Running head: BIPOLAR MOTHERS AND COLLEGE STUDENTS

Interpersonal Effects on College Age Children based on the Parenting Style in Mothers with Bipolar I Disorder

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Abstract

Bipolar Disorder is a socially crippling disease. Not only does it affect the one with the diagnosis, but it also affects the family through caregiver burden, particularly the children. Children of mothers with Bipolar Disorder encounter positive and negative effects from an upbringing by mothers with Bipolar I Disorder. Some symptoms of a mother's Bipolar Disorder influence the child's attachment style, coping mechanisms and sociability. A study was conducted testing how the parenting style of mothers with Bipolar I Disorder affected the college age students in their childhood and their current interpersonal experiences. A two part survey rated statements about close relationships and focused on those to whom the participants turned for social support and how satisfied the participants were with their social support. The response for students with mothers who have Bipolar I Disorder was significantly smaller than expected (n=3); however, the survey revealed a need for an integration and potential comparison of the prevalence of mothers with Bipolar I Disorder between secular and evangelical campuses. The survey raised awareness for stronger availability of social support satisfaction based on responses and an investigation of reasons for anxiety and a lack of personal security in relationships.

Interpersonal Effects on College Age Children based on the Parenting Style in Mothers with Bipolar I Disorder

Bipolar Disorder has an effect on the family as well as the person with the diagnosis. According to Attachment Theory, within mother-child relationships there are critical developmental needs early in childhood (Diehl, Elnick, Bourbeau and Labouvie-Vief, 1998). If these developmental needs are not met, the mother-child relationship will potentially positively or negatively affect the child's interpersonal skills through adulthood. Numerous studies exist with small samples sizes about general mentally ill patients, combining groups of schizophrenic, bipolar and unipolar patients; strictly Bipolar I Disorder samples are represented in fewer studies. Literature emphasizes caregiver burden within the mental illness populations. Limited research exists specifically focused on the caregiver burden of patients diagnosed with Bipolar Disorder. Articles center on young caregiver burden, described as the children caring for their parents with mental illness, yet few articles identify the parents with Bipolar Disorder. Specific articles on the effects of mothers with Bipolar Disorder and how their parenting styles affect the adult children are limited. Numerous authors cite positive outcomes for children with parents who have mental illness (Aldridge & Becker, 2003; Maybery, Ling, Szakacs, & Reupert, 2005), yet others cite negative cognitive and psychiatric effects on the children of parents with Bipolar Disorder (Donaldson, Goldstein, Landau, Raymont, & Frangou, 2003). Examination of Bipolar Disorder shows how the relationship between the mother with Bipolar Disorder and the child will affect the child's future relational needs.

Confounding variables

Potential confounding variables and issues arise, such as the expectation that college students will have an awareness of their mothers' treatments, students' involvement in the treatment and knowledge about the disorder, and families' religious views on mental illness treatment. Mentors, social support availability and involvement of parents and father figures will likely influence the effects or predictions of the adult child's interpersonal development.

Operational definitions

Adult children who were raised in homes by parents with mental illness have to live with the impact that their parents with mental illness had on their lives in various categories of development (Mowbray & Mowbray, 2006). Young caregivers are children who help the parent with mental illness by doing daily tasks or giving emotional and psychological support (Aldridge & Becker, 2003; Maybery et al., 2005). Caregivers are those who spend significant amounts of time during the day or week meeting the needs of the mentally ill individual. Caregivers are many times family members or friends (Elgie & Morselli, 2007).

Interpersonal development manifests itself in college through different avenues. Interpersonal skills involve communication, perception of relationships (Lee, Draper, & Lee, 2001), and attachment styles (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998). The student*s* often have developed coping mechanisms from different situations, based on past events which display themselves through behaviors in the present (Lee, Draper, & Lee, 2001).

Literature Review

Common Themes

There are significant themes in the literature concerning attachment, caregiver burden, family treatment options, coping mechanisms and social support. Attachment and the relationship with the mother or parent will develop in either positive or negative ways (Ainsworth 1994; Diehl, et al., 1998). General caregiver burden and misconceptions of health care professionals occur frequently (Chakrabarti & Gill, 2002; Elgie & Morselli, 2007; Ogilvie, Morant & Goodwin, 2005). Family members become involved in treatment (Simoneau, T. L., Miklowitz, D. J., Richards, J. A., Saleem, R., & George, E. L., 1999). Young caregivers of parents with a mental illness must handle parental responsibilities yet as children, still need to rely on relationships with parents and other social networks (Aldridge & Becker, 2003; Beardslee & Podoresfksy, 1988; Fudge & Mason, 2004; Maybery, et al., 2005). Coping mechanisms are exhibited in children with insecure attachment styles (Diehl, et al., 1998) and children of parents with mental illness display coping styles (Beardslee & Podoresfksy, 1988; Maybery, et al., 2005; Williams and Corrigan, 1992). Social support is important to a child's social adjustment and development if his or her parent has a mental illness (Lee, et al., 2001).

Attachment Theory

Attachment theory is defined as the study of the link between primary attachment interaction, usually between the mother and child, during early childhood and how this relationship sets the precedent for the child's development and later relational successes (Maybery, et al, 2005). Bowlby's *internal working model of close relationships* "is thought to affect the formation and maintenance of close relationships for the remainder

of an individual's life course" (Bowlby, 1988 as cited in Diehl, et al., 1998, p. 1656). Bowlby said that the internal working model "integrates basic beliefs about the self, others, and the social world in general" (Bowlby, 1973 as cited in Diehl, et al., 1998, p.1656). Mary Salter Ainsworth used the term "secure base" in her dissertation *An Evaluation of Adjustment Based on the Concept of Security,* to describe the "secure base" as the foundation or launch pad for the child, in her words, "forming new skills and interests in other fields" (as cited in Mikulincer and Shaver, 2007, p.8). Though the need for attachment does not increase over time until the breaking point, the "attachment behavioral system"(p.10) signals the need for assistance and "proximity" (p.10) from an *attachment figure* (p.11); this process, for an individual without secure attachment givers or a "secure base" (p.8), will encounter difficulties in attaining "set goals" (p.10) which can include any goal to fulfill any need. The individual can learn skills to comfort his self or herself since he or she was "comforted by caring attachment figures earlier in life" (p.12). This type of support is crucial in adulthood. Throughout life, in stressful situations "lack of access to an attachment figure" whether thought or actual access, "compounds distress and triggers the highest level of attachment-system activation" (p. 13). "Proximity seeking," whether to a physical figure or through "mental representations" (p.13) of past comforting allows the individual to calm his self or herself in stressful situations, to meet his or her own needs, or get accomplished what is necessary. When 'felt security' is acquired, "a person can devote attention to matters other than self-protection" (p.14) or survival, and at any time lack of 'felt security' will prompt this stressful process to repeat. Secure attachment is essential for an individual's interaction with his or her surrounding world. "Autonomy and relatedness" are "compatible"

meaning the individual's ability to explore and accomplish within the world is based on how he or she related to his or her attachment figures in early childhood (p.14).

