

CHAPTER 17

Growing Up in a Family with Bipolar Disorder

Personal Experience, Developmental Lessons, and Overcoming Stigma

Stephen P. Hinshaw

My aims in this chapter are, by design, different from those in the other, more research-based entries in this volume. Whereas the preceding chapters utilize the best of current science to inform readers about assessment, diagnosis, etiology, and mechanisms related to bipolar disorder, as well as evidence-based prevention and treatment strategies, this chapter focuses on personal and family experience. Specifically, I describe the life of my father, a philosopher, who had his first episode of severe, lifelong bipolar disorder at age 16—misdiagnosed for the next 40 years as schizophrenia—and of my emerging reactions to both the silence that surrounded my childhood with regard to his condition and the disclosures he began to make to me as I attained young adulthood. All of these issues are described at book length elsewhere (Hinshaw, 2002; see also Hinshaw, 2004), so my goal here is to provide a cogent yet vivid summary. In addition, I hope to illuminate a number of themes related to the narrative of my father's life and to my growing up in a home with this level of psychopathology. Most of these issues (e.g., multiple risk factors for bipolar disorder, implications of adolescent-onset conditions for ultimate self-concept, effects on the family system, the importance of accurate diagnosis, the possibility of resilience, silence and communication within family systems, and stigma) have major developmental undercurrents. My ultimate hope is that the current qualitative material can help the next generation of investigators and clinicians to address key developmental questions related to

etiology, maintenance, prevention, and treatment of the important, fascinating, and devastating condition known as bipolar disorder.

In all, this work is related to my growing conviction that the more that people in the mental health professions—clinicians, teachers, and scientists alike—tell their personal and family experiences of mental illness and relate raw clinical narrative material with evidence-based discovery, the less the entire topic will be infused with silence, suffering, and stigma and the greater the chances for a fundamental shift in public attitudes and responses (see Hinshaw, 2008a). Indeed, narrative accounts can convey to scholars and scientists a sense of the right questions to ask in future investigations of mechanisms, developmental course, and intervention; they can also inform policymakers of directions for key future initiatives related to bipolar disorder in particular and mental illness in general. So, with the objective of “telling my story” in the service of pressing for ever more accurate science and ever more responsive intervention, I begin my narrative.

A SINGULAR LIFE

Early Years

My father, Virgil Hinshaw, Jr., was born in November 1919, the fourth of four boys, in the town of LaGrange, Illinois, outside of Chicago. His father, Virgil Sr., was chairman of the Prohibition National Party of the United States from 1912 to 1924, whose greatest achievement—the passage of the 18th Amendment (the Prohibition Amendment)—occurred in the year of my father’s birth. His wife, my father’s mother, Eva Piltz Hinshaw, was a missionary. The three older brothers were between 1½ to 7 years older than Junior, as he was known. The family was quite religious, with a strong sense of Quaker ideals; they were a dedicated and active group.

Before he turned 3½, however, my father lost his beloved mother, who died in 1923 during surgery for an ovarian tumor. Distraught, my grandfather moved his group of four boys out West, finally settling in Pasadena, California. His letters at the time (he was an inveterate letter writer throughout his life) commented on his own sadness at seeing the attempts of the older boys at night to console his smallest son, little Junior, who tearfully grieved for his mother.

My grandfather remarried several years later, and his second wife was also a missionary. They had two more boys, my father’s half-brothers. Among the six boys, however, my dad’s stepmother singled Junior out for special treatment, in the form of both strong praise for his academic, athletic, and church-related accomplishments and special punishment for even minor infractions. In fact, as my father wrote in his personal journals many years later, he came to realize that her treatment of him became abusive. For example, he was made to wait, for an hour or 2, in her room for the switchings and strappings that she administered with respect to his having violated even small household rules. She sometimes

eased his subsequent pain by massaging him with oil, a practice that came to take on a sexual flavor as he neared adolescence. I comment later on my father's (1) early loss of his mother and (2) abusive treatment at the hands of his stepmother as potential risk factors for his subsequent serious mood disturbance, exacerbating his undoubted genetic vulnerability (i.e., several clear cases of depression and bipolar disorder, as well as suicides, exist through several generations of my paternal family). Certainly, his memories of waiting for severe punishment suffused his mind, and he wrote many years later that this experience was quite similar to the feelings he had when he was committed to mental hospitals: The sense of waiting for degradation and for deserved punishments over something he must have done wrong, knowing that the punishment would be extremely severe.

Adolescence and Young Adulthood

The home was a center of intellectual, athletic, and political activity. The six boys were a verbal and competitive group. Prohibition-oriented international leaders sometimes visited the family home in Pasadena during the early-to-mid 1930s, particularly once the U.S. experiment in Prohibition ended, discussing policies related to alcohol as well as the international political scene, increasingly marked by world depression and the growth of fascism in Europe. My father, a precocious student and a follower of history, began to take heed of these discussions, wondering about the gravity of the world situation. Still, he played sports (football, shot put), studied hard, and took to heart his Sunday school and church lessons. He was popular, intelligent, and hard working.

At age 16, however, during the summer before his junior year in high school, he became preoccupied by thoughts of world domination by the Nazis and other fascist groups, the words of the international visitors resonating in his mind. At the end of the summer, he began a period of several days essentially without sleep, with growing agitation and grandiosity. He quickly became convinced of two ideas: first, that he could fly; and second, that his flight would send a message to world leaders that Hitler and fascism must be stopped. In clinical language, he escalated from experiencing ideas of reference (specialized meanings attributed to everyday events) to frank delusions, which had both paranoid and grandiose flavors. Fueled by his agitation, activity, obsessionality, and lack of sleep, he was fast escalating through the stages of a severe manic episode (Carlson & Goodwin, 1973), which was tinged with depressive themes.

On a September morning, following a night of wandering the streets, he returned to the family home (fortunately, a low-slung bungalow), ascended to the roof, and jumped, again with the delusional belief that his flight would send the all-important message of stopping fascism to world leaders. He crashed to the walkway below, emerging with a broken wrist but no other physical injuries.

He was taken to the huge Los Angeles County Hospital by his startled family, who had emerged from the house, wondering where he had been. Two weeks later,

he was sent to a nearby public mental hospital in Norwalk, where he was treated by being chained to his bed, with a diagnosis of schizophrenia. Intriguingly, one psychiatrist gave a presumptive diagnosis of manic-depressive psychosis, but the consensus diagnosis was schizophrenia, as it was for much of the past century in the United States for any patients displaying psychotic symptoms (for discussion of these diagnostic practices, see Hinshaw, 2002).

He remained there for nearly 6 months, initially with delusions of grandeur (“celestial voices singing all night long,” as he wrote in his journal years later) but subsequently with far more paranoid ideas, such as the belief that the hospital food was poisoned. As a result, during the fall he plummeted from a weight of nearly 180 to 121 pounds, becoming so malnourished that his life was threatened. The superintendent called in my grandfather to speak of the strong probability that his son would not pull through; the staff was convinced that he would starve to death.

Somehow, however, with no medication and no psychological treatment, my father regained his rationality and began to eat. He longed to be released in time for Christmas, but his symptoms were still severe. Several months later, he emerged with a return to euthymic, rational functioning. At that point, in March, he was released to start 11th grade, half a year late, without any pharmacological treatment (no true psychotropic medications existed at that time), any psychotherapy, or any psychoeducational discharge plans. Yet by June he had earned straight As for the entire academic year, making up quickly for lost time.

His family scarcely knew what to believe: How could their beloved, athletic, talented son and brother have plunged so quickly into madness, in the form of schizophrenia, and have come so near death—and then recovered, apparently in full, with almost equal speed? My father’s next older brother, Robert, who had seen Junior sprawled on the walkway beneath the family home, told me decades later that he had decided then and there to go into the mental health professions, subsequently becoming both a psychologist and psychiatrist and assisting my father through a number of subsequent, severe episodes. The next oldest, Randall, who became an internationally renowned economist, was a source of comfort and compassion to my father for many years to come.

