

Effect of Marriage on Clinical Outcome of Persons with Bipolar Affective Disorder: A Case-control Study

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Abstract

Background: Whether marriage can cure mental illness has been a topic of discussion since many years. Marriage can impact on either way on a person's life. Often, mental health professionals are faced with having to give advice regarding the marriage of a person suffering from bipolar disorder. There is a belief in the community that marriage is a solution to all the mental illness.

Aim: To know the impact of marriage on clinical outcome of persons with bipolar affective disorder.

Materials and Methods: A total of 55 case subjects who got married whilst under treatment, and who fulfilled the selection criteria (bipolar affective disorder- ICD-10 Criteria for Research) were selected consecutively. Similarly, 55 patients who are never married were selected as control subjects. Brief psychiatric rating scale (BPRS) was used to find out the clinical outcome of patients. Data were collected over a period of one and a ½ year. The study was started after taking approval from institute ethical committee. The analysis was done using Chi-square test.

Observations and Results: It was found that in comparison to never married bipolar controls (23.6%) more than double number (52.7%) of married cases were having a longer duration of illness (>5 years). There were more episodes (3 to 5) in married subjects 41.8% as compared to never married subjects (20%). BPRS mean scores showed that there was no significant difference in the severity of mental illness among married and unmarried subjects.

Conclusion: Married persons had experienced more episodes of illness and for longer duration. Males are more prone for illness than females in both groups (married and never married). Marriage did not influence the severity of illness in persons with bipolar affective disorder.

Key words: Bipolar affective disorder, Brief psychiatric rating scale, Marriage

INTRODUCTION

Marriage has been, since ancient times, one of the most important social institutions in human society. Whether marriage can cure mental illness has been a topic of discussion since many years. The relationship between marriage and mental illness is very complicated matter. A happy marriage may provide substantial emotional

benefits. It can improve physical health, by reducing the toll stress, depression, and other mental health problems can take on physical well-being. On the other hand, marriage can theoretically impose some harm on the mental health of a person; many studies found that there is high percentage of marital discord, separation and divorce among psychiatric patients than in the general population.^{1,2}

Bipolar disorder is defined as an affective disorder characterized by the occurrence of alternating mania, hypomania, or mixed episodes and with major depressive episodes. The manual of mental disorders specifies the commonly observed patterns of Bipolar I and Bipolar II disorder and cyclothymia. About 4% of people suffer from bipolar disorder. Mania is the defining feature of bipolar

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disorder. Mania is a distinct period of elevated or irritable mood, which can take the form of euphoria, and lasts for at least a week. Hypomania is mild to moderate level of elevated mood. Depression is the other extreme to mania. The patient feels sad, may cry a lot, has a sense of being worthless, energy levels are extremely low, there is loss of pleasure and sleep problems.^{3,4}

Often, mental health professionals are faced with having to give advice regarding the marriage of a person suffering from bipolar disorder. There is a belief in the community that marriage is a solution to all the mental illness. In our country, there is paucity of studies regarding this matter. Considering the magnitude of the problem, such studies can be of vital importance in giving advice to the patients and relatives for marriage. This study is an honest effort in this regards. At the end of the study, we will know the impact of marriage on clinical outcome of persons with bipolar affective disorder.⁵

MATERIALS AND METHODS

Sample Selection

The study was conducted in the psychiatry outpatient and inpatient settings of a AVBR Hospital. A total of 55 case subjects who got married whilst under treatment (the decision of marriage was of either family members or the patient him or herself), and who fulfilled the selection criteria (bipolar affective disorder- ICD-10 Criteria for research) were selected consecutively. Similarly, 55 patients who are never married were selected as control subjects. The inclusion criteria were patients of either sex, patients who fulfill diagnostic criteria for bipolar affective disorder (ICD-10 Criteria for research), those patients or accompanying relatives willing to give written informed consent for participation in study. The exclusion criteria were patients having co-morbid physical or other psychiatric disorders and where informants were not able to communicate verbally.

