COPING STRATEGIES OF MANIC DEPRESSIVES

Ruben L. Encarnacion
Ateneo de Manila University

In a two-randomized groups design, twenty bipolar (manic depressive) subjects answered questionnaires to explore what coping patterns (DV) are utilized by bipolars to maintain functionality. These 20 Ss were divided into high-functioning and low-functioning groups (IV). Taken all together, the pre-identified coping strategies—Biochemistry/Lithium Compliance, Self-Monitoring, Kin and Peer Support, Work, Creative/Athletic Pursuits, and Confidentiality—were found to be not significant in determining whether a bipolar subject would be high- or low-functioning. However, two trends were found ($p < .10$): (a) High-functioning bipolars tend to have more continuous work that they find fulfilling, and (b) Low-functioning bipolars tend to be more secretive about their condition. Since high-functioning bipolars tended to belong to high SES, SES as a possible confounding variable is discussed. Psychotherapy, group therapy, and the psychoeducational approach for the patients' families are presented as recommendations.

Characterized by wild, unpredictable roller-coaster shifts of emotion in the extreme, and states of despair and exhaustion, alternating with periods of hard work and very effective functioning in milder cases, bipolar disorder is a mood disorder that afflicts 0.4% to 1.2% of the U.S. adult population, equally among females and males (American Psychiatric Association, 1987), with a suicide mortality rate of 15%—an extremely high risk, the highest among mental illnesses (Fieve, 1989). Together with unipolar recurrent depression, the other mood disorder classified by the APA which has the same biochemical nature and treatment, bipolar disorder is the single most frequently encountered mental health problem in the U.S. (Fieve, 1989).

What are the features of bipolar disorder? The earliest symptoms of the mild manic state called hypomania ("below-mania") are pleasant, including a surge of confidence and capability that are desirable among normal people (Fieve, 1989). Due to mild elation and the "manic advantage" (Fieve, 1989) of quick intuition, unbounded energy, and enthusiasm that are compatible with the creative temperament (Leo, 1984), persons in the hypomanic state objectively experience hypercompetence, high drive level, and rapid ascendancy at work, sometimes leading to a failure to pace oneself. A 1970 study by Shobe and Brion which found that bipolar patients tended to be better educated and belonging to high socioeconomic status provides some basis to Fieve's (1989) observation that the ability to lead, inspire, and persuade is typical of intelligent manic leaders who commonly have some messianic urge. Abraham Lincoln, Theodore Roosevelt, and Winston Churchill are three great world leaders who were manic depressive (Fieve, 1989).

This pleasurable and productive early stage may develop into an overt manic state or switch to depression. With inability to pace themselves, mildly elated hypomanic persons may go too high. Colleagues may recognize their irrationality and lose faith in them as leaders, and relatives or friends may try to persuade or take them for treatment. Otherwise, manic depressives are seen as highly effective, forceful, energetic, and likeable and are not labeled as ill except during crushing depressions when they unexplainably and unexpectedly lose all drive and zest for life, including hope (Fieve, 1989).

What are the behaviors of a person in the manic state? Carlson and Goodwin (1973) studied 20 patients in the manic phase of the illness. Among the prevalent manic symptoms observed were hyperactivity, extreme verbosity, pressure of speech (talking, telephoning, and letter-writing), grandiosity, manipulativeness (must impose his will with unwavering confidence in doing things "my way," with complete lack of tact for his colleagues), irritability, euphoria, mood lability (fluctuation or changeability), hypersexuality, flight of ideas, and delusions of sexual, persecutory, passivity, and religious nature. Thought patterns are speeded up but with logical thinking intact, unlike the looseness of associations of schizophrenics (Eaton, Peterson, & Davis, 1976).

Psychoanalytic theory describes a manic depressive attack as an oral fixation, a literally insatiable "taking in"—visual, auditory, and manual through busy handling and destroying of whatever comes to hand, including relationships (Cameron, 1963). Furthermore, the superego of the manic patient seems not to exist anymore, overridden by the pleasure ego of early childhood, or an ego that has fused with the ego-ideal (Cameron, 1963).