Robert Marvin interviewed Mary D. S. Ainsworth about her three-category attachment theory of secure, anxious-ambivalent, and avoidant styles and how these early attachment behaviors affected individuals later in life. Through numerous studies, she formed her concepts of secure and insecure attachment. If a child forms an insecure attachment with his or her mother, another strong influential person can replace the insecure attachment. Normally, the mother will begin as the child's "secure base" (p. 7), to establish a safety point of exploring the world. Bowlby's studies displayed how the study of attachment "primarily" focused on the infant and mother relationship and how the mother became the "most influential attachment figure" in a child's life; this concept of "monotropy" is debated (Mikulincer and Shaver, 2007, p. 14). Bowlby saw a "hierarchy" of influences in the child's life though he did not focus the majority of his work on this concept (p. 15) since his focus was on a mother's influence; this concept illustrates how a community influence can impact a child. Ainsworth says, '"it is not attachment but the security of attachment that is affected by the mother's sensitivity"' (Ainsworth and Marvin, 1995, p.15), and that security is what influences the child's behavior. The way the mother responds to the baby's behavior, such as crying, decides if the attachment will be secure or insecure. Ainsworth found evidence that if the child was comfortable with the mother, he or she would branch out and form relationships with peer groups. If the child had an insecure relationship with his or her mother, the lack of socialization of the child by the mother could affect the child's later relationships. The socialization of the child is an indirect result of the attachment based on '"how sensitive a

mother is in introducing her baby to unfamiliar people"' or if the child is comfortable '"exploring his environment"' (p.18). Eventhough she specified that attachment does usually affect later adult relationships, "intimate" relationship analysis has the most documentation. There is hope that an originally insecure attachment with an initial attachment figure can be positively influenced by other relationships and, in effect, replace the insecure relationships with a healthy one (p.19). Ainsworth's observations of attachment styles identify links in childhood and adult relationships.

According to Bartholomew and Horowitz (1991), there are four prototypes of adult attachment--secure (positive self-positive others), dismissing (positive self-negative others), preoccupied (negative self-positive others), and fearful (negative self and others) which were created by narrowing Bowlby's theory of how self and others are perceived (as cited in Diehl, et al., 1998). Diehl et al. (1998) emphasized the work of past studies on college age adults and their attachment and decided to study and compare different age brackets of adults. The young and middle adulthood participants "described themselves in terms of the preoccupied or fearful attachment style[s]" (Diehl et al, 1998, p.1664). These "other oriented" attachments signified potential continuation of the influence of family life formation in the lives of young adults. Older adults were using coping strategies that "may be an indication of the resourcefulness of the aging self in response to age-related losses in interpersonal relationships" (Brandtstädter & Greve, 1994 as cited in Diehl et al., p.1665). This study reinforced the concept that attachment effects occur throughout life and, by observing the different stages of life, demonstrated how people's reactions can be identified and potentially changed. According to Griffin and Bartholomew (1994b), the "attachment styles describe prototypical patterns of

emotional responses and interpersonal behavior and should be seen as part of larger system of human motivation" (as cited in Diehl, et al., 1998, p. 1667). People function differently in life based on attachment developed from "current and past family climate" (Diehl et al., 1998, p. 1667) and influences.

Maybery, et al. (2005) did a study recognizing the needs of children with parents diagnosed with mental illness. A portion of their research stemmed partially from literature integrating attachment experiences and inconsistent or unresponsive relationships with parents who have mental illness. There was a potential link between the two such as the "core attachment needs of love, security, physical and emotional nurturing" are "essential to the emotional and physical development" along with an "appropriate socialization of children" (Maybery et al, 2005, p.2). Maybery et al. (2005) states that families with parents diagnosed with mental illness are likely to exhibit "inconsistency and/or neglect" towards the children (p.2) which can be harmful to the child's development of "avoidant, anxious or insecure/ disorganized attachment". Along with lack of stability in the home and roles of the family, issues such as these pose potential problems for the responsibilities of the child.

Caregiver burden

In the Chakrabarti & Gill study (2002) burden was "defined as the 'presence of problems, difficulties or adverse events which affect the life (lives) of a [sic] psychiatric patient's significant others'" (Platt, as cited in Chakrabarti & Gill, p. 52). The disorder in the patient will likely affect those close to him or her, creating a sense of burden. Elgie & Morselli (2007) investigated the 'social functionality' of bipolar patients adapting to social norms like friendships, jobs, and levels of comfort by analyzing numerous surveys

that studied patients' and relatives' perspectives of how the disorder affected the social functioning of the patient. Social functioning is defined as the '"ability to establish and maintain relationships with friends and family as well as to undertake work and leisure activities and to cope with day-to-day activities"' (145) such as lack of interest in maintaining and developing relationships, continued difficulty with daily responsibilities, and communication. Other specific factors were revealed in the studies –suicidal tendencies, employment status and stigma; however they are not included in the scope of the current study. The main focus is familial and social interaction since fifty percent of the patients in all the surveys were married and in a family atmosphere.

In the 1997 and 1998 Gamian International Survey, "50%-100% reported a reduction in social, familial and working functionality" (147). In 2000, the second National Depressive and Manic Depressive Association (NDMDA) survey cited "68% of the respondents reported that the disorder significantly impacted upon their family and lifestyle. Thirty-three percent mentioned poor relationships with family members", 58% felt their family members did not understand them, "60% [had] difficulty in maintaining long-term friendships", "65% [had] difficulty maintaining intimate relationships" and "64% referred to the negative impact the disorder had on the relationship with their children" (Elgie & Morselli, 2007, p.149). Other results displayed marital difficulties and "80% [of the patients] experienced psychosocial problems including relationship problems" (147). The Gamian Europe/ BEAM survey and the first NDMDA logged similar data, which has risen since the latter comparison.

The Gamian Europe/BEAM survey noted how the "disorder appeared to impact mostly within the family setting, preventing the development of a normal loving/caring

family environment" (148). The IDEA survey reported patient difficulties with keeping in contact with friends and family. The mental disorder affected the lifestyle of the caregiver and the Gamian Europe/ BEAM and IDEA survey results could infer potential conflicts and problems between patients and family. Among the numerous reports analyzed about family members' viewpoints, the first report of the subgroup of participants from the Gamian International Survey; sons and daughters of patients with Bipolar Disorder made up 44% of the survey population; part of the difficulty with Bipolar Disorder is knowing when to seek help and when to give help, which can be a potential stressor. "In all surveys where relationships within the family were evaluated, difficulties were reported" (149). Though these statistics are not specified between a mother and child relationship, these discoveries are significant. In the first U.S.-community-based survey, women with bipolar more commonly reported "an impairment in social and leisure interactions" than men (150), which could explain potential mother child social issues. The marital and relationship problems patients with Bipolar Disorder generally experience may lead to emotional surrogacy and the child spending more time with the parent than peer relationships (Aldridge, & Becker, 2003). This type of stress could be potentially harmful though the children in the source's sample were fairly satisfied. Elgie and Morselli (2007) reported in the first U.S. community-based survey studied that "19% of bipolar patients reported poor social family interaction versus 5% in the non bipolar group". The bipolar group shared about difficulties of "implementation of their parental role" or "extended family interaction" (149). A balance between the disorder and role as a parent can be difficult to attain. In the IDEA survey, sons and daughters of patients noticed social problems in the parent; the disorder is not ignored by the child. "Family appears to be the

environment in which the majority of the respondents experience their greatest problems" (154); though this statement has a patient's perspective, if the patient is potentially discontent with his or her disorder and treatment, he or she can create extra strain on the familial caregivers.