Back at home and proceeding with his high school and junior college career as though the 6-month span were a nightmare, my father was class valedictorian and entered Stanford University, where he received a bachelor’s degree in philosophy and psychology. He was clearly attracted to “big ideas” about the mind and the world as well as the hidden mechanisms underlying our species’ mysterious existence in the universe. Although the United States had now entered World War II, my father did not join the military, a joint consequence of the family’s Quaker, pacifist leanings and his 4-F classification resulting from his lengthy bout with mental illness. He went on to earn a master’s degree in philosophy at Iowa and then a doctorate in philosophy at Princeton University, sole-authoring several erudite publications related to epistemology and theory of knowledge during his graduate school days.

He had incredible experiences at Princeton. Early in his career he attended weekly, one-on-one meetings with the visiting Bertrand Russell for a term, and he later came to know Albert Einstein, contributing a chapter on Einstein's social and moral philosophy to an edited volume on the great physicist. Yet despite his strong academic accomplishments and heady company, shortly after completing his dissertation in early 1945, my father again ended up in a mental hospital following another period of agitation, paranoia, and psychosis. The loss of his girlfriend appeared to be a real trigger. Furthermore, the completion of a doctorate, which would usually be thought of as a positive event, may have signaled the transition to adult responsibilities and therefore, served as an instigating event as well (for a review of the effects of psychosocial stressors on illness course, see Johnson, 2005).

This time he was hospitalized at the infamous Philadelphia State Hospital, known as Byberry and soon to become the subject of the late 1940s book and film, *The Snake Pit*. It was considered to be the worst mental hospital in the United States (Grob, 1994). While there, my father was beaten by fellow inmates. Sometime in the late spring, his older brother Randall, working as an economist for the government in Washington, DC, got a gas ration card and headed to Philadelphia to take his beloved brother for a drive out of the hospital on a day pass.

Reporting to me over 40 years later, Randall said that Virgil immediately shocked him by translating the road signs into German. "What are you doing, Junior?" he asked. "I'm being held in a concentration camp in Europe," my father immediately replied, stating that they should soon return, lest the guards notice. Startled, Randall tried to convince him otherwise, but to no avail. Although my father's statement reveals a clear delusion, perhaps he knew at some level that Hitler's avowed goals were to rid the earth not only of Jews but also of gay and lesbian individuals, Gypsies, those with mental retardation, and those suffering from mental illness. Moreover, the conditions at Philadelphia State were truly horrendous; the conditions he described were all too real.

By the summer my father again fully recovered—his chief treatment had been several rounds of insulin coma therapy—and he was released by late July. He returned to California to work and apply for academic positions. With his strong academic record, he received a number of offers and accepted a position at Ohio State University, moving to Columbus in 1946, beginning a career of 49 years that spanned the titles of instructor, assistant professor, associate professor, and full professor. He had been trained in modern philosophical methods, such as formal logic, but was widely knowledgeable about all aspects of the field. He became known as a brilliant scholar and galvanizing teacher.

Professorship, Marriage, Family—and Severe Episodes

He met my mother, a graduate student in history, on a blind date; they fell in love, getting married in 1950. As my mother later told me, however, her husband-to-be disclosed extremely little about his history of episodes, stating only that he had

“had some problems” in high school and at Princeton. In those days of silence and stigma, he said no more than he deemed necessary about a diagnosis of schizophrenia and having been warehoused in mental hospitals.

It was during her pregnancies with me and then my sister, in the early 1950s, that my mother learned firsthand about her husband’s condition. When I was born, my father was symptomatic but at least present; when my sister was born, he was in a mental hospital. Indeed, during that decade he experienced several severe bouts of full mania, with the “mixed” features of manic-level energy, paranoia, grandiosity, irrationality, and sporadic bouts of extremely irritable, depressive mood. He was hospitalized not only in Columbus but also in California, with his brother Robert periodically needing to come to the Midwest and escort my father back to facilities out West. Only his tenured status at Ohio State allowed him to retain his professorship once he returned to campus, many months after an episode had begun.

He received Thorazine as early as 1954, the year of its introduction into the United States, one of the first patients in this country to be prescribed this, the first antipsychotic medication. He also received electroconvulsive therapy, in a day and age of long-pulse, bilateral currents. Some of these latter treatments led to severe memory loss, as my mother recounted to me years later: She recalled helping her disoriented husband, back home from the hospital, as he struggled to remember the names of the neighbors, despite his superior academic abilities and qualifications. Indeed, through her heroic efforts (performed with almost no support from the mental health system), the family remained intact.

Yet between episodes, my father was caring and loving at home, showing patience and sensitivity. Here is a remembrance I have from my kindergarten year, exemplifying some of my father’s key qualities (Hinshaw, 2002, pp. 52–53):

At age five, however, I have a . . . worry . . . about a fact that I have learned. I cannot now recall where I learned of this fact—perhaps on television, perhaps in a book or almanac. It must be true, given that I had seen or heard it, but I cannot seem to comprehend it.

I walk downstairs to the basement of our first house, the colonial-style home across the river from campus. My father’s study is there, always cool and musty in its basement location. His books—the many books on philosophy, history, arts, math—line the walls. The books give a reddish-brown tint to the room, smelling faintly of the dampness of the basement. They signify, to me, how much there is to learn. Although the study has a makeshift feel, with cinderblocks serving as many of the bookshelves, it is my father’s sanctuary.

He is reading, writing notes on a yellow legal pad, using his fountain pen, his elegant strokes filling the page. I ask to interrupt, as the fact I have learned is bothering me. Ever patient, he smiles at me and asks what I need.

I tell him that I can’t understand something I’ve heard and read. He must sense the puzzlement on my face. “What could that be?” he gently inquires.

“Well, it says that Russia is the biggest country on earth in land”—by this, I mean in area—and I think that this must be right. But they also say that

China has more people than Russia, a bigger population. Is that really true? How could it be?" Clearly, the concept is beyond my comprehension.

My father explains that yes, it is actually true. He begins to discuss how more people could crowd together in a smaller area. I can't quite hear his explanation, however, because another, even more pressing question has now entered my mind, which I must ask before he has finished.

"If it's true," I interrupt, "then how many more people live in China than Russia?" I am searching for some way to quantify this incredible state of affairs.

"A great many more," my father replies, pausing for me to take this in.

I think for a while, then dare to ask the most puzzling question of all: "Could there be a *hundred* more people living in China than in Russia?"

With infinite patience and without a hint of bemusement, he responds gently: "Son, I know that this will be hard to believe, but there are actually *more* than 100 more people living in China than Russia."

My amazement has peaked, and I try to absorb this onslaught of information.

Overall, it is a blatant stereotype to contend that people with severe mental illness are never fit to be parents. This vignette is one of many that reflect my father's patience and sensitivity. Laws that deny parental rights to individuals with mental illnesses are not only discriminatory but also potentially extremely counterproductive for the entire family (see Hinshaw, 2007).

What did my sister and I know of any of the difficult events of this time period? Nothing, because my father's doctors had told him quite clearly during the 1950s: "Never tell your children about mental illness—they can't understand." So my parents did their best to hide the worst of my father's destructive episodes. And when he was away, nothing was said. During my third-grade year, for example, my father was hospitalized in the West for a period of 1 year. I recall asking my mother where Daddy was, but all she could say was that "Daddy is resting in California." With no more information forthcoming, I learned not to ask any more questions. One day during the summer before fourth grade, without fanfare or any special notice, he returned, and life resumed pretty much as it had before—my sister's and my work at school and playing sports and my Dad's return to the classroom. By now, however, my mother had returned for additional graduate education and resumed a career. As she later told me, no one knew when the next episode might come. As noted in later sections of this chapter, evidence now documents the value of clear communication within families in which a parent has a mood disorder.

Going against Medical Advice: Disclosure

During the 1960s, following my father's longest episode, he was free of severe mood swings for some years. With hindsight, I can recall periods of flatness and low energy, as well as periods of excitement and energy but without disappear-

ances for hospitalization. I still knew nothing about my Dad's history and psychological functioning.