Manic persons typically go with very little or no sleep at all for days or weeks, making sleeping habits critical in diagnosis (Fieve, 1989). In addition, Carlson and Goodwin (1973) identified three stages of mania. The euphoric bipolar Stage I moves to anger and irritability in Stage II, and to panic in Stage III. On the path to recovery, the patient goes back to Stage II and then Stage I, before reaching a period of relative normalcy. Researchers noted that the duration in each stage varied among patients. In milder cases, patients were observed not to have reached the panic and dysphoria of Stage III, or even of Stage II. It was observed by nurses that the "mania rating rises first, then, psychosis ratings." Dysphoria, or subjective suffering, unbearability, or inner anguish, was always fairly high throughout the episode, but increased with mania and psychosis.

Furthermore, it was observed that during periods of mania, there were momentary breakthroughs of depression (Eaton et al., 1976). In addition, towards the end of the manic phase, there were common reports of feelings of guilt, shame, or embarrassment over the recent grandiose activities. These feelings might precipitate a depression after a manic attack (Eaton et al., 1976).

In what externally appears to be a stark contrast to the manic phase, the depressive phase is marked by severe dejection, anxiety, extreme mental and motor retardation, agitation, guilt, insomnia (Calhoun, 1977) or hypersomnia (over-sleeping), terrible pessimism, self-doubt, and emotional impoverishment (Fieve, 1989). Although the symptoms and behavioral features are virtually identical, an important distinction has to be made between *reactive* depression, a normal response to loss that usually goes away and rarely leads to suicide, and *chemical* depression (Fieve, 1989). Psychiatric evidence over the past 25 years show that manic depression is primarily biochemical in nature and may only be secondarily precipitated by environmental events (Fieve, 1989). In contrast to reactive depression, chemical depression in bipolar depression is marked by functional impairment and unmistakable psychomotor retardation (Eaton et al., 1976; American Psychiatric Association, 1987). Even more dangerous, a "double depression" may occur as a combination of biochemical depression and reaction to loss (Fieve, 1989).

An important question that this research asks is, how do bipolars cope with their illness to keep themselves functional?

This research falls along the tradition of belief that Bipolar Affective Disorder is a genetic and biochemical disorder, interacting with environmental factors.

Recent advancements in medicine, particularly the breakthrough in the use of lithium carbonate in the treatment of manic depression, established the biochemical nature of the illness. Prior to this, traditional psychoanalysis viewed depression as unexpressed anger, or rage turned inwards against the self. Modern psychoanalysts saw depressed persons as depending on external forces to maintain self-esteem (Fieve, 1989). On the other hand, mania was seen as a way of coping with depression—a reaction formation, a flight into activity—against depressed feelings. Sociability in mania is more compulsive than spontaneous. *Joie de vivre* is an act, a mask, a persona (Eaton et al., 1976), not consciously put on but nevertheless a tenuous happy mask that melts to reveal a suffering soul within.

Bipolar Affective Disorder is marked by depression, elation, or both (Eaton et al., 1976). The onset of bipolar depression is the early 20s, and characterized by a lifetime of alternating mild-to-serious highs and lows (Fieve, 1989). Bipolar cycles typically cover periods of weeks to months of depression, periods of relative normalcy, and limited but unpredictable periods of mania (Rimm & Somerville, 1977). Furthermore, variations of the illness include several depressive episodes followed by mania, or vice versa—several manic episodes followed by depression (Rimm & Somerville, 1977).

Manic or depressive episodes tend to be short; untreated, an attack lasts a few weeks to a year, rarely becoming chronic. It is important to note that untreated, bipolars have *no* self-knowledge of their illness (Eaton et al., 1976). They do not see why they need professional help whether they are manic or depressed, and resist well-meaning efforts of their loved ones to bring them to treatment.

In Shobe and Brion's longitudinal study (1970), the mean duration of an attack was found to be 7.9 months. (The shortest recorded cycle is 48 hours in which a Wall Street executive alternated between high and low days (Fieve, 1989). In the study, 45% of the patients had only one attack. In Eaton et al.'s (1976) research, 20% of patients had only one attack. Those who had a second attack usually continued to have recurrences throughout life (Eaton et al., 1976), although each attack seemed to decrease the chances of a next one (Calhoun, 1977). It could be that growing self-knowledge after each episode, and knowledge of the warning symptoms, together with psychotherapy, enables patients to monitor themselves, to know when to seek professional help and nip mania or depression just as the early symptoms are recognized.

The result of lithium therapy is stabilization of the mood disorder, thus enabling millions of bipolars (and pure depressives) to lead normal, productive lives after years of waste and suffering, not to mention the dramatically reduced cost in treatment.

