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Caregivers' Perspectives on Supporting Loved Ones with Psychosis Triggered By Substance Use

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Abstract

The SIPD is one of the conditions causing substantial problems to the patients and their relatives, who perform all the care duties in most cases. This paper will delve into both the emotional, psychological, and social effects of being a family caregiver to individuals with SIPD by examining their experiences. Themes of stigma, caregiver burnout, communication breakdown and difficulty in attaining mental healthcare became evident because of long-form qualitative interviews. Respondents stressed that more organized support systems are necessary, the issue of healthcare participation should be enhanced, and the level of awareness must be raised. The results reiterate how demanding SIPD care can be and support family-based comprehensive treatment planning.

Keywords: ***Substance-induced psychosis, family caregivers, mental health, caregiving burden, qualitative study, substance abuse, support systems, lived experiences, stigma, psychiatric care.***

1.Introduction

As a health issue, substance abuse can be considered one of the most widespread health challenges of the 21st century completely changing not only the life of people, who are directly impacted by substance abuse, but has the ripple effects, which impact the whole family system and the community. The substance induced psychotic disorders phenomenon has become a rather complicated form of this crisis, and it has raised many specific problems which consider far more than just the person who is using any drug, that all have ties with his or her family, society ties, and societal concerns related to it. Once humans experience psychotic symptoms directly related to substance use, their relatives are additionally placed into the positions of caregivers without being prepared or properly assisted in such role which further leads to a snowball-effect of psychological (namely, mental imbalances, neurosis, etc.), social (such as marital and familial problems related to the exacerbated stress of being placed into a situation where they are forced to take care of others) and even financial stress that may potentially transform the composition and nature of the family and relationships that once were considered its definitive core constituents(1).

Such episodes of substance-induced psychosis are complex by the fact they are unpredictable and they tend to confound the voluntary and involuntary relationship between substance use and mental symptoms. Substance-induced psychosis, unlike its psychiatric brethren which could exhibit more discernibly delineated etiological processes, is the meeting point of behavioral decision making, neurobiological predisposition, and environmental influences which is the perfect storm of a family dysfunction. Caregivers often report to have conflicting feelings: on the one hand, being angry at their relative who has accepted substance use treatment, and, on the other hand, having strong sympathy with the relative who suffers and is lost in the chaos of psychosis. This emotional complexity was especially added by the social stigma not only in the substance abuse but also in mental illness, which leaves the families feeling lonely and condemned by the society.

There are also numerous economic repercussions of having such a relative with substance-induced psychosis, most of which require high levels of medical costs, lost income on the part of the caretaker, damage to the property in the form of violent times, and the costs of the recurrent medical processes of rehabilitation. Most families spend all their finances following different modes of treatment ranging between traditional medical procedures and alternative therapies yet there is no lasting convalescence. The economic burden leads to further pressure in family systems, which may have the impact of either increasing the already existing stress in the relationships or even generate new conflict sites as family members differ in methods of resource distribution and provision of other treatments.

Moreover, the recurrent occurrence of substance-induced psSC causes a certain special circle of anticipatory grief and trauma among families since a caregiver has always to balance an optimistic attitude of recovery and a pessimistic attitude of relapse. It is not just the primary caregivers that are dealing with this emotional rollercoaster as it extends to siblings, children, and extended family members, leaving intergenerational trends of stress and trauma well after the acute episode is over(2). The randomness of psychotic attacks implies that the afflicted families have to keep a consistent watch, which influence their capability of functioning normally in the social system, consistent keeping of the employment, and working on their personal plans and desires.

2.The Neurobiological Panorama of Substance-related Psychosis

The neurobiology involving the neurotransmission system that implies the substance-induced psychotic disorder is an interesting crossroad of medicine, biology, and ecology in the field of neurochemistry and neuropharmacology that is still a mystery of human brain performance and mental disorders. A range of psychoactive substances, such as marijuana, methamphetamines, cocaine, hallucinogens, and synthetic drugs may give rise to psychotic symptoms following distinct neurotransmitter systems, which, in turn, may have a significant impact on the shifts in the perception, thinking, and behavior. The dopaminergic system which has always been considered key in psychotic experiences gets thrown out of order in using substances thus initiating a chain reaction of neurochemical misbalances that may linger even after the acute intoxication phase has passed.

