement categories such as Mildly agree, Strongly agree, and Very strongly agree .This indicates that many respondents perceive their families as reliable, caring, and emotionally supportive. Even though a few participants selected neutral or disagreement options, the percentage of positive responses is clearly higher compared to the spouse and friends domains. This suggests that, for most respondents, families play a primary role in meeting emotional and practical support needs. Overall, the family domain reflects high perceived support and appears to be the most stable and dependable support system for the participants.

Table 4.5

*Levels of Social Support Across the Friends Domain Among Patients with Bipolar Mood Disorder***.**

Friends support	**very strongly disagree % (n)**	**strongly disagree % (n)**	**Mildly disagree % (n)**	**Neutral % (n)**	**Mildly agree % (n)**	**Strongly agree % (n)**	**very strongly agree % (n)**
My friends really try to help me	38.7(41)	3.8 (4)	7.5 (8)	8.5 (9)	29.2 (31)	1.9 (2)	10.4 (11)
I can count on my friends when things go wrong	39.6 (42)	4.7 (5)	9.4 (10)	12.3 (13)	23.6 (25)	1.9 (2)	8.5 (9)
I have friends with whom I can share my joys and sorrows	40.6(43)	5.7 (6)	9.4 (10)	15.1 (16)	15.1 (16)	3.8 (4)	10.4 (11)
I can talk about my problems with my friends	48.1 (51)	5.1 (6)	2.8 (3)	13.2 (14)	8.5 (9)	5.7 (6)	16.0 (17)

The table - 4.5 shows a mixed pattern of support. Very strongly disagree **(**ranging from 38.7 to 48.1%) indicating that many respondents feel that they cannot depend on their friends for emotional support, problem sharing, or mutual help. Moderate percentage (15–30%) marked Mildly agree or higher, showing that some participants do receive meaningful social support from friends, such as comfort, help during difficulties, and the ability to share personal feelings. Overall, the friends domain shows moderate perceived support, with noticeable variations among participants. Some benefit from strong friendships, while many others lack reliable or emotionally available peer support.

4.4 Level of social support among patient with Bipolar Mood Disorder

Figure 4.1

Level of social support among patient with Bipolar Mood Disorder.

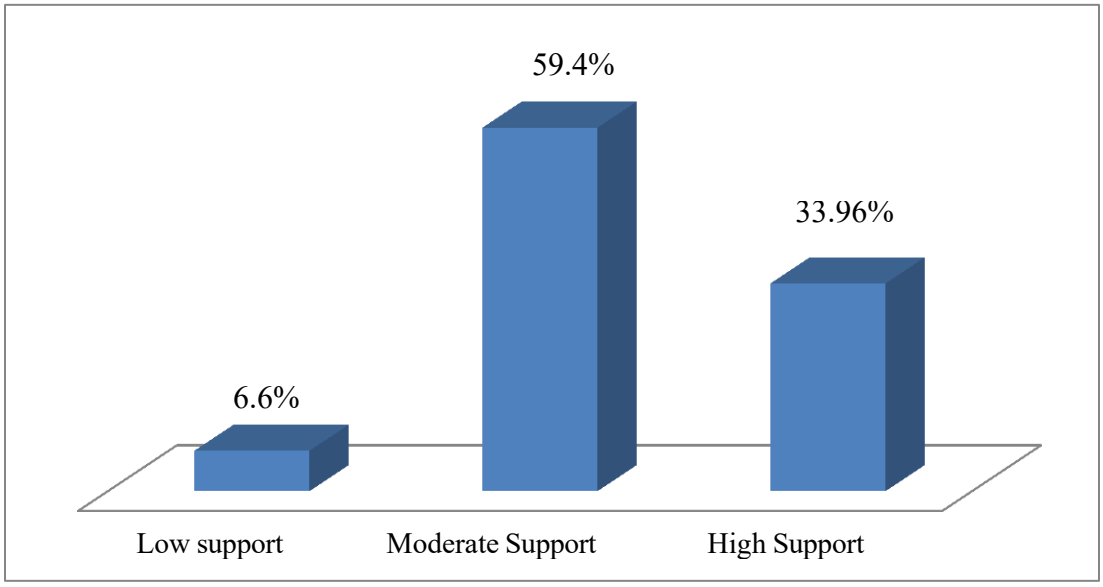


Figure 4.1 shows gives us a clear picture of the levels of social support among the respondents. In this column chart, it can be seen that the largest group, 59.4% (63), reported receiving moderate support. This shows that more than half of the participants have a fair level of social support in their lives.

On the other hand, 33.96% (n=36) experienced high levels of support, showing that a significant portion of respondents have strong social backing. At the same time only 6.6% (7) reported low support, making it the smallest group.

Overall, the results highlight that while most respondents have moderate to high social support, a small fraction still experience inadequate support, underlining the importance of addressing the needs of those with low social backing.

Table 4.6

Distribution of Social Support Levels Among Participants

Items	**Mean**	**SD**
Spouse support	15.12	10.161
Family support	23.95	3.707
Friends support	12.69	8.011

The Table 4.6 shows the descriptive statistics of social support domains among the participants. Family support had the highest mean score (M = 23.95, SD = 3.71), indicating that participants generally perceived strong support from their families. Spouse support showed a moderate mean score (M = 15.12, SD = 10.16), while friends' support had the lowest mean score (M = 12.69, SD = 8.01), suggesting comparatively less support from friends. The standard deviations indicate more variability in spouse and friends' support compared to family support.

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4.5 Association between Social Support and Sociodemographic Information

Table 4.7:

Association between Social Support and sociodemographic information (Living area, Marital status, Family history of mental illness, Caregiver)

		Social Support				
Variables	**catagory**	**Low support %(n)**	**Moderate support %(n)**	**High support %(n)**	**χ^2 / Fishers Exact**	**P value**
Living area	Rural	4.0(3)	36.3(43)	20.7(15)	7.287	.022
	urban	3.0(4)	26.7(20)	15.3(21)		
Marital status	Unmarried	3.8(4)	33.9(41)	19.4(12)	15.005	.002
	married	3.0(2)	26.7(19)	15.3(2 4)		
	Divorced	.3(1)	2.4(3)	1.4(0)		
Family history of mental illness	Yes	2.2(4)	19.6(23)	11.2(6)	6.661	.025
	No	4.8(3)	43.4(40)	24.8 (30)		
Caregiver	Parents	5.4(3)	48.7(52)	27.8(27)	10.571	.020
	Siblings	1.1(4)	10.1(9)	5.8(4)		
	Friends	.5(0)	4.2(2)	2.4(5)		

Notes: (Chi-Square Test)

The Table 4.7 shows Association between Social Support and sociodemographic information (Living area, Marital status, Family history of mental illness, Caregiver). Living area *(P* = 0.022), marital status *(P*= 0.002), family history of mental illness *(P* = 0.025), and caregiver type *(P*= 0.020) were significantly associated with participation restriction. These findings indicate that sociodemographic characteristics play an important role in determining the level of participation restriction among the participants. Differences in living environment, marital status, family background, and caregiver support may affect individuals' opportunities for social involvement and engagement in daily activities.

CHAPTER V: DISCUSSION

The present cross-sectional study was conducted among 106 participants diagnosed with Bipolar Mood Disorder to assess the level of perceived social support and its association with selected sociodemographic variables. Social support is widely recognized as a critical psychosocial determinant that influences the course, severity, and long-term outcome of mood disorders (Cohen & Wills, 1985; Thoits, 2011). According to the World Health Organization (2022), mental disorders are among the leading contributors to global disability, and psychosocial determinants such as family involvement, community integration, and interpersonal relationships significantly affect recovery trajectories. In individuals with Bipolar Mood Disorder, fluctuations between manic and depressive episodes often disrupt interpersonal relationships, occupational functioning, and emotional regulation, making stable social support an essential protective factor (Goodwin & Jamison, 2007). Therefore, examining the level and pattern of perceived social support provides important insight into psychosocial wellbeing and rehabilitation needs.

