

Running Head: FAMILIAL DYNAMICS AND BIPOLAR DISORDER

Familial Dynamics that Contribute to the Development of Bipolar Disorder

Rebecca Chaney

Professor Oler

PSYC 1A Introduction to Psychology, M, W 8:10-9:30 a.m.

Gavilan College

April 27, 2008

Why I Chose to Write on My Topic

My choice of bipolar disorder stems from my experience with the disorder in my personal life. I was raised in a healthy family environment with an abundance of stability. My family environment had very little conflict and my parents were attentive to my health and well being. I was never exposed to mental illness in my family. My parents never spoke about people with mental illness and I knew very little about the different types of disorders. Against my parent's wishes, I married my high school boyfriend at eighteen.

He came from a very dysfunctional family and his mother suffered from extreme depression. In addition to his mother's illness, his father was also severely depressed. His parents had divorced several years earlier but both still suffered from depression. He had little contact with his father which left his mother the primary caregiver for three boys. His mother's depression prevented her from providing for the boys. Often times the boys had no food or running water.

He was always a very moody person and could go from one extreme to the next. My family disliked him for the moodiness; however, I grew accustomed to it. Unfortunately, most of his employers had issues dealing with his hot temper. His temper would usually flare up after a couple of months on a job and he would be terminated because of it. The loss of jobs would drive him into a deep depression that would last for months at a time. During the months when he wasn't depressed, he would spend days and nights working on projects, never stopping to sleep. One morning I awoke to find our entire garage painted with elaborate murals.

During a time when he was depressed, I was away on business for a week. When I returned from my trip, I discovered that he had never moved from the bed. He had been unable to feed and supervise our two children. The boy's, six and seven, had prepared their own meals and tried to take care of their father. Needless to say, the entire house was in shambles. I rarely traveled for work after that incident, and on the rare occasions that I needed to, I left the boys in the care of my mother.

Throughout the course of our sixteen year marriage the ups and downs became increasingly severe. During the last few years of our marriage he developed a drug problem which created even worse mood swings. After two failed rehabilitation efforts, I decided it was in my best interest to file for divorce. During his rehabilitation, it was determined that he had manic depressive disorder and was in severe need of medication for stabilization. He refused to accept this diagnosis and wouldn't take any medication. When he was diagnosed with manic depression it put the last sixteen years into perspective.

I am not writing about bipolar disorder in an attempt to explain or understand my past. I am writing about bipolar disorder to better understand my oldest son and become better informed about bipolar disorder. I have noticed my oldest son showing some of the same behavior that his father did. I want to help my son get treatment, if needed, early in his life. If my son has bipolar disorder, I do not want him to suffer throughout his life like his father did.

What the Research Says About My Topic

Familial dynamics, including environment, expressed emotions, and stressful life events, appear to be a contributing factor in the development of bipolar disorder. A cohesive and loving

family environment appears to be a key element in the mental health of a person. It is understandable that an individual brought up in a home with conflict and family stress would be more prone to developing bipolar disorder in addition to familial loading for the disorder. Familial loading for bipolar disorder, in itself, is a predictor for the disorder, but dysfunction in the family setting may have more effect on when, if ever, the illness actually presents.

In Freud's psychoanalytic theory it seems as if individuals are impacted unconsciously by their past life experiences. It is no wonder why the research shows a high probability for bipolar disorder to run in families. A large amount of research on bipolar disorder indicates that family interactions often contribute to the actual on-set and recurrence of bipolar disorder. This research paper will substantiate several different areas in which familial dynamics contribute to the development of bipolar disorder. Additionally, I will review the need for more "family focused" treatment in combination with pharmaceutical treatment.

According to a study by Morris, Miklowitz, and Waxmonsky (2007), bipolar disorder afflicts 3 to 5% of the population with the initial onset in 15 to 18% of patients before the age of 13 years, and between 50 and 66% before the age of 19 years. Individuals with bipolar disorder face a lifetime risk for mood variations, often with devastating-even fatal-consequences. "It is the sixth most common cause of disability in the United States" (Leahy, 2007, p. 418).

The World Health Organization (WHO) in its 1999 annual report listed mood disorders as one of the most common causes of morbidity and mortality in developed countries. A recent U.S. survey using the Mood Disorders Questionnaire suggests that the prevalence of bipolar disorder may be higher than previously estimated. The results of the community-based survey found that 3.7% of 125,000 adults screened probably had bipolar I or II disorder. "In the United

States alone, bipolar disorder illness accounts for more than 16 million outpatient physician visits each year” (as cited in Ogilvie, Morant, & Goodwin, 2005, p. 27).