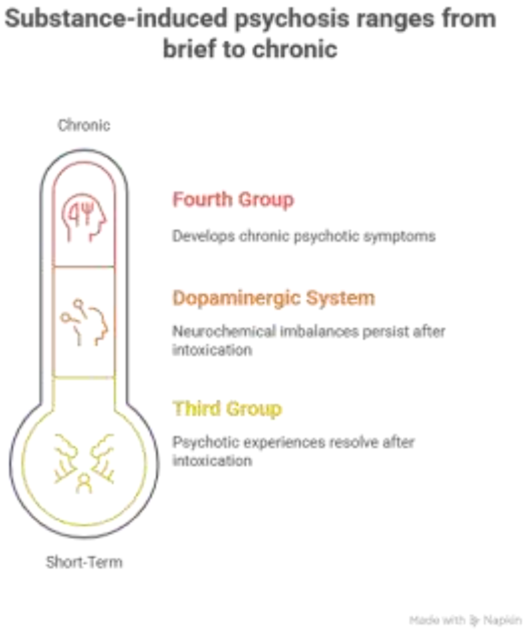

FIGURE 1 Substance-induced psychosis ranges from brief to chronic

Some studies have proven that there are genetically vulnerable individuals who when exposed to certain substances develop psychotic symptoms implying that substance induced psychosis might be the exposure of psychiatric predispositions instead of being substance specific diseases. This mix of genetic influences with ecological stresses and developmental trauma and unique pharmacology of diverse agents produces a complex matrix of risk factors so that forecasting and prevention are especially difficult. First use age seems to be especially problematic, as teenage users have much greater chances of second psychotic episode developing, which is probably caused by the developmental activities that are still taking place in the teenagers brain.

The length and the intensity of the substance induced psychotic attack differs significantly on the basis of various parameters that include the substance in use, the time of usage, the metabolism differences of individual users as well as the co-morbid mental disorders. There is a third group of people who receive short term psychotic experiences that get resolved immediately after they get intoxicated with the substance in their body and a fourth group who develop chronic psychotic symptoms and may receive another diagnosis of psychotic disorder. This uncertainty presents extreme difficulties to make the families comprehend condition of their relative and properly choose method of treatment(3).

Neuroplasticity in the brain presents an optimistic and worrying clause when it comes to substance-induced psychosis since the capability of the brain to be altered in a permanent manner by a substance works both ways in that it is just the same system which enables the substances to foster lasting modifications on the brain function to hold the hope of recovery and healing as well. The neurological recovery period however, can sometimes take extremely long compared to what the families expect only to be followed by prolonged abstinence period and holistic treatment responses, which not only treat the substance abuse but its root cause that can be the alteration in the neurobiological alterations that lead to certain psychological attributes. Learning such neurobiological underpinnings is imperative to families in their decision-making process concerning treatment strategies and realistic time projections regarding the recovery process(4).

3.Methods

3.1 Research Design Architecture

The case study followed qualitative research framework that involved use of interpretative phenomenological approach to explore the lived experiences of family caregivers to relatives with substance based psychotic related disorders. This research methodology is informed by a specific methodological selection that will enable exploration of subjective and nuanced experiences made by the participants, as well as enable exploration of meaning-making processes within caregiving context on a deeper level. The theoretical approach of the interpretative phenomenological analysis framework helped explain how the members of the family devise meanings out of their experiences related to the process of care giving, how they mentally work through the emotional reactions they feel to tough events, and how they come up with their appropriate coping mechanisms of dealing with tedious family interactions.

