Psychological Resilience and Suicidal Thoughts in Bipolar Disorders Patients

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Abstract

Background: Bipolar disorder is a serious mental illness associated with an increased risk of suicidal thoughts and behaviour. Resilience, or the ability to adapt and manage stress and adversity, maybe a major factor in lowering this risk and improving outcomes for people with bipolar disorder. **Aim:** The current study aimed to assess the relationship between psychological resilience and suicidal thoughts in bipolar disorder patients. **Design:** A descriptive correlational design was adopted in the present study. **setting:** The research was carried out in the "Psychiatric Medicine and Addiction Prevention Hospital—Cairo University Hospitals" inpatient and outpatient departments. **Sample:** A purposive sample of 50 male and female bipolar illness patients selected for this investigation. **Tools**: A structured interview sheet collecting socio-demographic and medical information, the Connor-Davidson Resilience Scale, and the Morey Suicidal Ideation Scale were used to collect data. **Results**: The results showed that (46.60%) of the bipolar patients tested had a low degree of resilience, (42.20%) had a moderate level of resilience, and only a small fraction (11.2%) had a high level of resilience. Suicidal thoughts were present in 66.60% and 33.40% of studied bipolar patients, respectively. In bipolar disorder patients, there is no statistically significant relationship between psychological resilience and suicidal thoughts. In order to build resilience and reduce the risk of suicide thoughts and behaviours in bipolar patients, a complete approach that treats both the medical and emotional elements of the condition is required. **Recommendation**: A patient education programme is necessary: Nurses can educate patients on the value of resilience and self-care in the management of bipolar disease, as well as providing information on coping techniques and self-care practises that patients can use to improve their well-being...

Keywords: Psychological Resilience, Suicidal Thoughts, Bipolar Disorders, Patients

Introduction

Bipolar disorder (BPD) is characterised by recurrent depressive periods followed by hypomanic or manic episodes (Lee, Cha, Park, Kim, Lee, Lee, Seo, Ah, Hun & Choi., et al., 2017), which has a significant impact on the quality of life of individuals, their families, and society. The estimated prevalence ranges from 3% to 8% of the human population, but these figures would be higher if bipolar spectrum disorders were included (Angeler Angeler, Allen, & Persson, 2018). BPD 1 affects both men and women equally, whereas BPD 2 affects women more than men (Carvalho, Firth, & Vieta, et al., 2020).

Bipolar disease affects more than 1% of the world's population and is one of the leading causes of impairment in young people, regardless of nationality, ethnic heritage, or socioeconomic position. Bipolar disorders were common across all cultures and ethnicities, with an overall lifetime prevalence of 0•6% for bipolar I disorder, 0•4% for bipolar II disorder,

14% for sub threshold bipolar disorder, and 24% for the full spectrum of bipolar disorders (Alonso, Petukhova, & Vilagut, 2011).

A serious illness, bipolar disorder causes significant psychological morbidity and excess death. A number of study studies, reviews, and commentaries published over the past few years have suggested that bipolar disorder is underdiagnosed and that many patients, particularly those with severe depressive illness, actually have the condition (Bowden 2001). Even for people with bipolar disorder, it frequently takes more than 10 years from the time of beginning treatment seeking to the proper diagnosis (Hirschfeld, Lewis, & Vornik, 2003).

Suicidal ideation, suicide attempts, and completed suicides are all much higher among bipolar disorder (BD) patients. According to the Epidemiological Catchment Area research (ECA), 29% of bipolar patients in the general community attempted suicide at least once in their lives (Chen & Dilsaver, 1996). According

to clinical samples, 10% to 19% of BD patients commit suicide in their lifetimes, while 25% to 56% of BD patients record at least one suicide attempt (Goodwin & Jamison, 2007).

Although suicidal ideation is common in BD, it is unclear whether it is a precursor to future suicide attempts (Oquendo, Currier, & Mann, 2006). Bipolar disorder patients have a high rate of suicidal thoughts (14-59%), according to Strakowski, McElroy, Keck, and West (1996), and studies have shown that 25-56% of these patients attempt suicide at least once in their lifetime, with 10-19% dying as a result (Abreu, Lafer, Garcia, and Oquendo, 2009).