Through middle school and junior high school, I became immersed in my studies and in various sports, fueling my denial of my Dad's prior absences and the hints, from certain behavior patterns, of his underlying problems. Yet I had also become interested in psychology. I did not realize, as I headed East for college, that my father was making a monumental decision: To go against medical advice and begin to tell me of his life. So during my first spring break back in Columbus, he called me into his study one afternoon, closed the door, and initiated our first open talk—of Pasadena, world fascism, mental hospitalization, and his diagnosis of schizophrenia. For the next 25 years, until his passing, we continued our discussions several times per year.

I had a host of emotions as he started his disclosures: sadness, concern, and fright, to be sure, but also a sense that I was at last hearing the truth and that I had always been waiting to hear what had really happened during those silences and those absences. Even so, my college years were a mixture of new learning and real anxiety. I worried, for example, about staying up too late: Would I, like my father, not be able to shut off my thinking? Would I go crazy, needing to be sent to a mental hospital? Periodically during adolescence, I had severe migraine headaches (a history I share with my father and many other relatives); when the pain was unrelenting, I would vomit uncontrollably. I now came to believe that the only way I could deal with the fears of not sleeping and relaxing, and the deeper fears of what might lie underneath my controlled life, was to make myself physically sick to my stomach, recapitulating the relief from a migraine. It took a number of years before I realized that I could simply let go and relax and that sleep would come without resorting to such self-punishment.

At the same time, I continued my growing interest in psychology. I volunteered as a Big Brother to two young boys, themselves brothers, throughout college; I taught in a Massachusetts prison; and I became part of a community mental health center therapeutic team, making home visits to an adolescent who had not spoken outside the family home and working with the psychiatrist, psychologist, and social worker who were the team's professionals. After graduation, when I directed a residential camp for developmentally delayed children in New Hampshire and coordinated a school program in Boston for youths who could not "make it" in Boston public school classrooms, I continued to read more about severe mental illness and came to the conclusion that my father did not have schizophrenia but rather manic-depressive illness, or bipolar disorder. Visiting my uncle Robert out in California, who had dedicated his life to mental health after experiencing his brother's near demise, I triggered the generation of a new diagnosis 40 years after my father's initial misdiagnosis. In short order, his doctor back in Ohio initiated treatment with lithium rather than antipsychotic medications, which he had been receiving for over 20 years.

Despite this rediagnosis (and despite his intensive reading about bipolar disorder), my father's self-image remained, at a deep level, fixated as that of a flawed

“psychotic,” an inmate of mental hospitals. As we continued our discussions and he began to show me his most intimate journals, I came to realize that he still felt as he had when a boy, waiting for the inevitable punishments at the hands of his stepmother for real or imagined misdeeds. As I discuss later, when adolescence is shaken by severe mental illness of psychotic proportions that is accompanied by punitive, inhumane treatment, deep alterations in one’s core identity are bound to ensue.

My Own Adulthood—and My Father’s Final Years

Pursuing a doctorate in clinical psychology at University of California, Los Angeles (UCLA), I continued to add to my knowledge of psychopathology, psychopharmacology, research design, and child behavior disorders. As an intern at UCLA’s Neuropsychiatric Institute, I took a rotation in the Affective Disorders Clinic, directed by Kay Redfield Jamison, who supervised me and with whom I have continued important contact over the years. Through her erudite seminars, I came to learn of the history of misdiagnosis of many thousands of Americans during the 20th century as well as the shift in thinking related to the viability of bipolar disorder as a diagnostic category. Although I began to sense that my father’s story had broad implications, I had internalized the stance of silence imposed on my family years earlier, telling almost no one about my father’s life and tribulations. I simply didn’t know how to talk about it and feared the responses of anyone I might tell.

Gradually, however, as a post-doc and assistant professor, I opened up to the idea of talking with more and more people (and eventually a far wider audience) about my Dad’s story as well as my own. I also decided to have children, something I thought during my 20s that I should simply not do, given my nascent knowledge of the heritability of bipolar disorder and my still-rampant fears of family “contamination.”

As a progressive, Parkinson-like illness came to take over my father’s later years, we talked even more deeply and he showed me all of his most personal journals and writings. Finally, in the last year of his life, I secured his blessing in writing an account of his experiences. In the years following his death in 1995 at the age of 75, I worked and reworked my manuscript about his life and became further interested in disclosure, narrative, and stigma, supplementing my more “mainstream” interests in developmental psychopathology, clinical trials, and longitudinal studies of youths with attention problems and related disorders. Today I find that my teaching, research, clinical supervision, and general interests are far more integrated than ever before, given that my disclosure (as well as the resultant connections with many thousands of people interested in the topic) has deepened my sense of commitment to and love of the entire field of psychology. In many respects, my passion for my work has only intensified as I have come to understand more clearly the deep roots of my interests in children, development, and mental illness.

Given space limitations, there is much that I have had to omit about my father's life and my responses to it. In the remaining sections of this chapter, I hope to illuminate a number of themes and lessons related to this brief narrative, beginning with key developmental processes and issues and concluding with several core themes related to developmental psychopathology, including diagnostic accuracy, resilience, family experiences of mental illness, and stigma. In so doing, I will add some additional details of events that both my father and I experienced.

DEVELOPMENTAL CONSIDERATIONS

In this section I deal with several interrelated questions: What are the important developmental themes and issues exemplified by my father's life with bipolar illness, including potential risk factors for his psychiatric problems, the role of his severe psychoses and brutal hospitalizations on his adult-self image, and his abilities as a parent? What are the parallel developmental themes related to my having grown up in the family I did—in utter silence—only to learn of key issues related to my father's condition after I had left home? How do the concepts of internalization and parentification fit into this picture? What are the consequences of having a genetic legacy of serious mental illness for a child in such a family, and how can individuals in such families and homes deal with the risk and the promise of “loaded” family histories? These queries and more inform the following pages.

Issues Related to the Individual with Bipolar Disorder

Risk Factors

Although it is abundantly clear that individual case studies often include idiosyncratic, uncontrolled variables that may not apply to other cases or that might be spurious, my father's life history may still prove heuristic. It certainly exemplifies the truism that multiple risk variables are at work in serious instances of psychopathology (e.g., Goodwin & Jamison, 2007). In the first place, many members of my father's family have shown high professional attainment in terms of academic, artistic, and business success; yet many others, across multiple generations, have evidenced high risk for psychiatric illness in terms of mood, anxiety, and eating disorders. (In my stepgrandmother's side of the family, schizophrenia-spectrum conditions are more prevalent; see Hinshaw, 2002, 2004.) Yet at this point the field still does not know the precise genetic risks for bipolar disorder, and it is a major mistake to think that there is a single gene responsible for any of the major psychiatric conditions (Kendler, 2005). Thus, despite the strongly heritable nature of manic-depressive illness (see Goodwin & Jamison, 2007), the surge of research in gene \times environment interplay across many areas of psychiatric disturbance (see reviews in Beauchaine, Hinshaw, & Gatzke-Kopp, 2008; Rutter, Moffitt, &

Caspi, 2006) suggests that there may well be environmental factors that moderate (via gene \times environment interaction) and mediate (via gene–environment correlation) the undoubted genetic vulnerability for this condition (Goodwin & Jamison, 2007).

Related to such factors, in my father's case I can point to the loss of his mother when he was 3 years of age and the abusive treatment he received at the hands of his stepmother. First, early loss of a parent is certainly a risk factor for later mood disturbance, but even more important is the quality of the caregiving that exists following the loss (e.g., Maier & Lachman, 2000). Second, maltreatment has clearly been established as a risk factor for a variety of negative outcomes, mediated by such processes as neurobiological insult, hostile attribution biases, and decreased emotion recognition and emotion regulatory capabilities (see Cicchetti & Valentino, 2006). In terms of bipolar disorder per se, there is no compelling evidence that maltreatment is a sole causal factor, yet the presence of abuse in persons with vulnerability to bipolar illness predicts a particularly pernicious course (Post, Leverich, Xing, & Weiss, 2001; see also Garino, Goldberg, Ramirez, & Ritzler, 2005; Neria, Bromet, Carlson, & Naz, 2005). At the very least, whether or not it propelled the episodes themselves, my father's experiences of waiting for severe, imminent punishments shaped his worldview about expected degradation for moral flaws—and contributed to his view that something he had done wrong must have led to his hospitalizations.