Diagnosing bipolar disorder in people presents its own challenges. Bipolar disorder consists of various mixed states. Medical professionals need to know the various mixed states a person is experiencing in order to accurately diagnose a person with bipolar disorder. The various states associated with bipolar disorder are manic, depressive, hypomania, and manic symptoms. The manic state is characterized by increased energy, creativity, and euphoria. The hypomania state is similar to manic but the symptoms are not as severe. People in the hypomania state are able to carry on with their normal lives and simply appear to be in an unusually good mood. During the manic depressive state a person might experience low energy, sadness, and fatigue. The manic depressive state can also cause problems with appetite and concentration (Elgie & Morselli, 2007).

Quality of life can be negatively impacted for people that suffer from bipolar disorder. People with bipolar disorder often have lower wages, higher unemployment, work absenteeism, reliance on workmen’s compensation, higher rates of divorce, lower levels of educational attainment, higher arrest rates, and hospitalization (Leahy, 2007). In bipolar disorder individuals, the loss of social functioning takes a considerable toll on caregivers and families that, in turn, can adversely affect the clinical outcome for patients. The families of bipolar disorder individuals become more secluded because of misinformation about the disorder, and develop resentment towards the bipolar disorder individual because of the increased burden on the families.

It was indicated in a study by Elgie and Morselli (2007) that the relationship with the family appears to be severely and adversely affected in most bipolar disorder cases. The

family's hostile attitude is often due to misinformation and a lack of understanding about bipolar disorder. Stigma surrounding bipolar disorder, delay in correct diagnosis, and high levels of unemployment were reported by many respondents in their study (Elgie & Marselli, 2007).

There is considerable evidence that life events, coping skills, and family environment contribute to the expression of manic and depressive disorders. Bipolar disorder is not only exacerbated by negative life events (e.g., loss of job or relationship), but also may cause these life events. Family context and conflict emerged as particularly problematic in patients with bipolar disorder. Familial dynamics do contribute to bipolar disorder.

The attitudes and emotions of families appear to have a significant roll in the initial onset and reoccurrence of bipolar disorder (Leahy, 2007, p. 423).

Affective attitudes, known as expressed emotion, or expressed emotion, focus on high levels of criticism, hostility, and/or emotional over-involvement displayed by family members toward a psychiatric individual. According to research by Goldstein, Miklowitz, and Richards (2002) in their paper on expressed emotion, it was shown that expressed emotion is a reliable predictor of relapse among bipolar disorder individuals. Goldstein et al. (2002) supports the findings of Miklowitz et al, 1988 that demonstrated the link between expressed emotion attitudes among parents and increased rates of relapse among bipolar individuals. They state that many other studies have concluded the same, that poorer outcomes are characteristic of bipolar disorder individuals in high-expressed emotions environments (Goldstein et al., 2002).

Rosenfarb, Miklowitz, Goldstein, Harmon, Nuechterlein, and Rea (2001) examined whether bipolar disorder symptoms and relatives' affective behavior, when expressed during

directly observed family interactions, are associated with the short-term course of bipolar disorder. The Rosenfarb et al. (2001) study found that bipolar patients had a higher incidence of relapse in high expressed emotion environments versus low expressed emotion environments. The emotional attitudes of a bipolar disorder patient's family do have an impact on bipolar disorder and a low expressed emotion family environment is more likely to help prevent future episodes of bipolar disorder.

In a study by Romero, Delbello, Soutullo, Stanford, and Strakowski (2005) on family environment in families with parental bipolar disorder versus families without parental bipolar disorder, it was hypothesized that children of a parent with bipolar disorder would be at higher risk of developing bipolar disorder than that of the general population. The objective of their experiment was to compare family environmental characteristics of families with at least one bipolar parent and families with parents without bipolar disorder. The family participants were recruited as part of the Cincinnati High-Risk Bipolar Study. The study recruited two groups of children (ages 8-12) based on their parents' psychiatric status. The study used 24 families with at least one parent with bipolar disorder and 27 families with healthy parents (healthy families). The families were assessed using the Family Environment Scale (FES). The FES scores were compared between bipolar disorder and healthy families. They also compared FES normal scores with scores of bipolar disorder families. Of the 24 bipolar disorder families, 17 of these families had at least one child with a mood disorder, compared to the healthy families with only one of their offspring having a mood disorder. Eleven of the 24 bipolar disorder families had both parents with a mood disorder, and 13 families had only one parent with bipolar disorder. The results from this study showed that bipolar disorder families scored much lower on family