The findings of the present study revealed that 59.4% of participants experienced a moderate level of social support, 33.96% reported high support, and 6.6% experienced low social support. These findings indicate that the majority of individuals receive some degree of emotional and practical assistance; however, a small yet clinically significant subgroup remains socially vulnerable. Moderate social support suggests partial availability of assistance, but it may not always be sufficient during periods of acute mood instability, particularly during severe depressive episodes characterized by hopelessness, withdrawal,

and low motivation (Ozbay et al., 2007). Individuals experiencing low social support may face greater challenges in adhering to medication, attending follow-up appointments, and maintaining daily routines, which can ultimately increase the risk of relapse (Miklowitz, 2007). The presence of high support among one-third of the participants is encouraging, as strong interpersonal connections are often associated with improved resilience, emotional regulation, and coping capacity (Taylor, 2011).

The domain-wise analysis demonstrated that family support had the highest mean score (M = 23.95, SD = 3.707), indicating that family members are the primary source of perceived support among participants. This finding reflects the collectivist sociocultural structure of Bangladesh, where family units play a central role in caregiving and decision-making (Hofstede, 2001). In many cases, individuals with Bipolar Mood Disorder rely on parents, spouses, or siblings for medication supervision, financial assistance, and emotional reassurance. Strong family cohesion may contribute to greater illness monitoring and crisis management, thereby reducing the likelihood of severe complications (Miklowitz et al., 2003). However, the quality of family interaction remains crucial. Supportive communication, empathy, and accurate understanding of symptoms are essential to ensure positive outcomes. Negative emotional expressions such as criticism, blame, or misunderstanding of manic behaviors may increase stress and potentially trigger relapse (Hooley, 2007). Therefore, while high family support is a positive finding, structured family psychoeducation programs remain necessary to enhance constructive involvement and reduce caregiver burden.

In contrast, support from friends showed a comparatively lower mean score (M = 12.69, SD = 8.011), suggesting weaker peer engagement. Bipolar Mood Disorder often

affects interpersonal functioning due to mood instability, impulsivity during manic phases, and social withdrawal during depressive phases (American Psychiatric Association, 2013). These behavioral fluctuations may strain friendships and reduce social confidence. Additionally, stigma surrounding mental illness in many communities may discourage open discussion about psychiatric conditions, leading individuals to conceal their diagnosis from peers (Corrigan, 2004). As a result, perceived support from friends may remain limited even when family support is available. Reduced peer support can contribute to feelings of isolation and loneliness, which are known to negatively impact emotional wellbeing (Hawkley & Cacioppo, 2010). Peer interaction, however, is essential for social identity, belongingness, and community participation. Therefore, interventions such as peer support groups and community awareness programs may help strengthen this domain of support.

Spouse support demonstrated a mean score of 15.12 (SD = 10.161), indicating moderate variability in perceived marital support. Bipolar Mood Disorder can significantly influence marital relationships due to mood fluctuations, occupational disruption, financial instability, and caregiver stress (Reinares et al., 2006). During manic episodes, impulsive spending or irritability may strain relationships, whereas depressive episodes may lead to emotional withdrawal and reduced communication. These challenges may explain the variability observed in spousal support scores. Nevertheless, supportive spouses can play a crucial role in encouraging treatment adherence, promoting healthy routines, and providing emotional reassurance (Miklowitz, 2007). Strengthening marital communication through counseling and psychoeducation may enhance spousal support and reduce relational stress.

The study further identified statistically significant associations between perceived social support and selected sociodemographic variables, including living area ($p = 0.022$), marital status ($p = 0.002$), family history of mental illness ($p = 0.025$), and caregiver type ($p = 0.020$). These findings suggest that contextual and family-related characteristics significantly influence the perception of support (House, 1981). Differences between rural and urban living areas may reflect variations in family cohesion, community closeness, and accessibility of mental health services (Patel et al., 2010). Rural communities may offer stronger interpersonal bonding but limited specialized care, whereas urban settings may provide better healthcare access but comparatively weaker extended family networks. Marital status influences access to spousal support, while caregiver type determines the consistency and quality of daily assistance. Individuals cared for by emotionally supportive and informed caregivers may perceive higher levels of support compared to those receiving fragmented or inconsistent care.

Although the majority of participants reported moderate to high levels of support, the existence of low support among a subgroup highlights the importance of targeted psychosocial interventions. Social support should not only be available but also emotionally meaningful and sustainable. Perceived loneliness may persist despite the presence of family members if emotional validation and empathetic communication are lacking. Emotional isolation has been associated with depressive relapse and reduced quality of life among individuals with mood disorders (Santini et al., 2015). Therefore, strengthening the emotional dimension of support is essential for holistic recovery.

The findings of this study have important implications for clinical practice and occupational therapy. Occupational therapists can facilitate structured group activities to

enhance peer interaction, promote social skills training to improve interpersonal confidence, and design community reintegration programs to strengthen social participation (American Occupational Therapy Association, 2020). Family-centered interventions, including psychoeducation and caregiver counseling, may improve illness understanding and reduce expressed emotion within households. Community-based mental health awareness initiatives may reduce stigma and encourage supportive environments (Corrigan, 2004). Additionally, integrating psychosocial rehabilitation strategies within routine psychiatric care may enhance long-term outcomes.

Despite its strengths, including quantitative assessment and domain-specific analysis of social support, this study has certain limitations. The cross-sectional design restricts causal interpretation, and findings cannot establish whether low support leads to poorer outcomes or vice versa. The study was conducted within a limited setting, which may affect generalizability. Furthermore, self-reported measures may introduce response bias, as participants may overestimate or underestimate perceived support (Podsakoff et al., 2003). Future research using longitudinal designs and larger samples is recommended to explore changes in social support over time and its impact on relapse and functional outcomes.

In summary, the present study demonstrates that most individuals with Bipolar Mood Disorder experience moderate levels of social support, with family serving as the primary source of assistance. However, comparatively lower peer support and variability in spousal support indicate areas requiring improvement. Significant associations between social support and sociodemographic variables further highlight the contextual nature of support perception. Strengthening family involvement, enhancing peer engagement, and

promoting community awareness are essential strategies to improve psychosocial wellbeing and recovery outcomes among individuals living with Bipolar Mood Disorder.

CHAPTER VI: CONCLUSION

6.1 Strengths and Limitations

6.1.1 Strengths

- Used a standardized and validated tool: Multidimensional Perceived Social Support Scale (MPSSS), ensuring reliable measurement of social support.
- Cross-sectional design with 106 participants, providing a clear snapshot of social support levels.
- The data of the study is completely valid because it was conducted through a face-to-face interview rather than a telephone survey.
- Focused on a culturally under-researched area in Bangladesh, filling an important gap in the literature.
- Clear inclusion criteria and structured methodology increased scientific rigor.

6.1.2 Limitation

- Conducted in a single hospital, limiting generalizability to other settings.
- Cross-sectional design cannot establish causal relationships between social support and mental health outcomes.
- Reliance on self-report measures may introduce bias (social desirability, recall bias).
- Did not control for other influencing variables (e.g., duration of illness, Due comorbidities, relapse episodes, socioeconomic status).
- Due to lack of time 106 participants data were collected.

6.2 Practice Implication

- Implement family-centered psycho education to improve understanding and support.
- Use occupational therapy interventions: peer-support groups, social participation, and community integration.
- Introduce spousal interventions, communication training, and counseling to improve intimate relationships.
- Integrate supportive counseling and case management in hospital settings.
- Reduce stigma through community awareness programs to enhance social inclusion.

6.2.1 For Policy & Service Development

- Strengthen policies on family involvement and caregiver support programs.
- Adopt multidisciplinary mental health care models involving psychiatrists, occupational therapists, social workers, and psychologists.

6.2.2 For Future Research

- Conduct multi-center or community-based studies for better generalizability.
- Use longitudinal designs to track changes in social support over time.
- Assess how peer-led groups improve outcomes and scalability
- Combine quantitative and qualitative approaches for a deeper understanding
- Investigate relationships between social support and relapse rate, functional outcome, and quality of life.
- Examine the impact of stigma, loneliness, and cultural factors on social support.