Significantly, it has been found that there is a *familial pattern* in Bipolar Disorder. "Bipolar Disorder has clearly been shown to occur at much higher rates in first degree biologic relatives of people with Bipolar Disorder than in the general population" (American Psychiatric Association, 1987). Furthermore, Fieve (1989) reported that a major clue to the diagnosis of manic depressives is the presence in the patient's family history of depression, moodswing, suicidal behavior, sociopathy, alcoholism, drug abuse, and compulsive gambling.

Gershon, Hamovist, Guroff et al. (1982) found that affective illness is concentrated in a limited number of families. Their family study revealed that 20% to 37% of patients with mood disorder had first degree relatives with mood disorder, compared to 7% who were sick but had normal relatives. The morbid risk was found to be 74% for offspring of two parents ill with affective disorder, and 27% for offspring of one ill parent (Gershon et al., 1982). Fieve (1989) wrote that if there is a first-degree relative who is manic depressive, the chances of his or her parents, siblings, or children developing manic

depression are 8 to 10 times higher than the general population (which is 0.4–1.2%).

Such data, together with the successful use of Lithium in treatment, provide the basis for the current theory that bipolar disorder is primarily genetic and biochemical in origin. Many physicians today believe that the illness is "transmitted mainly through the genes and less so by the environment. The environment helps shape the personality but does not determine the relentless course of manic depression" (Fieve, 1989, p. 131). But whether the illness is passed on through the genes and not the environment and atmosphere engendered by the sick relative's behavior and attitudes is still a subject of debate, reminiscent of the nature versus nurture issue in psychology.

Could it be due to genes, or the flavor of parental interaction that children of patients with bipolar disorder were found to be significantly weaker in personal and social resources compared to children of normal control subjects? Pellegrini et al. (1986) referred to personal resources to include social problem-solving ability, internal locus of control, self-esteem, and self-perceived competence. On the other hand, social resources involved social network structure and support. While children of normal subjects had wider peer, sibling, or kin support and seemed to be more adept at extracting maximum benefit from his/her social milieu, children of bipolar parents relied more heavily on nonkin adult supporters (Pellegrini et al., 1986). In addition, Eaton et al. (1976) suggested that bipolars were generally extroverts who are outgoing, sociable, little given to introspection, and, with their ability to conceal shyness and inadequacy, tended to be good salespersons. Under the Jung-based MBTI ratings, this seems to describe Extravert-Sensing (ES) personalities. Heredity or environment?

Furthermore, Eaton et al. (1976) reported the higher incidence of affective disorders among the relatives of bipolar patients. They cite the following family characteristics of patients: (a) more concern with social approval, coming from an uncomfortable status in the community; (b) the child being expected to change this through his/her achievements; and (c) an attempt of the child to live up to family expectations despite feeling inadequate, leading to the child feeling different, alone, sensitive, and vulnerable.

These findings seem to show that while bipolar disorder, in the light of recent scientific developments, is primarily genetic and biochemical in origin and nature, the role of the environment in precipitating the illness and as an important focus of therapy, if desired by the patient, may also be recognized. "Genetic predisposition interacts with stress factors in the environment" (Fieve, 1989, p. 237). Whether or not stresses in life actually precipitate depressions or highs is still a much debated problem in psychiatric research.

Under the psychodynamic framework, precipitating factors that may be responsible for the onset of mania or depression are loss of love, personal security, and self-esteem (Cameron, 1963). In Shobe and Brion's (1970) study of 111 bipolar patients, 50% believed that their illness was precipitated by identifiable factors, notably home stress, being physically ill before the attack, postpartum depression, financial and career difficulties, although these may have been uncovered as convenient reasons in the absence of any knowledge of the physical basis of the illness at that time (Fieve, 1989).

Does socioeconomic status (SES) of bipolar patients affect their coping behavior? The only data found in the literature are Shobe and Brion's (1970) contentions that (a) bipolars tended to be better educated and to belong to high SES, and (b) rich and poor bipolars have equal chances of recovery from an episode.

These findings may be true in the American setting where even the low SES have access to free quality elementary and secondary education, and welfare, insurance, and other social

security benefits ensure the minimum basket of goods and services. Might there be differences for Filipino bipolars whose SES means access to education, medical services, medication, food, and leisure? Due to the limitations imposed by their quality of life, can low-income Filipino bipolars indeed remain as functional as their more fortunate counterparts after recovering from an episode? The present research sheds some insights on this issue.