Several key concepts from developmental psychopathology are relevant to this discussion. The search for causal factors for bipolar disorder forces consideration of *multiple levels of analysis*, ranging from molecular processes at the level of genes and neurons to mechanisms more related to personal, family-related, and social factors (see Cicchetti, 2008). Indeed, the “holy grail” for much current work in psychopathology involves understanding the linkages between and among genes, gene products, temperament and other building blocks of personality, child-rearing and other socialization practices, self-organization, peer relationships, neighborhood and community-level processes, and transmission of cultural beliefs—to name several of the most salient levels—in creating both normal-range and disordered functioning. My father's experiences also bring to life core constructs pertinent to developmental trajectories, including *multifinality*, the branching into differentiated outcomes from similar initial conditions or risk factors, and *equifinality*, the progression into a similar outcome from variegated vulnerabilities, pathways, or trajectories (Cicchetti, 2006; Hinshaw, 2008c). That is, family history and genetic vulnerability may or may not yield frank psychopathology, depending on a host of mitigating (or exacerbating) psychobiological and psychosocial influences; and it is extremely likely that a variety of processes may lead to the outcome of bipolar spectrum disorders in different individuals. The more the field gains understanding of psychopathology, the more we come to realize that (1) the categories of disturbance to which people are assigned are not static entities but rather dynamic conceptualizations and (2) reciprocal, transactional processes as well as variegated developmental trajectories characterize nor-

mal as well as atypical functioning (Hinshaw, 2008b, 2008c; Jensen, Hoagwood, & Zitner, 2006).

Implications of Adolescent Pathology for Self-Perceptions and Ultimate Self-Image

By all indications, my father's premorbid adjustment as a child and early adolescent was healthy. He was an intelligent, athletic, and spiritually minded boy who thrived in school and on the playing field even if he was succumbing to severe punishments at home and even if he was, at times, a bit tempestuous and headstrong. For example, he wrote in his journals about a time in first grade when he was confronted with a substitute teacher. He had been acting "smart" in the classroom, leading the teacher to call attention to his brash attitude. Climbing high on top of a desk, he quickly retorted: "Well, if you don't like my attitude, how about my altitude?" Unfortunately, the school reported this incident to my father's family, leading to a severe punishment from his stepmother.

Still, nothing led him or his family to prepare for his monumental escalation through the stages of mania at age 16, replete with grandiosity, paranoia, and psychosis and resulting in a devastating hospitalization—and the near loss of his life from jumping from the roof of his home and his refusal to eat for many weeks while hospitalized. It is difficult to imagine how individuals and family members alike readjust to such drastic changes of behavior and overall functioning. In addition, all members of the family system must now contend with a psychiatric label, the stigma of being a "mental patient," and the shift to viewing the individual in question as carrying a deep and fundamental flaw lying at the core of his or her being.

Note that there is major debate today about the nature of child-onset bipolar disorder and its chronic, ultrarapid, or ultradian cycling nature (Blader & Carlson, 2008; Geller et al., 1998; see also other chapters in the current volume). In cases with childhood onset, which often include impulsive, aggressive, and emotionally dysregulated symptoms from an early age, identity may well form around themes of chronic instability and the need for special education or restrictive placements. Yet in the case of the more classic presentation that my father displayed, with mid- to late-adolescent onset following a childhood and adolescence marked by high functioning, the contrasts between such strong performance and utter devastation are likely to present a huge challenge for the maintenance of any stability of subsequent self-perceptions.

Overall, given the major adolescent task of consolidating a core identity, which is linked to a number of underlying cognitive, emotional, and social processes (Harter, 2006), the repercussions of a major breakdown of contact with reality—and of dehumanizing, punitive "treatment" in the back ward of a mental hospital—can only be expected to be devastating during this phase of life. Even after my father returned to high levels of functioning between episodes, he retained a belief that his core self was flawed, tainted, and deserving of punish-

ment. And even in his latter years, with his newly gained diagnosis of bipolar disorder replacing his four-decade-old label of schizophrenia, he viewed himself as “a psychotic,” an individual whose foundation was forever eroded by his delusions, his sense of difference, his underlying despair at ever being able to communicate his experiences, and his treatment as subhuman by fellow inmates and staff (Hinshaw, 2002). All of the “book learning” he undertook at this late phase of his life regarding the biological, heritable nature of bipolar disorder did little to sway this fundamental self-perception. As for the treatments we currently administer and develop for the future, it will be essential that youths are given humane and compassionate care, with the best of evidence-based medicine and therapy, so that the overwhelming emotions they experience as a result of their bipolar condition are not magnified by a sense of difference, unworthiness, and hopelessness related to negative experiences in treatment. Social support, especially from interactions with others who have been through and successfully coped with bipolar disorder, could well be a major countervailing force along these lines.

Issues for Spouses and Family Members

Family members are the unsung heroes in a large proportion of cases of severe mental illness. Typically vilified by mental health professionals, who believed until recent decades that families were the causal agents for mental disorder in terms of faulty parenting and socialization practices, relatives must cope with shame, financial hardship, time away from work, demeaning responses from professionals, and other types of severe burden (Lefley, 1989; Struening et al., 2001; Wahl, 1999; see also Hinshaw, 2007). But we often don't consider the lengths to which family members must go in order to cope with the incomprehensibility of serious mental illness (for a compelling volume, see Tessler & Gamache, 2000; for recent evidence on family burden in relation to bipolar disorder, see Perlick et al., 2007).

As an example, in the late 1950s, when I was about 4 years of age and my sister not quite 3, an incident occurred on an autumn evening. Quoting from *The Years of Silence Are Past*, the book I wrote about my father's life:

My mother has seen the signs before, over the past few years: A particular glint in her husband's eye, a too-ready smile, a penchant for nonstop talking, a different level of energy. A sure sign is his playing, at volumes far too loud, religious choral music on the phonograph. At these times it feels to her that a chemical change is overtaking him, although she gets nowhere when she tries to tell any doctors of this intuition. She knows what is bound to ensue with him: grand plans, sleeplessness, irritability, increasing irrationality, and paranoia, soon followed by utter disorganization. On some occasions, he has required hospitalization, and she is left with taking care of the household and the children, having to “cover” in front of friends and relatives. No one has really dwelled on it, but the term schizophrenia has floated in the air. When his episodes are over, however, they are really over, as mysteriously as they had begun. He acts

as though nothing has happened, without discussion. Silence lingers between the couple.

Back to the fall evening: The hour is getting late, as it is now after 10 P.M. A popular variety show is on the television, broadcast from Cincinnati, 100 miles away from Columbus. An attractive female singer is singing on a variety show. My father has seen her on this program before, but tonight it is different: He has become obsessed with her. He believes, in fact, that her lyrics are communicating messages to him. He needs to see her, to continue the communication in person. It is urgent.

For a week or more, his behavior has been escalating, increasingly energetic, enthusiastic, bombastic. My mother's worry increases daily: Where will it stop this time?

Growing even more excited and agitated with the show, my father contends that they must drive to Cincinnati to find the singer, so that he can respond to her messages. The idea takes complete hold of him; he can't let it go.

My mother is terrified: to Cincinnati, in the car, at this time of night? She knows better than to try and talk him out of such a plan when he has reached this state, as his anger will escalate. So should she let him drive off—and perhaps learn of a fatal accident the next day, given his growing impatience and irrationality? Or should she accompany him to Cincinnati . . . but then what of the children? There is no reasoning with him; he must leave. Thinking fast, she decides to go along, fighting her terror that the children may awaken in the night with no one to look after them.

One last thought: Could she call anyone at this late hour? Even if she did, what would she say? And there's no opportunity to wait for someone to arrive, given her husband's impatience and force. What can she do? Maybe her presence will somehow contain him.

They head for the family car, a 1956 Ford Victoria with a strong engine, and tear off in a southwesterly direction. The interstate highway system does not yet exist, and the roads are mostly two-lane highways. Yet he drives frightfully fast, possessed of his need. At speeds of over 90 miles per hour, they fly through the night. Does she dare allow herself too many thoughts of the children, asleep at home?

