

Diagnosis, Discovery and Adaptation: the getting of wisdom

My wife's bipolar diagnosis instigated a process of discovery and adaptation. Because the characteristics vary between individuals, a broad understanding of the illness was needed to become astute and make decisions that were relevant to her specific case. I'd like to explain how we have gained wisdom from reflecting upon my wife's history, and discuss how we distinguish the 'highs' from her normal behaviour; and the strategies we use to manage elevated moods. An opinion of the upside of bipolar disorder will also be presented.

It is possible my wife's journey with mood disorders began during adolescence, a follow-on from cyclothymia. This disorder is characterised by mild hypomanic episodes, with depressions not severe enough to be classed as 'major' depression. Whilst her behaviour was not inconsistent with that of other rebellious teenagers, she can identify brief bouts of depression, rapid conversation, risky behaviour that was out of her 'normal' character and a marked change in her lifestyle during such mood swings. Through further reading, I discovered there is evidence of a link between cyclothymia and Bipolar I Disorder. For example, Joyce's (2001) research emphasised the importance of diagnosing cyclothymia in adolescence and claims: "...it predicts the later development of full-blown bipolar disorder" (p.41). On reflection, we both believe she continued to experience regular mood fluctuations throughout her early twenties. For instance, she would often feel down and unmotivated in the morning and her mood would elevate at night. Some characteristics of her elevated mood included excessively visiting a close family friend, increased conversation, rapid speech and a poor ability to judge quantities and manage time. Although there were also times of more balanced moods, it is evident that there may have been something wrong.

After the birth of our second child, at the age of twenty eight, my wife received psychiatric treatment for severe postnatal depression. As the depression subsided she found employment as a sales representative and became obsessed with the product she was marketing. She began to purchase large quantities of unnecessary items and would become irritable and irrational if you suggested her behaviour was unrealistic. Further, since she continued to experience residual depression in the mornings she worked mostly at night – which was when her mood was high. These characteristics continued for a further two years until she became manic on a flight returning from a business trip in Hawaii, and was hospitalised with psychosis. She was diagnosed with Bipolar I Disorder, and told that an SSRI antidepressant drug may have triggered the mania. It was suggested that this was a possibility if she was genetically susceptible to bipolar disorder and was not using mood stabilising medication in conjunction with the antidepressant.

It appears the diagnosis of bipolar disorder may have been initially overlooked because she only sought treatment for depression and was unaware of her 'highs'. Dr Kay Jamison's (1990) research acknowledges that this is often a problem when assisting a patient during psychotherapy. For instance, during my wife's elevated mood leading up to her psychotic episode she had a decreased libido. This may have been a side effect from the SSRI antidepressant that was mistaken for one of the symptoms of residual depression. This view parallels Smith's (2003) who writes: "...it is common to mistake sexual dysfunction caused by an SSRI drug for a symptom of depression" (p.14). However, after her libido increased during a recent bout of hypermania, whilst using SSRI drugs in conjunction with a mood stabiliser, we now regard it as a warning sign. This further highlights the complexity of this illness.

To my wife's credit, she now accepts and acts responsibly with her illness. Through unpacking the characteristics of her previous elevated moods, we both can identify reliable warning signs of her developing extreme 'highs'. British psychologists Jones, Hayward and Lam (2005) refer to these idiosyncratic warning signs as "individual relapse signatures" (p.49). The warning signs that we have established, together with a professional, are:

- requiring less sleep
- rapid conversation
- poor ability to recognise inappropriate and excessive behaviour
- becoming irrational, making poor decisions, less common sense
- purchasing unnecessary items and storing them

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- flights of ideas
- excessive interest with a person, a family or product
- gullibility
- excessive use of internet, phone, text messages
- poor ability to manage time and judge quantities, with little regard for consequences
- excessively involved with work, less time for family
- increased libido, creativity

Even with this insight, diagnosing a 'high' is a frustrating experience for everybody involved. For instance, my wife's reaction to exciting activities and occasions is not inconsistent to other people's and only becomes problematic when the excitement continues with 'relapse signatures'. At this stage she may not be able to recognise that her behaviour is unrealistic. Consequently, we have strategies to counteract the possibility of the mood escalating. For example, with close friends, we established a small support group. Together, during times when her mood was more balanced, we had frank discussions outlining the 'relapse signatures', built a strong rapport and reached an agreement with her, that if she demonstrates ongoing hypermanic characteristics, our intervention is justified. During periods of elevated mood, this collective approach has been effective in encouraging my wife to:

- recognise and avoid further stimulating events,
- sleep and participate in calming activities,
- surrender credit cards and cash,
- come to terms with a possible increase or change in medication and
- realise she may need to seek professional advice.