Parents with Mental Illness

The bond between the mothers and young caregivers in this Aldridge and Becker (2003) sample was closer since their social networks were strained. At times, if the father was present, he would provide for the family so the child would care for the mother who was mentally ill. The parents displayed a higher response that their children were negatively affected by the illness. The children, however, had a higher percentage response of being positively affected by the parents' mental illness (Aldridge and Becker, 2003, p. 76). Aldridge and Becker (2003) presented the concept that children encounter life experiences growing up, and stated for this sample, having a parent with a mental illness is a type of life experience. The parent's disorder does not have to hurt the child's life permanently. The children are at the most risk when their parents have a combinative illness with other problems like alcoholism or drugs. Many parents with mental illness have co-morbidity with another illness (Aldridge and Becker, 2003); however, the parents and children in this sample maintained a relationship. Aldridge and Becker (2003) cited the finding that children do not automatically have long term emotional or behavioral damage resulting from parental mental health problems. However, Bowlby (1977) revealed that if there is an "'inversion of parent-child roles' then 'the parentification reflects role dysfunction or reversal among children, and thus becomes an 'attachment disorder'"(as cited in Aldridge and Becker, 2003, p.58). If the child is

accepting parental responsibilities, he or she may not be nurtured as much as a child needs to be nurtured by a parent. Appropriate communication and understanding between the parent and child about the parent's disorder is essential to the emotional health of the child and to the healthy support of the parent (Aldridge and Becker, 2003; Maybery et al., 2005). There is hope that these "caring relationships can ...help cement secure attachments with their parents" (Aldridge & Becker, 2003, p. 95). Caring relationship provided opportunities for understanding the parent's needs, and many children genuinely wanted to help; assisting a parent is a time commitment.

Young Caregivers

Children of parents with mental illness are often young caregivers. Mental illness can impede life. When the patient has difficulty in the areas of "work-related, interpersonal, and leisure activities" (145), the child is potentially affected. Burden is expected with the sacrifice a caregiver makes to help a patient with mental illness. He or she must be available for assistance with daily tasks, preparation for the family's needs, and financial difficulties, along with medication administration and potential restraint upon need. A young caregiver is forced to mature quickly and must sort through the events of life to establish his or her self identity more independently of the parent (Beardslee & Podoresfksy, 1988; Williams & Corrigan, 1992).

Aldridge and Becker (2003) cite different misconceptions of young caregivers' motives and demands for caring. Even though there are many assumptions and dangers associated with young caregivers' lives, there is "no evidence to show that, by itself, parental mental illness necessarily causes child maltreatment or necessarily leads to children taking on caring responsibilities" (Aldridge & Becker, 2003, p.25). There is an

element of social discrimination keeping the parents dependent on young caregivers, since the parents cannot supply their own needs. Children many times take over parental duties because no one else is available to do these responsibilities. At times, health professionals do not get involved based on a lack of understanding for the young caregivers' situation; relatives many times meet the emotional needs of the parents but neglect the children's practical needs, for instance, assisting the children in their daily contributions to the household, i.e. chores and caring for younger siblings. Concern arises if the child is an emotional surrogate for the parent. "Parents can lack reflexivity about the children's needs and it is here that children can become more vulnerable to neglect or adverse experiences of childhood and care" (Aldridge & Becker, 2003, p. 54); the parent is consumed with his or her illness; at times, he or she cannot always be available if the child needs him or her help. At times the child may sacrifice his or her own needs for the parents. Falkov (1998, p.57) said "effects will depend on the age and developmental stage of the child when the parent becomes mentally ill" (as cited in Aldridge & Becker, 2003, p.54). Due to the mental illness, the parent may be unavailable at times, but this action does not always have a lasting affect on the child throughout his or her life span (Aldridge & Becker, 2003, p. 58).

Maybery et al (2005) surveyed young caregivers and found that the relationship with the mother is essential to the child's development. Mothers provide less security and self identity leading to detrimental attachment styles which are likely to manifest themselves in the children of mothers with mental illness based on the mother's response to the children. Parents felt the children should have a 'qualified person to whom they could vent' (p.5) their feeling and problems. Communication within the family about the

disorder was not highly present due to denial, lack of understanding of how to discuss it, and limited disclosure due to the age of the children. Problems of hospitalization added stress for the children. Not only were children many times placed under different care than their siblings, but the children felt guilt for overextending their welcome based on the children's requirements for shelter, financial burdens, and visits to their mothers at the hospital. The parents and children agreed that having siblings and friends leads to positive coping, even though children exhibit negative coping mechanisms while the parent is sick (Fudge & Mason, 2004). A balance must be reached at how to interpret the drastic difference between the children's true needs and the parents' perspective of the children's needs along with how the children will handle the illness.

Caregiver Coping

There is a link between the early childhood relationship with a child's mother and his or her interpersonal and social development. Beardslee and Podoresfksy (1988) studied children, comparing their responses to their relationship with their mother at the initial interview and the interview three years later while in high school. A few teens felt blame and depression, but the majority exhibited motivation towards goals and plans. The research of Beardslee and Podoresfksy, (1988) said that "relationships have been found to be protective in a wide variety of situations. Because parental affective illness seriously impairs relationships within the family, the possible protective effects of relationships are relevant to the study of resilient offspring of parents with affective disorders" (p. 486). Adolescents and potentially young adults (Diehl, et al., 1998; Williams & Corrigan, 1992) learn "certain temperamental characteristics…ways of responding, thinking, and acting, for example…coping styles, positive self esteem, and a

sense of being in control" (Beardslee & Podoresfksy, 1988, p.486). Beardslee and Podoresfksy highlighted in past work the importance that "self-understanding was an essential component of resilient individuals who dealt successfully with various stressful situations" (1988, p. 486). This concept was also supported in Diehl et al. (1998). The Beardslee and Podoresfksy (1988) study used subjective questions for the "investigation of the subject's own perceptions of what enabled him or her to function effectively, which provides important information for understanding the psychological processes" (486). The parents and children were interviewed with subject-tailored specific tests. The sample was of children who had "behavioral functioning" (488) and who had lived with a severely, affectively ill parent when they were between the ages of 6 and 12 years old. Fifteen of the eighteen of the participants were not psychologically ill for the second assessment and all were psychologically healthy for the first assessment. The results displayed positive coping skills and existence of social support. This study demonstrated the ability of children to separate themselves from the parents' disorders, which proved essential for healthy development.

The children would reach out to others for help to understand the situation or for comfort (Beardslee & Podoresfksy, 1988). Successful coping occurred when the children had a correct "understanding of themselves and their parent's illness" (Beardslee & Podoresfksy, 1988, p. 492; Williams & Corrigan, 1992). The children knew that they could establish a life different from their parents, and not live a self fulfilling prophecy. The children "made peace with or [came] to an understanding of the experience" of their parents (Beardslee & Podoresfksy, 1988, p. 492). The children and teens realized that the problem with their parents was not caused by themselves. They did not blame

themselves, and the parents did not appear to blame the children. The children could recognize the disorder was separate from the parents. Understanding self and the disorder was the children's means of coping.

Later in life, adult children are affected by their parents' disorder, which is displayed through coping mechanisms. In Chakrabarti & Gill (2002), the two study groups, one of caregivers of patients with Schizophrenia and another of caregivers of patients with Bipolar Disorder showed different coping strategies. The Bipolar Disorder caregiver group used more problem-focused strategies such as positive communication and encouragement of the patients' social involvement while the Schizophrenic caregiver group showed emotion-focused coping mechanisms, used during highly stressful and non compliant situations, for instance, collusion, defined as passively reacting to the patient by giving him or her unnecessary and sometimes dangerous control along with spiritual help. When there was more social support available, the caregivers used collusion less. The caregivers of the Bipolar group had significant styles of coping in the categories of "emotion- focused" "strategies" (52): collusion, coercion, which is an aggressive, uncontrollable emotion directed at the patient, and spiritual seeking, where the caregiver participates in spirituality since he or she cannot handle the patient on his or her own. Healthy caregiver coping occurred when social support was available. The patient had lower "levels of dysfunction" which led to the ability of the caregivers and the patient to discuss problems. This action lowered the potential for stressful situations and presented a means of accomplishing problem focused communication about medication adherence.

