26 For Families: How to Help Relatives with Mood Disorders

Essential Concepts

- When patients refuse treatment or have poor insight, they should seek psychoeducational psychotherapy and join support groups.
- In the case of bipolar disorder, the problem is usually lack of insight, which is part of the illness.
- In the case of unipolar depression, the problem is "psychopharmacologic Calvinism," the fear that there is something morally wrong with taking a pill to be happy.
- If all efforts are refused, only the "school of hard knocks" remains.
- Find good books and websites to educate yourselves, but beware of sensationalism: Believe none of what you hear and only half of what you see.
- Reduce expressed emotion: Families need to tone down verbal anger and conflict.
- Replace it with a loving, nonviolent resistance: Take the political methods of Martin Luther King, Jr., and apply them in your personal lives.

In much of this book I am speaking to the reader as if he or she is a clinician—a working psychiatrist, nurse practitioner, psychologist, social worker, psychiatry resident, or other trainee. But that voice is also meant to be directed toward families and friends of persons with mood disorders or persons with mood disorders themselves. This is so because patients themselves and their loved ones are part and parcel of the decision-making process. Thus they need to understand the whys and wherefores of diagnosis and treatment in as much detail as clinicians. Despite some medical lingo, I have tried to write this book in a way that

educated patients and their families and friends can understand. In this chapter I address them, rather than clinicians, directly to discuss how patients and their loved ones can themselves better understand, appreciate, and engage in their medical care for mood disorders.

THE PROBLEM OF INSIGHT: HOW TO GET PATIENTS TO ACCEPT TREATMENT

About half the people with bipolar disorder do not realize that they are experiencing or have experienced manic symptoms; they often thus disagree with the diagnosis or refuse mood stabilizer treatments. Although insight into unipolar depression is much more common, many individuals fear the stigma of getting psychiatric help or taking psychotropic medications. How can families and concerned friends help?

In the case of bipolar disorder, there is research evidence that insight improves when a manic episode resolves and that insight may improve over time. Insight is correlated with the number of hospitalizations as well. It could be, then, that the best antidote to poor insight into bipolar disorder is time and life's hard knocks (such as being repeatedly hospitalized). If a patient is willing to do psychotherapy, I also recommend psychotherapy with someone who is well experienced with bipolar disorder, where the focus of the psychotherapy is to gradually and respectfully educate patients about bipolar disorder and begin to show patients over time what signs and symptoms in their lives may be related to the illness. If a patient is unwilling to enter psychotherapy, or a therapist with such skill in bipolar disorder is unavailable, I also recommend that patients and their families attend support groups, if possible, such as local chapters of the Depression and Bipolar Support Alliance. (I recommend attending such groups even if psychotherapy is accepted.) If the patient refuses to attend such groups, refuses psychotherapy, and refuses medications, then perhaps only the experience of poor outcomes, with hospitalization or other hard knocks, can influence the individual to be open to the bipolar diagnosis. In such cases, where poor outcomes occur, it is best to justify medication use in terms of behaviors rather than diagnoses: "If you want to avoid going back and forth to the hospital, then it is probably better to take this medication rather than have to suffer all that hassle."

KEY POINT

If patients do not have insight into their diagnosis of bipolar disorder or depression or refuse appropriate medication treatment, a stepwise process should be implemented of first trying to engage them in psychoeducational psychotherapy and, if that is rejected, trying to have them attend advocacy-group-based support groups. If all these options are rejected, poor outcomes (hard knocks) may be the only source of education left.

In the case of unipolar depression, many patients resist treatment owing to what has been called "psychopharmacologic Calvinism." As H. L. Mencken, the literary critic, once said, "Puritanism is the haunting fear that someone, somewhere, may be happy." Applied here, it reflects our cultural bias against using drugs in general but also against using psychotropic drugs, in particular, *so as to be happy.* Now, this cultural Calvinism is not absolute; some of us are Calvinists, and some of us are pill poppers, all too eager to search for a pill for every problem. But the issue here is that many of the persons who refuse to acknowledge and get treatment for clinical depression are psychopharmacologic Calvinists. In such cases, it might be useful to enter into psychotherapy with a therapist who understands the nosology of mood disorders and appreciates the utility of psychopharmacology. Just as in the preceding scenario with bipolar disorder, this kind of therapist would engage in a gradual and sensitive long-term psychoeducation whereby the patient eventually might drop some of his or her Calvinist biases. Although many psychotherapists these days are open to psychopharmacology, many are not, and there has been a tradition of resistance to that horrid "medical model" among some psychology and social work circles. Thus it is important to try to have psychotherapy conducted by a person who is open to medical approaches to depression. If the patient refuses medications and refuses psychotherapy, again, support groups may be recommended as the least threatening (and cheapest) alternative. If even this option is rejected, one is again left with the school of hard knocks, with all the unavoidable risks that are entailed.