Conclusion

To conduct this study, it was essential to collect comprehensive information that reflects the lived experiences of individuals with Bipolar Mood Disorder (BMD) and the factors influencing their social participation. Sociodemographic details such as age, gender, education, occupation, and living arrangement were gathered to understand how personal characteristics shape their level of involvement in society. Clinical information, including the type and duration of BMD, treatment status, and episode history, was needed to explore how illness-related factors affect functioning. Data on social support from family, spouse, friends, and the community were essential as weaker support networks were found to significantly limit participation. Information related to stigma—both social and self-stigma was also collected to researcher how negative attitudes and discrimination.

CHAPTER VII: LIST OF REFERENCE

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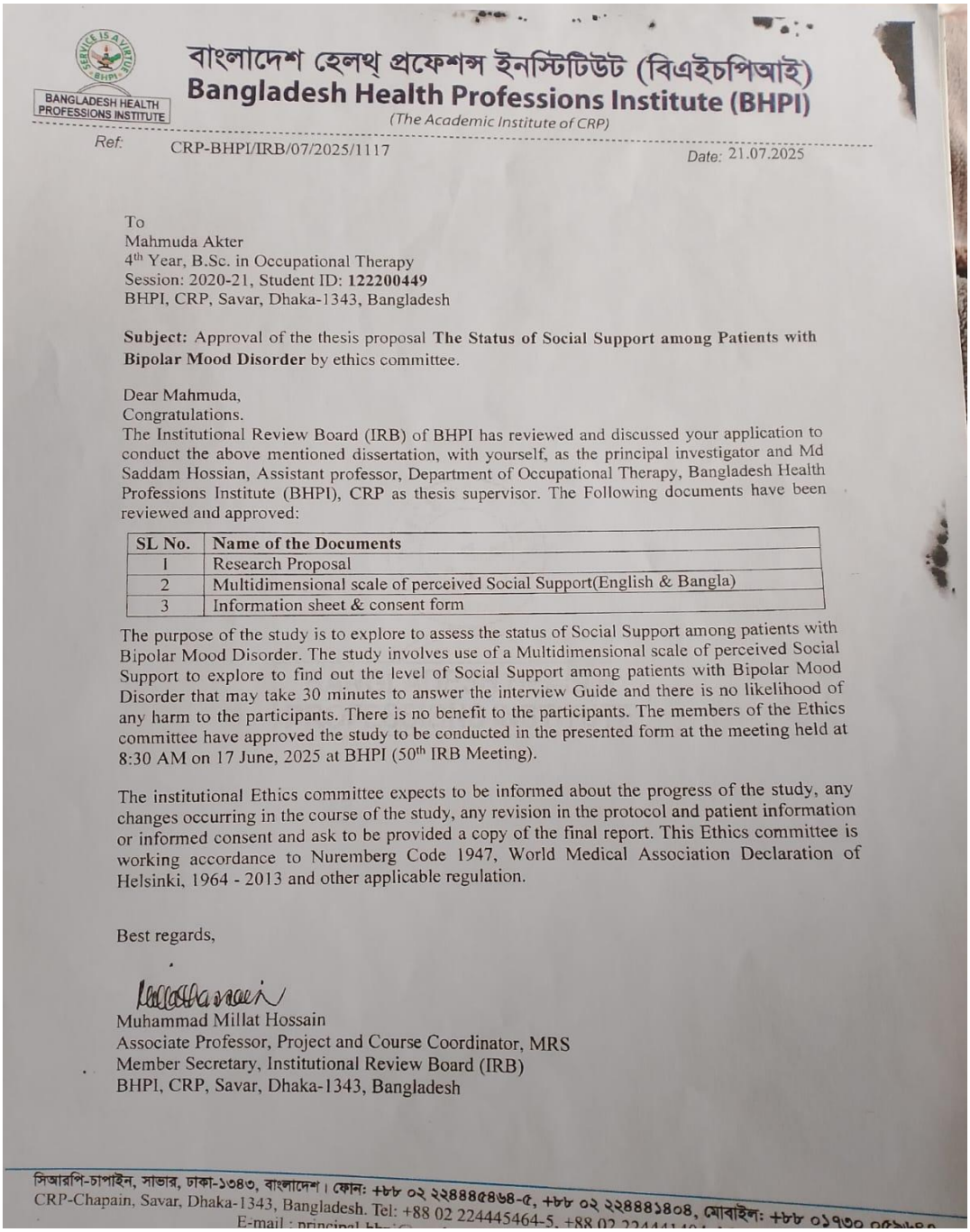
APPENDICES

Appendix A: Approval /Permission letter



বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

BANGLADESH HEALTH PROFESSIONS INSTITUTE

Ref: CRP-BHPI/IRB/07/2025/1117 Date: 21.07.2025

To
Mahmuda Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21, Student ID: **122200449**
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **The Status of Social Support among Patients with Bipolar Mood Disorder** by ethics committee.

Dear Mahmuda,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and Md Saddam Hossian, Assistant professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as thesis supervisor. The Following documents have been reviewed and approved:

SL No.	Name of the Documents
1	Research Proposal
2	Multidimensional scale of perceived Social Support(English & Bangla)
3	Information sheet & consent form

The purpose of the study is to explore to assess the status of Social Support among patients with Bipolar Mood Disorder. The study involves use of a Multidimensional scale of perceived Social Support to explore to find out the level of Social Support among patients with Bipolar Mood Disorder that may take 30 minutes to answer the interview Guide and there is no likelihood of any harm to the participants. There is no benefit to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8:30 AM on 17 June, 2025 at BHPI (50th IRB Meeting).

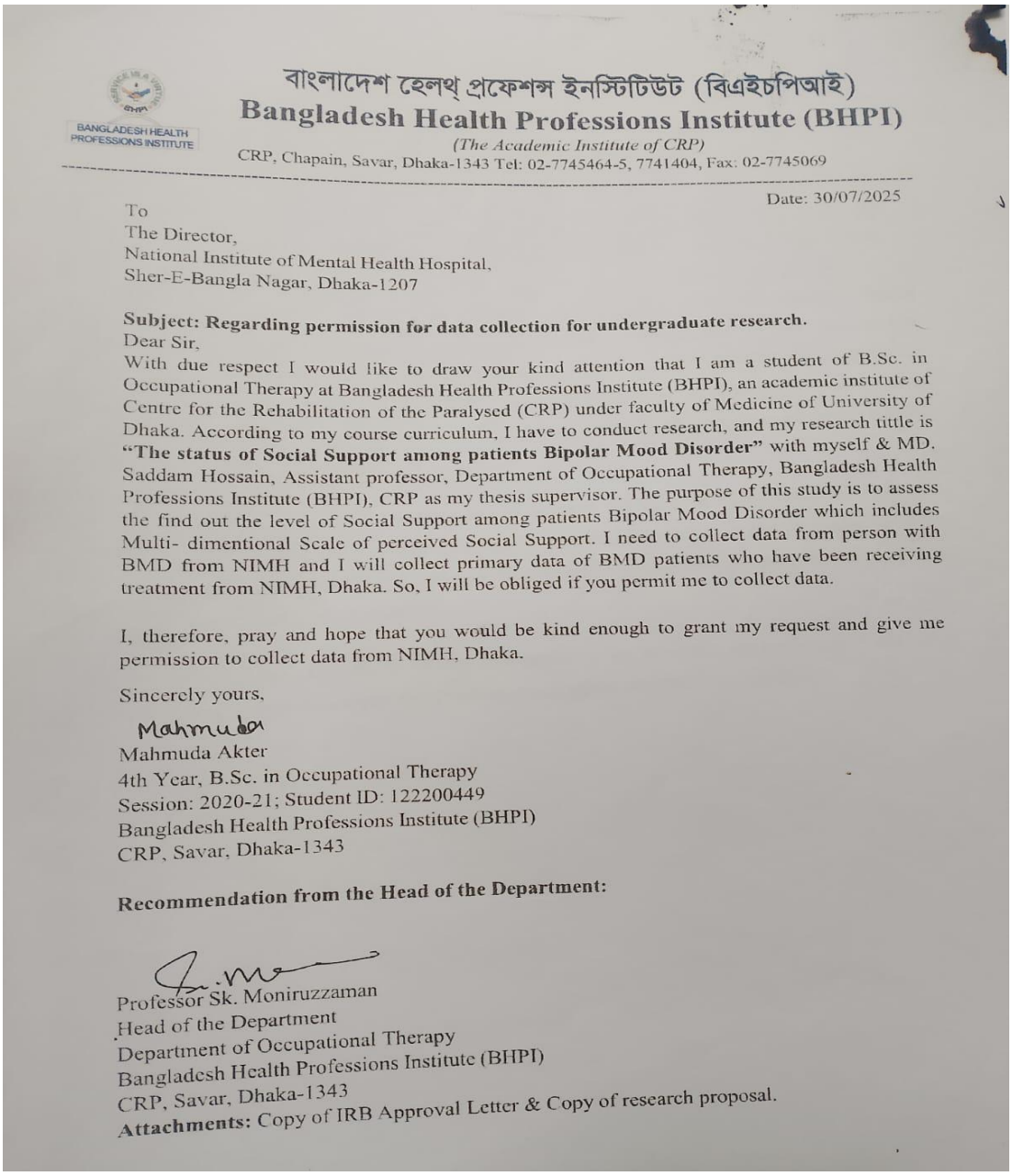
The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,