The qualitative paradigm seemed the most suitable in terms of this exploration since it puts emphasis on the views of the participants, it enables exploration of the intricate social phenomena, and it gives the opportunity to adopt the flexibility in data collection procedures, which could relate to the sensitivity of the mental health and substance abuse subjects in question(5). The qualitative framework, unlike the quantitative one, which could limit the reduction of experiences to quantifiable ones, allowed the researchers to experience and approach the complete range of the emotional, psychological, social, and even spiritual aspects of the experience of care giving. The phenomenological orientation intentionally paid attention to the subjective process by which participants gather, interpret, and create meaning of the experience instead of trying to create a causative link or extend the results to other groups of the population.

3.2 Contextual and Geographic Setting

The study targeted the Giyani municipality, which falls under Mopani district, Limpopo province, South Africa, whose residents face serious socioeconomic problems, such as, high unemployment rate, low access to education and a lack of access to mental health services. It was of strategic significance to select this geographic area absolutely because it is a representation of a prototypical rural South African locality, where households usually play the critical role of caregivers of their family members with mental disorders owing to the short supply of institutional support and a cultural proclivity to more family-centered ways of assisting relatives.

The contextual setting was instrumental in offering the distinct perspective on the role of economic limitations, culture, and resource restraints in determining the experience of providing care to members of the family and coping with it. The demographic state in Giyani, a deprived environment with almost forty percent of the population living below the poverty threshold and thirteen point two percent of the houses having no source of income added further dimensions to challenges faced by families coping with the problems of taking care of the people with substance induced psychosis. The study location was in the homes of the participants, and this was done keeping in mind that the domestic place of the home is the major location of the activities relating to care provision and where family relationships are most naturally displayed.

3.3 Strategy of Participant selection and Recruitment

Purposive sampling was employed to find and enroll the eight members of the family to guard against any wherein they did not have the relevant experiences to offer and are not able to offer the rich, detailed description of their path of caregiving. Purposive sampling was chosen instead of the random sampling methods due to the fact that the research was demanding in terms of participants with specific experiences and in possession of specific characteristics that could be used to thoroughly explore the phenomenon to be investigated. With such a sampling strategy, the focus was on getting as much information as possible rather than on the statistical representativeness of the sample, and the key was to have people who were capable of describing their experiences insightfully and offer a variety of opinions on the dynamics of family caregiving(6).

The purpose of developing inclusion criteria carefully was to provide relevance of participants, without compromising their ethical treatment and practical implementation. The subjects had to be eighteen years old, allowing them to sign the informed consent form and at the same time ensuring that they had enough life experience to talk about in-depth issues during the interview. The restriction that the participants had to be taking care of their relative within the last five years gave them a long term experience of challenges and adaptations they face in the caregiving relationship. The language requirements indicated that participants were supposed to be fluent in either English or Sepedi in line with the major languages spoken in the research environment, but also making sure that there was effective communication in the interviews.

The criterion that relatives in the sample had to have the experience of psychiatric hospitalization of relative with substance-induced psychosis met several goals: it could certify objectively the severity of the condition; it could certify that families had practical exposure to formal mental health services; and it could certify that the care giving difficulties were beyond the customary family supporting role functions. Telephone access requirement was based on the necessities of contacting participants at the most practical times due to COVID-19 restrictions as well as on the need to make the participants reachable so that it could perform follow-up clarification or member checking tasks.

3.4 The Procedures and Protocols Involved in Data collection

Data were collected through deep individual interviews over the telephone as a measure of adherence to COVID-19 safety guidelines without sacrificing the sense of personal interaction required in discussing both sensitive and emotional issues. The interview strategy was based on the open ended method of questioning to ensure participants tell their story as is, through their conceptual frameworks, and in the language of emotions. Procedures were formulated and agreed upon to be involving both structure and flexibility so that adequacy of guidance could facilitate coverage of major topics in research but with enough flexibility to allow emergent themes and issues and subsequent participant directed exploration of especially powerful experiences(7).

The main research question is as follows: What is it like, to have a relative with substance-induced psychotic disorder? was purposefully general and open which is meant to encourage participants to recount their experiences without specific limitations or assumptions of what the researcher believes are most crucial. In order to obtain elaboration, clarification, and further development of emerging stimulating patterns during individual interviews, follow-up probing questions were asked. To initiate safe places, the researcher used micro list skills, empathetic reactions, and culturally considerate communication methods to invite participants to share possibly traumatizing or stigmatizing experiences.