HOW TO USE BOOKS AND THE INTERNET

Patients and families need to educate themselves about mood disorders. Books and the Internet are valuable potential resources, although one has to sift through much junk to find helpful material. In Table 26.1 (and in Appendix C) I provide the list of books and websites that I currently hand out to all my patients. I have chosen the websites that I find reliable and useful for mood disorders in particular and recent books written for the general public that I find to be solid in their content.

Regarding the Internet in general, I would mostly recommend against reading much material from chat rooms; those sites tend to encourage comments from the most voluble and motivated persons, who are often persons who have had either extreme reactions to treatments or have extreme opinions. I also recommend against any website with an agenda;

TABLE 26.1. Books and Websites List for Patients and Families

Books

Ghaemi N. *Mood Disorders: A Practical Guide, Second Edition* Philadelphia: Lipincott–Williams & Wilkins; 2008.

Phelps J. *Why Am I Still Depressed?* New York: McGraw-Hill; 2006.

Oliwenstein L. *Taming Bipolar Disorder.* New York: Penguin; 2005.

McManamy J. *Living Well with Bipolar Disorder and Depression.* New York: HarperCollins; 2006.

Websites

www.mcmanweb.com A great website by John McManamy, a writer who has bipolar illness, on depression and bipolar disorder.

www.psycheducation.org—This is a great educational resource run by Dr. Jim Phelps, an active clinician with experience in bipolar disorder.

www.mhsource.com This is a very good website run by a company named CME, Inc., which is highly regarded in medical education.

www.bipolarworld.net This is a website with good educational information and useful links to other relevant websites.

www.dbsalliance.org This is the website of the depressive and bipolar support alliance. It can help you find local support groups.

www.nami.org This is the website of the National Alliance for the Mentally Ill. It can help you find local support groups.

patients and families should seek mainstream middle-of-the-road sites for basic information. Overall, the amount of content that is scientifically valid is higher on those websites. They should not take anything as true just because it is on a website, however. They might want to print out web pages with material of concern to discuss with their clinicians.

Regarding books in general, since I have begun to work as a book author recently more so than as a writer for scientific journal articles, I have been impressed by the fact that, unlike scientific journal articles, there is little, if any, peer review of most books that are published. In other words, if I want to publish a scientific journal article, I know that whatever I write will be read by usually three anonymous scientists who are qualified to assess my material; if they find that my article is off-base or wrong in certain ways or poorly substantiated, they will reject it, and the editor of the journal will refuse to publish it. In contrast, as a book author, I can write more or less whatever I want, and commercial publishers in particular will assess the content mainly in terms of whether it will sell books. Whether or not the content is scientifically valid or true is less relevant. This is why so many popular books range widely in all kinds of extreme directions of opinion. Some people lend a false sense of validity to the printed word; especially in a book, it seems that if it was published between two hard covers, it must be right. My point here for families and patients is that books are no more reliable in general than Internet websites, and thus one should expect much junk, and one should read with a skeptical eye. Nonetheless, scientifically solid and clinically sound books often are written for the general public, and they should be given much more attention, whereas sensationalist tracts should be ignored as much as possible. The old adage may wisely apply here: *Believe none of what you hear and only half of what you see.*

TIP

Books and Internet websites are invaluable resources, but *caveat emptor!* Most of the material is junk that deserves to be ignored; look for the good books and websites that will provide excellent educational material.

NONVIOLENT RESISTANCE: REDUCE EXPRESSED EMOTION

There is much research now in bipolar disorder that patients do worse if there is a lot of argument and verbal fighting in their households. This is called *expressed emotion,* the extent to which families are yelling and conflicting with each other in an aggressive manner.

Despite the fact that it is part of the nature of mood disorders that such persons tend to be irritable or down or hyper and otherwise difficult to tolerate, family members in particular should remember that the best response, when in doubt, is no response. If given the option of fighting or retreating, it is best to retreat.