cohesion and expressiveness. The cohesion scores indicate the degree of commitment, help, and support family members provide for one another. “A cohesive family can positively influence cognitive and emotional development. This study showed that lower family cohesion and expressiveness did have an impact on the onset of bipolar disorder in children” (Romero et al., 2005, pp. 619-620).

Again, it appears as if family environment is a key contributor in the onset of bipolar disorder and the presence of family bipolar disorder loading in combination with lower family cohesion increases the chances of the development of bipolar disorder. Since family environments do have a significant effect on the onset of bipolar disorder, what types of familial environmental characteristics have the most significance in the development of bipolar disorder? In a study from Chang, Blasey, Ketter, and Steiner (2001), it was stated that the familial transmission of bipolar disorder has been well established by pedigree analyses and twin studies. Since the bipolar disorder concordance rate in identical twins did not approach 100%, it was proposed that bipolar disorder develops in a child with a genetic predisposition in response to external stressors. A formative entity in a child’s development is the family environment, which may provide both protective factors, as well as act as an external stressor.

Evidence suggests that having a psychiatrically ill parent will increase a child’s chance of having psychopathology. A child with a bipolar disorder parent who becomes psychotic, dysfunctional, neglectful, or absent would be a powerful influence on a child’s development. Chang and his colleagues found that families with a bipolar parent reported significant differences in their family environments as compared to families without a bipolar disorder parent. The differences were less cohesion and organization, and more conflict and control. The

bipolar disorder families also reported less independence and achievement orientation. (Chang et al., 2001). Chang et al. (2001) stated that they were not surprised by the findings because of the chaotic and debilitating nature of bipolar disorder. Another interesting find in this study was that the bipolar disorder families scored higher than the non-bipolar disorder families in intellectual and cultural orientation. They further state that a link seems to exist between bipolar disorder and creativity, with many musicians, artists, and writers having been historically or currently diagnosed with bipolar disorder. “The higher intellectual-cultural orientation may be due to the theory that bipolar disorder causes increased creativity but also that the higher scores could be attributed to the fact that the study was conducted in the San Francisco area, where people have more access to cultural activities” (Chang et al., 2001, p. 76).

A study by Petti, Reich, Todd, Joshi, Galvin, Reich, DePaulo, and Nurnberger (2004) looked at the frequency of risk related variables for developing an affective disorder using a within-pedigree control group. Their study sought to determine the effect of life events, social relationships, self-perceived competence, and aspects of home environment for the children from extended families with loading for bipolar disorder. This study used juvenile offspring and their parents from 14 bipolar disorder families and consisted of 50 children. Structured interviews and self or parent reported instruments were used to compare offspring with an affected first-degree relative to those without and to compare offspring with or without an affective disorder. The results of the study found only one significant psychosocial difference between offspring with or without a parent with an affective disorder but several differences were found between offspring who themselves did or did not have an affective disorder. The differences were in the areas of the need for discipline, social support, and dependent negative life events. Based on the results of

this study, one would conclude that bipolar disorder family environments lack in adequate direction and support for their children (Petti et al., 2004).

In conclusion, the familial dynamics that contribute to bipolar disorder are the expressed emotions of family members towards each other in combination with familial loading for bipolar disorder (Rosenfarb et al., 2001). Through my research I have found that the presence of bipolar disorder is genetic but the onset of the disorder is related to ones family environment. A family environment containing a parent with bipolar disorder is a large predictor for whether or not the genetic predisposition for bipolar disorder will occur. A parent suffering from bipolar disorder would create a very chaotic and unstable environment for their offspring. The chaos and overall lack of stability would cause emotional distress for a child (Rosenfarb et al., 2001).