Therapy

Since the discovery of lithium as treatment for manic depression by the Australian psychiatrist John F. Cade in 1949, to its acceptance by the U.S. Food and Drug Administration in 1970, and to its 80%–85% success rate in normalizing mania and preventing or dampening future lows of manic depression, many physicians feel that the fact that lithium is specific for manic depression is proof positive of the biochemical nature of this mental disorder. Lithium is the first drug to "biochemically assault and control the illness itself," unlike tranquilizers and antidepressants in the 50s that relieved the symptoms of psychosis, anxiety, and depression, but didn't specifically get to the core of the illness. Lithium on the other hand "works so quickly, specifically, and permanently for recurrent mood states" (Fieve, 1989, p. 4).

Lithium not only effectively normalizes the manic state; it also prevents or dampens many future lows of manic depression. Lithium is the first truly prophylactic agent in psychiatry to control, prevent, or stabilize the future lifetime course of a major mental illness. There are no side effects except if the dosage is too high and the patient may experience hand tremors, nausea, excessive urination, or diarrhea. Lithium may not be used on patients with a kidney and thyroid condition. For some patients who do not respond very well to lithium alone, support antimanic-depressive medications, such as carbamazepine (Tegretol) and haloperidol (Haldol or Serenace) are available.

What is the role of psychotherapy then? First, psychotherapy may not be effective *before* drug stabilization is achieved. Dr. Fieve's (1989) experience was that most patients did not want or need psychotherapy after drug stabilization. They apparently wanted rapid relief from internal pain, not deep insight or personality growth. Furthermore, according to Fieve (1989) there has been no well designed study that clearly shows whether psychotherapy on manic depressives works or not. "Drugs are helpful and rapid for unipolar and bipolar manic depression, in which they are clearly the therapy of choice" (Fieve, 1989, p. 166).

While the specific effects of psychotherapy have not been established to the research psychiatrist's satisfaction, psychotherapy may address secondary interpersonal conflicts, for example, problems in readjustment after depressions or mania. Patients may benefit from supportive psychotherapy, behavior modification, group or marital counseling. But often, "simply having an explanation of one's distress may have a salutary effect on many patients" (Fieve, 1989, p. 164).

For those who choose to go to therapy, the goals or thrusts of psychotherapeutic intervention range from reducing suffering and preventing future recurrences (American Psychiatric Association, 1989) to changing the personality structure not just to alleviate symptoms but "improvement in interpersonal trust, intimacy and generativity, coping mechanisms, ability to experience a wide range of emotions, and the capacity to grieve" (Kaplan & Sadock, 1989, p. 934).

In interviews with six Filipino psychiatrists, their therapeutic goals included stabilization of condition in the short term—how to contain unbounded energy if manic and if depressed, how to prevent self-hurting behavior and relieve severity of depression (Banaag, 1991; De Guia,

1991; Jurilla, 1991; Lapuz, 1991; Ocampo, 1991; Santiago, 1991). The options are to hospitalize the patient in order to put stimulation within control, and to find the right medication, both on an in- or out-patient basis. The patients' cooperation with medicine compliance is important.

The condition is stabilized when the patient is back to his or her normal self, based on a descriptions given by relatives and the patient and based on clinical assessment (Ocampo, 1991; Lapuz, 1991; De Guia, 1991; Santiago, 1991). After stabilization, control of episodes through medication and continuing supportive therapy can proceed on a more even keel. When this point is reached, the goal of therapy is helping the individual maintain adjustment in life (Banaag, 1991). Increased functionality, or adaptability to environmental and interpersonal areas of functioning with more flexibility (Jurilla, 1991), is sought. To maintain a hold on reality, the patient is encouraged to do some of his regular work if there is minimal tension in terms of interpersonal relations (Santiago, 1991; Lapuz, 1991).

According to Santiago (1991), psychiatrists ideally work to help the patients become more aware of their own condition so they can control it to some extent. For example, they could do first aid when mood changes occur, e.g. increase medications on their own when the doctor is not available. Knowing themselves and their condition best, patients are encouraged to have more control over their illness through awareness.

The following coping strategies were formulated based on interviews with six Filipino psychiatrists and a review of the related literature:

1. Understand the biochemical nature of the illness and comply with treatment of lithium and other medications.

2. Develop self-monitoring and awareness of the illness and the symptoms of mood fluctuation in order to get help when needed and be more in control.