Individual interviews between 40 and 60 minutes were planned to allow enough time to report the complete experiences of the participants without infringing their time limitations and emotions. The largest part of the interviews has been provided on Sepedi which coincides with the language preference of the participants and also cultural sensitivity and effectiveness to communicate. Use of recording audio was also applied with the consent of the participants recording the entire content of the interview and enabling the researcher to concentrate more to the interaction than more on note taking during the interaction with the participants.

3.5 Framework of Data Analysis and Interpretation

The analytical strategy was based on the Tesch open coding strategy of thematic analysis since it offered a reproducible methodology framework of detecting trends, subjects, and significant units of the data obtained. The reason why this analytical approach was chosen is its ability to present flexibility in dealing with varied forms of qualitative data at the same time ensuring rigor in the identification and development of relevant themes to represent actual experience of participants. The process of analysis started in the first part of the data collection, as analysts were undertaking constant thoughts and initial data evaluation to find out the emergent themes and to attain data saturation.

Analysis process incorporated several stages of the engagement with data, including full transcription of audio-recorded interviews, translation of Sepedi material into English, which would be used to analyse it. Reflective reading Non-verbatim transcription was conducted and the transcription read repeatedly to gain immersion within the data and start the initial discovery of codes and themes. The identification of the discrete units of meaning within the narratives of the participants was done administering open coding procedures where the attainment of codes was based on the language of the participants and was not imposed by the variables of the existing theoretical models.

Another code was employed to increase analytical perspective and add credibility to findings since analytical triangulation was used. The independent coder was chosen based on his/her experience of working with the area of qualitative research methodology and was coded independently, using the same analytical protocols to check emerging themes and foster their improvement. Since the study demanded several COVID-19 restrictions, the sessions of consensus discussion between the primary researcher and the independent coder were carried out over the phone aiming at obtaining a consensus regarding the identification of themes, their definition, as well as the contexts to support these themes.

3.6 Ethical and protection of the participants

The entire ethical legal authorization was provided by the Research Ethics Committee of the Faculty of Health Sciences at the University of Johannesburg (reference number REC-671-2020) and by a mental institution in Limpopo province that all the expert operations were performed according to the universal standards of ethical research with human subjects. Research protocols, data collection procedures, consent processes and the plans to protect the confidentiality and wellbeing of participants during the research study were evaluated in detail(8).

All research activities and decisions were carried using the four core principles of research ethics, that is, autonomy, nonmaleficence, beneficence, and justice. Autonomy was upheld because sufficient informed consent measures were followed and the participants had been informed of the purpose of the research, the procedures that would be followed, the possible risks and the expected gains and their rights as research participants which included the right to withdraw/terminate the study any time without any consequence. Having of informed consent was provided to the participants with participants being treated as autonomous agents able to make an informed choice of participation that was supported and given information needed to give informed consent.

Benefits considerations- concerns regarding the possible emotional distress that may ensue during the disclosure of some hard moments in care giving were taken care of and in case one of the caregivers did not feel good, the researchers had plans to offer referral information on counseling services and펑 purchase the emotional support services. Nonmaleficence principle was adopted to design interview procedures and train the researchers to reduce the possible harm and to realize that certain amount of emotional experience may be but normal as the participants analyzed their experiences. The principles of Justice also meant that such study participants were correctly chosen without any unfairness concerning their social, cultural, racial, or other status and got ensured that the research benefits would be distributed properly among the participating communities.

3.7 Credibility and Methodical Strictness

Credibility, transferability, dependability and confirmability have been achieved using the framework of Lincoln and Guba and this was achieved by employing various methodological strategies aimed at improving the reliability and validity of the findings. The credibility was attained by spending a lot of time with the data, by triangulating various sources of the data like interviews and field notes, and by using member checking methods that gave participants an opportunity to evaluate and vindicate researcher interpretations of their experiences.