Emotional stress and lack of support seem to be a major contributor to the onset and reoccurrence of bipolar disorder. People that suffer from bipolar disorder tend to create their own problems by virtue of the disorder. Bipolar disorder places added burdens on family and caregivers because of emotional strain and often times financial difficulties (Elgie & Morselli, 2007). The financial difficulties are caused when the bipolar disorder individual is unable to work because of the disorder. The burden of bipolar disorder on the family is often expressed through negative feelings about the individual with bipolar disorder. The families often feel that the family member suffering from bipolar disorder has the ability to control the illness but chooses not to (Elgie & Morselli, 2007). This hostile attitude towards the bipolar disorder family member can sometimes cause the bipolar disorder family member to become worse. Today there is no cure for bipolar disorder, but people suffering from bipolar disorder can lead a normal life through pharmaceutical and family therapy. A warm and supportive family environment seems

To be one of the most effective ways to prevent and treat bipolar disorder.

What I Learned Personally, Interpersonally and Professionally

I learned personally that people with bipolar disorder do not have control over their actions. I learned that the illness does control the person and without treatment they have a high risk for suicide.

I learned that a person suffering from bipolar disorder needs compassion and understanding. I also learned that a person with bipolar needs the support of their friends and family.

I learned interpersonally that I should not ignore the warning signs in my oldest son. I learned that bipolar is a genetic disorder and that he could have the disorder.

I learned professionally that when a co-worker is having a bad day or bad attitude that it could be caused from a disorder. I learned that I should treat my fellow co-workers with understanding.

How I Plan to Apply What I Learned Personally, Interpersonally and Professionally

I plan to apply what I learned personally by understanding that people may not have as much control over their action as I thought they did. I plan to take into consideration that a person may be dealing with a mental illness when she or he behaves annoyingly, and not just being a mean person.

I plan to apply what I learned interpersonally by talking with my son about seeing a professional about his mood swings. I plan on using more forgiveness in my interactions with my boyfriend's uncle that suffers from bipolar disorder.

I plan to apply what I learned professionally by treating my difficult clients with more care. I plan to not let my boss's mood swings bother me so much, and to be more considerate of co-workers that suffer from depression.

References

- Chang, K., Blasey, C., Ketter, T., & Steiner, H. (2001, April). Family environment of children and adolescents with bipolar parents. *Bipolar Disorders*, 3(2), 73-78. Retrieved April 18, 2008, from MEDLINE database.
- Elgie, R., & Morselli, P. (2007, February). Social functioning in bipolar patients: the perception and perspective of patients, relatives and advocacy organizations – a review. *Bipolar Review*, 2(2), 144-157. Retrieved March 1, 2008, from MEDLINE database.
- Goldstein, T., Miklowitz, D., & Richards, J. (2002, Winter). Expressed emotion attitudes and individual psychopathology among the relatives of bipolar patients. *Family Process*, 41(4), 645-657. Retrieved February 24, 2008, from MEDLINE database.
- Leahy, R. (2007, May). Bipolar disorder: Causes, contexts, and treatments. *Journal of Counseling Psychology*, 63(5), 417-424. Retrieved March 1, 2008, from MEDLINE database.
- Morris, C., Miklowitz, D., & Waxmonsky, J. (2007) Family-focused treatment for bipolar disorder in adults and youth. *Journal of Clinical Psychology*, 63(5), 533-445. Published online in Wiley InterScience (www.interscience.wiley.com). DOI: 10.1002/jclp.20359.
- Ogilvie, A., Morant, N., & Goodwin, G. (2005). The burden on informal caregivers of people with bipolar disorder. *Journal of Psychopathology*, 7 (1), 25-32. Retrieved March 22, 2008, from MEDLINE database.
- Petti, T., Reich, W., Todd, R., Joshi, P., Galvin, M., & Reich, T. (2004, April). Psychosocial variables in children and teens of extended families identified through bipolar affective

disorder probands. *Bipolar Disorders*, 6(2), 106-114. Retrieved March 22, 2008, from MEDLINE database.

Romero, S., Delbello, M., Soutullo, C., Stanford, K., & Strakowski, S. (2005, December).

Family environment in families with versus families without parental bipolar disorder; a preliminary comparison study. *Mood Disorders*, 8(6), 617-622. Retrieved February 24, 2008, from MEDLINE database.

Rosenfarb, I., Miklowitz, D., Goldstein, M., Harmon, L., Nuechterlein, K., & Rea, M. (2001, Spring). Family transactions and relapse in bipolar disorder. *Family Process*, 40(1), 5-14. Retrieved February 24, 2008, from MEDLINE database.