Somehow they arrive in Cincinnati after 11:30 P.M., managing to find the TV station from which the show had originated, its huge broadcasting tower providing a beacon. Almost as if in a dream—but if this is a dream, it's fast becoming a nightmare—my father insists on leaving the car to enter the station and find the singer. My mother fears for an ugly confrontation at the front desk. Fortunately, the hour is late enough that the gates are locked.

She struggles to maintain composure, concentrating on reining him in. Will he try to jump the fence? She talks simply and rationally, convincing him that the singer has left and that there is no use in staying. His internal struggle is apparent, but finally he relents, suddenly eager to return home. They roar back onto the highway. She can't believe the speedometer. What if a highway patrolman were to pull them over, with her husband in his state? Will there be a physical confrontation? Will they end up in jail? What will happen when the children awaken?

Luck is with them, however, and they make it back to Columbus safely by the wee hours of the morning, racing over the rolling hills of Southern Ohio as they flatten out into the farmland plains of Central Ohio. She can't believe it; they are back in the driveway at home. Heart in her throat, she rushes upstairs to find the two children still asleep in their beds, oblivious to the disruption and absence. Her heart begins to slow, but the terror hasn't left. How long can this last? she wonders, relieved, terrified, wishing for some rest. What is next? (Hinshaw, 2002, pp. 10–13)

How can we understand the terror that my mother felt—indeed, the terror and utter confusion that far too many parents, spouses, and offspring experience in the wake of irrational symptoms and impossible situations? What was the correct choice: To leave her children and try to head off her husband's demise, or to stay with my sister and me and learn, the following day, that her husband would never return? If we can appreciate the additional complexities that arise when no viable communication exists within a family and when professionals encourage silence, then we are forced to realize that the types of family burden experienced in relation to mental illness are multiplied immeasurably when shame and stigma are added to the mix (Hinshaw, 2007; see also further discussion of stigma later in the chapter).

In the case of bipolar disorder, despite the strong heritability of this condition, evidence reveals that family attitudes, including conflict and hostile emotion, are related to negative outcomes (Du Rochler Schuldich, Youngstrom, Calabrese, & Findling, 2008; Kim & Miklowitz, 2004; see also Simoneau, Miklowitz, & Saleem, 1998). Clearly, genetic vulnerability can be exacerbated by difficult family reactions, which are understandable given the severity of the symptoms and impairments related to this condition. Thus, as explained in the section on family intervention, procedures that can help increase understanding and communication and reduce conflict may well be helpful for optimal prognosis.

Parenting Abilities of Individuals with Serious Mental Illness

Less than a year after the incident just described, when I was in kindergarten and my father was again well, he showed great sensitivity as I pondered my 5-year-old questions about geography and populations (see earlier excerpt). When I was in fourth grade, following his return from a year away, he comforted me at night when I could not sleep, coming from my parents' bedroom to tell me that my fears of illness and dying could be remedied by the miracles of modern medicine (indeed, perhaps he wondered whether similar miracles could ever help his own mental problems). He immediately soothed me by stating that I would probably live to be 100 years of age because of such medical miracles; the number of 100, which had figured so prominently in my kindergarten amazement over the populations of Russia and China, seemed once again mysterious and healing. And in high school, he intervened with sensitivity and impact during a critical period when I believed I had made a terrible decision that caused me great despair.

In short, it is a myth to believe that individuals with severe mental illness cannot be sensitive, caring parents. Certainly, during the throes of psychosis or in the depths of a suicidal depression—or when substance abuse is added to the mix, as it so often is with mood disorders—parenting is inevitably compromised, and children require protection and adequate caregiving from the alternate parent or other supports. Yet the assumption that a diagnosis of bipolar disorder automatically disqualifies an adult from any rights to being a parent, or that “mentally ill parents” are, by definition, unable to provide support to their children, is simply false. (For a review of restrictive and discriminatory state legislation related to child custody as well as other domains, see Corrigan, Markowitz, & Watson, 2004; Corrigan et al., 2005.) It is essential to break stereotypes, which are themselves a key component of stigmatizing responses, and tell the real-life stories, both good and bad, about what mental illness is really like, and the ways in which individuals and families who cope with mental disorder can maintain a number of important life roles, especially when the condition is recognized and when adequate treatment and support are forthcoming (Hinshaw, 2007).

The Child in a “Bipolar Family System”

Several important questions from a family perspective are as follows: How did I respond to my Dad’s episodes (which were almost entirely hidden from me) and from the doctor-ordered silence about his absences and hospitalizations? What are the consequences if a child does, in fact, witness disruptive, psychotic behavior? As a late adolescent, how did I integrate my new knowledge about his life into my identity, my sense of myself and my family, and my life goals?

Silence, Internalization, and Parentification

My father’s doctors, operating via the ignorance and stigma of the time, clearly believed that keeping a child in silence about parental disruption and parental absences related to mental disorder would be optimal, given that children “can’t understand mental illness,” in their words. But what are the consequences of silence? When children realize that conflict is occurring but have no real explanation for it, they are likely to blame themselves, internalizing the conflict and disruption (see review in Hinshaw, 2004). On the face of it, this strategy seems maladaptive, even self-destructive. Yet it may be far better to hold oneself responsible for negative events than to either blame the person on whom one depends for love and support or, alternatively, to believe that the world is simply a cruel, heartless, random place.

As for me, I adopted a typically midwestern style of silent coping, using academics and athletics as means of keeping myself focused. Nonetheless, I was lonely, and there was simply no one to talk with about my fears, doubts, and insecurities. In addition, even as a child I had a high need for control and carried

a strong sense of responsibility. I had become somewhat parentified, meaning that I took on an adult-style identity, although not to the extent of some youths from highly chaotic families or who have been sexually abused, who are prone to behave essentially in adult, parental roles from early ages (for discussion, see Byng-Hall, 2008; Peris & Emery, 2005).

In terms of my denial and my family's silence: Even during high school, when it had become quite clear that my father was in partial hospitalization during my senior year, my involvement in sports and studies essentially blinded me to this fact. So when he began his revelations to me once I was at Harvard and returning home for vacations, his words were the truth that I had always needed to hear. Over the many years since that time, I have gradually been able to relinquish some of my tight control and come to terms with being part of a family with both high promise and high risk.

Responses to Disclosure

Still, as noted in the beginning narrative of this chapter, his words engendered considerable anxiety in me during my college days. I now had a secret myself and one that I dared not tell roommates, teammates, or girlfriends. What would it mean to say that my father was a mental patient, with schizophrenia—and that I may well be at risk myself? Silence breeds silence, and I kept private my father's conversations with me.

Most striking were the fears that I would have at night, especially the fear that if I stayed up too late and couldn't sleep, I might lose control of my mind. Although I was learning psychology, the knowledge base I got in college with respect to clinical psychology was thin indeed with respect to modern differential diagnosis of schizophrenia versus bipolar disorder. And the academic learning I was doing was no match for the gnawing sense I had that my own hold on control and rationality could be tenuous. It took more than a year beyond college to come to terms with the fact that I didn't need to punish myself through induced vomiting to be able to relax enough to rest and sleep.

My volunteer work and my subsequent work as a camp director and therapeutic school coordinator provided me with real motivation to go to graduate school in clinical psychology and learn more directly about mental illness as well as a number of important related topics, most notably developmental psychology, research methods, and psychopharmacology. Maybe, I hoped, I could truly understand the causes of severe mental illness and better approaches to treatment than my father had experienced for most of his life. It is clear, with hindsight, that the roots of my deep commitment to clinical psychology and developmental psychopathology had emanated, in large part, from my experiences in my family of origin.

Also, through a committed relationship, I realized that my fears about having children were becoming replaced by a sense of deeply wanting to be a father. This change in attitude took time, however. In the wake of serious family mental

illness, I have found that fundamental alterations in deeply entrenched responses of fear and overcontrol come quite slowly.