Transferability was achieved by adequate thick description of the context of research, characterization of participants and methodological procedures of a research to ensure that the findings are also assessable in others with relative similarity in context and populations. The transferability was also facilitated through purposive sampling and data saturation procedures which had ensured that the degree of relevant experiences is adequately reflected in the sample of participants. In dense descriptions of findings there was prolonged use of direct quotations of participant interviews to describe themes and sustain interpretive claims.

Dependability was achieved by a thorough report of all the research steps thus making an audit trail through which outside readers could trace the real course of the research and make an evaluation of the relevance of methods choices adopted(9). The dependability was established with the help of audio recording interviews, extensive field notes and systematic documentation of analytical procedures. Confirmability was attained by the use of audit trail documentation as well as the analysis process being involved with an independent coder to give external confirmation on the process of analysis and development of themes.

4.Results

Contextual characteristics and Demographic Profile of Participants

The study analysis effectively involved eight family members as caregivers who included different demographic groups but had one thing in common, i.e., long-term care experience of relatives with substance-induced psychotic disorders. The sample comprised seven (7) female and one (1) male caregivers aged 39-68 years both because of the gendered division of the roles of the caregivers in this particular culture and family, with women taking the responsibilities of primary care providers to their family members with mental health issues. The length of care giving experiences varied widely between a low of six years and up to twenty-six years, meaning that the participants had plenty and long-term experience with the complexities and changing nature of caring about the family members with a substance induced psychotic disorder.

The relationship patterns among individuals and their affected relatives disclosed critical patterns of the family caring structure, where the largest number of caregivers was associated with mothers (four participants) and then sisters-in-law (two participants), the rest being girlfriend (one participant), and father (one participant). These relationship patterns tend to represent cultural expectations and the composition of the family when mothers are the main nurturers and care providers irrespective of the age of their children and the nature of the conditions they live with. Presence of sisters-in-law as caregivers puts the extended family networks into spotlight which tend to be subject to care-giving tasks especially where limited resources of nuclear family exist in a situation or where marriage brings family roles to the fore.

Various marital statuses within the group of participants indicated that the issue of caregiving is beyond the classical family and embraces individuals of different life situation irrespective of whether they are widowed, singles, married, divorced, and cohabiting. A greater prevalence of widowed and single female participants (four of them) may indicate the economic vulnerabilities that predispose these individuals to the family support systems and, at the same time, increase their share of the care load(10). They all belonged to the group of Black South Africans, which correlates with the population structure in the location of the research but also emphasizes the targeting of specific cultural and socioeconomic factors that can shape the experience of caregiving in the particular population.

Since the format of the interview was telephonic due to COVID-19 restrictions, it lasted between 40 and 60 minutes per interviewee, and the vast majority of the conversation was carried through the language of Sepedi due to the need to create cultural adequacy and communicative effectiveness. The linguistic accommodation demonstrated the dedication towards the cultural sensitivity of the researchers and the awareness that including participants ability to provide a detailed emotional and experience related content in their first language will provide the higher quality authentic data. Mechanisms such as translation were put in place to uphold the integrity of participant narratives in order to make the data structured as information that is calculable and consumable to wider audiences.

Theme One Psychological, Social Destabilization through Caregiving

All the participants referred to their experiences of care giving as overwhelmingly destabilizing experiences which had violated the normal ways of the family functioning, personal wellbeing and relationships in a way that went far beyond what seemed like normal requirements of family support. The destabilization occurred on various aspects of family life and this created a discontinuity impact that shaped all aspects of the family such as daily routines, family management, way of life, future plans, and family relationships. Caregivers reported being frustrated by instability in symptoms of their relatives which might be quickly increasing to the situations when urgent intervention and strategies to manage crisis had to be taken.