The capacity to respond favourably to stressful situations in life or to psychosocial stress is known as resilience (Edward, 2005). It is a continuous process involving the individual's adaptation to highly adverse circumstances; a protective component that modifies, increases, or changes the individual's response to risky events that might otherwise predispose them to less adaptive outcomes (Rutter, 2012).

It is a widespread phenomenon (Masten, 2007), as opposed to a singular occurrence, and is distinguished by adaptive behaviour patterns in risky and difficult situations. Although always with strong associations to mental health, the notion of resilience has been more popular in fields like employment, education, and social policy (Cabanyes, 2010).

Adults may be exposed to developmental stressors such as declining health, caregiving obligations, loneliness, and the cumulative effects of physiological stress or chronic illness. As a result, the mechanisms that promote psychological resilience in adults may differ from those that promote resilience in children. Adult resilience in the face of disasters and continuous adversity is enhanced by social support, community support, and spirituality (Canvin, Marttila, Burstrom, & Whitehead, 2009; Salloum, & Lewis, 2010). Social support and meaning-making remain essential.

Significance of the study

Analysing resilience's effects in psychiatric disorders and how it interacts with other factors is becoming more and more popular. A high level of resilience has been shown to reduce the prevalence of suicidal ideation in people with depression. (Nrughamet et al., 2010) discovered that bipolar patients with low resilience had more depressive episodes and were impulsive (Choi et al., 2015).

There is scant evidence that BPD patients' resilience and suicide thoughts are related. These findings are crucial because psychological resilience can guard against BPD and lessen the incidence of suicidal thoughts, attempts, and depressive episodes There is a shortage of research on psychological resilience-focused intervention programs for BPD patients who have tried suicide in this area (Ozawa et al., 2017).

In this study, the relationship between psychological resilience and suicidal ideation in bipolar individuals is better understood and investigated. Patients who have been diagnosed with bipolar disorder will benefit immediately from the study's findings. If mental health professionals managed the concept of resilience, patients with BPD would be better able to comprehend and deal with stressful situations, such as their own illness process.

Lower psychological resiliency could alert psychiatric/mental health nurses to the fact that BPD patients are more vulnerable. Nurses may improve psychological resilience in this population and assist people in better coping with difficult circumstances, such as suicide ideation, by developing novel intervention strategies. This work will have a substantial impact on future practice.

Patients with BPD who are encouraged to build resilience will be better equipped to manage with their condition and recover faster. More study is needed to establish the effectiveness of psychological resilience development programs for BPD patients. They can also investigate the role of specialty nurses in this field.

Aim of the study

The aim of the current study was to assess the relationship between psychological Resilience and suicidal thoughts in bipolar disorders patients.

Research Questions:

In order to meet the study's goal, the following research questions were established.

Q1- what is the level of resilience in bipolar disorders patients?

Q2- what is the prevalence of suicidal thoughts among bipolar disorders patients?

Q3- Is there is a relationship between psychological resilience and suicidal ideation in bipolar disorder patients?

Sample:

A purposive sample of 50 male and female patients with bipolar disorder recruited for this study according to G power analysis. According to the monthly reports of the mental outpatient clinics that follow up in the psychiatric clinics two to three times per month, the population was roughly 578/month. In order to estimate the mean number of visits per month, this number was divided by two. 14 patients with bipolar illnesses from the three inpatient divisions are also included. Which means there were a total of: 578/2 + 14 = 289+14 = 303

The sample size was calculated using the following formula, which is simply applicable to descriptive studies: n=N/1+N (e)2

n= Sample size, N= study population, E= margin of error which is usually calculated to be(0.5), confidence level= 95%

N=303/1+303(0.5) ²= 50 participant

Inclusion criteria:

Male and female patients, aged 15 to 65, who had been diagnosed with bipolar disorder types I and II, were admitted to the in-patient department for a period of four months. Patients also attended the out-patient clinics for psychiatric medicine and addiction treatment at Cairo University hospitals.El-kaser El-Aini.