3. Build sibling and kin support.

4. Build peer support.

5. Continue working or do work that one finds fulfilling.

6. Engage in creative and athletic pursuits.

7. Protect confidentiality and the private nature of one's condition.

If a patient who has been stabilized on lithium agrees to go into psychotherapy, this may provide a working framework by which he or she can be helped in psychotherapy.

As one of the first studies on manic depression in the Philippines, this report attempts to determine if there are culture-specific coping strategies based on interviews with six Filipino psychiatrists. In this way it hopes to remain sensitive to Philippine cultural, social, and economic realities that may somehow affect a Filipino bipolar's effectiveness in coping with a universal illness.

METHOD

Because the present research intended to investigate the coping patterns of bipolars, it confined itself to a study of a small number of Filipino bipolars in a two-randomized groups design.

Twenty bipolar adults and young adults, all undergoing or having undergone some form of therapy, were studied using three questionnaires. Two questionnaires were to be answered by the patients, and the third one was for either a relative (for nonhospitalized patients) or a nurse (for hospitalized patients) to answer. One patient-questionnaire used a 5-point agree-disagree rating scale and it provided a quantitative measure of the patient's stressors and coping patterns. The second patient-questionnaire used a sentence completion task to arrive at a qualitative measure of the same things. The third questionnaire for a relative or nurse attempted to measure the patient's areas of functioning.

Two clinical judges—a psychiatrist and a clinical psychologist—were asked to determine face validity and reliability of the instruments. The three questionnaires were then pretested to six subjects—three normal, two who were below average in IQ but strong in Filipino, and one who quit school with an unknown diagnosis. Some questions were revised and retranslated accordingly for better understandability.

The first two questionnaires covered questions on the seven coping strategies cited by the six Filipino psychiatrists. Responses provided quantitative and qualitative measures of the patients' coping strategies, the dependent variable of this study. Copies of these questionnaires may be obtained from the author. Sample items are given in Table 1.

Table 1. Sample Items from the Coping Strategies Questionnaire and the Sentence Completion Test

Strategy 1: Biochemistry/Lithium
I know that my episodes are biochemical and temporary.
The medicines that my psychiatrist gives me ...
Strategy 2: Self-Monitoring
I know myself—basic personality, likes and dislikes, interests and abilities—very well.
I have to consult my psychiatrist when ...
Strategy 3: Kin Support
With my own family, there is someone I can talk to about my problems.
My parents ...
Strategy 4: Peer Support
I like friends who are my age.
I often turn to friends who are ...
Strategy 5: Work
I feel that school or my work is boring and routinary.
I wish I can find a job that ...
Strategy 6: Creative/Athletic Pursuits
I am good at a special artistic skill.
In my own free time, I like to ...
Strategy 7: Confidentiality
Authorities at work or in school know about my illness.
I talk about my condition to people who ...

The third questionnaire was based on Carlson and Goodwin's (1973) Areas of Functioning test which measured the relative or caretaker's rating of the patient's job or schooling status, interpersonal and family relationships, social functioning, and mental status. This questionnaire provided the basis for dividing the sample into the high-functioning and low-functioning groups, which was the independent variable.

Subjects

Purposive sampling was utilized to select patients for inclusion in this research. The subjects were 12 private patients of Metro Manila psychiatrists, 6 from the National Center for Mental Health, and 2 acquaintances of the author. The subjects were selected on the basis of their doctors' diagnosis.

The ages of the subjects ranged from 21 to 53 years, the mean age being 36.4 years. Four subjects did not specify their age.

When the questionnaires were administered, all subjects were judged by the psychiatrists to be in their euthymic (normal or stable) state, that is, neither manic nor depressed. This was a condition for inclusion in the sample.

Data Analysis

A two-randomized groups comparison was made between the high-functioning and low-functioning bipolars. The sample was separated into two groups using the areas of functioning ratings (the independent variable). Out of a highest possible average of 4 among four areas of functioning, the high-functioning group scored above 3. The low-functioning group scored 3 and below.

The dependent variable was the Coping Strategies score: averaged across seven coping strategies, and scored for each strategy. Strength of coping was measured in this manner: in general, a "Strongly Agree" response was given a rating of 5; "Agree," 4; "Uncertain," 3; "Disagree," 2; and "Strongly Disagree," 1. To avoid validity threats due to response bias such as acquiescence or negativism, some questions were purposely phrased in reverse so that a "Strongly Disagree" response was given a rating of 5; "Disagree," 4; and so on. Higher scores indicated more effective coping. For example, a subject who strongly agrees that he knows himself very well would be coping better than one who is uncertain about his self-knowledge.