In fact, it may be best to use nonviolent methods of interactions with others, methods that have proven effective in society at large and that should be just as effective in society at small—in families and in the interpersonal relations of our private lives.

In this respect, irrespective of one's religious beliefs or disbeliefs, I would recommend listening to the sermons of Martin Luther King, Jr. (such as the collection *A Knock at Midnight*). There, we see a psychologically sound approach to interacting with other human beings who are difficult; in the case of Dr. King's adversaries, the problem was racism; in the case of Mahatma Gandhi, the problem was colonialism; but in principle, any kind of conflict can be addressed with their nonviolent methods. For families and patients who adhere to Christianity, this approach in fact may dovetail nicely with cultural and religious values that they already accept

Here is the crux of the nonviolent approach: Love your enemies. Now, the patient is not the enemy of the family, so this should be even easier. The key is to know that any adversary in life, anyone who conflicts with me, is someone I should love. My natural reaction is to fight; if someone is aggressive with me and yells at me, I want to fight back. In our society, we usually fight back verbally rather than physically, but violent words are little better than violent fists.

TIP

Verbal violence is little better than physical violence.

High expressed emotion means "verbal violence." Here is an example: The patient is irritable and angry toward his mother:

"You and everyone else here in this family are a bunch of hypocrites! You just want to control me. You want me to take these drugs to control my mind. You don't want me to be successful in life. You never have. I don't want to be a failure like you!"

His mother thinks about all the hospitalizations and all the lost years: "Jimmy, I can't believe you still talk like that!! You have never been able to hold a job or get through college because of your illness. Can't you see that? If you don't do something about it, you'll ruin the rest of our lives as well as your own!"

Now what the mother says here is true, but it is verbally violent. She responded with the same emotional tone and with the same defensiveness as did the patient. If her goal is to state the truth, she did so. If her goal is to convince the patient to change his mind, she failed.

There are three options (whether in politics or in families): violent resistance, nonviolent resistance, and acquiescence. Resistance of any kind is preferable to acquiescence, which in the case of mental illness is simply a form of enabling: If the family simply gives up on trying to get help for the patient or accepts the patient's wrong opinions, then the family is harming the patient. But violent resistance usually fails to achieve its goals.

KEY POINT

There are three options for interacting with a family member who has a mood disorder and is behaviorally difficult: violent resistance, nonviolent resistance, and acquiescence. Acquiescence is enabling, and violent resistance worsens the illness; only nonviolent resistance based on loving goodwill can help the patient.

What is the nonviolent resistance option? One begins by loving the patient; this means always searching for what is right and acceptable in what the patient believes or says. *Loving* your enemies, as Dr. King points out, is not about actually *being in love* with the other person (the Greeks called this *eros*), nor is it about even *liking* that person (the Greeks called this *philia*). It is about having goodwill toward that person (the Greeks called this *agape*). Despite hate, anger, harm, and spite—the reaction should be one of goodwill, of seeking to appreciate the good aspects of that person, and of trying to see those things from that other person's point of view that might be valid. Dr. King says that this kind of goodwill is *redemptive;*

simply by treating the other person in this manner, he or she can come to change his or her behavior and beliefs.

Recall, though, that one is still engaging in resistance; this goodwill does not imply acquiescence. One can still disagree with the other person, one can point out why and what aspects of their beliefs or behaviors are wrong, but at the same time one agrees with whatever can be agreed on, and one never develops any personal hatred toward that other person. One loves the sinner while hating the sin, as Dr. King put it.

Thus how could the mother have responded as if she were walking on the march from Selma to Montgomery? Perhaps thus: "Jimmy, I know it must be hard on you. The drugs do control your mind, and they would mine too, and anyone else's. But the point is that in some ways they might make your mind function better so that you could work and go to college and be successful as you and we wish you would. You have a good mind; let's make it stronger."

Now, obviously, this kind of reaction can't be rehearsed, and it might not be easy to think up on the spot, and we are all human beings: We get angry and anxious and respond instinctively to anger with anger. But the point of the nonviolent method is not that it is natural or easy. It is exactly the opposite—difficult, drawn out, and the result of long effort and practice.

This is the hard task for families—to continue to love the person with the illness while at the same time patiently guiding them toward treatment.