Exclusion Criteria:

This study excluded patients with addiction issues, mental retardation, acute psychotic symptoms, and cognitive impairment.

Research Design:

This study utilized a descriptive correlational design to describe the associations between variables without attempting to establish causal linkages. It was used to determine whether changes in one or more variables are connected to changes in others (Melnyk, Morrison Beedy, and Cole, 2015).

Setting:

This study was conducted at the "Psychiatric Medicine and Addiction Prevention Hospital - Cairo University Hospitals" in-patient and out-patient clinics. For nearly 1790 mental patients with a variety of diagnoses (such as bipolar disorders, schizophrenia, major depressive disorders, and addiction), the hospital provide inpatient and outpatient services. Consists of 5 floors: the group therapy room is located on the below-ground floor. There are outpatient clinics on the ground floor, including 5 psychiatric clinics, ECT rooms, and clinics for addiction, gerontology, and adolescents.

There were two waiting spaces in front of the outpatient clinics, which were open every day but Friday. Additionally, the inpatient male area for paid Services is located on the first floor. The second level is divided into two sections: one side is the inpatient male portion, which offers free paid services, and the other is the inpatient female part, which offers the same free paid services. Two areas for inpatient female and male addiction services are located on the third level and are both free.

Tools of the study:

For this study, three tools had been used to collect data.

Tool 1: Structured interview sheet for socio-demographic and clinical characteristics it was designed by the researchers after they studied the relevant literature. It examined socio-demographic and clinical characteristics such as age, gender, and marital status, level of education, occupation, diagnosis, and number of suicide attempts for bipolar patients.

Tool 2: Connor-Davidson Resilience Scale

(Connor & Davidson 2003) created the Connor-Davidson Resilience Scale. Arabic version as a means of assessing resilience. It had 25 elements divided into five subscales. The first subscale, titled Personal competency, high standards, and tenacity and comprised (8) items. Second Subscale called trust in one's instincts, tolerance of negative affect, and strengthening effect of stress Included (7) items.

The third Subscale was about positive acceptance of change and secure Relationships, it consisted of (3) items. The fourth Subscale was about dimension, control and Included (4) items. The fifth Subscale called spiritual influences and consisted of (3) items. All statements were scored on a five-point Likert scale ranging from Zero to Four: Not true at all (0), rarely true (1), sometimes true (2), often true (3), and true nearly all of the time (4The Total score goes from 0 to 100, with a higher number reflecting greater resilience. In the current study, a score of less than 50% indicated a low level of resilience, a score of 50-75% showed a moderate level of resilience, and a score of 75% and above suggested a high level of resilience among bipolar disorder patients. The Scale Cronbach's alpha Coefficient had an internal consistency of 0.89. Test and retest reliability was strong, with an interclass correlation coefficient of 0.87 (Connor & Davidson, 2003).

Validity & Reliability:

In the creation of the scale, the CD-RISC displayed strong reliability (=. 88 and. 89), test-retest reliability (.87), and convergent and divergent validity (Connor & Davidson, 2003; Gucciardi, Jackson, Coulter, & Mallett 2011) (Gonzalez, Moore, Newton, & Galli, 2016).

Tool 3: Morey Suicidal ideation scale

Suicidal ideation (SUI), Developed by Leslie Morey (1991). Translated into Arabic by (Hanors, 1998). It measured a respondent's frequency and severity of suicidal ideation and Plans. A Self-report 12-items personality test that assessed a respondent's severity of Suicidal ideation and plans. All items are scored on a four-point Likert scale ranging from zero to three. Not true at all (0), rarely true (1), sometimes true (2), true nearly all of the time (3). The total score runs from 0 to 36, with a high number indicating a high level of suicidal ideation. the cut point of the scale was: less than 60% indicated low level of Suicidal ideation, 60-70% indicated high level of Suicidal ideation, and more than 85% indicated the case is serious or dangerous. There were two reverse questions (number 10, 12).

