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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). Philippine data is almost impossible to recover at the present time. Together with unipolar recurrent depression, the other mood disorder classified by the American Psychiatric Association 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). This article studies the coping strategies of 20 Filipino bipolars against the background of international studies on bipolar mood disorder.

Bipolar Mood Disorder

The earliest symptoms of the mild manic state called hypomania are pleasant, including surges 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 1971 study by Shobe and Brion which found that bipolar patients tended to be better educated and belonged to high socioeconomic classes provides some basis for 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 them to seek 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).

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 (imposing his will with unwavering confidence in doing things "my way," with complete lack of tact for his colleagues), irritability, euphoria, mood liability (fluctuation or changeability), hypersexuality, flight of ideas, and delusions of sexual, persecutory, passive, and religious nature. Thought patterns are speeded up but with logical thinking intact, unlike the looseness of association of schizophrenics (Eaton, Peterson and 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, Peterson and Davis 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, Peterson and Davis 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 (oversleeping), 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 shows 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, Peterson and Davis 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).

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, Peterson and Davis 1976), not consciously put on, but nevertheless a tenuous happy mask that melts to reveal a suffering soul within.

Bipolar mood disorder is marked by depression, elation, or both (Eaton, Peterson and Davis 1976). The onset of bipolar depression is in the early 20s, and characterized by a lifetime of alternating mid-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 and Somerville 1977). Furthermore, variations of the illness include several depressive episodes followed by mania, or vice versa—several manic episodes followed by depression (Rimm and 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, Peterson and Davis 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 (1971), 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, Davis and Peterson (1976) research, 20% of patients had only one attack. Those who had a second attack usually continued to have recurrences throughout life (Eaton, Peterson and Davis 1976), although each attack seemed to decrease the chances of the next one (Calhoun 1977). It could be that growing self-knowledge after each episode, and knowledge of the warning symptoms, together with psychotherapy, enable patients to monitor themselves, to know when to seek professional help and nip mania or depression in the bud as the early symptoms are recognized.

Lithium therapy stabilizes 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 of treatment.

Significantly, it has been found that there is a *familial pattern* in bipolar mood disorder. "Bipolar disorder has clearly been shown to occur at much higher rates in first-degree biologic relatives of people with bipolar mood 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 et al. (1982) found that affective or mood 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 risk was found to be 74% for offspring of two parents ill with mood 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 mood 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, 131). But whether the illness is passed on through the genes, and not through 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 mood 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, Peterson and Davis (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 Myers Briggs Type Indicator ratings, this seems to describe Extravert-Sensing personalities. Heredity or environment?

Furthermore, Eaton, Peterson and Davis (1976) reported the higher incidence of mood disorders among the relatives of bipolar patients. They cited the following family characteristics of patients: more concern for social approval, coming from an uncomfortable status in the community; the child is expected to change this through his/her

achievements; and the child attempts 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 mood 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, 237). Whether or not stresses in life actually precipitate depressions or highs is still a much debated problem in psychiatric research.

In 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 (1971) 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 (1971) contentions that bipolars tended to be better educated and to belong to a high SES, and that 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 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 1950s 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 quickly, specifically, and permanently for recurrent mood states" (Fieve 1989, 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, unless the dosage is too high, in which case the patient may experience hand tremors, nausea, excessive urination, or diarrhea. Lithium may not be used on patients with a kidney or 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, 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 depression 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, 164).

For those who choose to go to therapy, the goals or thrusts of psychotherapy intervention range from reducing suffering and preventing future recurrences (American Psychiatric Association 1989)

to changing the personality structure, not just to alleviate symptoms but for "improvement in interpersonal trust, intimacy and generativity, coping mechanisms, ability to experience a wide range of emotions, and the capacity to grieve" (Kaplan and Sadock 1989, 934).

Interviews with six Filipino psychiatrists indicated that 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 on both an in- and out-patient basis. The patients' compliance with medicine requirements is important.

The condition is stabilized when the patient is back to his or her normal self, based on 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 to help 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 provide 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 the six Filipino psychiatrists and a review of the related literature:

1. Understand the biochemical nature of the illness and comply with lithium treatment 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 with lithium agrees to go into psychotherapy, this may provide a working framework by which he or she can be helped.

As one of the first studies on manic depression in the Philippines, this article 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.

The Study of 20 Filipino Bipolars

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

Twenty bipolar adults and young adults, all undergoing or having undergone some form of therapy, were studied using three questionnaires. Two questionnaires were answered by the patients, and the third was for either a relative (for nonhospitalized patients) or a nurse (for hospitalized patients). One patient-questionnaire used a 5-point agree-disagree rating scale to provide a quantitative measure of the patient's stressors and coping patterns. The second patient-questionnaire used a sentence completion form 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 the content validity of the instruments. The three questionnaires were then pretested with 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. Sample items are given in Table 1.

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- and low-functioning groups, the independent variable.

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
In 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 could 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 . . .

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 (NCMH), 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 random-group comparison was made between the high- 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.