I have long had a major dose of survivor guilt. That is, I ask myself why I have made it through my life relatively unscathed. I do carry a certain level of emotional intensity: a real energy and a sense at other times that things are extremely bleak. After two significant losses, as well, I have experienced serious depression. But I have a sense of stability underneath, and despite my earlier fears, I have never become psychotic or experienced life in a mental hospital. Rather, I have been blessed with key talents, I have a sense of purpose in my life, and I continue to have wonderful family and professional experiences. Yet why should this be the case when so many relatives have truly suffered, some permanently? For example, two of my first cousins—each the first-born son of my father's half-brothers—have severe mental disorders, with one having committed suicide at age 30 secondary to schizoaffective disorder and the other now having completed four consecutive decades of chronic, debilitating schizophrenia. Even in my immediate family, my mother has suffered from severe rheumatoid arthritis for over 30 years, doubtless triggered at least in part from the unimaginable stress of having to contend with my father's episodes and absences throughout her family life.

So I often carry a sense of wonderment, befuddlement, and unease about having never had to contend with such debilitating problems while so many around me have struggled so greatly. Although it has not limited me in terms of family or career pursuits, at times I have felt burdened by my sense of having pulled through. Indeed, this sense has gnawed at me, as I try to understand the “luck of the genetic draw,” perseverance, or some combination of the two has permitted me to be where I am. Certainly, others with personal or family histories of serious mental disorder grapple with similar issues (Hinshaw, 2008a; Jamison, 1995).

Intergenerational Transmission

A related worry concerns the risk for mental illness in future generations of my family. As noted, I was convinced during my 20s that I should never have children of my own, but that fear dissipated as I matured. I now have two wonderful sons and an equally wonderful stepson. What does the future hold for them? The oldest clearly has seasonal mood issues, present since high school. Yet a combination of meditation, athletics, a strong sense of humor, and hard work at maintaining social networks has made a huge difference. The youngest is an exuberant 5 years of age, with many of the characteristics of his grandfather, who died years before he was born. His wonderful qualities predominate, but does any of his precocity and intensity foreshadow deeper problems as he grows up?

My current struggle is to be watchful but not overinvolved, with enough flexibility to follow and be guided by each boy's temperamental “lead.” How much, I continue to wonder, is my reflex to become vigilant (or overvigilant) an attempt to deal with the gaps I experienced as a child when my dad simply wasn't there versus a “prudent” monitoring of potential risk for serious mood disturbance, with all of the attendant impairment and misery it can create? What I now realize is

that if crises occur, my family and I will be armed with awareness and the ability to quickly mobilize allies and interventions.

This entire topic is linked with the blending, in many “bipolar families,” of creativity and productivity with despair and disorder (e.g., Jamison, 1993; Richards, Kinney, Lunde, Benet, & Merzel, 1988). Indeed, when genetic screening for risk for psychiatric conditions like bipolar disorder emerges as a viable enterprise, societies should think long and hard before emerging with any future plans to eliminate such genetic propensity. Lessening or eliminating any “bipolar risk” from the gene pool may well lead to a marked reduction in important genetic variability across our species, with the potential for squelching a range of important traits and features that are productive and adaptive.

ADDITIONAL ISSUES

My father’s life, along with my experiences in the family system in which I grew up, reveals several additional themes and issues that I believe to be of major scientific and clinical importance. For more detail regarding the following themes, see Hinshaw (2002, 2004, 2006, 2007, 2008b).

Accurate Diagnosis and Evidence-Based, Responsive Treatment

Back in the 1930s, during and after my father’s initial episode, it may not have really mattered whether his diagnosis was schizophrenia, manic-depressive illness, or any other condition: There were no viable treatments for any categories of mental illness. Hence, accurate diagnosis may have served only an administrative or strictly nosological function. Today, however, with a growing array of pharmacological and psychosocial treatment modalities of proven effectiveness—and many more of still-questioned validity awaiting clinical trials—accurate diagnosis indeed matters to the extent that specific treatments for different conditions have been documented (for bipolar disorder, see Keck & McElroy, 2007; Miklowitz & Craighead, 2007). Thus, rather than serving as a dehumanizing label, an accurate diagnosis may well point to treatment modalities that can not only ease symptomatology but also curtail suicidality and enhance overall functioning.

Still, there are major questions throughout the field of psychopathology as to whether the diagnostic categories currently in existence are actually valid. Indeed, there is no evidence that all individuals diagnosed with, for example, schizophrenia, bipolar disorder, attention-deficit/hyperactivity disorder (ADHD), or any other category of pathology have underlying similarities, given what we know about multiple risk factors, equifinality, and the sheer diversity of clinical presentations and underlying mechanisms (Jensen et al., 2006). Furthermore, there is increasing recognition that both psychotropic medications and key psychosocial interventions (e.g., cognitive therapy, interpersonal therapy, many types of family intervention) exert “transdiagnostic” effects, meaning that they may address fundamental dimensions of neural, behavioral, or emotional functioning that

transcend any given diagnostic entity (e.g., Harvey, Watkins, Mansell, & Shafran, 2004). In short, the field cannot rest on its laurels, because it is highly likely that the diagnostic nomenclature currently in use (DSM-IV; see American Psychiatric Association, 2000) will be supplanted in the coming decades with a fundamentally different approach.

These points are particularly salient with respect to the growing tendency for children and adolescents to receive diagnoses of bipolar disorder, despite major uncertainties about the validity of many such diagnostic decisions (Blader & Carlson, 2008), as well as an evidentiary base, for a multiplicity of mood-stabilizing and second-generation antipsychotic medications, that is growing slowly in relation to the numbers of youths who are prescribed these medications. A core challenge for the years ahead will be to balance the urgent clinical needs of a large number of children and adolescents who have serious emotional and behavioral disturbance with appropriate caution regarding (1) “jumping on the diagnostic bandwagon” and (2) the practice of polypharmacy in the absence of sound evidence-based intervention. Clinicians and research investigators will need to forge important new linkages in order to contend with the serious pathology exhibited by troublingly large proportions of children and adolescents, with major efforts required to achieve the important goal of enrolling youths in clinical trials of treatment efficacy and effectiveness as well as developmental investigations related to long-term outcomes (Hinshaw et al., 2004).

Finally, treatments must be responsive to the needs of the patient and family in question. Bipolar disorder often produces frightening, hope-depriving symptoms, frequently leading to confusion, disruption, despair, and hopelessness for all involved. Although pharmacological treatments are clearly indicated for nearly everyone with manic-depressive symptomatology, they need to be supplemented with psychoeducation, family involvement, and various forms of psychological therapy to motivate problem-solving and emotion regulation (see Miklowitz & Craighead, 2007). Clinicians need to show sensitivity to the huge tumult caused by bipolar symptomatology and to be responsive to the befuddlement, anger, shame, and confusion that are so clearly linked to the condition in patients as well as family members. My father’s experience of being warehoused, in an era of both ignorance about the disorder and lack of respect for the dignity of patients, provides a tragic lesson for all who are concerned with mental health. In the current era of major closures of public mental hospitals (more than 550,000 Americans were institutionalized in such facilities in 1955 vs. fewer than 50,000 today), the challenge is to ensure that adequate community care and community supports are available.

Resilience

Can individuals at high risk for psychopathology, or even those who have exhibited clinical-level symptomatology, recover and thrive? More generally, are there systematic means of understanding how a subgroup of those with vulnerabilities

for poor outcomes can overcome the odds and show positive trajectories? The study of resilience is concerned with just such issues (for reviews, see Luthar, 2006; Luthar, Cicchetti, & Becker, 2000; Masten, Burt, & Coatsworth, 2006).

My father provides a telling example, given that, despite devastating episodes and horrendous experiences in treatment, he maintained his ability to be a caring parent and was able to keep his teaching and research interests alive. Moreover, he maintained a philosophical attitude throughout his life. For instance, in the last years of his life, he told me that he would not have traded any of his life experiences, even those that had resulted in his hospitalizations, given his belief that he had learned and benefited from all such experiences. Among the potential factors related to his resilient functioning, several come readily to mind: his sense of humor; his strong religious faith, which coexisted with his scientific and philosophical interests; his strong work ethic and sense of responsibility; the tenure system (which enabled him to hold on to his job, even when severe episodes hit); his incredibly supportive wife (my mother); and his continuous desire to search for deeper meanings in life, which doubtless helped him to overcome the trauma and shame related to many of his episodes. Clearly, it is not the case that individuals experiencing serious mental illness are necessarily doomed to limited, sterile, impaired lives.