Validity & reliability:

The suicidal ideation scale, a multidimensional self-report assessment of deviant personality traits, was tested for reliability, discriminant validity, and construct validity in the Australian context. There were 151 healthy people, 30 alcoholics, and 30 schizophrenics among the participants. A subsample of 70 nonpsychiatric people completed the PAI items twice over a 28-day test-retest interval. The median retest coefficient obtained was 0.7, indicating less than optimum stability. The median alpha (KR21) coefficient was 0.8, indicating that measurement scales were rather narrow. After controlling for age and gender, a significant multivariate main effect was obtained across groups. As indicated, several comparisons for each of the PAI scales revealed substantial differences between the groups. The stated PAI structure was not well supported by higher-order scale factoring. The purported PAI factor structure could not be replicated for the standardisation clinical sample (N=1246) in reanalysis of the correlation matrices included in the Professional Manual, and a confirmatory factor analysis using the normative (validation) correlational data (N=1000) revealed poor fit indices, raising further concerns about construct validity. 1994 (Gregory, Boyle, Tania, and Lennon)

Face validity:

Tools 1, 2 &3 were given to three psychiatric mental health nursing professors and their Opinions were sought whether at face value the tools appeared to be assessing the desired Qualities. All psychiatric mental health nursing professors agreed with respect to the Relevance of the items in measuring suicide ideation and resilience among patients with Bipolar disorders.

Procedure:

Permission to conduct the study was gained by submitting an official letter to the director of psychiatric medicine and addiction prevention hospitals at Cairo University." The researcher examined the patient data to find those who had been diagnosed with bipolar disorder.

During the actual research period, each patient with bipolar disorder who met the inclusion criteria was contacted individually

and interviewed confidentially after describing the nature and aim of the interview and study and obtaining oral consent to participate. The researchers interviewed each patient in order to complete the study tools. The questionnaire was explained, and the respondents' choices were recorded. The average time required to complete the tools ranged from 20 to 25 minutes, depending on the respondent's level of knowledge and responses. Data was gathered during a four-month period.The date was collected in the period of the prevalence of covid19 pandemic from February2020 to Jun 2020. Therefore the flow of patients in out and in patient was limited.

It was crucial to take precautions during the COVID-19 pandemic to stop the virus from spreading. The following general safety measures were implemented during data collection: Apply social distance: Keep a distance of at least six feet when speaking with the patient. Put on a mask that covers your mouth and nose, and Use hand sanitizer with at least 60% alcohol. Avoid sharing objects like pencils, keyboards, phones, and papers so that oral consent can be given to participating in the study.

Pilot study

An initial pilot study was carried out before the main investigation. 10% of the total sample was recruited for the pilot trial. The primary goals of the pilot research are to assess the tools' application and relevance, the language of the questions, the time required to administer the tools, any obstacles that may impede the data collection process, and the instruments' reliability and validity. The main study population did not include participants who took part in the pilot trial.

Ethical considerations:

All participants were informed that their participation in the current study was voluntary, that no names were included on the questionnaire sheet, and that each participant's anonymity and confidentiality were safeguarded by assigning a code number to each response to the Questionnaire. They were advised that they might reject to participate in the study without giving reasons, and that their refusal would not affect their care or their relationship with the researchers. Subjects were promised of confidentiality and informed that the content in the tools would be utilized purely for research purposes. Oral informed consent taken from the patients and their relatives who came with them to the hospital and this is to avoid sharing objects like written consents to avoid spread of coved 19 infections

Statistical analysis:

The statistical package for social science (SPSS) for Windows Version 21 was used to analyse the data. The frequency and percentage, as well as the mean and standard deviation, were used to express numerical data. To describe the relationship between variables, the correlation coefficient was used. A Pearson Correlation coefficient ® of 0.5 was taken to be fair; anything more than 0.5 to 0.75 was considered good. If the correlation was more than 0.75, it was regarded as a very good correlation. A probability of less than 0.05 was determined to be significant, while a probability of less than 0.001 was determined to be extremely significant.