Muhammad Millat Hossain
Associate Professor, Project and Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৬৮৪৪
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404
E-mail : principal

Permission letter



বাংলাদেশ হেলথ্ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)
CRP, Chapain, Savar, Dhaka-1343 Tel: 02-7745464-5, 7741404, Fax: 02-7745069

Date: 30/07/2025

To
The Director,
National Institute of Mental Health Hospital,
Sher-E-Bangla Nagar, Dhaka-1207

Subject: Regarding permission for data collection for undergraduate research.

Dear Sir,

With due respect I would like to draw your kind attention that I am a student of B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI), an academic institute of Centre for the Rehabilitation of the Paralysed (CRP) under faculty of Medicine of University of Dhaka. According to my course curriculum, I have to conduct research, and my research tittle is **"The status of Social Support among patients Bipolar Mood Disorder"** with myself & MD. Saddam Hossain, Assistant professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP as my thesis supervisor. The purpose of this study is to assess the find out the level of Social Support among patients Bipolar Mood Disorder which includes Multi- dimentional Scale of perceived Social Support. I need to collect data from person with BMD from NIMH and I will collect primary data of BMD patients who have been receiving treatment from NIMH, Dhaka. So, I will be obliged if you permit me to collect data.

I, therefore, pray and hope that you would be kind enough to grant my request and give me permission to collect data from NIMH, Dhaka.

Sincerely yours,

Mahmuda

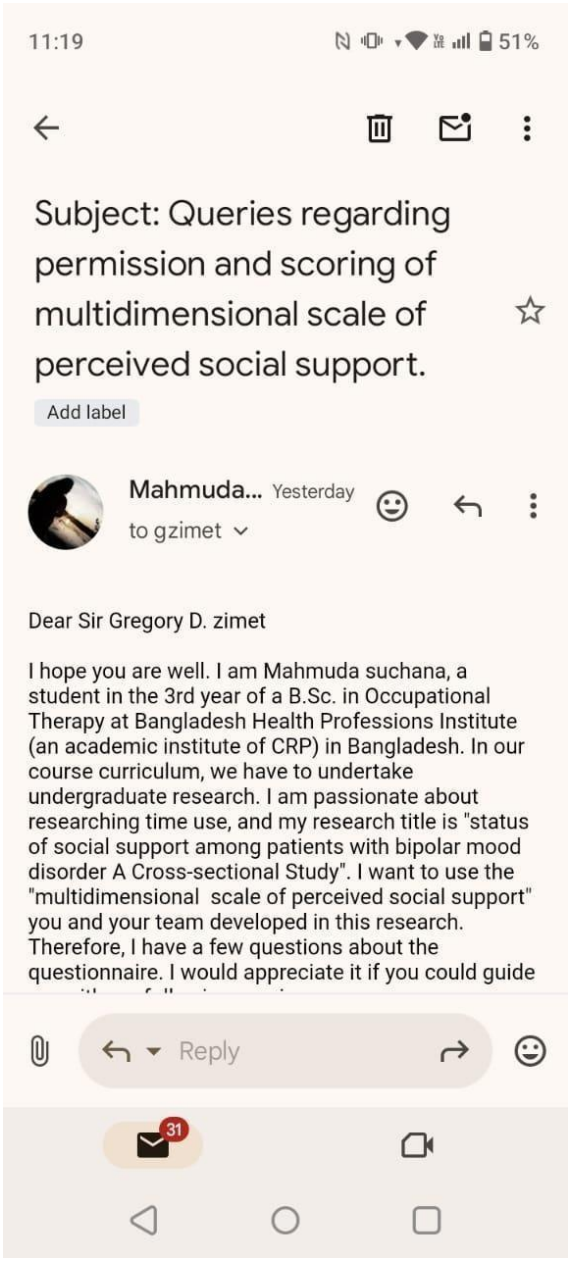
Mahmuda Akter
4th Year, B.Sc. in Occupational Therapy
Session: 2020-21; Student ID: 122200449
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343

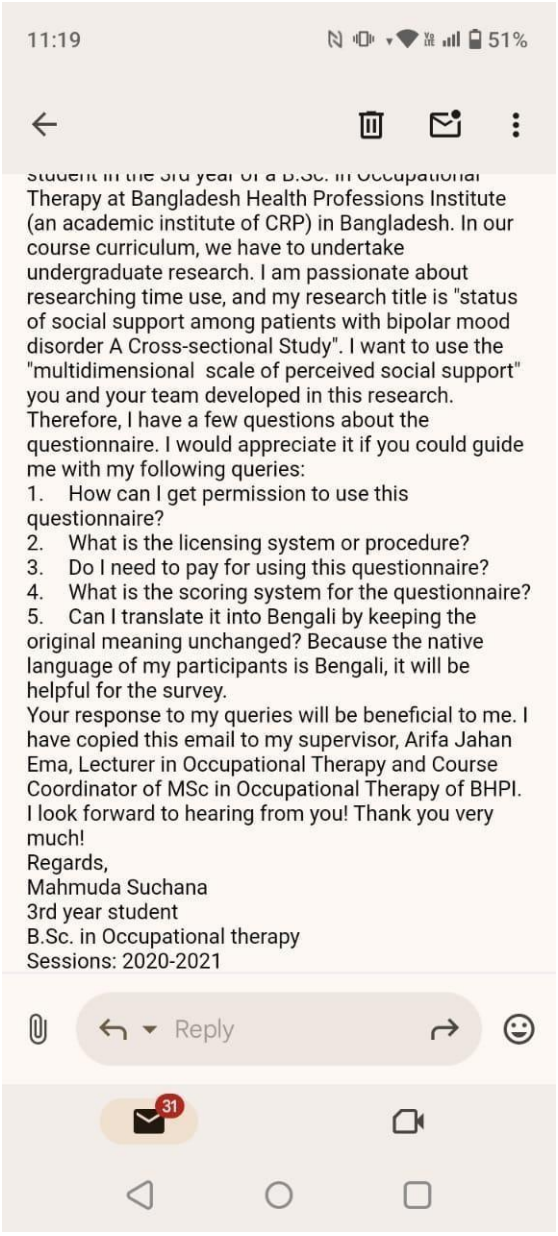
Recommendation from the Head of the Department:

Professor Sk. Moniruzzaman
Head of the Department
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
CRP, Savar, Dhaka-1343

Attachments: Copy of IRB Approval Letter & Copy of research proposal.