It should be borne in mind, though, that inferential statistics would be problematic due to the small sample size and the purposiveness of the sampling procedures used.

RESULTS

A two-tailed t test comparing the means of the total coping strategies of the two groups revealed that high-functioning bipolars do *not* have significantly better coping strategies than low-functioning ones.

There were seven pre-identified coping strategies: understanding of biochemical nature of illness and compliance with medications; self-monitoring of symptoms; sibling and kin support; peer support; fulfillment in work; creative and athletic pursuits; and confidentiality of their condition.

The two-tailed t test showed none of the coping strategies to be significant (Table 2) in determining whether a bipolar would be high- or low-functioning. However, Work and Confidentiality both showed a trend at $p < .10$. Thus, high-functioning bipolars tend to continue working or do work that they find fulfilling more than low-functioning bipolars, and these high-functioning bipolars also tend less to protect the confidentiality and the private nature of their condition.

Table 2. Results of the t tests for Means: High-Functioning versus Low-Functioning

Coping Strategies	x	s.d.	x	s.d.	tcomp
Coping Strategies Ave.	3.745	.409	3.683	.349	.365
Strategy 1: Biochemistry/Lithium	4.033	.734	4.100	.568	-.228.
Strategy 2: Self-Monitoring	4.222	.636	4.176	.602	.160
Strategy 3: Kin Support	4.250	.456	3.950	1.129	.779
Strategy 4: Peer Support	2.800	.610	2.750	.635	.180
Strategy 5: Work	3.699	.589	3.064	.786	1.828+
Strategy 6: Creative/Athletic	3.889	.811	3.778	.914	.273
Strategy 7: Confidentiality	3.361	.486	3.769	.463	-1.823+

+ – trend at $p < .10$ (two-tailed test)

In addition to the Total Coping Strategies Average, Strategies 1, 2, 3, 4, and 6 were not found to be significant in differentiating high-functioning bipolars from low-functioning ones.

Starting with the two coping strategies, Work and Confidentiality, that tended to differentiate high-functioning from low-functioning bipolars, the qualitative results from the Sentence Completion Test did not yield clear differences. For Confidentiality, both high- and low-functioning bipolars were secretive to the general public. Both groups were open only to a select group of close confidants. However, more subjects from the low-functioning group followed this trend. This may have been the telling factor as to why, statistically, low-functioning bipolars tended to be more secretive about theirillness compared to high-functioning bipolars.

On Coping Strategy 5, Work, the sentence stems were, "I wish I could find a job that ..." and "I'd like to be involved in activities that ..." The responses of the low-functioning subjects were more utilitarian than functional, like, "a job that needs me, keeps me busy, *kapakipakinabang*, and *magkapera*." High-functioning bipolars tended to describe job situations that were more specific and better defined and involved people ("deals with the market and housework," "suits my interest"), compared to the aforementioned vague responses of the low-functioning group.

It was seen that except perhaps for Work and Confidentiality, there were little qualitative differences in the responses of both high- and low-functioning across the coping strategies.

DISCUSSION

The first trend shown by this research was that high-functioning bipolars tend to have more continuous work that they find fulfilling than low-functioning bipolars. It must be noted that the direction of causality is not clear; that is, do bipolars become high-functioning because they

have work, or are they able to work because they are high-functioning? The results of this study point to work as a coping strategy that tends to make bipolars cope better with their illness. However, it cannot be denied that among bipolars it is the high-functioning ones who have better chances of finding and holding their jobs.

Without getting caught in a chicken-and-egg discussion, the importance of fulfilling work is stressed. After all, work is not just for economic security but for self-actualization as well.

Why is it that bipolars who work and find fulfillment in their work tend to be high-functioning? Three hypotheses are offered. First, work keeps their mind off their concerns, problems, and futile, endless cogitation. Second, work provides a good outlet or channel for their energies. Third, by working with people who are "normal," a manic depressive's social function remains normal. The manic depressive has the opportunity to model his or her grooming and appearance, conversation, and behavior to what is socially acceptable.

As can be gleaned from the Sentence Completion Test, the high-functioning bipolars tended to be more specific and clear in describing job situations. In addition, they tended to describe job situations that involved people. Thus, the third hypothesis is supported.