Results

Part I- Socio-demographic and personal characteristics of the studied subjects

Table (1) illustrated that the average age of the studied bipolar patients was 34.42 ± 11.341. 71.1% of the studied bipolar patients were educated and 28.9% of them were illiterate. 62.2% of the studied bipolar patients were diagnosed with Bipolar1 and 37.8% of them were diagnosed with Bipolar2. Regarding Suicide attempt (35.6%) of the studied bipolar patients committed suicide. 15.6%, 11.1%, 2.2%, 4.4%, &2.2 % of the studied bipolar patients were committed suicide one, two, three, four, and five trails respectively.

As regard marital status, figure (1) declared that 46% of the studied bipolar patients were married and 54% of them were single.

Figure (2) showed that (56%) of the studied bipolar patients were females and 44% of them were male.

Figure (3) showed that (53%) of the studied bipolar patients were not working. While 47% of them were worked

Figure (4) revealed that, (46.60%) of the studied bipolar patient had low level of resilience, while (42.20%) of them had moderate level of resilience & (11.2%) had high level of resilience.

Figure (5) showed that, 66.60% and 33.40% of the studied bipolar patients had low and high level of suicidal ideation respectively while no one of the studied bipolar patients (0 %) had high level of suicidal ideation.

Table (2) revealed that, there was no statistically significant correlation between psychological resilience and suicidal ideation in patients with bipolar disorder

Table (3) revealed that, there was statistically significant relationship between level of education and the psychological resilience where F= 15.625 & P= 0.000. While there was no statistically significant relationship between age, marital status, gender, occupational status, diagnosis, suicidal attempt and its number and the psychological resilience in bipolar disorder patients.

Table (4) illustrated that, there were statistically significant relationship between age, suicide attempt and its number and the suicide ideation where F=3.000, 19.763, &4.849 and P= 0.012 ,0.000,& 0.001 respectively. While there was no statistically significant relationship between marital status, gender, level of education, occupational status & diagnosis and the suicide ideation in patients with bipolar disorder.

Table (1) Frequency distribution of socio-demographic and personal characteristics of the studied bipolar patients: (N=50).

Variables		
Age	**Mean ± SD**= 34.42 ± 11.341	
Personal data	**No**	**%**
Level of education		
Educated	35	71.1
Illiterate	15	28.9
Diagnosis		
Bipolar1	28	62.2
Bipolar2	22	37.8
Suicide attempt		
Commit	17	35.6
Not commit	33	64.4
Number of suicide attempt		
None	33	64.4
One trail	8	15.6
Two trails	5	11.1
Three trails	1	2.2
Four trails	2	4.4
Five trails	1	2.2

Figure (1): Frequency distribution of marital status of studied bipolar patients (N =50)

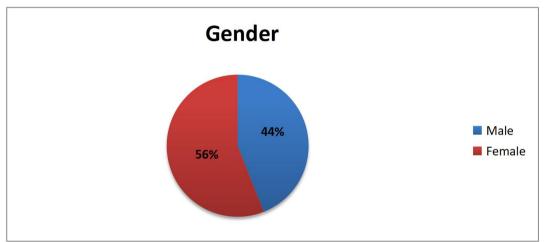**Figure (2)**: Frequency distribution of gender of studied bipolar patients (N =50)