Taking permission for using the tool





Appendix B: Information Sheet, Consent from, Withdrawal From (English version)

Bangladesh Health Professions Institute (BHPI)

Occupational Therapy Unit

CRP, Savar, Dhaka-1343

Information Sheet

Research title: The status of social support among patient with Bipolar Mood Disorder

Name of researcher: Mahmuda, 4th year, B.Sc. in Occupational Therapy.

Supervisor: Md. Saddam Hossain, Lecturer, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka**.**

Purpose of the Research

The purpose of this study is to find out the status of Social Support among patients with Bipolar Mood Disorder using the Multidimensional Scale of Perceived Social Support (MSPSS)This research aims to find out the status of social support among patient with BMD including support from family, friends, and significant others. By investigating the role of social support, the study seeks to contribute to a better understanding of its impact on the mental well-being and recovery process of patients, leading to the development of improved support systems and interventions.

What Does the Research Involve?

Participants will be invited to complete a structured questionnaire designed to assess their perceived social support levels using the MSPSS. The survey will take approximately 20-30 minutes to complete and will be administered either in person or online, depending on the participant's preference. . In addition to the MSPSS, the questionnaire will include

demographic questions and other relevant mental health assessment tools to provide a comprehensive understanding of social support status among bipolar mood disorder patients.

Why Were You Chosen for This Research?

Your participation in this study is valuable because you have been diagnosed with bipolar mood disorder and are currently receiving mental health support. Your experiences will provide critical insights into the role of social support in managing bipolar disorder, which is essential for understanding and addressing the needs of individuals with similar conditions.

Source of Funding

This research is funded by the researchers themselves and is conducted without external funding or sponsorship. The study is part of an academic project aimed at contributing to the field of mental health and social support research.

Consenting to Participate in the Project and Withdrawing from the Research

Your participation in this study requires your consent, which you can provide by signing the consent form prior to completing the survey. Participation is entirely voluntary, and there is no obligation to participate. If you decide to withdraw from the study at any point before the analysis phase, you may do so without any penalty or consequence. You may also choose to skip any questions you are uncomfortable with.

Possible Benefits and Risks to Participants

While there may not be any direct personal benefits from participating in this research, your contribution will help advance knowledge about social support and its effects on individuals with bipolar mood disorder. This research aims to improve interventions and

support systems for patients experiencing bipolar disorder. The study is designed to be low-risk, but there is the Potential for psychological discomfort when discussing social support and personal experiences.

Confidentiality

All participant information will be kept confidential. No personal identifying details will be published in any reports. A unique code will be assigned to each participant to ensure anonymity during data analysis. Only the research team will have access to identifying information, and data will be stored securely on a password-protected computer system. All hard copies of the data will be stored in locked filing cabinets to ensure privacy and security

Storage of Data

The collected data will be stored electronically on password-protected systems and in physical storage at secure locations. Only authorized research personnel will have access to the data. These measures ensure that all participant information is kept confidential and protected throughout the duration of the study.

Results

The data collected from this study will be analyzed quantitatively, and the results will be compiled into a detailed report. . Findings may be published in peer-reviewed academic journals or presented at academic conferences. A summary of the results will be available to participants upon request.

Complaints

If you have any concerns or complaints about the research's conduct, you are welcome to contact the supervisor.

MD. Saddam Hossain Assistant Professor

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI), CRP Call; 01766494605

Email : saddamot6@gmail.com

Thank you

Consent Form

I, **Mahmuda Akter** , a 4th year student of B.Sc. in Occupational Therapy at Bangladesh Health Professions Institute (BHPI), under CRP, Savar, Dhaka, I am conducting a study titled - **Status of Social Support Among Patients with Bipolar Mood Disorder**. This study is being carried out as part of the academic curriculum of the Department of Occupational Therapy.

As part of the research, I will collect answers from participants through a set of questions, and this information will be used solely for research purposes. All collected data will remain confidential. I assure you that participation in this research will have no harmful effect on you. You may withdraw from the study at any time if you wish.

Please read the following statements carefully and tick Yes or No to indicate that you have read and understood the information, and that you voluntarily agree to participate in the study.

I confirm that I have read the research-related information thoroughly, understood its purpose and benefits, and agree to participate in the study.

Yes / No

I have received satisfactory answers to my questions related to this study.

Yes / No

I understand that my participation in this study is completely voluntary and that I may withdraw my consent at any time. I am aware that the results of this study may be published, and it will not cause me any harm.

Yes / No

If I have any further questions about the study, I will discuss them with the researcher and participate only after receiving satisfactory answers.

Yes / No

I have given enough time to those who are interviewing me for the purpose of this study.

Yes / No

I agree to participate in this study ___.

Yes / No

WITHDRAWAL OF CONSENT FORM

Research title: The status of Social Support among patients with Bipolar Disorder

Student investigator: Mahmuda Akter

I,

(the participant),…… wish to WITHDRAW my consent to the use of data arising from my participation. Data arising from my participation must NOT be used in this research project as described in the Information and Consent Form. I understand that this notification will be retained together with

my consent form as evidence of the withdrawal of my consent to use the data I have provided specifically for this research project.

Name of the participant……. Signature of participant/ thumb print…… Date……..

Appendix B: Information Sheet,Consent from,Withdrawal From (Bangla version)

গবেষণার উদ্দেশ্য :

ঐই গবেষণার মূল হলো বাইপোলার মুড ডিজঅর্ডার আক্রান্ত রোগীদের মধ্যে সামাজিক সহায়তা অবস্থা নিধারন করা। এটি মাল্টিডাইমেনশাল স্কেল অফ পারসিভড সোশ্যাল সাপোর্ট ব্যবহার করে করা হবে। পরিবার সদ্যস্য, বন্ধু ও বিশেষ কারো কাছে প্রাপ্ত সামাজিক মাত্রা ও উৎস যাচাই করা হবে। সামাজিক সহায়তা ভূমিকা বিশ্লেষণ করে রোগীদের মানসিক সুস্তা এবং পুনরুদ্ধার এর প্রভাব বোঝার চেষ্টা করা হবে, যা উন্নত সহায়তা ব্যবস্তা গড়ে তুলতে সাহায্য করবে।

গবেষণায় কি অন্তর্ভুক্ত থাকবে?

অংশগ্রহনকারীরা MSPSS এর মাধ্যমে তাদের সামাজিক সহায়তা মাত্রা নিরুপণের জন্য একটি প্রশ্নবলী পূরণ করবেন। এই জরিপটি আনুমানিক ২০- ৩০ মিনিট সময় নেবে এবং অংশগ্রহণকারি পরিচয় ও অন্যান্য মানসিক স্বাস্থ্য মুল্যায়ন থাকবে, যাতে বাইপোলার রোগীদের সামাজিক সহায়তা ব্যাপক ধারণা পাওয়া যায়।

আপনাকে কেন নির্বাচিত করা হয়েছে?

