

Marital Problems among Partners of Patients with Bipolar Affective Disorder

Parakkal Drisya, Kavungathodi Bindumol, T. K. Saleem, Dayal Narayan¹

ABSTRACT

Background: Partners of patients with bipolar affective disorder (BPAD) have problems with their marital life. Identification of these problems is important to develop strategies to solve them for improving quality of life. **Aims:** To identify marital distress and problem areas in their marital life among the partners of patients with BPAD. **Materials and Methods:** A cross-sectional descriptive design was used to collect data from 125 participants, 59 males and 66 females, who were partners of patients with BPAD. The study was done in outpatient clinics of Community Mental Health Clinics of District Mental Health Program. Tools used for data collection included a semi-structured interview schedule to collect socio-personal data of partners of patients with BPAD and clinical data of the patient, Couple Satisfaction Index (CSI), and Problem Areas Questionnaire (PAQ). Purposive sampling technique was used. **Results:** Majority of the participants (male - 55.9%, female -54.5%) expressed marital distress on CSI. Handling family finances and career/job decisions were the most problematic areas for male participants, whereas household tasks, handling finances, and career/job decisions were the most problematic areas for female participants. **Conclusion:** A significant proportion of spouses of BPAD patients have marital distress in important areas of life, with a potential for long-term consequences in their lives.

Key words: Bipolar affective disorder, marital problems, partners

Key messages: Marital problems in partners of patients with bipolar disorder is a significant clinical issue deserving attention.


Bipolar affective disorder (BPAD) can damage relationships and impair various aspects of an individual's life. Marriage may be stressful for vulnerable people, which may lead to the development of mental health problems.^[1] Cyclical mood swings may create major changes in the life of individuals, including their marital life. Partners of patients with BPAD face various problems, of which marital

problems is an important one.^[2] A high proportion of patients with BPAD get married when compared with those suffering from schizophrenia.^[3] But, patients with mental disorders have higher rates of marital discord, separation, and divorce.^[4] BPAD often starts early in life. Patients who get married often suffer from many

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Department of Psychiatric Nursing, Government College of Nursing, ¹Department of Psychiatry, Government Medical College, Kozhikode, Kerala, India

Address for correspondence: T. K. Saleem
Government College of Nursing, Medical College, Kozhikode - 673 008, Kerala, India.
E-mail: tksaleem@gmail.com

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negative consequences in their marital life due to the illness, and there are high rates of divorce/separation among BPAD patients.^[3]

Studies have reported a deteriorating marital process in which an initial concern and caring by the spouse is eventually replaced by resentment and impatient reactions, leading to further complications. Marital problems and conflicts may be common in families in which one of the members is suffering from BPAD.^[5] Specific marital problems like sexual dysfunction among patients receiving various psychotropic medications have been reported to be high.^[6] Poorer marital adjustment among patients with BPAD and their spouses have been reported earlier.^[3]

It is important to understand the marital and sexual adjustments of patients with various mental illnesses and their spouses. Health care providers have a responsibility in identifying these problems. Lack of a warm and comfortable relationship may put great stress on the partner, which may interfere with providing care and support for the patient.

Aims

The study aimed at identifying marital distress and problems areas in their marital life among partners of patients with BPAD. In addition to the primary objective, gender-wise comparison was done and association of these variables with marital distress was analyzed for variables such as age, education, occupation, religion, and type of marriage of the partners, and clinical variables of the patient such as the presence of physical illness, medication, present clinical condition and duration of treatment

MATERIALS AND METHODS

A quantitative descriptive survey approach was used. Twenty-two mental health clinics coming under the District Mental Health Programme (DMHP) were selected as the setting for the study. The partners of patients with BPAD constituted the study population.

The sample consisted of 125 participants accompanying their partners with BPAD attending the community clinics. The sample size was calculated based on previous literature on depression and marital satisfaction, offsetting for variability.^[7] Purposive sampling technique was used. Permission for the study was granted by the Institutional Ethics Committee and Scientific Review Committee of the institution. Informed consent was obtained from each participant before data collection.