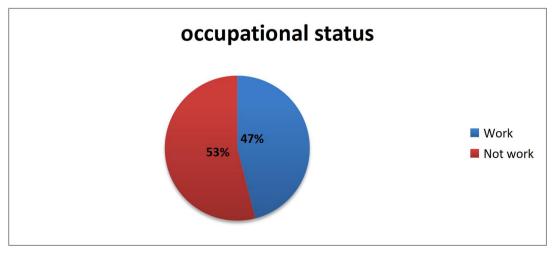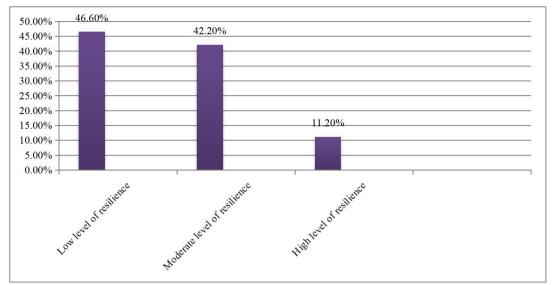**Figure (3)**: Frequency distribution of occupational status of the studied bipolar patients (N= 50)
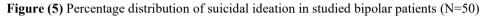
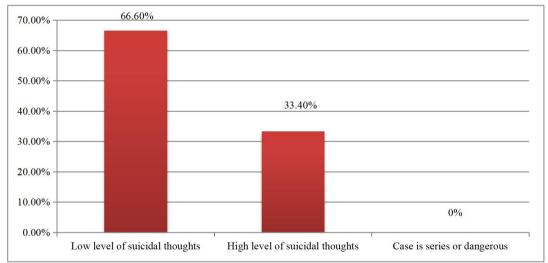**Figure (4)**: Percentage distribution of resilience among studied bipolar patients (N=50)

Figure (5) Percentage distribution of suicidal ideation in studied bipolar patients (N=50)

Table (2): Relationship between psychological resilience and suicide thoughts in patients with bipolar disorder (N= 50)

Items	Psychological resilience in patients with bipolar disorder	
	R	P
Suicide thoughts in patients with bipolar disorder	0.315	0.839

*Significances (P<0.05)

Table (3): Relationship between patient's socio-demographic characteristics and psychological resilience in bipolar disorder patients (No=50)

Socio-demographic characteristics of the patients	Psychological resilience in patients with bipolar disorder	
	F	P value
Age	1.349	0.268
Marital status	1.648	0.206
Gender	2.284	0.138
Level of education	15.625	0.000*
Occupational status	2.675	0.109
Diagnosis	1.121	0.296
Suicide attempt	0.264	0.610
Number of suicide attempt	0.175	0.970

*Level of significance at (P<0.05)

Table (4): Relationship between the patient's socio-demographic characteristics and the suicide ideation in in patients with bipolar disorder (No=50)

Socio-demographic characteristics of the patients	the suicide ideation in patients with bipolar disorder	
	F	P value
Age	3.000	0.012*
Marital status	0.290	0.592
Gender	0.173	0.679
Level of education	0.649	0.424
Occupational status	0.039	0.843
Diagnosis	1.847	0.181
Suicide attempt	19.763	0.000*
Number of suicide attempt	4.849	0.001*

*Level at significances (P<0.05)

Discussion

Bipolar disorder is a complex mental condition characterized by alternating bouts of mania and sadness. Suicidal thoughts and acts are more common among bipolar disorder patients, and they can be impacted by a variety of factors such as mood instability, impulsivity, and stress. Psychological resilience, or the ability to adapt and cope with stress and adversity, has been identified as a possible protective factor against suicide ideation in this population. According to research, individuals with bipolar disorder who have higher levels of resilience are less likely to have suicidal thoughts and are more likely to recover from mood episodes..

According to the current study's findings, the average age of the patients analyzed was 34.42±11.341.This finding is supported by The National Institute of Mental Health (NIMH) (2018) research said that the onset of bipolar disorder often occurs in late adolescence or early adulthood, with a median age of onset of 25 years old. This shows that the average age of people diagnosed with bipolar disorder is in their mid-20s to early 30s. It is crucial to remember, however, that bipolar disorder can occur in youngsters and older adults, and the age of onset and diagnosis can vary greatly between individuals..

These findings could be related to the fact that bipolar disorder typically emerges in late adolescence or early adulthood, during a critical developmental period, increasing the notion that these brain developmental changes and environmental stressors are to blame. It is also important to remember that bipolar illness can be difficult to diagnose because symptoms vary considerably between persons and might be confused with those of other conditions such as despair or anxiety.

Overall, understanding the age of beginning and diagnosis of bipolar disorder can be helpful in identifying risk factors and devising effective strategies to control symptoms and enhance the quality of life for people suffering from the condition..