Initially, resilience was viewed as an all-or-none, “you-have-it-or-you-don’t” kind of phenomenon (indeed, it was formerly termed “invulnerability” or “invincibility”; see Anthony, 1974). Investigators of resilience now view it as a set of processes that may promote strength and competence in different areas of functioning, distinguishing at least three levels of protective factors for those at high risk: intraindividual, dyadic/relational, and community/systemic. In terms of individual factors, evidence now exists that resilience may, in fact, be partly heritable; in other words, there are genes that confer “protection” for some individuals in high-risk contexts (see Kim-Cohen, Moffitt, Caspi, & Taylor, 2004). Solid evidence exists as well that strong interpersonal relationships are perhaps the key protective factors that vulnerable individuals may encounter (Luthar & Brown, 2007). Yet in the account of potential factors for my father, the only variable in the “community/systemic” category had to do with the tenure system. Indeed, given the institutional abandonment that he received, as well as the community/societal stance that essentially shunned and isolated those with mental illness, I cannot think of other systems-level factors that helped him. As noted later in the section on stigma, a key challenge is to institute attitudes and practices in schools, in the workplace, in the marketplace, and in our general culture that promote openness, knowledge, and tolerance of many forms of deviance, including mental illness. This is not to say that aberrant, psychotic behavior should be accepted; indeed, as emphasized later, access to treatment is a necessary part of resilience-fostering practices.

The construct of resilience has come under challenge (see Luthar et al., 2000). Indeed, many so-called protective factors are essentially the polar opposites of risk factors, calling into question the contention that resilience constitutes a distinct

set of processes. Also, debate exists about whether one needs to have experienced vulnerabilities or high-risk circumstances in order to show resilient functioning. Still, focus on this concept is of enormous benefit because it not only removes the field from a nearly exclusive focus on negative outcomes and pathology but also reveals that normal and disordered functioning are not as separate as one might believe. In other words, most forms of mental disorder involve the interspersing of healthy with less healthy functioning; symptoms wax and wane (particularly in the case of bipolar illness); and understanding the factors that promote strength and recovery goes hand in hand with the discovery of risk processes (see Cicchetti, 2006; Hinshaw, 2007). In short, stereotypes of mental disorder as chronic, hopeless, and unrelentingly negative not only are untrue, but they also fly in the face of a wealth of evidence related to protective processes and the potential for rehabilitation and recovery.

Silence and Communication in Family Systems

Despite the strong heritability of bipolar disorder, important research reveals that family processes are important for outcome (e.g., Miklowitz, 2004; for related evidence regarding the importance of family socialization regarding another highly heritable condition, ADHD, see Hinshaw et al., 2000). My focus here is not to review the many potential family factors that could be related to outcome in bipolar disorder but rather to address the particular stance that my family took, namely, on doctor's orders, to remain silent about my father's illness and absences.

As discussed earlier, such a stance is likely to promote internalization among children, who are prone to blame themselves rather than those on whom they count for love and protection. William Beardslee has examined this aspect of family communication in relation to parental mood disorders (both depression and bipolar disorder), emerging with a provocative and important brand of family treatment. In brief, his argument begins with the statistic that having a parent with a mood disorder provides a substantial risk for the offspring's parallel risk for mood disturbance. Indeed, people who have a parent with major depression have a 60% chance of experiencing major depression themselves before the age of 30, a substantially increased risk over the base rate (Beardslee, Versage, & Gladstone, 1998). Yet the mediating factors in this regard are not exclusively genetic (particularly in the case of unipolar depression): A large number of variables, including insecurity of attachment bonds, parental irritability and/or withdrawal, the modeling of emotion dysregulation, harsh or lax parenting, interparental conflict, and many more, increase the risk for mood disturbance in the children who live in such families (Goodman & Gotlib, 2002).

A factor of core interest to Beardslee is precisely the one under discussion: namely the shame and silence that all too often prevent any family discussion of the parent's condition. Parents are typically ashamed of their behavior patterns and diagnoses, lacking any viable means of discussing their own situations with

their children. Thus, a core goal for this family therapy approach is to prevent the child's self-blame for family disruptions, erratic discipline, and the parent's suffering, which, in combination with other risk factors, serves to increase the probability that offspring will develop adjustment problems or mood disorders themselves. To combat this tendency, parents work with the therapist, initially without the children present, to form a plan for a series of family meetings in which the parents engage the child directly in discussions of the parent's mood disturbance. In other words, the parents begin to create a narrative, in language the child can understand, to promote understanding of Mom's irritable behavior or Dad's absences (or whatever the particulars) to prevent self-blame on the part of the offspring and to encourage a far more open style of communication. The therapist provides ample support for the parents as they construct their story, modeling and shaping direct and sensitive communication to the child (see Beardslee, 2002).

Other objectives are addressed in this family intervention, including motivation for the affectively disordered parents to receive evidence-based treatment for their condition and provision of other forms of family support. Still, a major factor that distinguishes it from other approaches is the emphasis on creating a narrative to end the typical stance of silence and shame. Importantly, controlled evidence reveals that this approach promotes better adjustment in the offspring immediately following the therapy, with effects on behavior and attitude changes in parents and youths up to 4½ years after treatment ends (Beardslee, Wright, Gladstone, & Forbes, 2007). In short, family intervention focused on promoting communication rather than silence may provide assistance in breaking an intergenerational cycle of mood disturbance (for an additional, evidence-based approach to the family treatment of bipolar disorder, see Miklowitz, 2008; see discussion in other chapters in this volume).

To conclude this section, what eventuated with respect to our own family's silence once I became an adult? My father's conversations about his life took place with me, not his wife (nor with my sister); indeed, he did not engage my mother in such parallel disclosure, perhaps because of the shame he felt when recalling his history of embarrassing, hostile, or out-of-control behavior that had sometimes required her to secure intervention for him. It may have also been difficult for him to be as open with females as with males, given the loss of his mother and the treatment he received at the hands of his stepmother. Thus, silence continued between them about key aspects of his life and their relationship.

Late in my father's life, and now in my role as a professor at Berkeley, I decided to write about his story, as noted earlier; and I talked about my intentions with my mother. She was not pleased, however, telling me that, although it would be fine with her if my observations appeared in academic journals, she did not want a story that was private, personal, and shameful to her to be widely known. I was, therefore, confronted with a dilemma: Do I continue write about my father's experiences (and my own), risking a rift with my mother, who had single-handedly kept the family together throughout my childhood, or acquiesce to her legitimate wish for privacy and her sense that continued silence was the optimal approach?

Truly conflicted, I persevered, trying to let her know of the importance of my writing about his life and receiving real support from my wife, Kelly, who let me know that my mother would come to understand the intent behind my desire to tell the narrative. Once the book was published, my mother was still unhappy, although perhaps resigned; our communication was tense. Yet not long after its publication, she called me and asked for additional copies, noting that her book-reading group back in Ohio, which included some of her childhood friends, had selected it. She told me that even these close friends hadn't known all of what the family had encountered decades earlier or of the heroic efforts on my mother's part to negotiate the sometimes chaotic experiences related to my father's episodes. They praised her courage and strength, providing invaluable support for her many years after the fact. Soon thereafter, my mother wondered out loud to me why the book had not received more reviews in mainstream newspapers and magazines! In short, she now realized that her role had been validated and that silence had not been the best option.

Although I had not known it at the time I pressed the issue with my mother, I now see that breaking the family silence was optimal for everyone, albeit initially painful. The hope is that removing the general shame and silence surrounding mental illness will facilitate openness, recovery, and access to services at broader levels as well.

Stigma

The previous section provides an appropriate transition into what many consider to be the major issue in the entire field of mental health: the stigma that still enshrouds mental illness (e.g., Hinshaw, 2007; Sartorius, 1998, 1999; U.S. Department of Health and Human Services, 1999). A term from ancient Greece denoting a literal mark of shame (i.e., a mark or brand placed on a traitor or slave), stigma currently signifies deep psychological degradation related to being a member of a devalued outgroup (Goffman, 1963). A host of research evidence reveals that mental illness—both the constituent behaviors and the labels used to designate mental disturbance—is one of the most stigmatized attributes an individual can have (for reviews, see Corrigan, 2005b; Link & Phelan, 2001; Thornicroft, 2006).