Data Collection

Over a period of one and a ½ year (between January 2012 and June 2013), the persons with bipolar affective disorder both married and unmarried attending psychiatry OPD or being admitted in psychiatry ward were interviewed. Patients were interviewed during the period of partial remission and complete remission. While interviewing the patient in partial remission, the assistance of primary caretaker was sort. The data were collected on a semi-structured proforma to obtain the details of socio-demographic profile, history of patient's illness, mental status examination using brief psychiatry rating scale (Overall and Gorham, 1962).⁶

This proforma was used to collect socio-demographic details of the patients (both married and unmarried). It included name, occupation, education, address, details of informant, diagnosis, duration of illness, relapse, past history, family history, family structure and additional information regarding marriage and divorce of cases. The brief psychiatric rating scale (BPRS) is rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations, and unusual behavior. Developed by Overall and Gorham (1962),⁶ it is probably the most widely used rating scale in psychiatry. This scale is the one of the oldest scales to measure psychotic symptoms and was first published in 1962. It has been in use since then for rating patient behaviors and symptoms. The BPRS is comprised 24 items that can be rated from not present (1) to extremely severe.⁷

- 1 - Not present
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Moderately severe
- 6 - Severe
- 7 - Extremely severe.

A total pathology score can be obtained by adding the scores from each item and sub-scores can be derived by adding scores on specific items together. It evaluates patients on the basis of symptoms they've had in a specified time frame. 24 items in the scale are somatic concern, anxiety, depression, suicidality, guilt, hostility, elated mood, grandiosity, suspiciousness, hallucinations, unusual thought content, bizarre behavior, self-neglect, disorientation, conceptual disorganization, blunted affect, emotional withdrawal, motor retardation, tension, uncooperativeness, excitement, distractibility, motor hyperactivity, mannerisms, and posturing. The subject is rated on the basis of observations, the subject's self-report, and, for some items, information obtained from collateral sources. This scale has been widely used in variety of settings in different countries.^{3,4} the study done for clinical implications of BPRS scores by Leucht *et al.*⁵ found that 'mildly ill' according to the clinical global impression (CGI) approximately corresponded to a BPRS total score of 31, "moderately ill" to a BPRS score of 41 and "markedly ill" to a BPRS score of 53. "Minimally improved" according to the CGI score was associated with percentage BPRS reductions of 24%, 27% and 30% at weeks 1, 2 and 4, respectively.

Ethical Considerations

The study was started after taking approval from Institute Ethics Committee for Research on Human Subjects. Throughout the study, ethical considerations were followed strictly. Confidentiality was ensured.

Statistical Analysis

The data were collected and entries were done using SPSS version 17 software. The analysis was studied using Chi-square test. Statistically significant $P < 0.05$ was considered statistically significant.

RESULTS

We interviewed 110 persons with diagnosis of bipolar affective disorder, half of them were married (cases) and rest (controls) were never married. Data were obtained from both in patients and out patients.

Table 1 shows the data of the socio-demographic characteristics, viz., age, sex, education, and occupation of cases and controls. Out of these, there are differences in the results of education and occupation which is statistically significant.

Table 2 shows the clinical profile of cases and controls. In comparison to never married bipolar controls (23.6%)

Table 1: Socio-demographic characteristics of the cases and controls

Variables	Cases (N=55) (%)	Controls (N=55) (%)	P value
Age (years)			
≤30	1 (1.8)	36 (65.5)	0.46 NS, $P > 0.05$
>30	54 (98.2)	19 (34.5)	
Sex			
Male	29 (52.7)	29 (52.7)	1.00 NS, $P > 0.05$
Female	26 (47.3)	26 (47.3)	
Education			
Illiterate	11 (20)	4 (7.3)	0.003 S, $P < 0.05$
<10 th standard	32 (58.2)	23 (41.8)	
>10 th standard	12 (21.8)	28 (50.9)	
Occupation			
Jobless	0 (0)	7 (12.7)	$P < 0.0001$ S
Farmer	20 (36.4)	20 (36.4)	
Housewife	17 (30.9)	-	
Job/Business	18 (32.7)	18 (32.7)	
Student	0 (0)	10 (18.2)	