Furthermore, although no hard data was gathered about socioeconomic status (SES), it appeared that a large majority of high-functioning bipolars belonged to higher SES. Could it be possible that the high-functioning bipolars who had fulfilling jobs got these through the advantages of their SES, like good education from a good school? In a sense, SES for this particular coping strategy is seen as a confounding variable that seems to be closely tied up with being high- or low-functioning.

The second trend shown by this research was that low-functioning bipolars tended to be more secretive about their condition than high-functioning bipolars. However, the only question in which the difference of means was almost significant was the question: "Authorities at work or in school know about my illness." This question is problematic because the first trend shows that low-functioning bipolars tend to have less continuous work or schooling.

It could be that the "everybody" or "others" that low-functioning bipolars refer to includes a much smaller population than that of high-functioning bipolars who tend to be out in public, working or studying. Earlier it was noted that low-functioning bipolars tended to be more withdrawn and isolated from society, without continuous work or schooling outside the home.

Low-functioning bipolars might be a bit more cautious because in their little circle of relatives, nurses, and caregivers, they have less opportunity and ability for developing closer relationships. They are less used to functioning socially. These factors show that the second trend cannot be taken at face value.

Furthermore, taking a look at the Sentence Completion Test, it was seen that more high-functioning bipolars were willing to talk about their condition in a forthright manner. This may be because they are more articulate, which is again a function of high SES and good education.

Taken all together, the pre-identified coping strategies—Biochemistry/Lithium Compliance, Self-Monitoring, Kin Support, Peer Support, Work, Creative/Athletic Pursuits, and Confidentiality—were not significant in determining whether a manic depressive would be high- or low-functioning. There are two possibilities: either the choice of coping strategies was erroneous, or there were confounding variables.

As to the first possibility, the choice of coping strategies was done after conducting interviews with six Metro Manila psychiatrists (Banaag, De Guia, Jurilla, Lapuz, Ocampo, Santiago, 1991). The researcher examined closely whether there were any important coping strategies employed

by the highly-functioning bipolars that were not captured in the questionnaire.

The biggest clue was in seeing their experiences as something that can help other people, and in turn, help the self be more understanding of similar people. Another was in focusing on the advantages of manic depression—knowing one's limits. Having a suitable work routine has been covered. Another was acceptance of things one has no control over, and instead to focus on things one can be happy about. Finally, perhaps the most important coping strategy was *psychotherapy*. It may be the most fecund coping strategy because through psychotherapy, one develops education about the biochemical nature of the illness and lithium compliance, self-monitoring and awareness of symptoms, strategies to build kin and peer support, pointers to find suitable jobs that match abilities with interests and encourage creative and athletic pursuits, discretion about the confidential nature of one's condition, acceptance of things that one has no control over; in general, to live one's life with *insight*.

In all probability there is a confounding variable that may explain the differences between high- and low-functioning bipolars in the coping strategies Work and Confidentiality: SES. This did not turn up in the literature probably because this may not have been a crucial factor in the U.S. where even the low SES have access to free quality elementary and secondary education. Welfare, insurance, and other social security benefits also ensure the minimum basket of goods and services. But in the Philippines, SES means having access to education, medical services, medication, food, leisure, or very little, if at all. In such a setting, while the rich and the poor bipolars have equal chance of recovery from an episode (Shobe & Brion, 1970), it is the rich who have better chances of becoming highly functional, because of the very quality of their life. They can find fulfilling work because they have good education. They can have the necessary individual psychotherapy and buy support medication because they have money. They can talk about their suffering and aspirations because they are articulate. They can uplift their spirits through leisure and art because they have access.

This is not to say that a bipolar who belongs to high SES means becoming highly functioning. In this study SES does not explain the lack of difference between the two groups as far as the five other coping variables are concerned. A depressed person cannot enjoy his or her blessings, no matter what SES. While no hard data was gathered, there were at least two subjects in the high SES who were low-functioning. One subject from the low-functioning group who came from a relatively high SES was confined in the National Center for Mental Health (NCMH). He had little kin support; his family would not take him back.

Of course, poor bipolars can avail of the good services at the NCMH. But in this research, five of six subjects from the NCMH were low-functioning, as rated by the nurses and one psychiatrist.

Shobe and Brion (1970) found that bipolars tended to be better educated and belong to a higher SES. The twenty bipolars in this small-group study, however, came from all walks of life. The trend did show that the bipolars who were better educated and belonged to a higher SES were the *high-functioning* ones. Except possibly for Work and Confidentiality, SES does not explain why bipolars from high SES tend to cope better.