আপনি বাইপোলার মুর্ভ ডিসঅর্ডার আক্রান্ত এবং বর্তমান স্বাস্থ্য নিচ্ছেন, এজন্য অংশগ্রহণ গুরুত্বপূর্ণ। আপনার অভিজ্ঞতা একই সমস্যা ভুগা অন্যদের সহায়তা ব্যবস্তার উন্নতিতে সহায়তা

হবে।

তহবিলের উৎস:

এই গবেষণার স্ব- অর্থায়নে পরিচালিত এবং এতে কোনো বহিরাগত অর্থায়নে বা স্পন্সর নেই। এটি একাডেমিক প্রকল্প হিসেবে মানসিক স্বাস্থ্য ও সামাজিক সহায়তা গবেষণায় অবদার রাখবে।

গবেষণায় অংশগ্রহন সম্মতি ও প্রত্যাহার

এই গবেষণার অংশগ্রহন আপনার ইচ্ছায় এবং সম্মতি সাপেক্ষ। প্রশ্নাবালী পূরণের আগে ফরমে সাইন করতে হবে। আপনি যেকোনো সময় বিশ্লেষণর আগে অংশেগ্রহণ থেকে সরে আসতে পারবেন, যা কোনো প্রকার অসুবিধা সৃষ্টি করবে না। অস্বস্তিকর প্রশ্ন এড়িয়ে যাওয়ার সুযোও থাকবে।

সম্ভাব্য সুবিধা ও ঝুঁকি

অংশগ্রহণ থেকে সরাসরি কোনো ব্যক্তিগত সুবিধা নাও পাওয়া যেতে পারে, তবে এটি সামাজিক সহায়তা ও বাইপোলার ডিসঅর্ডার প্রভাব নিয়ে জ্ঞান বাড়বে। গবেষণাটি কম ঝুঁকিপূর্ণ হলেও, সামাজিক সহায়তা ও ব্যক্তিগত অভিজ্ঞতা নিয়ে কথা বলার সময় মানসিক অস্বস্তি হতে পারে। প্রয়োজন গবেষণা দল সমর্থন দেবে এবং অংশগ্রহণকারী বিরতি নিতে বা সরে আসতেও পারেন।

গোপনীয়তা

অংশগ্রহনকারী সব তথ্য গোপন রাখা হবে। কোনো তথ্য প্রকাশ করা না প্রতিটি অংশগ্রহনকারীকে একটি অন্যন্য কোড দেওয়া হবে যাতে গোপনীয়তা বজায় থাকে। শুধুমাএ গবেষণা দল তথ্যের সাথে পরিচিত থাকবে এবং সব তথ্য পাসওয়ার্ড সেইভ কম্পিউটারে এবং লক করা ফাইলিং

ক্যাবিনেটে থাকবে।

অভিযোগ

প্রধান গবেষক

মো সাদ্দাম হোসাইন

সহকারী অধ্যাপক

বাংলাদেশ হেলথ প্রফেশন ইনস্টিটিউট

ফোন: ০১৭৬৬৪৯৪৬০৫

সম্মতি পত্র

আমি মাহমুদা আক্তার, বাংলাদেশ হেলথ প্রফেশনস ইনস্টিটিউট (বিএইচপিআই) অধিভুক্ত সাভার, ঢাকা এর অকুপেশনাল থেরাপি বিভাগের ৪র্থ বর্ষের ছাত্রী। এই গবেষণা "**দ্বিধাবিভক্ত মেজাজজনিত ব্যাধি রোগীদের মধ্যে সামাজিক সহায়তার অবস্থা**" শিরোনামের উপর পরিচালিত হচ্ছে। এই গবেষণা অকুপেশনাল থেরাপি বিভাগের কোর্স কারিকুলামের অংশ হিসেবে পরিচালিত হচ্ছে। গবেষণার অংশ হিসেবে আমি অংশগ্রহণকারীদের কাছ থেকে কিছু প্রশ্নের উত্তর সংগ্রহ করব এবং এই তথ্য গবেষণার একটি অংশ হিসেবে ব্যবহার করা হবে। গবেষণার তথ্য কেবলমাত্র গবেষণার উদ্দেশ্যে ব্যবহার হবে এবং একান্তই গোপন রাখা হবে। আপনি ইচ্ছা করলে যেকোনো সময় অংশগ্রহণ থেকে নিজেকে প্রত্যাহার করতে পারবেন।

অনুগ্রহ করে নিম্নলিখিত বিষয়গুলো পড়ুন এবং হ্যাঁ বা না-তে টিক দিন যাতে বোঝা যায় আপনি তথ্য পড়েছেন, আপনার সম্মতি বুঝতে পেরেছেন এবং আপনি উপরোক্ত গবেষণায় অংশগ্রহণ করতে সম্মত হচ্ছেন।

১। আমি নিশ্চিত করছি যে, আমি গবেষণা সম্পর্কিত তথ্য যথাযথভাবে পড়েছি এবং তার উদ্দেশ্য ও উপকার সম্পর্কে অবগত হয়েছি এবং আমি গবেষণায় অংশগ্রহণ করতে সম্মত হয়েছি।

হ্যাঁ / না

২। এই গবেষণার সাথে সম্পর্কিত প্রশ্নের যথাযথ সন্তোষজনক উত্তর পেয়েছি।

হ্যাঁ / না

৩। আমি বুঝতে পেরেছি যে, গবেষণায় অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাসেবক এবং আমি যেকোনো সময়

আমার সম্মতি প্রত্যাহার করতে পারবো, এমনকি গবেষণার ফলাফল প্রকাশিত হবে তাও জানি এবং এতে আমার কোনো অসুবিধা হবে না।

হ্যাঁ / না

৪। তবে, গবেষণার বিষয়ে কোনো অতিরিক্ত প্রশ্ন থাকলে গবেষকের সাথে আলোচনা করে এবং সন্তোষজনক উত্তর পেলে আমি অংশগ্রহণ করবো।

হ্যাঁ / না

৫। আমি এই গবেষণায় অংশগ্রহণ করতে সম্মত _____।

হ্যাঁ / না

অংশগ্রহণকারীর নাম:

অংশগ্রহণকারীর স্বাক্ষর:

তারিখ:

গবেষকের স্বাক্ষর:

তারিখ:

প্রত্যাহার ফর্ম

গবেষণার শিরোনাম: **দ্বিধাবিভক্ত মেজাজজনিত ব্যাধিতে আক্রান্ত রোগীদের মধ্যে সামাজিক সহায়তার অবস্থা**

শিক্ষার্থী গবেষক: মাহমুদা আক্তার

আমি,

(অংশগ্রহণকারীর নাম) .....

আমার অংশগ্রহণ থেকে প্রাপ্ত তথ্য ব্যবহার করার জন্য দেওয়া সম্মতি প্রত্যাহার করতে চাই। আমার অংশগ্রহণ থেকে প্রাপ্ত তথ্য ও সম্মতি ফর্মে বর্ণিত এই গবেষণা প্রকল্পে ব্যবহার করা যাবে না। আমি আরও বুঝতে পারছি যে, এই নোটিশটি আমার সম্মতি ফর্মের সাথে সংরক্ষিত থাকবে, যা প্রমাণ করবে যে আমি এই গবেষণা প্রকল্পের জন্য প্রদত্ত আমার তথ্য ব্যবহারের সম্মতি প্রত্যাহার করেছি।

অংশগ্রহণকারীর নাম: _____

অংশগ্রহণকারীর স্বাক্ষর / আঙুলের ছাপ: _____

তারিখ: _____

Appendix C: Questionnaire (English)

Sociodemographic Questionnaire (English version)

Participant ID: _____,

Phone Number: _____,

Address: _____

1. Age of the participant

Please mention: _____ years

2. Gender

a) Male

b) Female

c) Other

3. Place of Residence

a) Rural area

b) Urban area

4. Number of family members

Please mention: _____ members

5. Marital Status

a) Unmarried

b) Married

c) Divorced

6. Educational Qualification

a) Primary

b) Secondary

c) Higher Secondary

7. Occupation

Please mention: _____

8. Approximate Monthly Income

Please mention: _____ BDT

9. Type of Family

a) Nuclear family

b) Joint family

c) Extended family

10. Family History of Mental Illness

a) Yes

b) No

11. Are you currently taking any medication?

a) Yes

b) No

12. Are you under regular follow-up treatment?

a) Yes

b) No

13. Duration of Treatment

Please mention:

_____ years / _____ months

14. For how long have you been taking medication for Bipolar Mood Disorder?

Please mention:

_____ years / _____ months

15. Are you regularly taking your prescribed medication?

a) Yes

b) No

c) Sometimes

16. Do you feel that people around you understand your mental health condition?

a) Yes

b) No

17. Do you feel isolated or lonely in your daily life?

a) Always

b) Often

c) Sometimes

d) Never

18. Do you feel comfortable discussing your mental health condition with others?

a) Yes, with everyone

b) Only with close family/friends

c) Only with professionals

d) Not at all

19. Do you receive any financial support from others for your treatment?

a) Yes

b) No

Scale name: Multidimensional Scale of Perceived Social Support

Iteam	**Very Strongly disagree**	**Strongly disagree**	**Mildly disagree**	**neutral**	**Mildly agree**	**strongly agree**	**Very Strongl y agree**
There is a special person who is around when I am in need							
There is a special person with whom I can share my joys and sorrows							
My family really tries to help me							
I get the emotional help and support I need from my family							
I have a special person who is real source of comfort to me							
My friends really try to help me							