Adult Children

Adult children of parents who have mental illness or alcoholism have problems in adulthood (Williams & Corrigan, 1992). "These problems include dysfunctional coping stress such as inappropriate emotional expression, dependency, or manipulation and …greater frequency of personality disorders (as cited in Williams & Corrigan, 1992, p.407). Support has been shown to maintain the child's level of coping and self esteem (Williams & Corrigan, 1992). The adult children of alcoholic parents or parents with mental illness have lower self esteem and a heightened chance for anxiety and depression. The prediction is based on how the parents have "limited social and coping skills;" therefore, the adult children will have "greater diminution of self-esteem and greater anxiety and depression" (407). The results of the Williams and Corrigan (1992) study showed that normal people functioned with less socially avoidant behavior than adult children of mentally ill parents (ACMI), adult children of alcoholics (ACOA) or the sets of both diagnoses, and had less depressive and anxious symptoms than in the ACMI. The study did not have a significant negative impact on social support. The study demonstrated that the adult children of mentally ill parents can rise above adversity. "An adult child's recollection and perception of problems experienced in childhood may alter the [sic] perception of the actual severity of parental symptoms" (Williams & Corrigan, 1992, p.412). The Williams and Corrigan study emphasized a support network as a leading response and solution to the childhood of being raised in a household where the parent has a mental illness or alcoholism.

Mowbray and Mowbray (2006) conducted a study through the National Institute of Mental Health in urban Michigan to collect data about the tangible effects of mothers

with Bipolar Disorder on adult children within the urban setting. This study related the mothers' disorder and upbringing to the life outcomes of the young adult children. Mowbray & Mowbray (2006) assessed adult children who grew up with mothers diagnosed with mental illness and how the children were affected in different areas later in life.

Social Connectedness

Most people, inferred as the general population, adapt to social situations but some do not; Lee, Draper, and Lee (2001) views social connectedness as the ability for social interaction at a basic level. Their ideas about the self and others form the self concept and people interact on the basis of their developed self concept. Lee and Robbins (1995) discovered that the person then develops a lowered self esteem and distorted perception of relating to others, and even though the person will develop some relationships, he or she is "more likely to manifest low connectedness in adulthood" (as cited in Lee, Draper, & Lee, 2001, p. 310). Children often learn socially how to copy the behavior of their parents, and in peer situations adolescents and adults learn to "identify" with others, which leads them to "develop appropriate interpersonal skills….to attract and maintain relationships" (Lee et al., 2001, p.311). The person needs a high level of social connectedness to relate. A Lee et al. (2001) study predicted that the "relationship between social connectedness and psychological adjustment is mediated by an individual's interpersonal behaviors" (Lee et al., 2001) such that those with higher connectedness have better interpersonal skills while negative social connectedness enables psychological distress and worsens into dysfunctional interpersonal behaviors.

Social Support

Beardslee and Podoresfksy (1988) found that 16 of the18 participants of parents of affective or other psychiatric disorder assessed the second time were "valuing close, confiding relationships and emphasized that these relationships were a central part of their lives. These relationships were with a wide variety of individuals (11 subjects were extremely close to their mothers, four to their fathers, 11 to their siblings, and 13 to friends)" (p. 490). The results are slightly vague since the gender of the parents that had the severe mental illness was not identified. Social support seemed to be essential to coping effectiveness for these children. Children and teens were "full of disillusionment, confusion and feelings of helplessness" and "many described the loss of a role model or an idealized loved one" (Beardslee & Podoresfksy, 1988, p. 491). The children identified the parent as not being "available to perform usual tasks" (Beardslee & Podoresfksy, 1988, p. 491). Clearly, there are negative effects on the children growing up with a mentally ill parent, yet there are ways to help the population of children and families affected by mental illness (Aldridge & Becker, 2003; Fudge & Mason, 2004; Maybery, et al., 2005).

Bipolar I Disorder

In 2000 the previously recorded population of 1 % with bipolar disorder rose to approximately 5% (as cited in Berk, Dodd & Berk 2005) and approximately 1.9 million of the 221.6 million people in the US in 2000 as having Bipolar I or II Disorder (Torrey & Knable, 2002). Varying percentages of people with Bipolar Disorder, though some studies consisted of over diagnosed samples, resulted in between 0.75% (Torrey & Knable, 2002) to 3% (Klein & Wender, 2005) of the U.S. population who either qualified

or were diagnosed with Bipolar Disorder; Evans, Charney and Lewis (2006) cited 3 to 4% of the US population has Bipolar I Disorder. According to the World Health Organization's 1990 study, Bipolar Disorder is "the sixth leading cause of disability-adjusted life years" for "people aged 15 to 44 years" (Shi & Tohen 2004) and "lists bipolar disorder as one of the top 10 disorders (sixth) reducing quality-adjusted life years" (Evans, Charney & Lewis, 2006, p. 6). Based on such debilitating statistics, patients are expected to require assistance.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) different classifications of Bipolar Disorder exist under the Axis I category. The mania present in Bipolar I Disorder is defined as "a distinct period of abnormally AND persistently elevated, expansive, OR irritable mood" (Evans et al., p. 96).To be diagnosed, the manic episode must have at least three or four of specific symptoms, the episode cannot be defined as a mixed episode: depression and mania combined, and the episode must continue into a minimum of one week duration. Certain symptoms include 'inflated self esteem or grandiosity", "decreased need for sleep", "pressured speech", "distractibility" and "involvement in pleasurable activity with high potential for painful consequences" (Evans et al., 2006, p. 96) to a degree that disrupts daily function (Torrey & Knable, 2002); the "average person with manic-depressive disorder loses about nine years from his or her life" based on inability to accomplish daily tasks (Klein 2005, p. 81). Symptoms impacting close relationships indirectly relates to the previously mentioned topics of caregiver burden and attachment. According to Klein and Wender (2005), the patient with Bipolar I Disorder, demonstrates depressive and manic moods; however only a manic episode is required for diagnosis, even though most individuals

diagnosed with Bipolar I Disorder have experienced depressive and manic episodes (Torrey & Knable, 2002). The DSM-IV-TR (2000) states that "Bipolar I Disorder is a recurrent disorder-more than 90% of individuals who have a single Manic Episode go on to have future episodes" (386) and approximately "60%-70% of Manic Episodes occur immediately before or after a Major Depressive Episode" (386), emphasizing how lifetime occurrence of the disorder is expected. The type of episode that the patient experienced as an onset to the disorder, either depressive or manic, will usually be prevalent during his or her lifetime (Torrey & Knable, 2002). "The course of bipolar disorder can be much more variable than the course of unipolar depressive illness" since the patient can experience extreme highs and lows, both in severity and symptoms (Klein & Wender 2005, p. 80) with an "unpredictable onset" (80-81). An estimated 60% of individuals with Bipolar I Disorder "experience chronic interpersonal or occupational difficulties between acute episodes" (DSM-IV-TR 2000, p. 386), signifying the impact that Bipolar Disorder has on their immediate surroundings. Bipolar Disorder affects the patients' immediate relationships (Serrett & Mandelli, 2004), especially concerning the symptoms effect on compliance with treatment and daily expectations of functionality (Miklowitz & Otto 2006; Torrey & Knable, 2002).

