COPING WITH A MANIC-DEPRESSIVE SPOUSE

The spouse of a manic-depressive patient must cope with formidable problems. Now appropriately called bipolar disorder, this disease is characterized by recurring periods of increased or decreased activity and thought expressive of a predominating mood of either depression or elation. Fortunately, the extreme manifestations are episodic. During periods of active disorder, the patient's symptoms may seem overwhelming, but they typically subside within weeks or months. Episodes may be separated by periods of years or may never recur.

Individuals subject to bipolar disorder often have attractive personal qualities. They are apt to come from families of high socio-economic status, and many are married. Their premorbid personality is frequently cyclothymic, but social; although they go through moody periods, they are most characteristically outgoing, glib, witty, socially aggressive, and full of ambitious schemes. The first psychotic break does not usually occur until adulthood - the mean age of onset is about 30, well above the mean age of marriage. By the time episodes of affective extremes begin, the couples are generally well established, have a home, and are often parents, as well.

At the time of a first manic or depressive episode, the patient - ordinarily well-adjusted, perhaps a little excessive at times but comfortably within the limits of tolerance - develops, over a period of days or weeks, an exaggerated version of previous highs or lows. The spouse may not even suspect mental illness. If this thought does occur, it is often denied, and the deviant behavior attributed to outside factors. Inevitably, the existence of a serious psychiatric disease becomes evident over time. Through the years such episodes are anticipated; thus, recognized earlier.

Effects on the Marriage

Compatibility. The manic phase is extremely disruptive. All of the patient's activities are greatly accelerated. Boundless energy, often scattered over a wide field of interests, leads to continuing projects from early morning to late at night. Advice to slow down goes unheeded and attempts at restraint may precipitate anger or combativeness. Tenderness and affection are obscured by self-satisfied brusqueness, careless gaiety, mischievousness, risqué remarks, and facetious comments. Good humor prevails only as long as every whim is gratified. On the slightest frustration, the patient's behavior changes to argumentativeness, haughtiness, arrogance, sarcasm, and often open hostility. This obviously places great strain on the marital relationship.

During a depressed phase, the pendulum swings to the opposite extreme. Gloom prevails. Communication declines to a minimum. There is little or no show of affection or even any interest in demonstrativeness. Personal grooming deteriorates and obligations at home or at work are ignored. Attempts at consolation and reassurance are rejected, withdrawal and pessimism weigh heavily on the spouse, test

tolerance, and produce frustration to the point of precipitating marital breakup.

Sexuality. Sexual relations also suffer greatly during episodes of bipolar disorder. The depressed phase with its lowered mood, lowered self-esteem, and reduced psychomotor- activity virtually eclipse sexuality. Interest in sex is low or non-existent, and performance is likely to be impaired. Men have varying degrees of impotence that, after a failure or two, may lead to chronic psychogenic inadequacy and continue long after the depression has lifted. Women, although capable of submitting passively, do not experience arousal with its facilitating relaxation and lubrication. Coitus under such circumstances tends to be unrewarding for both partners, possibly painful, and may lead to aversions causing frigidity for years to come.

The manic phase, on the other hand, may bring on markedly increased libido. Sexual gratification may be demanded and achieved on a crude hedonic level, without any tenderness and sensitivity. The manic person embarrasses or infuriates the spouse by making vulgar remarks, ignoring morals and common decency, propositioning friends or strangers, or by indulging in indecent exposure in public. Extramarital affairs may occur at this time in either sex or may involve multiple partners. Not all manic are hypersexual; however, some are so pressured or so fragmented that in their pursuits of whims and fancies, they become rather asexual. Sex life in manic depression is truly chaotic, and the psychic scars inflicted upon the spouse may be permanent.

Alcohol abuse is often used in either phase as a means of avoiding unpleasant symptoms and to induce sleep. Unfortunately, the remedy may backfire; instead liberating increased activity, aggressiveness and among the depressed, suicidal thoughts or behavior. The magnitude of this problem has led some authorities to believe that the excessive use of alcohol distinguishes those who require hospital care from those who can be managed at home. Among those who drink to excess during both the manic and depressed phases of the illness, consumption is generally, but not always, greater during the manic phase.

Financial problems. The depressed patient may disregard bills and obligations or just never get around to paying them. Money or valuables are of little interest and may be left unprotected to be picked up by the first unscrupulous person who happens along. Moreover, the depressed patient may be gullible and subject to swindle and fraud.

The manic, on the other hand, may be quite loose with money, and squander it on unsound business schemes, investments, or riotous living, eventually draining family reserves or incurring huge debts. The developing manic phase poses special perils. If the patient has formerly been aggressive and reasonably effective in financial matters, insidious deterioration in judgement may go undetected until a series of misfortunes has occurred. Since anyone can have an occasional bad break, or even two in a row, some families only realize that a mental illness is responsible once financial disaster is upon them.

Family planning. Many patients are in their childbearing years. Should they have any children-or more children? The two main factors to be considered are childcare and

heredity. With future episodes of illness possible, the couple must consider the responsibility of having children in view of the possibility that the patient may have to be removed from the family at times or, as a minimum, may periodically be impaired for weeks or months. Another factor to consider is the common occurrence of manic depressive psychosis in the same family, which suggests a contributing genetic cause.

The incidence among siblings of patients is 25 times that of the general population. Recent research has shown that manic-depressive illness and the Xg blood group (a genetic marker on the X chromosome) exist in co-related inherited linkage in successive generations. This supports earlier-speculation that a dominant X-linked factor is involved in transmission of predisposition.to the illness. Thus, some families may choose not to have any children. In such situations, special thought must be given to the method of birth control. A continuing, fail-safe system is preferable, since intermittent or more difficult methods are not likely to be effective, given the impulsive behavior of the manic, or the indolence of the depressive patient.

Remission

Though chances for a breakup of the marriage of a manic-depressive patient exist and increase with successive exacerbations, the presence of an abiding and tolerant spouse is a great aid in achieving and maintaining remission. Major tranquilizers and antidepressants offer hope of control of symptoms without need for hospitalization, but the spouse must make sure that the drugs are taken. If hospitalization becomes necessary, the spouse often must negotiate the patient into the hospital - no small task in many cases.

Control and prevention of episodes - now almost exclusively accomplished with lithium carbonate - can be achieved safely by maintenance of a carefully regulated therapeutic blood level. Here again, the spouse must ensure regular administration of the drug as well as regular blood level determinations; be on alert to detect incipient relapses to allow more intensive treatment to be instituted promptly; prevent situational problems.

Implications for the Physician

Spouses play such a significant role during a manic-depressive patient's illness that they need and deserve individual therapeutic attention. The physician can provide support without being judgmental by acting as a sounding board or merely by being available. Although occasional guidance and advice may be necessary, listening is the most important aspect. If a drastic move - such as divorce - is being considered, the physician can make certain that all possible choices are given due consideration, then be available to provide needed support for whatever decision is reached. Reassurance is always helpful and reasonably safe, since the course of the disease is episodic and the prognosis for remission is generally good.

"You are not alone."