I can talk about my problems with family							
I have friends with whom I can share my joys and sorrows							
There is a special person in my life who cares about my feeling							
My family is willing to help me make decisions							
I can talk about my problems with my friends							
I can count on my friends when things go wrong							

Appendix C: Questionnaire (Bangla)

Iteam	**খুবই অসম্মত**	**অনেকটা অসম্মত**	**কিছুটা অসম্মত**	**নিরপেক্ষ**	**কিছুটা একমত**	**অনেকটা একমত**	**খুবই একমত**
এমন একজন বিশেষ ব্যক্তি আছেন, যিনি আমার প্রয়োজনের সময় পাশে থাকেন।							
এমন একজন বিশেষ ব্যক্তি আছেন, যার সাথে আমি আনন্দ ও দুঃখ ভাগাভাগি করতে পারি।							
আমার পরিবার সত্যিই আমাকে সাহায্য করার চেষ্টা করে।							

আমি আমার পরিবারের কাছ থেকে প্রয়োজনীয় মানসিক সাহায্য ও সহায়তা পাই।							
আমার এমন একজন বিশেষ ব্যক্তি আছেন, যিনি আমার জন্য প্রকৃত শান্তির উৎস।							
আমার বন্ধুরা সত্যিই আমাকে সাহায্য করার চেষ্টা করে।							
আমার কিছু ভুল হলে আমি আমার বন্ধুদের উপর নির্ভর করতে পারি।							
আমি আমার পরিবারের সাথে আমার সমস্যাগুলো নিয়ে কথা বলতে পারি।							

আমার জীবনে এমন একজন বিশেষ ব্যক্তি আছেন, যিনি আমার অনুভূতির প্রতি যত্নশীল।							
আমার পরিবার আমার সিদ্ধান্ত গ্রহণে সাহায্য করতে আগ্রহী।							
আমি আমার বন্ধুদের সাথে আমার সমস্যাগুলো নিয়ে কথা বলতে পারি।							

অংশগ্রহণকারী আইডি: _____

ফোন নম্বর: _____

তারিখ: ___ / ___ / _____

ঠিকানা: _____

1. অংশগ্রহণকারীর বয়স (দয়া করে উল্লেখ করুন: _____ বছর)

2. লিঙ্গের অবস্থা

a. পুরুষ

b. নারী

c. অন্যান্য

3. আপনি কোথায় থাকেন?

a. গ্রামীণ এলাকা

b. শহুরে এলাকা

4. পরিবারের সদস্য সংখ্যা

(দয়া করে উল্লেখ করুন: _____ জন)

5. আপনার বৈবাহিক অবস্থা কী?

a. অবিবাহিত

b. বিবাহিত

d. তালাকপ্রাপ্ত

6. আপনার শিক্ষাগত যোগ্যতা কী?

a. প্রাথমিক

b. মাধ্যমিক

c. উচ্চ মাধ্যমিক

7. আপনার পেশা কী?

দয়া করে উল্লেখ করুন: _____

8. আপনার আনুমানিক মাসিক আয় কত?

(দয়া করে উল্লেখ করুন: _____ টাকা)

9. আপনি কোন ধরণের পরিবারে থাকেন?

a. একক পরিবার

b. যৌথ পরিবার

c. বিস্তৃত পরিবার

10. বর্তমানে কি আপনি কোনো শারীরিক বা মানসিক অসুস্থতায় ভুগছেন?

a. হ্যাঁ

b. না

11. পরিবারের ইতিহাসে মানসিক রোগ আছে কি?

a. হ্যাঁ

b. না

12. আপনি কি বর্তমানে কোনো ওষুধ সেবন করছেন?

a. হ্যাঁ

b. না

13. আপনি কি নিয়মিত ফলো-আপ চিকিৎসা নিচ্ছেন?

a. হ্যাঁ

b. না

14. চিকিৎসার সময়কাল

(দয়া করে উল্লেখ করুন: _____ বছর / মাস)

15. আপনি কতদিন ধরে বাইপোলার মুড ডিসঅর্ডারের জন্য ওষুধ সেবন করছেন?

(দয়া করে উল্লেখ করুন: _____ বছর / মাস)

17. আপনি কি নিয়মিতভাবে আপনার প্রেসক্রাইব করা ওষুধ সেবন করছেন?

a. হ্যাঁ

b. না

c. মাঝে মাঝে

18. সহায়তাকারী ব্যক্তি

a. পিতামাতা

b. ভাইবোন

c. বন্ধু

19. আপনি কি মনে করেন আপনার চারপাশের মানুষ আপনার মানসিক স্বাস্থ্য পরিস্থিতি বোঝে?

a. হ্যাঁ

b. না

20. আপনি কি দৈনন্দিন জীবনে একা বা বিচ্ছিন্ন বোধ করেন?

a. সবসময়

b. প্রায়ই

c. মাঝে মাঝে

21. আপনি কি অন্যদের সঙ্গে আপনার মানসিক স্বাস্থ্য নিয়ে কথা বলতে স্বাচ্ছন্দ্যবোধ করেন?

a. হ্যাঁ, সবার সাথে

b. শুধু কাছের পরিবার/বন্ধুদের সাথে

c. শুধু পেশাদারদের সাথে

d. একেবারেই না

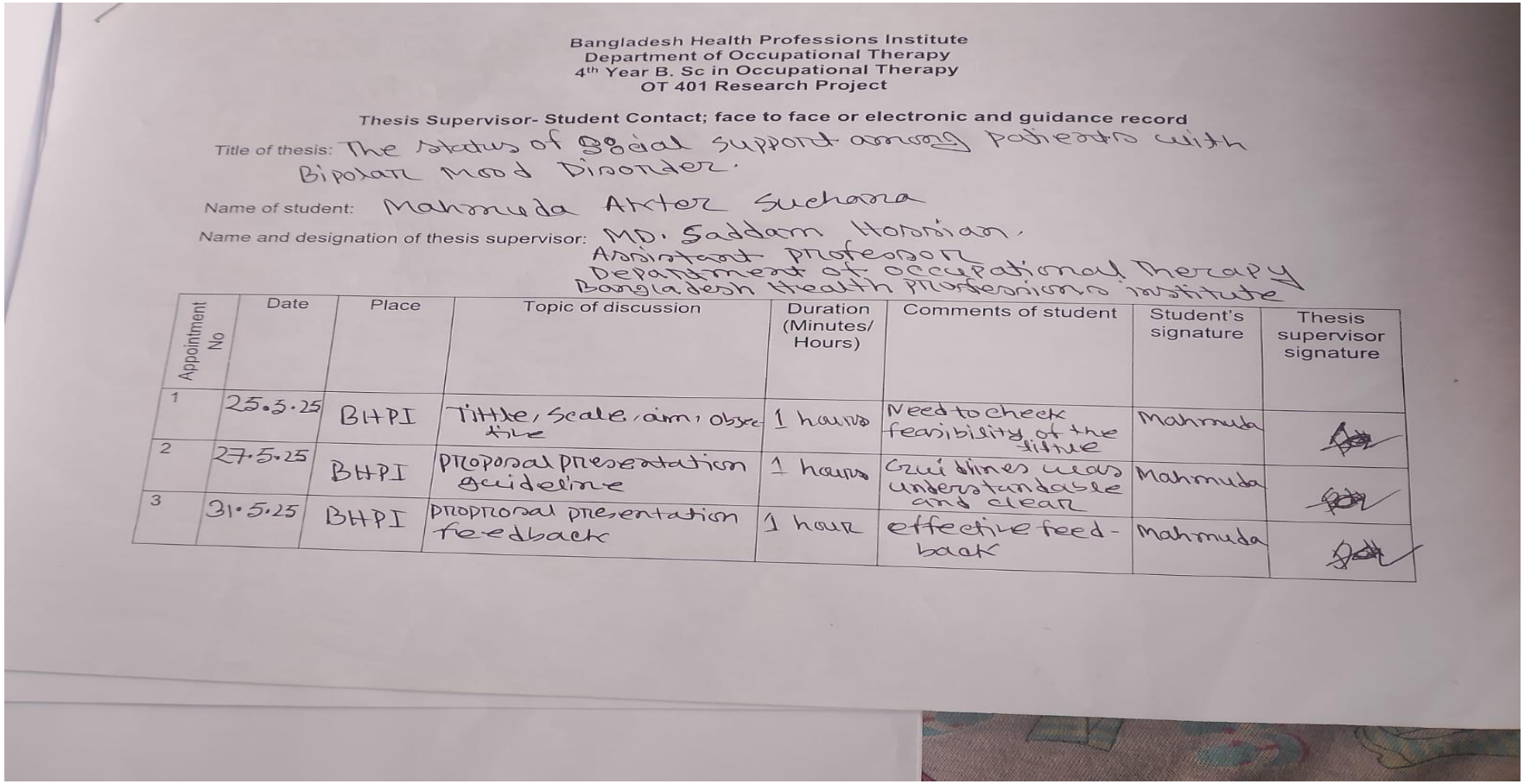
23. চিকিৎসার জন্য কি আপনি অন্যদের কাছ থেকে কোনো আর্থিক সহায়তা পান?