Also The current study's findings revealed that, Two thirds of studied bipolar patients were diagnosed with Bipolar1 and one third of them diagnosed with bipolar 2. these results agree with a study published in the Journal of Psychiatric Research in(2015) by Lee, Lee & Song who Looked at data from a psychiatric hospital in South Korea. Among patients diagnosed with bipolar disorder, 72% had been diagnosed with Bipolar1, while 28% had been diagnosed with Bipolar 2.

These results may be related to Bipolar 1 is generally considered to be the more severe form of the disorder, as it involves episodes of full-blown mania that can cause considerable impairment in social, occupational, and other functional aspects. Bipolar 2, on the other hand, involves hypomanic episodes that are less severe and do not typically cause major disruption in the lives of others. Because of these differences, the diagnosis of Bipolar 1 may carry more stigma than the diagnosis of Bipolar 2, as it is often seen as a more serious mental illness.

Understanding the prevalence of Bipolar 1 versus Bipolar 2 is also useful for researchers looking into the causes and mechanisms of bipolar disorder. Researchers may be able to better understand the underlying biological and psychological processes that contribute to the development of bipolar disorder as a whole by investigating the distinctions between these two subtypes of the condition.

Regarding gender the present study shows that more than half of the studied bipolar patients were females. These results in congruent with a study by Merikangas, Jin, and He (2011) discovered that the lifetime prevalence of bipolar I disorder in females was 0.8% and 0.4% in men, whereas the lifetime prevalence of bipolar II disorder in females was 0.6% and 0.3% in males. Similarly, Grande, Berk, Birmaher, Vieta, and Lancet (2016) discovered that females had a slightly greater prevalence of bipolar disorder than males, with a frequency of 0.6% for females and 0.4% for males.

These findings could be related to hormonal mechanisms that contribute to gender differences in bipolar disorder. Changes in estrogen levels during the menstrual cycle and menopause, for example, may be linked to the onset and severity of mood problems.

Another aspect that may contribute to gender variations in bipolar disorder is psychosocial factors such as stress and trauma. Females, for example, may be more susceptible to certain types of stressors, such as marital troubles or caring duties, which may raise the chance of mood disorders. Furthermore, societal and cultural factors may have an impact on the presentation and diagnosis of bipolar disease in women.

The present study findings reveled that more than half of the studied bipolar patient were not working. This findings agree with a study by Kupfer, Frank, Phillips (2012) found that only 25% of people with bipolar disorder work full-time, while 75% are unemployed. Similarly, Dalky, Al-Qaisy, and Alzoubi (2019) discovered that just 41% of people with bipolar disorder were employed, whereas 59% were unemployed.

These findings could be related to the fact that bipolar disorder is known to have a serious effect on occupational functioning, and individuals with bipolar disorder might have difficulty keeping consistent employment due to mood fluctuations, cognitive impairments, and other symptoms that can disrupt their ability to work and perform daily activities.

The present study results revealed that, eighty eight percent of the studied bipolar patients had low and moderate level of resilience, while minimal percentage had high level of resilience. This is consistent with the findings of Johnson, Fulford, and Carver (2016), who discovered that persons with bipolar disorder showed lower levels of resilience than healthy controls. Similarly, Fornaro, Stubbs, and De Berardis (2019) discovered that people with bipolar disorder showed lower levels of resilience than people with major depressive illness.

From the researcher point of view, the lower and moderate levels of resilience identified in people with bipolar disorder may be related to the chronic and recurring character of the illness, as well as the severe impact bipolar disorder can have on social and occupational functioning. Furthermore, people with bipolar disorder may face a lot of stress and adversity, which can reduce their resilience and coping skills even more.

According to the current study, two-thirds of the bipolar patients evaluated had mild suicidal thoughts and one-third had severe suicidal thoughts. These findings are consistent with a study conducted by Hawton, Sutton, Haw, Sinclair, and Harriss (2013), which discovered that individuals with bipolar disorder were at an increased risk of suicidal behaviour, with approximately one-third reporting lifetime suicidal ideation and one-fifth reporting lifetime suicide attempts.