Limitations of the Study

The present research is limited in the size of the sample and the purposive manner in which the respondents were selected. Only 20 subjects participated in the study.

Because the subjects were selected from the patients of five psychiatrists practicing in Metro Manila, and patients from the National Center for Mental Health (NCMH), the data and in-

ferences cannot be generalized to the population of manic depressive individuals. Undiagnosed bipolars, or confirmed bipolars who are not in therapy, are not represented in the present sample. The dynamics of stress and coping among individuals not utilizing therapeutic services may necessarily be different from those described in this research.

The aspect of research methodology that may have been a confounding variable was the lack of inter-rater reliability in rating the level of functioning of the manic depressives. In the cases of the six NCMH subjects for example, the level of functioning ratings were done by only one nurse or psychiatrist for each patient. Some of these raters observed the patients only for a week or so, and may have had different standards of wellness compared to a relative of an outpatient. Different raters of different patients may have had different standards to distinguish between "some" and "moderate" social withdrawal or between "obvious emotional symptoms" and "symptoms requiring constant care." This lack of inter-rater reliability may have caused some inaccuracies in dividing the sample into high- and low-functioning bipolars.

This consideration was carefully examined in planning the research methodology. In order to improve inter-rater reliability, the researcher sought to rate the patients' level of functioning as an objective observer. However, this proved to be untenable because none of the participating private psychiatrists were willing to compromise their patients' concern for confidentiality and to expose them to the unnecessary anxiety of being questioned by a stranger. Another option explored was to have the patients rated separately by multiple nurses or relatives. Again this proved difficult since outpatients, who comprised 70% of the subjects, were accompanied by only one relative during their consultations with their psychiatrist.

In the end this difficulty could only be addressed somewhat by assisting the nurses or relatives, whenever possible, in accomplishing the level of functioning questionnaire to ensure accurate understanding of the four questions. Still, this lack of inter-rater reliability may have been a confounding variable. This problem could only have been avoided if all subjects were institutionalized patients, thereby missing out on bipolars who could cope better and function with relative normalcy, which is what this research wanted to study. Besides, NCMH had only six bipolar patients at the time.

Recommendations

First, this study can be improved by increasing the size of the sample of bipolars or manic depressive subjects.

Second, the questionnaire can be more fruitful if the following variables are included:

1. *Socioeconomic status.* If this variable were obtained, the element of confounding due to this variable would be eliminated. In the research design, the independent variable might be SES, and the dependent variable, level of functioning.

2. *Age at onset.* This would be useful in determining how many years the subjects have been ill and how this correlates with their coping strategies and level of functioning.

3. *Positive family history of mood disorder.* This would ascertain the familial pattern of manic depression that has appeared prominently in the literature (APA, 1987; Fieve, 1989).

4. *Level of internal locus of control.*

5. *Level of self-esteem and self-perceived competence.* According to Pellegrini et al. (1987), these are two things that children of bipolars seem to be low at. Following the theoretical framework of the genetic nature of the illness, it follows that children of bipolars are highly vulnerable to the illness themselves. These two personality attributes may be worth looking into for diagnostic purposes, leading to possible coping and therapeutic strategies.

6. *Comfort of status in the community.*

7. *Parents' expectations of children.* Finally, a family systems approach may be taken. With such an approach, the family would need to participate more closely in the research. Measures would have to be found or devised to measure variables 6 and 7. Practitioners may be able to identify and spot these "family danger signs" as a prelude to bipolar disorder.

Implications for Service

If indeed bipolars are outgoing (Eaton et al., 1976) and have a need to reach out to people, then what may help bipolars share stress and learn to cope better may be *group therapy*, provided the concern for confidentiality can be assuaged.

Another form of therapy worth exploring may be the *psychoeducational approach* to the illness where the patient and his or her family are involved in modules that inform them of the illness, its causes, interventions known, and possible things the patient and the family can do. In this manner, the family faces the illness of a family member together and the patient can draw emotional and moral support from his or her family. This approach may be welcome in the Philippines considering the importance we give to the family unit.

It has been seen that even when bipolars have gotten in relative control of their illness, they still feel different, alone, sensitive, and vulnerable at times. Their sensitivity is translatable to compassion and understanding not only for kindred souls, but for people, in general. If only for this they have something that many "normal" people do not. They have depth of feeling.

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