NS: Not significant, S: Significant

Table 2: Clinical profile of cases and controls

Variables	Cases (N=55) (%)	Controls (N=55) (%)	P value
Duration of illness			
Up to 2 years	12 (21.8)	21 (38.2)	0.006 S, $P < 0.05$
2-5 years	14 (25.5)	21 (38.2)	
>5 years	29 (52.7)	13 (23.6)	
Total no of episodes			
Upto 3	24 (43.6)	38 (69.1)	0.021 S, $P < 0.05$
3 to 5	23 (41.8)	11 (20)	
>5	8 (14.5)	6 (10.9)	

S: Significant

more than double number (52.7%) of married cases were having longer duration of illness (>5 years) and the findings are statistically significant. There were more episodes (3 to 5) in married subjects 41.8% as compared to never married subjects (20%). Married bipolar patients had more episodes (between 3-5 and more than 5) as compared to other group.

Figure 1 shows that maximum number of never married bipolar patients (38) had suffered up to 3 episodes and the figures gradually decrease for case group category, i.e., married, 22 patients; widowed, 19 patients; and divorced, 7 patients. It seems that marriage is a protective factor from the illness.

In addition to this, the majority of those patients having more than 5 episodes of illness belonged to control group (6 patients). It again shows that marriage is a protecting factor from the illness.

Figure 2 shows assessment of difference in mean of cases and controls using brief psychiatry rating scale, but the difference is statistically non-significant. It shows that there

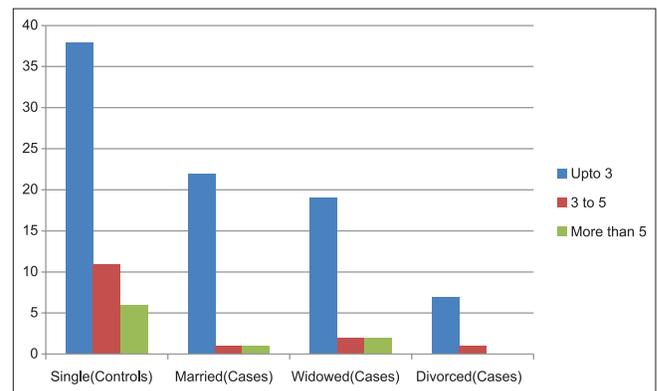


Figure 1: Marital status and number of episodes

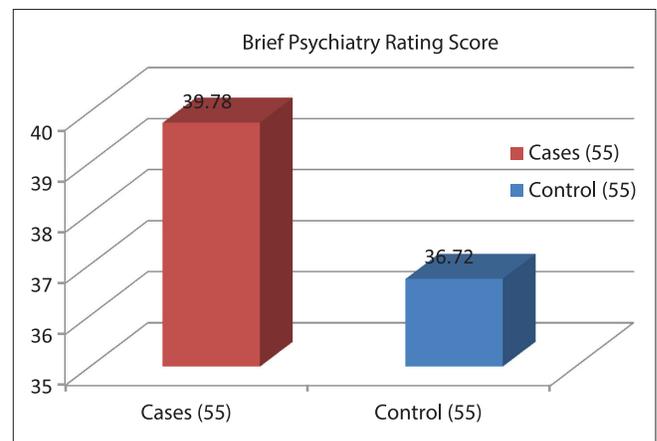


Figure 2: Brief psychiatry rating scale score in case and control group

was no significant difference in the severity of mental illness among married and unmarried subjects.