The destabilization of emotions of the participants involved thick layers of love, frustration, fear, anger, disappointment, and grief that ensured the persistence of internal conflicts most of the time as the caregivers sought to manage conflicting issues of affection to their relatives on the one hand and difficult behaviors and safety issues related to the psychotic substance-induced episodes on the other. Most of the participants reported to being caught in between their moral duty to help their family members on the one hand, and their personal safety, stability, and self-realization needs, on the other hand. Psychologically, this was aggravated by the occurrence of unstable cycles of relative stability and the development of acute symptoms, resulting in a state of chronic stress and hypervigilance that did not allow caregivers to have time to relax and live a normal life.

Financial destabilization came up as one of the most vitally important themes, and the participants explained how the role of caregivers became a leading contributor to financial destabilization in terms of direct costs of medical and rehabilitation care and property repairs, but also in terms of indirect costs such as loss of employment opportunities, reduced capability in earning income, and family savings. Even some of the participants reported depleting their financial capacity in seeking all forms of treatment that could include using conventional medical interventions or using traditional practices of healing with minimal success in improving the conditions of their relatives. The economic pressure resulted in further stressors in the family systems and hampered the capacity of families to seek other objectives or respond to other conflicting family priorities.

Social destabilization presented itself in the disruption of community relations and loss of social networks and other support systems at both the individual and familial level as families attempt to deal with the stigma linked to both mental illness and substance abuse. Participants expressed being judged, blamed, and excluded socially by the members of the community who opined that the actions of their relatives were a poor representation of the family values and the manner in which they were brought up. These social effects were not localized within the family circle and were reflected in the life of schoolchildren, the ability to find a job, and including relationships between men and women, thus producing intergenerational effects that affected the life path and the chance at social integration and promotion of several family members.

The second theme is Spiritual Resources and Community Support Networks

The participants showed incredible resilience because they were able to recognize, develop, and develop most diverse types of support available that allowed them to find emotional sustenance, practical aid, and a means of making sense of their experiences. Spiritual resources namely, prayer, and religious faith, proved to be major coping tools that offered participants a sense of meaning, future and hope, as well as, constructs of the world that have adequately structured and given explanation to suffering in an even wider cosmological picture of divine providence, testing, and ultimate redemption.

Practices of prayer fulfilled several purposes to its members such as emotional control in situations of crisis, access to transcendent sources of comfort and wisdom and acting as a unification process with other believers in situations of shared religious episodes with whom they could find reassurance and support. A great number of participants counted their religion as something that gave them the means of sustaining hope, at times when medical measures seemed useless and the situations of their relatives seemed hopelessly impossible to change. Spiritual component of coping helped the respondents to stay committed to the caregiving relationship in long term despite discouraging results in the short-run or insignificant progress.

Although stigma and social judgment often established boundaries to the providing the needed support to families in varying degrees, community support networks offered practical and emotional support in essential dimensions that allowed families to extend their caregiving activities at length. Uncles and other male relatives were frequently a large part of the crisis intervention as well as safety management during exacerbations of the problem when the relatives were found to be aggressive or dangerous. When neighbors were good, they offered more safety nets and avenues of practical support and assistance, even if the respondents indicated that the support in the community was not always reliable, and would close ranks when family circumstances got too disorderly or burdensome.

This process of acceptance became one of the most important adaptive mechanisms that contributed to the participants abandoning their choice of fighting their relatives conditions toward one of being more practical in their choice of living long-term care and managing relations with their relatives. The acceptance was not a way to resign and give up on the potential of the situation getting better; it was the practical understanding of the fact that such substance-induced psychotic incidents were chronic and that one would have to devise a way of coping with them which would be prolonged in time. Such mindset change allowed participants to spend less time engaging in self conflict, form more attainable expectations, and invest energy into the controllable parts of the situation instead of exhausting themselves when trying to deal with things beyond their power.

Translational theme three: Resource advocacy and deficits in systemic support

The participants were able to provide complex insights into the systemic factors that made their caregiving experience more challenging, as well as define particular areas where the government can have an impact and alter the policy accordingly that can have a tremendous effect on families affected by substance-induced psychotic conditions. The theme of shortage of systemic support services involved various realms such as flaws on the part of healthcare system, social services shortcoming, as well as issues on housing and infrastructure, and lack of special programming on patients with dual diagnosis where not only substance abusers, but patients with mental problems as well.