As her carer and husband I also use additional strategies such as massage, warm baths, limiting her visitors and phone calls and encouraging her to sleep, to further calm her mood. I ensure she continues with her medication and may contact her psychiatrist or G.P. if the 'high' continues. Under their professional guidance, I may then have to administer neuroleptic (anti-psychotic) medication and keep them informed of her progress. If her mood escalates to severe mania, she may talk rapidly for over an hour, then exhausted fall asleep for a short period, after which she resumes her conversation. She becomes delusional, paranoid and believes she has psychic powers. This requires constant monitoring because of the potential danger to herself and others, and hospitalisation is the sensible option.

Through medication and support she has been able to resume a relatively normal lifestyle. She believes that walking regularly and participating in pilates helps to further stabilise her moods. The mood fluctuations that are characteristic of bipolar disorder are still apparent, but with reduced intensity. She works part time and demonstrates energy and enthusiasm in her new position. However, she believes at times her medication suppresses her 'true' feelings, restricts creativity and leaves her feeling unmotivated domestically.

These feelings appear to have been compounded by the ongoing relationship difficulties she has with people who are important to her who show little support and empathy for her illness. This stress has also triggered episodes of mood disorder. Relationship counselling has been beneficial, but we recently decided to begin cognitive behavioural therapy (CBT) with a clinical psychologist who specialises in bipolar disorder. Smith (2003) explains that "People who are vulnerable to mood disorder appear to react more to stressful situations" and suggests that CBT may be useful "to stay calm in difficult situations..., improve the way you feel and leave more energy to focus on the important things" (p.1 6). We are optimistic that psychotherapy may also help her distinguish normal from elevated moods, lead to a reduction in medication and increase her creativity.

Managing bipolar disorder is not easy and the strategies that have been outlined are not meant to sound idealistic. Even when my wife's mood is more level, she often feels slightly high or low and this can place our relationship under stress. However, through showing empathy, drawing from past experiences, and working with professionals, we have both grown closer and broadened our life skills. We often look at other successful families and sometimes it appears they are skimming the surface of life, when by <http://www.blackdoginstitute.org.au/media/writingcomp/index.cfm>

necessity, we have had to plumb greater depths. My wife claims a further advantage of having bipolar disorder is being able to experience increased positive emotions and feelings. For example, it is apparent she has a greater ability to express and receive love, and her vibrant personality and conversation has contributed to her popularity and has provided her with many opportunities in life. Perhaps, this is why so many successful people have bipolar disorder.

Knowledge comes from experience and learning and manifests itself in competent judgements, effective strategies and avoiding catastrophes. My wife's journey has demanded this level of wisdom with empathy and educated patience from all who provide support for her: it is possible that her illness may have gone undiagnosed for years, and her 'highs' are often underpinned with irritability. It appears that medication is a key element in controlling bipolar disorder, however, a combination of understanding friendships, domestic support, psychiatric treatment and psychotherapy also have the potential to harness her creativity and further improve her quality of life.

References:

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Comments: Dr Kay Redfield Jamison is an Associate Professor of Psychiatry at The John Hopkins University School of Medicine. She has suffered with bipolar disorder since adolescence and is regarded as an international authority on bipolar disorder.
- Jones, S. Hayward, P. Lam, D.(2005), *Coping with Bipolar Disorder*, Oneworld Publications Oxford, England.
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- Joyce, P. (2001), *Current Therapeutics*, Christchurch.
Comments: Peter Joyce, MB Chb, PhD, FRANZCP, is Professor and chairman of the Department of Psychological Medicine, Christchurch. His main clinical and research interests are affective mood disorders.
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