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

There were seven preidentified 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 Strategy	x	s.d.	x	s.s.	tcomp
Coping Strategies Ave.	3.745	.409	3.683	.349	.365
1. Biochemistry/Lithium	4.033	.734	4.100	.568	-.228
2. Self-Monitoring	4.222	.636	4.176	.602	.160
3. Kin Support	4.250	.456	3.950	1.129	.779
4. Peer Support	2.800	.610	2.750	.635	.180
5. Work	3.699	.589	3.064	.786	1.828+
6. Creative/Athletic	3.889	.811	3.778	.914	.273
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- from low-functioning bipolars.

Starting with the two coping strategies, Work and Confidentiality, that tended to differentiate high- 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 their illness.

On 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, *kapaki-pakinabang,* 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 of Findings

The first trend shown by this study was that high-functioning bipolars tended to have more continuous work which they found fulfilling. 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 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 minds 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 functioning remains normal. The manic depressive has the opportunity to model his or her grooming and appearance, conversation, and behavior on 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 describ-

ing 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 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.

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 is 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 preidentified 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 looked closely for any important coping strategies employed by the high-functioning bipolars that were not captured in the questionnaire.

The biggest clue was in seeing their experience as something that could 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 to accept 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 learns 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, one learns 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, low SES means having no 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 and Brion 1971), 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 to them.

This is not to say that a bipolar who has a high SES will become 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 NCMH. He had little kin support; his family would not take him back. Of course, poor bipolars can avail of the 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 (1971) 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 had 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.

Conclusion

In this study of 20 Filipino bipolars, those who tended to function better in life were those who had continuous, fulfilling work, and those who could talk about their condition selectively in a forthright manner. The direction of causality, however, is not clear. Do bipolars function better because they have work and can talk about their condition, or are they able to work and talk about their condition because they are better-functioning?

Data from the study also showed that a large majority of high-functioning bipolars belonged to a higher SES. It is thus possible that it is this advantage, particularly access to good education, that enables high-functioning bipolars to land jobs and to be articulate about their condition.

The study shows that taken all together, the preidentified 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. Aside from lithium therapy which attacks the biochemical roots of bipolar mood disorder, and individual psychotherapy which can enable bipolars to develop insight about their lives and their environmental, how then can bipolars be helped?

If indeed bipolars are outgoing (Eaton, Peterson and Davis 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 is the *psychoeducational approach* where the patient and his or her family are involved in modules that inform them of the illness, its causes, known interventions, 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 as a source of succorance and support.

It has been seen that even when bipolars have gained relative control over 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. The have depth of feeling.

References

American Psychiatric Association. 1987. *Diagnostic and statistical manual of mental disorders.* 3d rev. ed. Washington, D.C.: American Psychiatric Association.

American Psychiatric Association. 1989. *Treatments of psychiatric disorders: A task force report of the APA* 3: 1745–50. Washington, D.C.: American Psychiatric Association.

Banaag, Cornelio G., M.D., psychiatrist. 1991. Interview by author. The Medical City, Mandaluyong, Metro Manila.

Calhoun, J. S. F. 1977. *Abnormal psychology: Current perspectives.* 2d ed. New York: Ramdom House.

Cameron, N. 1963. *Personality development and psychopathology.* Reprint. Philippines: JMC Press, Inc.

Carlson, G. A. and F.K. Goodwin. 1973. The stages of mania. *Archives of General Psychiatry* 28 (February): 221–28.

De Guia, Elizabeth R., M.D., psychiatrist. 1991. Interview by author. The Medical City, Mandaluyong, Metro Manila.

Eaton, M. T., Jr., M. H. Peterson, and J. A. Davis. 1976. *Psychiatry.* 3d ed. New York: Medical Examination Publishing Co., Inc.

Fieve, R. R. 1989. *Moodswing*. New York: Bantam Books.

Gershon, E. S., et al. 1982. A family study of schizoaffective bipolar 1, bipolar 2, unipolar, and normal control probands. *Archives of General psychiatry* 39 (October): 1157–67.

Jurilla, Eduardo L., M.D., psychiatrist. 1991. Interview by author. Makati Medical Center, Makati, Metro Manila.

Kaplan, H. I. and B. J. Sadock, eds. 1989. *Comprehensive textbook of psychiatry*, 859–944. 5th ed. Baltimore: Williams and Wilkins.

Lapuz, Lourdes V., M.D., psychiatrist. 1991. Interview by author. St. Luke's Medical Center, Quezon City.

Leo, J. 1984. The ups and down of creativity. *Time*, 8 October.

Ocampo, Teresito, M.D., psychiatrist. 1991. Interview by author. The Medical City, Mandaluyong, Metro Manila.

Pellegrini, D., et al. 1986. Personal and social resources in children of patients with bipolar affective disorder and children of normal control subjects. *American Journal of Psychiatry* 143 (July): 856–61.

Rimm, D. C. and J. W. Somerville 1977. *Abnormal psychology*, 156–59. New York: Academic Press, Inc.

Santiago, Luciano P.R., M.D., psychiatrist. 1991. Interview by author. The Medical City, Mandaluyong, Metro Manila.

Shobe, F. O. and P. Brion. 1971. Long-term prognosis in manic-depressive illness. *Archives of General Psychiatry* 24 (April): 334–37.