The barriers in the healthcare system were the lack of access to special services, the disintegrity of care coordination both between mental health and addiction treatment professionals and insufficient community-based care, which had the potential to offer an alternative to hospitalization during the period of crisis. Respondents reported frustrating experiences in dealing with healthcare bureaucracies, difficulties with healthcare providers who had little knowledge of substance-induced psychotic disorder and the inability to become stabilized through continuity of care that could then embrace long-term recovery and stability. There were no unified treatment interventions and therefore families used to juggle caregivers who were not communicating with each other.

The weakness of the economic assistance was focused on the ineffectiveness of providing grant support and social services which could not provide the measures of all needs related to taking care of the relatives with psychotic conditions developed as a result of the usage of drugs. Respondents observed that whatever was available in terms of financial aid was not sufficient to cover essential needs of maintaining life, leave alone extra expenses due to specialized care, restoration of property, and crisis management costs. There were also no programs to support caregivers, and thus, family members were left with the entire economic cost of caring without support and help in regard to their needs and sacrifice.

Infrastructure demands and housing requirements were expressed as a cognisance by participants of the extent to which environmental contributory factors affected the stability and recovery potential of their relatives; most polled participants favoured special residential programs, therapeutic institutions, and suppressed housing initiatives which might offer rigid establishment supporting recovery and eliminate the necessity of taking care of their relative around the clock. The participants revealed advanced insights into how environmental changes and special programming could facilitate recovery processes and admit that these tools were simply inaccessible in their geographical area, so the families had to give intensive support, most of the time without training, resources, or crisis response support systems.

5.Disruption of Family System and its Adaptive Mechanisms

Effects of psychotic disorders caused by substances on family systems, far greater than their effect on the care of any specific individual, it has been transformed through the family-wide processes determining future family functions, communication styles, and relations that may go on long past the limelight culminating in the family system. The normal roles and order of the traditional family can change as parents face a potential need to offer close supervision of the person who has been affected, siblings might have to take up parental duties, and spouses might have to make harsh choices concerning safety and further maintenance of the relationships. Such reversal in roles and boundaries generates stress within the entire family system and may cause resentfulness, mixing, and conflict between family members that find it difficult to cope with new demands and functions.

When a family is infected with substance-induced psychosis, communication styles tend to turn into hypervigilance, eggshell talking style, cautious observation of the mood, and behavior of an affected person who can manifest the symptoms of possible relapse or relentless progression. Members of a family can devise intricate systems of coded communications, aimed at talking about their relative without causing aggressive/paranoid reactions. This accumulating circle of vigilance in the house makes stress chronic and may trigger the following problems, including the emergence of the anxiety disorders, depression, and other stress-related cases in family members who are forced to caregiving and check-up roles.

The very idea of enabling and supporting gets notably complicated in case of substance-induced psychosis since the family member finds it hard to understand where their support is helpful and when it is actually contributing to the issue. Conventional models of addiction which are based on a tough love, natural consequences approach complicate the introduction of the psychotic symptoms since family members are faced with the challenge of having to insist on accountability measures and at the same time safety measures to address the ills of the mental condition as well as the meting out of the natural consequences of the actions of the individual during the course of psychotic breaks. This puts in place moral and ethical conflicts and confusion which can cause a family to fall apart and bring a lot of conflict regarding the rightful responses and intervention measures.

Some of the adaptive mechanisms incorporated by families are construction of safety plans, development of crisis management strategies, establishment of support systems between affected families, and development of stress management and stress coping strategies within the family. The effective resiliency of the family can be achieved through some assistance of professionals who can assist the family members to develop healthy boundaries, advance the level of interaction, and build sustainable caregiving healthy systems that will not jeopardize the health of other family members but will provide the necessary care to the affected individual. The building up of such mechanisms of adaptability can be fairly slow and involved a constant adaptation to the environment as the family figures out how to work through the difficulties of their new existence.