a. হ্যাঁ

b. না

c. মাঝে মাঝে

Appendix D: Supervision Record Sheet



Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

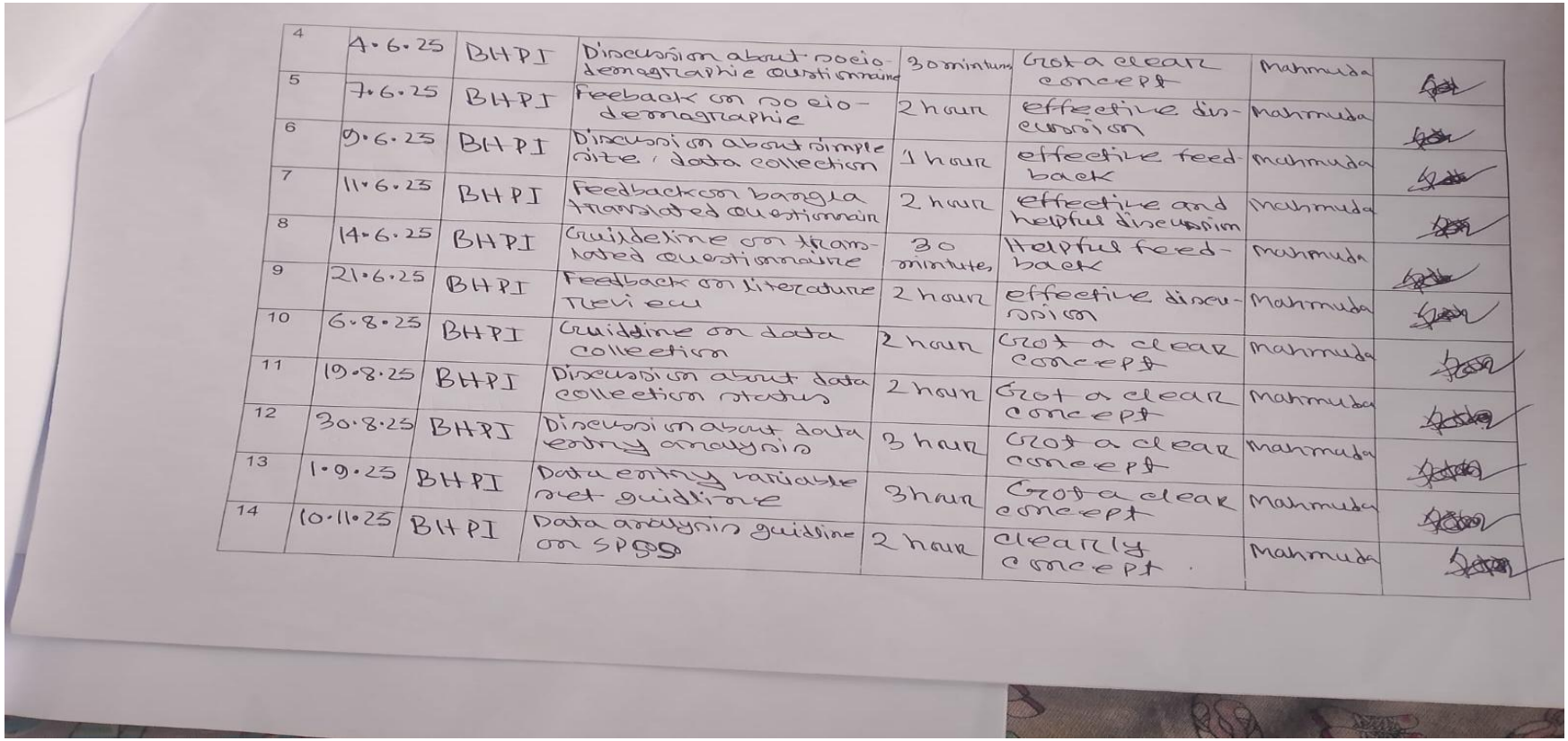
Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: The status of Social support among patients with Bipolar Mood Disorder.

Name of student: Mahmuda Akter Sucharo

Name and designation of thesis supervisor: MD. Saddam Hossian.
Assistant professor
Department of occupational therapy
Bangladesh Health professions institute

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	25.5.25	BHPI	Tittle, Scale, aim, objective	1 hours	Need to check feasibility of the tittle	Mahmuda	
2	27.5.25	BHPI	proposal presentation guideline	1 hours	Guidelines was understandable and clear	Mahmuda	
3	31.5.25	BHPI	proposal presentation feedback	1 hour	effective feed-back	Mahmuda	



4	4.6.25	BHPI	Discussion about socio-demographic questionnaire	30 minutes	Got a clear concept	Mahmuda	
5	7.6.25	BHPI	Feeback on socio-demographic	2 hour	effective discussion	Mahmuda	
6	9.6.25	BHPI	Discussion about simple site, data collection	1 hour	effective feedback	Mahmuda	
7	11.6.25	BHPI	Feedback on bangla translated questionnair	2 hour	effective and helpful discussion	Mahmuda	
8	14.6.25	BHPI	Guildeline on translated questionnaire	30 minute,	Helpful feedback	Mahmuda	
9	21.6.25	BHPI	Feedback on literature review	2 hour	effective discussion	Mahmuda	
10	6.8.25	BHPI	Guiddine on data collection	2 hour	Got a clear concept	Mahmuda	
11	19.8.25	BHPI	Discussion about data collection status	2 hour	Got a clear concept	Mahmuda	
12	30.8.25	BHPI	Discussion about data entry analysis	3 hour	Got a clear concept	Mahmuda	
13	1.9.25	BHPI	Data entry variable set guidline	3hour	Got a clear concept	Mahmuda	
14	10.11.25	BHPI	Data analysis guidline on SPSS	2 hour	clearly concept	Mahmuda	

15	11.11.25	BHPI	Descriptive or descriptive analysis result	4 hour	effective and clear guidline	Mahmuda	
16	12.11.25	BHPI	Discussion on inferential analysis	4 hour	effective discussion	Mahmuda	
17	13.11.25	BHPI	Feedback on result writing	3 hour	effective discussion	Mahmuda	
18	15.11.25	BHPI	Descriptive analysis feedback	3 hour	effective feedback.	Mahmuda	
19	16.11.25	BHPI	overall feedback on result writing	3 hour	effective feedback	Mahmuda	
20	23.12.25	BHPI	Feedback on 1st draft	1 hour	Got a clear concept	Mahmuda	

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.