Tools included a semi-structured interview schedule to collect socio-personal data of partners of patients with BPAD and clinical data of the patient. The CSI^[8] was used to identify whether the partners of patients with BPAD reported marital satisfaction or marital distress. This study used the 16-item format (CSI-16), which is available in the public domain. The maximum score possible for CSI-16 is 81, and the minimum score is zero. A score of less than 51.5 indicates marital distress, and a score above this indicate marital satisfaction or couple satisfaction.^[9] CSI scales are demonstrated to have strong psychometric properties.^[8] The scale was translated to Malayalam and language validity was established by sending the tool to an expert panel of seven members from the field of mental health after the forward and backward translation procedure.

The Problem Areas Questionnaire (PAQ) was used to identify the marital problem areas where the partners of patients with BPAD report dissatisfaction about their spouses' behavior.^[10] The tool is available in the public domain for academic use. PAQ lists areas in which couples are often dissatisfied or have disagreements about other's behavior. This scale has 14 items with seven ratings. It is used to identify the problem areas and also to identify the most problematic area from a list of 14 problems. For the purpose of analysis of each item, this study adopted a scoring ranging from 1 to 7. An open space was given at the end of the rating scale for mentioning any other related problem, to which none of the participants responded. PAQ scale was also translated to Malayalam and language validity was established.

Data collection

Data collection was done by the first author during the months of February and March 2017. A pilot study was conducted in a sample of 10, and necessary modifications were made. The investigator went through the written records of each patient attending the clinic, and available details were collected. Patients diagnosed with BPAD as per ICD-10 criteria for mental and behavioral disorders^[11] by the treating psychiatrist were selected. Spouses of the patients who accompanied their partner to the clinic were selected, based on the inclusion criteria. Partners who were the primary caregivers and staying with the patient at least for the last six months were included. Partners with known mental illness and significant physical problems were excluded. Using the semi-structured interview and record review, the demographic data of the partners and clinical data of the patients were collected. After providing sufficient instructions, the CSI and PAQ were given to the participants, which were completed by them. Data collection from a participant took approximately 20 minutes, and on

an average, four to six participants were evaluated in a day. The data collected from 125 participants were tabulated, analyzed and interpreted using descriptive and inferential statistics using SPSS 11th version for Windows.

RESULTS

Among the 125 participants, 47.2% (*n* = 59) were males and 52.8% (*n* = 66) were females. Also, 35.6% of male participants belonged to age group 51-60, and 31.8% of female participants belonged to the age group 41-50. Similarly, 44.1% of male participants and 45% of female participants had attained secondary school education. Majority of male participants (62.7%, *n* = 37) were manual laborers, whereas two-thirds of the female participants were unemployed. Most of the participants had a monthly income of less than 2500 rupees, and almost all of them belonged to nuclear families. Majority of the participants belonged to the Hindu religion, had a rural domicile, and were in an arranged marriage. Five female participants did not have any children [Table 1].

For male participants, the mean age at the time of marriage was 28.68 (± 6.8) years and for female participants, it was 21.89 (± 4.47) years. Mean age at onset of BPAD in male patients was 32.29 (± 11.45) years and in female patients, it was 34.23 (± 13.97) years. The mean duration of illness in male patients was 20.39 (± 11.48) years and in female patients, it was 20.86 (± 11.92) years. The mean duration of treatment in male patients was 20.37 (± 11.54) years and in female patients was 20.38 (± 12.37) years.

When the present clinical condition of the patients was analyzed, 67.8% (*n* = 40) of males and 59.1% (39) of the female patients were in remission as per their clinical records. Manic episode was present in 16.9% (*n* = 10) of the male patients and 30.3% (*n* = 20) of the female patients. Similarly, depressive episode was present in 15.3% (*n* = 9) and 10.6% (*n* = 7) of male and female patients respectively. Any of the physical illnesses such as diabetes, hypertension or thyroid dysfunction was present in 42.4% of males and 50% of females. It was found that 84.7% of the male participants and 51.5% of female participants had onset of BPAD after marriage. Sodium