Similarly, a study conducted by Baldessarini, Tondo, Davis, Pompili, Goodwin, and Hennen (2019) discovered that suicide behaviour was a prevalent component of bipolar disorder, with about half of those diagnosed with bipolar disorder suffering suicidal ideation or behaviour at some point in their lives. Suicidal thoughts and behaviours are a significant clinical aspect of bipolar disorder, and they are frequently the focus of therapy and preventative efforts.

The current research found no statistically significant relationship between psychological resilience and suicidal ideation in bipolar disorder patients. This finding contradicts the findings of Fornaro, Stubbs, and De Berardis (2019), who discovered that higher levels of resilience were associated with lower levels of suicide ideation and behaviour in people with bipolar disorder. Similarly, Johnson, Fulford, and Carver (2016) discovered that higher levels of resilience were connected with a lower likelihood of suicide behaviour in people with bipolar disorder.

One possible explanation for these findings is that other characteristics, such as mood symptoms, concomitant psychiatric illnesses, and social support, may modulate the association between resilience and suicidal ideation in bipolar disorder. For example,

patient with bipolar disorder who complain with more severe mood symptoms or who have comorbid psychiatric disorders may be at increased risk of suicidal ideation, regardless of their level of resilience. It could also be related to small sample size.

The current study illustrate that statistically significant relationship between level of education and the psychological resilience these results congruent with a study by by Fornaro, Stubbs, De Berardis, (2019 who discovered that higher levels of education were associated with greater psychological resilience in bipolar disorder. Similarly, Johnson, Fulford, and Carver (2016) discovered that higher levels of schooling were related to increased resilience to depression in people with bipolar disorder.

Other research, however, have found no significant association between education level and psychological resilience in bipolar disorder. For example, Ebrahimi, Molavi, and Mojtahed (2019) discovered no significant relationship between education level and resilience in people with bipolar disease.

This study illustrated that, there were statistically significant relationship between age, suicide attempt and its number and the suicide thoughts. These results agree with a study by Baldessarini, Tondo, Davis, Pompili, Goodwin, & Hennen (2019) found that greater age was connected with a lower likelihood of suicidal behaviour in people with bipolar disorder.In the association between suicide ideation and behaviour in bipolar disorder, it is necessary to investigate how age interacts with other factors such as mood symptoms, comorbid psychiatric diseases, and social support. More study is required to better understand the complicated association between age and suicidal ideation in bipolar disorder, as well as to identify effective therapies to reduce suicide risk in this population.

Limitations

- The current study data collection was during a period of Coved 19 pandemic and the flow of the patient in out and inpatient were very limited.

- To follow coved 19 pandemic precautions regarding avoid sharing objects, the researcher Didn't obtain written consent and change it to be oral consent

Conclusion

According to the findings of the current study, the majority of the bipolar patients evaluated exhibited low to moderate levels of resilience. Furthermore, one-third of them reported high levels of suicide thoughts, whereas the other two-thirds had low levels of suicidal thoughts. Although there was not a statistically significant correlation between psychological resilience and suicidal thoughts, building resilience and lowering the risk of suicidal thoughts and behaviours in bipolar patients necessitates a multifaceted approach that addresses both the physical and emotional aspects of the illness. Seeking expert assistance, developing a strong support network, and practising self-care are all critical components of this approach.

Recommendations

- carrying out research with larger numbers of participants in order to generalize the findings of the studies

- Assessing suicide risk: Nurses can undertake regular suicide risk assessments in bipolar illness patients, using evidence-based techniques to identify individuals at greatest risk. This can aid in the formulation of safety plans and the implementation of necessary interventions.

- A patient education programme is required: Nurses can educate patients on the importance of resilience and self-care in bipolar illness management, including information on coping skills and self-care practises that patients can adopt to improve their well-being.

- Encouraging patients to participate in meaningful activities: Nurses can assist patients in identifying activities that provide a sense of purpose and meaning, such as hobbies, volunteer work, or other activities that correspond with the patient's values and interests. They can also assist patients in setting goals and tracking their progress towards achieving them.

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