Bipolar disorder affects the person with the disorder physically, emotionally and socially (Berk & Berk, 2005), specifically the family, who many times participates in medication administration and treatment options. Compared to a chronic pain patient's sample, patients with bipolar disorder showed lower difficulties in physical and social abilities (Shi & Tohen 2004), yet a patient with bipolar disorder showed significant relationship and "global functioning" issues (Serretti & Mandelli 2004, p.15). Most

patients reach improvement yet not total recovery from Bipolar Disorder (Torrey & Knable, 2002); however, if untreated, "the average duration of a single episode of mania or depression…is three to twelve months", more or less (97). Proven treatments include medications such as mood stabilizers— specifically lithium or valproate and anticonvulsants—Tegretol (otherwise known as carbamazepine—though this has high risks), Lamictal or Topamax which are often times utilized together or the mood stabilizers are taken alone; antidepressants—Selective Serotonin Reuptake Inhibitors (SSRI) are common initial methods of antidepressant treatment and Tricyclic and Monoamine Oxidase Inhibitors (MAOI) are used when the first line pharmaceutical interventions do not work; and antipsychotics are utilized under direct, careful supervision (Evans, et al., 2006; Klein & Wender, 2005; Miklowitz & Otto, 2006; Serretti & Mandelli, 2004; Torrey & Knable, 2002). Though debated for necessity (Torrey & Knable, 2002), a strategic psychotherapy supplement is well supported in research (Miklowitz & Otto, 2006). No matter the choice of medication, the patient is encouraged not to discontinue immediately if there are no improvements as medication takes time to show results. Many times family is involved to keep the patient accountable in taking medication. Patients are highly likely to take a type of medicine for the duration of their lives (Torrey & Knable, 2002). Based on difficulties with medication compliance, certain behaviors are exhibited such as enjoying manic grandiosity, denial of illness and delusions among other symptoms, which can interfere with social situations, and sometimes increase aggression in the patient (Torrey & Knable, 2002). Patients with Bipolar I Disorder at times participate in dangerous actions such as promiscuity and

substance abuse or may act irritable, which can effect the family's emotion, cohesion and stability.

Cognitive Behavioral Therapy (CBT), Interpersonal and Social Rhythm Therapy (IPSRT), Family Therapy and Family Focused Therapy (FFT), and Group Therapy are the main types of psychotherapy used with patients who are diagnosed with Bipolar Disorder and are viewed as another avenue to control Bipolar I Disorder symptomlogy; though only FFT is specifically family oriented, the other types discuss family matters and while presented from the patient's perspective, these therapeutic strategies can aid the family dynamic based on equipping the patient with skills to maintain his or her disorder.

In Cognitive Therapy "conscious thoughts are most important" such as "identify[ing] and monitor[ing] what are called 'automatic negative thoughts' (ANT)" (Torrey & Knable, 2002, p. 208). Miklowitz and Otto (2006) cited four studies (p.220). The first study displayed "significantly better compliance with lithium and fewer hospitalizations" over the time interval in the experimental group of participants compared to the control group. The second study showed "30% fewer manic relapses, longer wellness intervals prior to manic relapses, and significantly better social functioning" excluding depressive episode "relapses". The third study used CBT with "psycho education, training in medication adherence, stress managements, cognitive restructuring, and regulation of activities and sleep" revealing "significantly greater improvements in depressive symptoms and global functioning". In study four, even though "44% of the patients in the CBT group had relapsed", a higher number in the control group relapsed and the CBT group had shorter episodes, less hospitalization and

"better social functioning" (Miklowitz & Otto 2006, p. 220). CBT utilizes psychotherapy techniques yet the key ingredients are "behavioral activation and cognitive restructuring".

Interpersonal and Social Rhythm Therapy balances "stressful life events and bipolar episode onset" (Torrey & Knable, 2002, p. 209) using a log of daily routines i.e. "meals, sleep" (Torrey & Knable, 2002, p. 210) and teaches skills to cope with stressful areas of life. IPSRT identifies four parts of life where problems potentially arise: "grief over loss", "interpersonal conflicts", "role transitions", and "interpersonal deficits" (Miklowitz & Otto 2006, p. 221). By recognizing events that disrupt life, and by learning how to deal with them, future situations are handled more effectively. Family therapy provides the family and patient together with education to encourage "medication compliance" (Torrey & Knable, 2002, p.211). Family-focused treatment shows that psychotherapeutic intervention such as "psycho education" about the disorder, tips for communication, and "problem-solving skills" (Miklowitz & Otto, 2006, p. 218) involving the family with the patients' use of medication, fare better than those with medication alone. These patients show lowered relapse rate and lowered risk of hospitalization. One study identified that even when the two sample groups (one with family involvement and the one without) were presented with psycho-educational materials, the family focused therapy group patients would fair better based on family accountability to identify relapse signs (Miklowitz & Otto, 2006). Group therapy is a "cost-effective" (Miklowitz & Otto, 2006, p.222) means of sharing understanding among others who are experiencing similar life problems, thus offering hope. Torrey and Knable (2002) noted the "improving [of] medical compliance, lessening symptoms, and decreasing hospitalization" (Miklowitz & Otto, 2006, p.211) by accountability for goal setting (Miklowitz & Otto, 2006). Family

involvement has proven beneficial (Miklowitz & Otto, 2006; Torrey & Knable 2002) since medical adherence can be an issue. Family therapy is a long process; if the patient and family are willing to wait, there is hope for change (Miklowitz and Otto, 2006).

Hypothesis and Research Question

This study will answer two questions:1) Are students at a private, evangelical university who have mothers with Bipolar I Disorder more negatively affected interpersonally or relationally (friendship, romantic) than those who do not have a mother with Bipolar I Disorder and 2) To whom do the college students normally go for social support?

The hypothesis is that children who were raised by mothers with Bipolar I Disorder have more difficulties within relationship development than children who were not raised by mothers with Bipolar I Disorder. Secondly, students raised by mothers with Bipolar I Disorder seek less social support than students not raised by mothers with Bipolar I Disorder.

Method

Participants

Undergraduate students from a southern evangelical university between the ages of 18 to 30 volunteered for the survey. The initial goal was for two groups of equal size: Experimental and Control; the expected number is a minimum of 20 participants in the experimental group and 20 participants in the control group with a maximum number of 100 in each group. The experimental group included students whose mothers had Bipolar I Disorder and the control group included students whose mothers did not have Bipolar I

Disorder or any other documented mental illness. Volunteers received psychology activity credit for participation.

Materials

The survey had three sections. The first section was designed to narrow the population of interest with demographic information, family of origin data, and definitions of bipolar disorder. The second section used the Experiences in Close Relationships-Revised (ECR-R) survey to study attachment behaviors with romantic and close partners. The ECR-R (Fraley, Waller & Brennan, 2000) was designed using Item Response Theory (IRT) and based on the Experiences in Close Relationships (ECR) survey. IRT tests if the "latent variables" (p.350), in this case avoidance and anxiety, can be effectively predicted through the test questions. IRT does not use stable measures of comparison i.e. alpha coefficients, though it does convert and compare to "classic" measurement methods. IRT identifies levels of trait, checking if the test gives an evenly—measured assessment of levels. The third section used the Social Support Questionnaire to identify who the participants go to for social support in each specified instance. For each Social Support: in the first part for each question, participants list individuals initials and relationship to the participants i.e. mother, friends, boyfriend. In the second part, the participant rates his or her general satisfaction with the social support in each specified instance. The Social Support Questionnaire (Sarason, Levine, Basham, & Sarason, 1983) was created to examine those whom participants turn for social support based on the relationship and number of people that the participant had for that particular question. The second part of the Social Support Questionnaire involved rating how satisfied participants were with their social support; though compared with many

variables in the initial study, both number and satisfaction social support yield high internal validity. The coefficient alpha of internal reliability for the satisfaction section is .97 and the coefficient alpha of internal reliability for the numbers section is .94.