Table 1: Sample characteristics

Characteristics	Category	Male (<i>n</i> =59)		Female (<i>n</i> =66)	
		F/Mean	%/S.D.	F/Mean	%/S.D.
Age	21-30	1	1.7	2	3
	31-40	2	3.4	16	24.2
	41-50	9	15.3	21	31.8
	51-60	21	35.6	19	28.8
	>60	26	44	8	12.2
Education	No formal education	4	6.8	1	1.5
	Primary education	25	42.4	30	45.5
	Secondary education	26	44.1	30	45.5
	Degree/professional	4	6.8	5	6.6
Occupation	Unemployed	19	32.2	44	66.6
	Manual labor	37	62.7	20	30.3
	Government job	3	5.1	2	3.0
Religion	Hindu	40	67.8	41	62.1
	Muslim	5	8.5	20	30.3
	Christian	14	23.7	5	7.6
Type of family	Nuclear family	57	96.6	62	93.9
	Joint family	2	3.4	4	6.1
Monthly Income	<2500	45	76.3	46	69.7
	2501-5000	6	10.2	13	19.7
	5001-1000	3	5.1	4	6.1
	>10000	5	8.5	3	4.5
Place of residence	Rural	49	83.1	59	89.4
	Urban	10	16.9	7	10.6
Type of marriage	Selection by self	5	8.5	1	1.5
	Arranged by family members	49	83.1	60	90.9
	Arranged after selection by self	5	8.5	5	7.6
Number of children	0	0	0	5	7.6
	1	7	11.9	11	16.7
	2	25	42.4	31	47.0
	3 or more	27	45.8	19	28.8

SD: Standard deviation

valproate was the current medication in 49.15% ($n = 29$) of male patients and in 33.33% ($n = 22$) of the female patients. Benzodiazepines ($m = 38.98\%$, $n = 23$; $f = 48.48\%$, $n = 32$), haloperidol ($m = 27.12\%$, $n = 163$; $f = 21.21\%$, $n = 14$), chlorpromazine ($m = 30.51\%$, $n = 18$; $f = 18.18\%$, $n = 12$), sertraline ($m = 22.03\%$, $n = 13$; $f = 10.61\%$, $n = 7$) lithium ($m = 20.34\%$, $n = 12$; $f = 21.21\%$, $n = 14$), risperidone ($m = 20.34\%$, $n = 12$; $f = 24.24\%$, $n = 16$) and trihexyphenidyl ($m = 42.38\%$, $n = 25$; $f = 33.24\%$, $n = 20$) were the other drugs received by the patients. A few patients received olanzapine, clozapine, imipramine, amitriptyline and quetiapine.

On CSI, marital distress (score < 51.5) was reported by 55.9% of the male participants and 54.5% of the female participants [Table 2]. In total, 55.2% of the participants reported marital distress. Comparison of mean scores of male ($52.69, \pm 13.19$) and female (50.59 ± 15.60) participants showed no significant difference between the groups ($P = 0.42$) [Table 3].

The relationship between marital distress and selected variables were tested using appropriate statistical tests for the whole sample ($n = 125$), as there was no gender difference on CSI. There was no significant relationship between marital distress and socio-personal variables such as education, occupation, religion, type of marriage, and clinical variables of the patient such as the presence of physical illness, medication, and duration of treatment. Notably, there was no significant difference between the mean age of participants ($P = 0.48$) who had marital distress ($n = 69, 52.48 \pm 11.94$) and those who had no marital distress ($n = 56, 53.98 \pm 12.01$). Similarly, the association between the present clinical condition and CSI was analyzed using one-way ANOVA ($n = 125$). It was found that participants whose partners were in remission ($n = 79, 53.96 \pm 14.49$)

had a significantly higher mean score ($P = 0.045$) in comparison to participants whose partners were in a manic ($n = 30, 46.53 \pm 14.77$) or depressive episode ($n = 16, 49.31 \pm 11.67$).

The Figure 1 shows mean scores for items of the PAQ by male participants ($n = 59$). Handling family finances (mean = 4.79); career/job decisions (mean = 4.20); aims, goals, priorities, major decisions in life (mean = 3.94); recreation and leisure time (mean = 3.94); and sex relations (mean = 3.70) were the important problem areas reported by male participants. Drugs or alcohol (mean = 2.04) and religion (mean = 2.68) were the PAQ items for which male participants scored the lowest.

The mean scores of item-wise analysis of the response of female participants on the PAQ are shown in Figure 1. Household tasks (mean = 4.56), handling family finances (mean = 4.39), career/job decisions (mean = 4.26), recreation-leisure time together (mean = 4.22), and sex relations (mean = 4.07) were the important problem areas. Item such as children or parenting (mean = 3.97); aims, goals, priorities, major decisions in life (mean = 3.92); and drugs or alcohol (mean = 3.75) also scored high. Comparison of mean scores of PAQ between male (53.37 ± 13.21) and female (49.17 ± 15.43) participants showed no significant difference between the groups ($P = 0.11$) [Table 3].