6.Conclusion and Future work

The collective body of knowledge which has now been gathered on the topic of Body Integrity Identity Disorder has essentially changed the viewpoint that humans have had of this rather complicated neurological condition, as it goes beyond the relatively simplistic early perceptions to present BIID as a valid medical disorder, with definite neurological etiological roots. Evidence has also recently been gathering heavily in support of the hypotheses that

BIID stems as a result of neural systems disturbance that are involved in obtaining body ownership and multisensory integration, chiefly those relating to the parietal cortex, premotor areas, as well as the insular regions. Such neurological abnormalities seem to be present at the early development stages and give the resulting individuals an inextricable mismatch between their inner sense of body structure and physical anatomy that cannot be treated by available psychological therapies. The reproducibility of the results of research teams and study methodologies has also given strong support to the experience of people with BIID, showing that this is a true neurobiological problem and not a psychological disorder or an example of seeking attention. There are significant implications associated with decreasing stigma and enhancing clinical care among various individuals through this scientific confirmation. The discoveries of the research have also shown a startling level of specificity of BIID, since the brain lesions are usually localized to the areas relating to the hated body parts, hinting that the disorder expresses localized disturbances in the neural circuits instead of general brain malfunctioning. Moreover, literature has revealed that in the case of BIID, the only common denominator is the desire to lose a leg in some patients or the desire to have a leg become paralyzed in other cases, but the distinction between these manifestations can be the extent or location of a neural pathway disruption. The new-found knowledge on BIID has a general implication in neuroscience which offers insights rarely provided on the neural processes involved in body ownership, self-identity, and the process of combining sensory events which helps develop the idea of our physical self. Such discoveries have also changed classical beliefs about the accord between mind and body as it has brought into light the extraordinary plasticity and pliability of the neural systems that mediate body representation. The study has also emphasized the necessity to listen to what the patients have to say and take at face value symptoms that might seem strange or incredible at first as the scientific establishment of BIID proves that such a symptom can be a manifestation of a real neurological illness that is treated in a surprising manner.

TreatmentDevelopment and Clinical Implications

The neurobiological knowledge acquired due to the studies on BIID have significant implications on the formation of effective and more ethical methods of treating the difficult disorder. Knowledge of the brain areas and circuits that cause BIID also provides an opportunity to conduct specific intervention in an attempt to treat the neural dysfunction and correct symptoms instead of treating the condition through interventions. Neurostimulation procedure like transcranial magnetic stimulation or deep brain stimulation may be modified in a way that it modulates the activity of disordered brain circuits, which may result in alleviation without irreversible surgical procedures. Finding abnormal connectivity among brain areas indicates that interventional strengthening or normalization of such crossings/ connections would be therapeutic, whether using intensive rehabilitation sessions or neurofeedback training. The technologies of virtual and augmented reality are also promising in terms of BIID treatment since they might create a controlled setting in which a gradual change in body perception might take place and even the dysfunctional neural pathways might be retrained due to frequent use of altered body images. The results of the research also serve to create more advanced assessment tools which would enable clinicians to assess the level of BIID more effectively and to track the progress of the treatment by using objective neurological parameters as opposed to subjective accounts. The neurobiology has also guided the argument of ethics of surgical treatment of BIID giving a more concrete basis of discussing whether a patient should be operated upon as long as it provides better grounds to approach the case that includes amputation in well-chosen patients after non-conservative measures have failed and the neurological abnormality can be proven adequately. The study has underscored the fact that there is need to establish specialized treatment centers that would deal specifically with BIID as BIID needs a special set of people with knowledge in the field of neurological, psychiatric and surgical experts which are hardly found in the general health sectors. The results also indicated that early intervention in childhood or teenage years may have the best results, since during childhood and teenage years, the neurons are prone to modifications thereby early intervention may help in preventing the complete exhibitions of BIID symptoms. It could be effective to develop family-based support and interventions as the study has shown that BIID usually develops in childhood and also has a serious influence on family relationships and functioning.

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Conflicts of interest

The authors have no conflicts of interest to declare

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