Design and Procedure

The survey was available on the Liberty University Psychology webpage under *PSYC Activities* link, under the heading: *Survey Opportunities:* http://surveys.pappasvolk.com/interpersonal/interpersonal.htm. Students could voluntarily agree to participate. Once the survey was opened, the participant was briefed on the purpose of the study, background information, procedure, potential risks, confidentiality, who to contact if problems occur, and information on where the results of the study would be located at the completion. Once the participant agreed, the survey immediately proceeded to section one.

The first section included demographic information and items to ensure that the participants fit the population. Items included age, gender, class rank and major. The next set of items clarified if the participants' parents are still married and if the participant grew up in a dual parent home. The next set of items asked whether the participant's mother has Bipolar I Disorder. If the participant answered yes, then the participant was placed in the experimental group. If the participant selected no for his or her mother having Bipolar I Disorder and no for his or her mother having a mood disorder, the participant was placed in the control group. He or she then continued to parts two and three of the survey. Participants in the experimental group answered Likert scale questions about severity and tendencies (symptoms) of the Bipolar I Disorder's effects on certain aspects of life before he or she proceeded to the next two sections of the survey.

The first section of the test had items that eliminated the participant based on his or her answer. If the participant was not in the age range or his or her mother had a mood disorder different from Bipolar I Disorder, the survey did not continue. Parts two and three of the survey immediately followed part one.

Results

Eighty-three participants submitted surveys; two were eliminated based on age and six were eliminated based on their mothers being diagnosed with a mood disorder other than Bipolar I Disorder. One of these participants selected yes for his or her mother having Bipolar I Disorder and yes for his or her mother having a mood disorder other than Bipolar I Disorder. The remaining 75 participants completed the survey. There were three participants who had mothers with Bipolar I Disorder in the experimental group and 72 participants with mothers without Bipolar I Disorder in the control group. The experimental group was significantly smaller than the expected participation. Due to the smaller experimental sample size, the data will briefly compare the experimental group with the control group while making general qualitative observations of all participants. For further understanding of item references and structure, please see Appendix.

Discussion

Demographics and Severity

The majority of participants were between 19 and 20 years old (42 participants). Sixty-six participants were female (80.5%) and most participants were first year students (29 participants) with second and third year students closely following (18 participants respectively). Psychology (34 participants), Nursing (8 participants) and Family and Consumer Sciences (4 participants) were the top representations of academic majors; this

prevalence may be linked to Psychology courses being included as general education requirements at the university. The majority of participants parents were still married (83.8%) and a higher number of participants grew up in dual-parent homes (93.8%). These were the inferred contributions to the decline of participants' parents' marriages mentioned in previous items: the mother not taking medication which put a strain on marriages and contributed to divorce, separation of parents, abandonment, or death of a parent are all possible contributors to the parents not currently being married. The marriage rate in the sample was relatively higher than expected which may be based on the sample's religious beliefs. In the experimental group, two respondents' parents were still married and one respondent's parents were not married nor did she grow up in a dual parent home.

The 3.6% of participants in the population had mothers diagnosed with Bipolar I Disorder which matched the expected percentage in comparison to the US population. All three were female and two were Psychology majors. Severity (ranked 1 *low* to 5 *high*) of the Bipolar I Disorder on the mother in the experimental group ranked *high* with *employment* and *finances*, with mid range responses about *daily activities* and varying responses on effect with *family life* the response ranked lower, higher and *high* severity. Interestingly, the participant who did not grow up in a dual parent home ranked the previous statement as lower severity of Bipolar I Disorder; this response was different than the literature predicted since a parent who has a mental illness usually creates a level of disruption to the family. For symptom tendencies of a mother with Bipolar I Disorder (on a scale of *never, once of twice*, *frequently*, *most of the time),* the most common for the control group were *irritability,* (ranked *frequently* and *most of the time*), *sped up thought*

process (ranked *most of the time* by two participants), *spending sprees and debt* (ranked *frequently* and *most of the time)* and *extramarital affairs* (ranked *never* by all three participants). The results could be based on many factors such as stress on the mother, religious views about adultery, and societal culture.

Tendencies

Varying symptom tendency responses were concerning *hyperactive motor behavior*, *loud, rapid and difficult to understand speech*, *suicide attempts*, and *substance abuse*. *Hyperactive motor behavior* ranked *frequently* and *most of the time,* which had higher prevalence with one respondent who marked *once or twice. Loud, rapid and difficult to understand speech* ranked the same as previous responses, except that the same respondent who put *once or twice* for the previous symptom answered with *never*. *Suicide attempts* were relatively rare except for one participant who claims *most of the time* for her mother attempting suicide. *Substance abuse* mirrored similar response patterns with the same respondent whose mother attempted suicide. The participant who did not grow up in a dual parent home ranked every symptom *most of the time* except for *extramarital affairs* while another respondent had *once or twice* and *never* and a few *frequently* rankings for common tendencies. The levels of severity and prevalence of symptoms between the two groups were diversified, even for the small sample.

ECR-R

Concerning the overall Experiences in Close Relationships scale-Revised, there were overall healthy relationship patterns in the general sample. A main weakness was within the Anxiety subgroups of items and not as many weaknesses in relationships compared to the Avoidance items of the ECR-R. In the ECR-RAN sections, Item 1: I'm

afraid that I will lose my partner's love, Item 2: I often worry that my partner will not want to stay with me and Item 9: I rarely worry about my partner leaving me, displayed variance in ratings and the control and experimental groups similarly (answered between *agree* and *disagree* with Item 9 being discussed further in this section). Item ECR-RAN 11: I do not often worry about being abandoned, relates to general fears in general relationships and not specifically romantic relationships; a majority of twenty-six participants agreed with this statement, including the whole experimental group, while the previously stated ECR-RAN Items 1, 2 and 9, framed to test similar pretenses of fears in specifically romantic relationships, were less strongly ranked responses. For the experimental groups, ECR-RAN items 1, 2 and 11 were answered differently from the control group. Participants exhibited positive and weak relationship tendencies in Avoidance and Anxiety categories.

Specifically within the ECR-R survey section, the majority of relationship issues did not stem from Avoidance categorization (ECR-RAV). ECR-RAV 1: I prefer not to show a partner how I feel deep down, ECR-RAV 2: I feel comfortable sharing my private thoughts and feelings with my partner, ECR-RAV 3: I find it difficult to allow myself to depend on romantic partners, ECR-RAV 4: I am very comfortable being close to romantic partners and ECR-RAV 18: My partner really understands me and my needs, had different majority responses between the control and experimental groups. Overall both groups exhibited comfort with romantic partner, open communication with intimate relationships and romantic partners (Item ECR-RAV 10 had a very high majority response ranking for both groups, such as *Agree strongly* and *Agree),* had dependable romantic partners during rough times (Item ECR-RAV 11 had high ranking of *agree*

strongly majority response between both groups), and being affectionate with close relationships (Item ECR-RAV 16 was very high with *agree* as the main response for both groups). ECR-RAV 18: My partner really understands me and my needs, had a *disagree* and *disagree slightly* for the experimental group but *agree* and *agree strongly* for the control group; the members of the experimental group did not feel understood by their partners, potentially based on many factors, such as family background, tendency to worry, etc. The results do not reveal the reasons why the participants held this belief about their partners.