DISCUSSION

Results were organized separately for male and female participants as their problems may be different. But, a meta-analysis on gender differences in marital satisfaction for nonclinical, community-based samples had indicated no significant gender differences between couples.^[12] Findings of our study are presented here separately for males and females as, unlike the general population, the context of a psychiatric clinical condition in one of the partners may give insights for direction of future research. Distribution of sociodemographic variables in this study is comparable to the findings of other studies on the topic.^[13]

According to similar studies done elsewhere, men and women were generally comparable in their symptom presentation, age of onset of BPAD, and in the total number of mood episodes, but differed in the type of episode at onset and comorbidity patterns.^[14] A study on age at onset and affective temperaments in a Norwegian sample of patients with BPAD showed that the mean age of onset of BPAD was 28 years.^[15] Findings consistent with this have been seen in our study as well.

Table 2: Distribution of participants based on marital problems

Characteristics	Male ($n=59$)		Female ($n=66$)		Total (%)
	Frequency	Percentage	Frequency	Percentage	
Marital distress (<51.5)	33	55.9	36	54.5	55.2
Marital satisfaction (>51.5)	26	44.1	30	45.5	44.8

Table 3: Comparison of male and female participants on CSI and PAQ mean scores

Characteristics	Male ($n=59$)	Female ($n=66$)	<i>t</i>	<i>P</i>
	Mean (S.D.)	Mean (S.D.)		
CSI	52.69 (± 13.19)	50.59 (± 15.60)	0.81	0.42
PAQ	53.37 (± 13.21)	49.17 (± 15.43)	1.63	0.11