DISCUSSION

Marriage and mental illness have always been a complicated matter, and it usually makes many people think about the relationship between the same. It is a general assumption that marriage can treat certain mental illnesses, because it is considered as providing a support system which can help people to overcome stresses of their life. Marriage demands a sustained level of adaptation and may induce more stress.⁷

Among the several mental illnesses, bipolar affective disorder is a disorder which occurs in the age group in which people plan to marry. Mental disorders and problems in marriage are related to one another but the sequence is still unclear. Most of the psychiatrists are asked to give suggestions about the marriage of bipolar affective disorder whether the patient should marry after the recovery of illness, or during the illness to get cured or never get married. However, there is no factual evidence to support whether a bipolar disorder patient should marry or not. The answers to most queries are not clear because of limited studies regarding marriage and mental illness. Considering the magnitude of the problem this study was carried out to provide some light to the questions of patients and family members.

There are not many studies in this area; in fact, this is a first of its kind studying the effect of marriage on bipolar affective disorder. However, there are a number of studies done on other areas of mental illness like schizophrenia, depression and anxiety disorder so we would be comparing the study findings in bipolar affective disorder with the findings of the former studies.

In this study, we tried to find out the number of episodes among married and never married bipolar disorder patients. We also tried to compare the severity of illness among married and never married persons with bipolar affective disorder.

First, an attempt was made to assess the demographic characteristics of the subjects under study. In the cases, 98.2% of subjects were above 30 years and in controls 65.5% of subjects were in the age group of <30 years, and the rest were more than 30 years of age. The two groups did not differ significantly with respect to age. Males predominated in both groups. Overall bipolar disorder is equally prevalent in men and women. It is possible that females might not have been brought for help due to stigma. Stigma also acts as a powerful barrier to treatment

not only because of the fear of being labeled as mentally ill but also because too often mental health professionals and mental health services as a whole hold, in a subtle way, negative or rejecting attitudes toward users and perpetuate practices fostering segregation, dependency, and powerlessness (Deegan, 1990).⁸ This may have contributed to the higher number of male subjects in the study. There was no significant difference in gender distribution between the two groups. The education level of control subjects was comparatively higher than married subjects. In the education subgroup, more number of cases were illiterate (20%) while approximately 50% of never married subjects were educated more than 10th standard. There was statistically significant difference in literacy rate among the married group and the never married group.

Majority of the subjects included in the study were either farmers/daily laborers (72.4%). Considering that the majority of the subjects were from the rural areas, as farming is the main profession in rural areas, thus this finding can be explained. However, in the case group, there were housewives, which constitutes 30.9% of the total case lot, which cannot be present in never married control group. Similarly, in control group, there was 18.2% of students which was not seen in the case group. These differences in the occupational status might have led to a significant difference in statistics.

In the comparison of number of episodes among married and never married bipolar patients, we found that there were more episodes (3 to 5) in married subjects 41.8% as compared to never married subjects (20%). We observed that married bipolar patients had more episodes (between 3 to 5 and more than 5) as compared to other group. In a study regarding life event and social support in married schizophrenics by Kulhara *et al.* (1998)⁹ also reported that life events are associated with relapses in schizophrenia, and the married group had higher stress score and greater number of undesirable life events, so our findings are in concordance with their findings that marriage and the related life events can act as stressors for the relapse or maintenance of illness.

In our study, it was found that mean scores of brief psychiatry rating scale in case subjects were 39.78 while in control subjects it was 36.72. It shows that there was no significant difference in the severity of mental illness among married and unmarried subjects. The results are in line with earlier study by Verma and Behere (2011)¹⁰ which showed similar results.

Limitations of the Study

- Small sample size
- Interviews were carried out once during the study and

cases were not followed up afterward. Longitudinal studies would have been better than cross-sectional studies

- It was a retrospective study. A prospective study would have been much better.

CONCLUSION

The relationship between marriage and its effect on bipolar affective disorder and vice versa is still unclear from available literature.

We conclude from this study that married persons had experienced more episodes of illness and for longer duration. Males are more prone for illness than females in both groups (married and never married). Marriage did not influence the severity of illness in persons with bipolar affective disorder. We have finally discussed the limitations of this study.

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