The majority of relationship issues stemmed from the Anxiety categorization scale (ECR-RAN). ECR-RAN 4: I worry that romantic partners won't care about me as much as I care about them, illustrated doubt in romantic partners' abilities to care about the participants. The responses of both groups showed healthy feelings for partners, appropriate intimacy with partners, no feelings of abandonment, and consistency in desires and expectations of the relationship. The character of the trust issues within the two sample groups' backgrounds should be studied in the future. There was numerous conflicting data between groups: ECR-RAN Item 6: I worry a lot about my relationships (*agree* and *agree strongly* for the experimental group), ECR-RAN Item 7: When my partner is out of sight, I worry that he or she might become interested in someone else (all three respondents for the experimental group ranked *agree* and *agree slightly*). In ECR-RAN Item 8, the control group agreed about sharing feelings with the partner. Item 9 showed evidences that the experimental group worried less than the control group about the partner leaving them, though this item had slight variety in responses within groups; this statement is conflicting with other dual group responses for comfort, felt stability and

safety in relationships from the control group (i.e. ECR-RAN 7, 8 and 10). ECR-RAN Item 10 showed how many of the experimental groups' romantic partners caused self doubt within the participants. In the experimental group, each participant commented on the statement from ECR-RAN Item 15: I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am"; ECR-RAN Item 16: it makes me mad that I don't get the affection and support I need from my partner; and ECR-RAN Item 17: I worry that I wont measure up to other people (which received *agree* and two *agree strongly* responses). The control group was split between *agree, agree strongly*, *agree slightly* and *disagree* which may mean that this feeling affects much of the total sample population. For Item ECR-RAN 18: My partner only seems to notice me when I'm angry, an experimental participant chose *disagree slightly* yet the experimental and control groups felt strongly about this previous ECR-RAN statement. The Anxiety scale demonstrated worry about stability among both groups but specifically the experimental groups concerning their close relationships.

Social Support Questionnaire

In part two: the SSQ section demonstrated that the satisfaction of the participants as a whole was *very dissatisfied* with their social support. One participant in the experimental group put zeros for her dissatisfaction instead of answering on a scale of 1 *very dissatisfied* to 6 *very satisfied* and did not include names and relationship in the first section of the SSQ. Most relationships mentioned included mothers, fathers, siblings, friends, best friends, significant others and some included pastors and professors. Most respondents showed evidences of social support in their lives however the satisfaction was still low.

Limitations

The experimental group was small and the social support was difficult to compare. A more detailed study of attachment with a larger sample of experimental group students can solidify answers about Bipolar I Disorders' affect on the individuals' relationships and whether there were differences between them and the general population. Students who are significantly stressed with life situations, i.e. their parents have a mental illness, would probably not take time for the survey since there are other distracting stressors in their lives that need more attention. Expecting the students to know detailed information about the disorder is difficult; therefore, specific questions about knowledge of the parents' disorders could narrow the study and add validity to the findings. Maybe a mother with Bipolar I Disorder does not increase the likelihood for attachment issues since she pays more attention to the children or tries to have a good relationship; a more objective way to measure this relationship needs to be created and utilized. The study never got on the Student Care webpage for Liberty University, which may have added more response to both groups. However, as the severity and tendencies section in the study did not seem to support this case, more investigations should be made between attachment, Bipolar Disorder and mothers.

Conclusion

Since the experimental group was significantly smaller than expected, the findings may not be as significant as hoped. However, the ECR-R raised concerns in the Avoidance section for both groups and in the Anxiety tendencies section specifically for the experimental group. The Social Support section satisfaction was disappointing based on the response of the participants even though the majority of the sample groups

identified numerous individuals in their lives to whom they turn for social support. The survey only studied the attachment and social support that was covered in the literature review, yet other areas such as caregiver burden and family involvement with the patient were not studied directly in the survey; the affect of the mother with Bipolar I Disorder was indirectly existent in the survey such as in severity questions; however, social support responses had confounding variables that needed further study since the satisfaction was so low. Social support is an issue as is finding the key contribution in college age students that would relate to both groups; this may not be connected to attachment with the mother. A wide range of topics were discussed in the research for the study: attachment, parent with mental illness, caregiver burden, young caregivers, adult children, social support and bipolar disorder with the premise that a mother with Bipolar I Disorder would contribute to insecure attachment in the child during childhood and the child would then have relationship problems and ideas in adulthood. The link between attachment and Bipolar Disorder needs more evidence.

Future Research

Potential topics of future research are the child's genetic inheritance or environmentally caused mood disorders or mental illness; how the number of siblings affects the interpersonal relationship effects on the sample; personality; emotional, behavioral and cognitive effects of being raised by a mother with mental illness, and personality and self esteem issues. In the future, a secular and evangelical institution can be surveyed and compared using a similar survey. The results can be combined for a larger sample to increase the research about adults with parents with Bipolar I Disorder. Investigating the contribution to the low social support responses of the whole sample

along with whether the mother having Bipolar I Disorder did actually affect the student negatively possibly directly studied and not just through a close relationship questionnaire. By potentially adding a section detailing extraneous factors contributing to low social support i.e. work, freshman, commuter, etc for the students to select to answer why they do not appreciate their social support, clarification would exist such as if the social support was due to parental attachment or other factors. An investigation of options to help students with mothers with mentally ill ex) group therapy, effective counseling services, etc should be investigated and implemented. The study opens the door for more thorough search to be conducted in the area of relationships and mothers with Bipolar Disorders' influences.

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Appendix

Read the instructions then carefully answer the questions. There are three parts to the survey.

Please choose an answer for the following questions about yourself:

Q. D1a

How old are you?

- ☐ 18
- ☐ 19
- ☐ 20
- ☐ 21
- ☐ 22
- ☐ 23
- ☐ 24
- ☐ 25
- ☐ 26
- ☐ 27
- ☐ 28
- ☐ 29
- ☐ 30
- ☐ Other [Goto question End]

Q. D1b

What is your gender?

- ☐ Male
- ☐ Female

Q. D1c

What year in school are you?

- ☐ 1st year
- ☐ 2nd year
- ☐ 3rd year
- ☐ 4th year
- ☐ 5th year
- ☐ More than 5 years

Q. D1d

What is your major?

_____

Q. D2Are your parents still married?

- ☐ yes
- ☐ no

Q. D3

Did you grow up in a dual parent home? This is defined as one male and one female.

- yes
- no

Q. D4

Has your mother been clinically diagnosed with a mental illness defined as a mood disorder other than Bipolar I disorder?

- yes [Goto question End]
- no

Q. D5

Has your mother been clinically diagnosed with Bipolar I disorder?

Bipolar I disorder must have at least one episode of mania for diagnosis. Mania is defined by the Diagnostic and Statistical Manual (DSM) as a mood disturbance of “a distinct period of abnormally AND persistently elevated, expansive, OR irritable mood, lasting AT LEAST 1 week." At least three or four key behaviors are present during manic episodes such as inflated self-esteem or grandiosity, decreased need for sleep, pressured sleep, flight of ideas (subjective experience that thoughts are racing), distractibility (attention too easily drawn to unimportant external stimuli), increased goa-directed activiy, excessive involvement in pleasurable activity with high potential for painful consequences (e.g., spending spree, sexual activity). Manic behaviors causes functional impairment.

- yes
- no [Goto question QECRRAV1]

Q. D6a

Daily activities

- 1
- 2
- 3
- 4
- 5

Q. D6b

Employment ie ability to hold a job, with coworkers, boss, etc.

- 1
- 2
- 3
- 4
- 5

Q. D6c

Finances ie over spending, debt, etc

- 1
- 2
- 3
- 4
- 5

Q. D6d

Family life

- 1
- 2
- 3
- 4
- 5

Q. D6e

- 1
- 2
- 3
- 4
- 5
- Other specify

_____

How often does your mother exhibit the following tendencies?