CSI: Couple Satisfaction Index; PAQ: Problem Areas Questionnaire

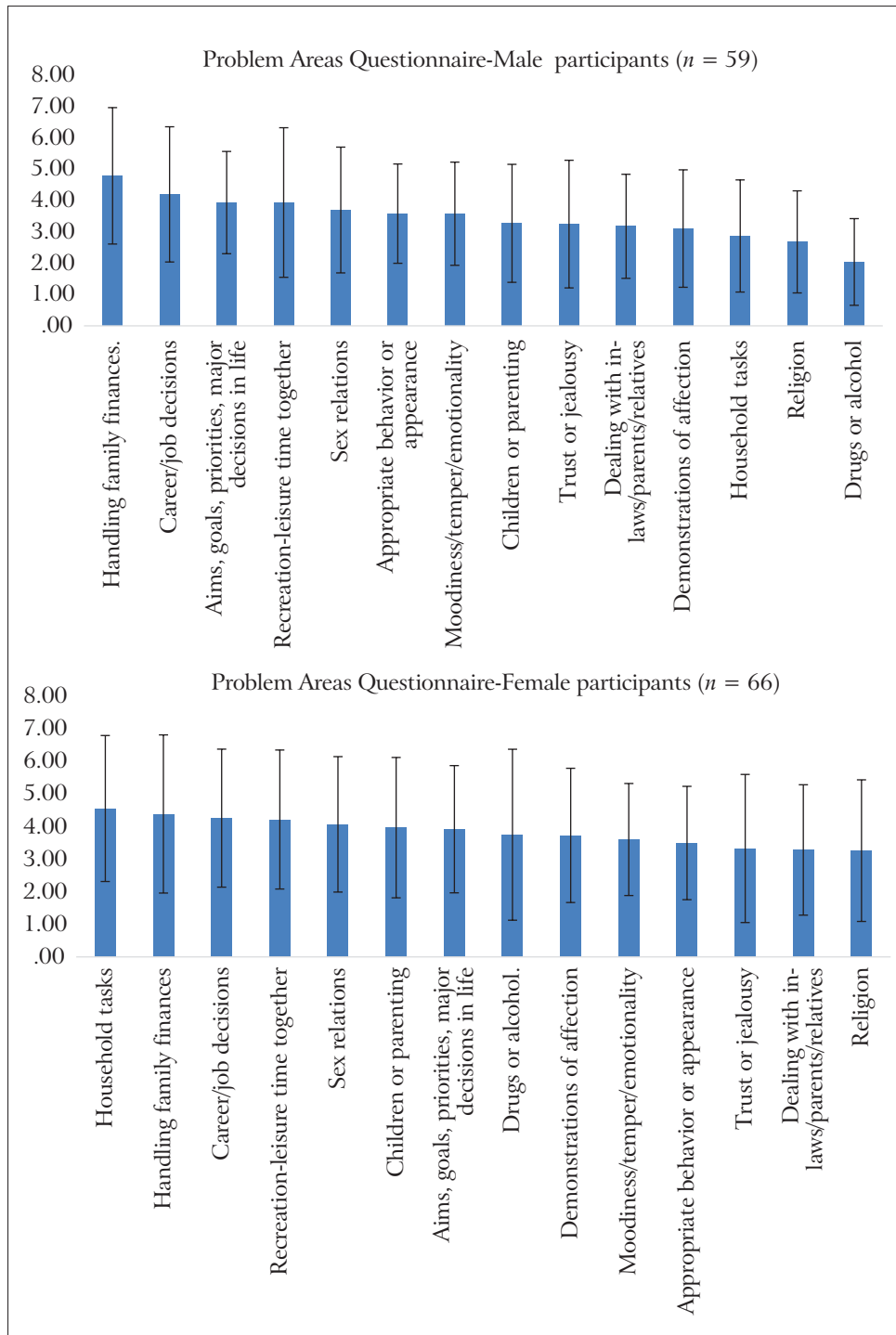


Figure 1: Problem Areas Questionnaire

The most important finding of our study is that 55.9% of the male participants, and 54.5% of the female participants reported marital distress. Comparison of mean scores of male and female participants showed no significant difference between them, which shows men and women have similar degrees of problems. Association between marital problems and depression has been reported earlier.^[16] Another study which

examined the caregiver burden and psychological distress among spouses of BPAD patients had reported a high level of psychological distress.^[17] A similar study compared marital satisfaction between patients with schizophrenia and BPAD, in remission, and reported that marital dissatisfaction was greatest among patients with schizophrenia (96%).^[18] Considering the high divorce rate among patients with BPAD, it is

important to uncover information related to the marital relationship in patients and spouses individually.^[19] As this study had limited scope of describing the extent of marital distress among spouses of patients with BPAD, future studies are recommended.

Management of BPAD involves a prolonged period of medication and attention to psychosocial issues for patients and their families. Economic burden among these patients is a result of treatment costs, indirect costs arising from mortality, and indirect costs related to morbidity and lost productivity.^[20] In our study, both male and female participants reported handling family finances as an important problem in their marital life. For improved long-term outcome, it is particularly important to support their families in economic terms through social security means.

Return to employment and family life are basic needs during remission in patients with BPAD.^[21] Occupation, finance, and other daily events were some of the problems articulated by the BPAD in a qualitative study.^[22] Our study found career/job decisions, major decisions in life, and recreation-leisure time together as problem areas in their marital life. Family support is an important contributor to patient well-being and a better prognosis.^[23] Female participants of our study reported household tasks as the most problematic area for them. It reflects the subjective burden in primary caregivers, particularly female partners of patients with BPAD.

The mental illness in the partner affects the social life and leisure activities of the caregiver. Despite their burden, relatives do not complain much.^[24] Our study also found that recreation-leisure activities is an important problem area for male and female participants. In a study that assessed the burden and marital and sexual satisfaction in the partners of patients with BPAD, participants reported reduced sexual satisfaction, which is consistent with the present study where sexual relations was one of the problem areas for both male and female participants.^[13] Consistent results by another study reported that quality of 'current sexual satisfaction' was significantly lower among the spouses of BPAD patients.^[25]

Limitations

Findings of the study may not be generalizable, considering the smaller sample size and use of purposive sampling technique. Similarly, this study did not look into the association of symptom severity of patients with couple satisfaction, which was an important variable. Effect of medicines on sexual functions was not within the scope of our study. But, a significant number of participants in this study were receiving sodium valproate, which is known to cause sexual dysfunction.^[26] Although this study did not find any

significant association between co-morbid physical illness of the patient and marital satisfaction, it is well-documented that the physical health of partners affects couple dissatisfaction.^[27] Despite these limitations, the study has clinical implications.

CONCLUSION

Partners of patients with BPAD experience various problems related to their marital life. Distress in the partner affects the quality of their relationship with the patient and adversely affects their prognosis.

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Conflicts of interest

There are no conflicts of interest.

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