Q. D7a

hyperactive motor behavior

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7b

irritability

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7c

sped up thought process

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7d

loud, rapid and difficult to understand speech

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7e

suicide attempts

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7f

spending spree and debt

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7g

extramarital affairs (or if single, frequent one night stands and prevalent sexual behavior)

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Q. D7h

substance abuse

- 1 never
- 2 once or twice
- 3 frequently
- 4 most of the time

Experiences in Close Relationships Scale-Revised (ECR-R)

INSTRUCTIONS

The following statements concern how you generally feel in close relationships (e.g. romantic partners, close friends). Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

1 Disagree strongly

2 Disagreee

3 Disagree slightly

4 Agree slightly

5 Agree

6 Agree strongly

Avoidance

Q. ECRRAV1

I prefer not to show a partner how I feel deep down.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV2

I feel comfortable sharing my private thoughts and feelings with my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV3

I find it difficult to allow myself to depend on romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV4

I am very comfortable being close to romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV5

I don't feel comfortable opening up to romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV6

I prefer not to be too close to romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV7

I get uncomfortable when a romantic partner wants to be very close.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV8

I find it relatively easy to get close to my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV9

It's not difficult for me to get close to my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV10

I usually discuss my problems and concerns with my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV11

It helps to turn to my romantic partner in times of need.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV12

I tell my partner just about everything.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV13

I talk things over with my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV14

I am nervous when partners get too close to me.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV15

I feel comfortable depending on romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q.. ECRRAV16

I find it easy to depend on romantic partners.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV17

It's easy for me to be affectionate with my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAV18

My partner really understands me and my needs.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Anxiety

Q. ECRRAN1

I'm afraid that I will lose my partner's love.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN2

I often worry that my partner will not want to stay with me.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN3

I often worry that my partner will not want to stay with me.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN4

I worry that romantic partners won't care about me as much as I care about them.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree

- 6-Agree strongly

Q. ECRRAN5

I often wish that my partner's feelings for me were as strong as my feelings for him or her.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN6

I worry a lot about my relationships.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN7

When my partner is out of sight, I worry that he or she might become interested in someone else.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN8

When I show my feelings for romantic partners, I'm afraid they will not feel the same about me.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN9

I rarely worry about my partner leaving me.

- 1-Disagree strongly
- 2-Disagree

- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN10

My romantic partner makes me doubt myself.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN11

I do not often worry about being abandoned.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN12

I find that my partner(s) don't want to get as close as I would like.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN13

Sometimes romantic partners change their feelings about me for no apparent reason.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN14

My desire to be very close sometimes scares people away.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN15

I'm afraid that once a romantic partner gets to know me, he or she won't like who I really am.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN16

It makes me mad that I don't get the affection and support I need from my partner.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN17

I worry that I won't measure up to other people.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Q. ECRRAN18

My partner only seems to notice me when I'm angry.

- 1-Disagree strongly
- 2-Disagree
- 3-Disagree slightly
- 4-Agree slightly
- 5-Agree
- 6-Agree strongly

Social Support Questionnaire

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part of each question, list all the people you know, ranking from the person you can most count on for help or support in the manner described, excluding yourself. Give the person's initials and their relationship to you (see example). If you do not include the initials, you must include the relationship. Please try to be specific with the relationship (for example, mother, stepmother, best friend, boyfriend, friend, aquaintance, classmate, etc.).Do not list more than one person next to each of the numbers beneath the question.

For the second part of each question, circle how satisfied you are with the overall support you have.

If you have no support for a question, leave the second part blank, but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all questions as best you can. All your responses will be kept confidential.

EXAMPLE:

QEXa.

Who do you know whom you can trust with information that could get you in trouble?

1 T.N. (brother)

2 L.M. (friend)

3 R.S. (friend)

4 T.N. (father)

5 L.M. (employer)

6

7

8

9

EX.a

How satisfied?

6 - Very Satisfied

5 - Fairly Satisfied

4 - a Little Satisfied

3 - a Little Dissatisfied

2 - Fairly Dissatisfied

1 - Very Dissatisfied

OR

QEX.b

1 (brother)

2 (friend)

3 (friend)

4 (father)

5 (employer)

6

7

8

9

EX.b

How satisfied?

6 - Very Satisfied

5 - Fairly Satisfied

4 - a Little Satisfied

3 - a Little Dissatisfied

2 - Fairly Dissatisfied

1 - Very Dissatisfied

Q. SS1

Whom can you really count on to listen to you when you need to talk?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS1a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS2

Whom could you really count on to help you if a person whom you thought was a good friend insulted you and told you that he/she didn't want to see you again?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS2a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS3

Whose lives do you feel that you are an important part of?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS3a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS4

Whom do you feel would help you if you were married and had just separated from your spouse?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS4a

How satisfied?

- 6 - Very Satisfied

□ 5 - Fairly Satisfied

□ 4 - a Little Satisfied

□ 3 - a Little Dissatisfied

□ 2 - Fairly Dissatisfied

□ 1 - Very Dissatisfied

Q. SS5

Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS5a

How satisfied?

□ 6 - Very Satisfied

□ 5 - Fairly Satisfied

□ 4 - a Little Satisfied

□ 3 - a Little Dissatisfied

□ 2 - Fairly Dissatisfied

□ 1 - Very Dissatisfied

Q. SS6

Whom can you talk with frankly, without having to watch what you say?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS6a

How satisfied?

□ 6 - Very Satisfied

□ 5 - Fairly Satisfied

□ 4 - a Little Satisfied

□ 3 - a Little Dissatisfied

□ 2 - Fairly Dissatisfied

□ 1 - Very Dissatisfied

Q. SS7

Who helps you feel that you truly have something positive to contribute to others?

1 _____
2 _____
3 _____
4 _____
5 _____

6 _____
7 _____
8 _____
9 _____

Q. SS7a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS8

Whom can you really count on to distract you from your worries when you feel under stress?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS8a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS9

Whom can you really count on to be dependable when you need help?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS9a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS10

Whom could you really count on to help you out if you had just been fired from your job or expelled from school?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS10a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS11

With whom can you totally be yourself?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS11a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS12

Whom do you feel really appreciates you as a person?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS12a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied

- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS13

Whom can you really count on to give you useful suggestions that help you to avoid making mistakes?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS13a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS14

Whom can you count on to listen openly and uncritically to your innermost feelings?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS14a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS15

Who will comfort you when you need it by holding you in their arms?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS15a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS16

Whom do you feel would help if a good friend of yours had been in a car accident and was hospitalized in serious condition?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS16a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS17

Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS17a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS18

Whom do you feel would help if a family member very close to you died?

1 _____

2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS18a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS19

Who accepts you totally, including both your worst and your best points?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS19a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS20

Whom can you really count on to care about you, regardless of what is happening to you?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS20a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS21

Whom can you really count on to listen to you when you are very angry at someone else?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS21a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS22

Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS22a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS23

Whom can you really count on to help you feel better when you are felling generally down-in-the-dumps?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS23a

How satisfied?

- 6 - Very Satisfied

- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS24

Whom do you feel truly loves you deeply?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS24a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS25

Whom can you count on to console you when you are very upset?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS25a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS26

Whom can you really count on to support you in a major decisions you make?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____

8 _____
9 _____

Q. SS26a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied

Q. SS27

Whom can you really count on to help you feel better when you are very irritable, ready to get angry at almost anything?

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____
7 _____
8 _____
9 _____

Q. SS27a

How satisfied?

- 6 - Very Satisfied
- 5 - Fairly Satisfied
- 4 - a Little Satisfied
- 3 - a Little Dissatisfied
- 2 - Fairly Dissatisfied
- 1 - Very Dissatisfied