Although even a cursory summary is not possible in the confines of the current chapter, several points are quite clear. First, humans may be predisposed, at the level of natural selection, to reject and stigmatize other people who signal threat, contagion, or major social norm violations (Kurzban & Leary, 2001). Even so, stigma is not inevitable; through individual effort and social programs, stereotyping and prejudice can be overcome. Second, some of the characteristics of severe mental illness may convey the very signals leading to castigation; thus, it is not completely surprising that mentally disordered behavior has received extreme levels of stigmatization, discrimination, exclusion, and even annihila-

tion across cultures and across history (Hinshaw, 2007). Stigma is revealed today in the desire for social distance from persons with mental illness, discriminatory behaviors and legal restrictions, and in unconscious, implicit attitudes of fear and negativity (Stier & Hinshaw, 2007).

Third, the stereotyping and prejudice directed toward individuals with disturbed behaviors or a mental illness label are likely to produce self-stigma for recipients, leading to greatly reduced life opportunities, self-castigation, decisions to conceal a history of mental illness, and either failure to enter treatment or premature cessation of treatment (Link & Phelan, 2001; Sirey et al., 2001). Fourth, individuals with hidden or concealable stigmas (such as a history of mental illness) are prone to considerable anxiety and conflict over the revelation of such stigmatized attributes, adding to intrapersonal conflict and interpersonal trouble (Quinn, 2006). Fifth, despite the large increases in knowledge about mental illness in contemporary society, paralleling the major scientific and clinical advances that have taken place in recent decades, levels of stigmatization are not showing parallel reductions, related to fears of dangerousness as well as rampant media stereotypes (Phelan & Link, 1998; Phelan, Link, & Pescosolido, 2000). Sixth, mental health professionals may be inadvertent promoters of stigmatizing attitudes, given the tendency for “us versus them” attitudes and beliefs that healers and scientists must be objective and without flaw (see Hinshaw, 2008a; Wahl, 1999). In short, the stigmatization that still surrounds mental illness adds a huge level of hopelessness, shame, and societal loss to the considerable impairment and burden that attends to mental illness itself (Hinshaw, 2007; Prince et al., 2007).

My father's experience reveals considerable stigma. He was an inmate of state hospitals, which were originally designed in the mid-1800s as humanitarian, medical-model alternatives to poorhouses or (for youths) orphanages but which soon deteriorated into large, decrepit “total institutions” (Goffman, 1961; Grob, 1994), intentionally built far from urban centers. Moreover, he was ashamed to tell his own wife about his experiences, he had to “cover” when back from mental hospitals about the experiences he had undergone, and he continued to believe that his episodes and treatments constituted punishments for wrong thoughts or behaviors he had committed. Until he revealed to me his secrets, his main communication about his life events had been through his own thoughts and journal entries. At one point when he was in his 60s, during one of our conversations, he told me that at times he had wished he had cancer or some physical illness, anything real, he said, not what the world considered to be an imaginary, “mental” affliction.

Stigma affects families as well. My father's stance of silence, prescribed by his psychiatrist, isolated our family from receiving needed support and help. Goffman (1963) introduced the notion of “courtesy stigma” to indicate that the stereotyping, prejudice, and discrimination surrounding persons with devalued traits often extend to their associates, including family members. The taint associated with a

severe mental illness and with involuntary psychiatric hospitalization doubtless extended to our entire family. For data on the stigma linked to caregivers of individuals with bipolar disorder, see Gonzalez and colleagues (2007).

Would it have made a difference had my father been told, during or following his initial episode, that he had bipolar disorder, a biochemically based illness with substantial heritability? In other words, would at least some of his lifelong shame have been mitigated had he—in fact, had all of society—been presented with a biogenetic attribution for his mental illness? One of the fundamental tenets of attribution theory, in fact, is that attributions of negative behaviors or characteristics to uncontrollable factors—those over which the person had no volitional input—should reduce blame and foster instead empathy and compassion (Weiner, Perry, & Magnusson, 1988). Indeed, a major aspect of many antistigma campaigns is to portray mental disorder as a genetically caused brain disease (e.g., Johnson, 1989), under the assumption that adoption of this view will dissuade the public from the view that mental disorders are results of faulty parenting or moral weakness, thereby serving to reduce stigma.

With regard to mental illness, however, the picture regarding attribution theory is not nearly so straightforward. In fact, experimental evidence reveals that biological/genetic ascriptions for mentally disturbed behavior may actually *increase* punitive responses and promote social distance toward both individuals and relatives (who are presumably tainted by the shared genes). For relevant research, with complex findings, see Mehta and Farina (1997); Phelan (2005); Phelan, Cruz-Rojas, and Reiff (2002); and Read and Harre (2001). Indeed, when the behaviors are as threatening and devalued as those constituting the core symptoms of severe mental illness, the belief that the behavior patterns are caused by faulty genes may fuel views of the permanence of the affliction and the fundamental subhumanity of the individual in question (Hinshaw, 2007). At the very least, attributing severe mental illness in reductionistic fashion to biogenetic causes is far from a panacea (Haslam, 2000).

Combating a phenomenon as complex as the stigmatization of mental illness will require multifaceted strategies (for a review, see Hinshaw, 2007). (1) Discriminatory laws must be repealed, and policies that deny equitable compensation for treatment of mental illness must give way to “parity.” At the same time, deinstitutionalization must be matched by adequate funding of community-based services, treatments, and advocacy. (2) Media images of mental illness, which are hugely negative and stereotypic (see Wahl, 1995), need to be replaced by accurate, humane portrayals that convey the truth about mental disorders, neither glorifying nor demonizing it. (3) Mental health professionals need to adopt a new set of attitudes about those whom they treat, given that recipients of care often view the individuals from whom they receive services as conveying a number of highly stigmatizing attitudes and responses (e. g., Wahl, 1999; see also Hinshaw, 2008a). For example, a removed, distanced therapeutic stance may actually increase the patient’s sense of being different or judged; jokes about “psychos” or other pejorative terms are extremely demeaning. (4) Increased public knowledge of mental

illness is important but it is far from sufficient: Contact with persons with mental disorder, under conditions of equity and informality, is required to break down barriers and increase empathy (for data on the “contact hypothesis” for reducing prejudice and stigma, see Pettigrew & Tropp, 2000). (5) Family members need to receive education, support, and admiration; along these lines, self-help and advocacy groups serve an essential role. (6) Individual treatment is also part of stigma reduction, in order to reduce threatening symptoms and enhance the person’s capabilities for independence and employment. Indeed, the situation is different from that of reducing racial prejudice: In that arena, societal attitudes are the sole locus of intervention, given that ethnic/racial status is a fixed characteristic of the individual in question. But mental illnesses are, in fact, dysfunctions—albeit dysfunctions reflecting complex, transactional, multilevel processes rather than simple, unidimensional causal forces. Thus, individual intervention for the person with a mental disorder, which requires policies of universal health coverage along with parity for mental health benefits, is a necessary component of any overall plan to reduce stigmatization.

In short, stigma reduction will require both access to evidence-based treatment and societal acceptance of a diversity of behavioral and emotional styles. Given the shocking waste of human potential and the real despair for families and individuals produced by mental disorder as well as its stigmatization, all of society stands to gain from intensive efforts toward reduction of prejudice and discrimination and toward assurance that treatment can be utilized (Corrigan, 2005a; Hinshaw, 2007).

CONCLUSION

Narratives help us construct the world and ourselves (Ochs & Capps, 2001). My father’s life with bipolar disorder, replete with disruption, terror, and stigma but also filled with deep humanity and compassion, conveys a number of essential themes and lessons for those interested in the development of bipolar disorder, its accurate diagnosis and responsive treatment, implications for self-worth, family shame and silence, and consideration of just what it will take to understand and treat this virulent form of psychopathology. There is no substitute for vigorous, precise science related to (1) risk and causal factors and (2) treatment development and dissemination, but narrative accounts can help to inform future generations of scientists, clinicians, and policymakers of the core issues that need to be pursued. Families bear much of the burden of mental illness; my fervent hope is that acknowledgment of the kinds of struggles and triumphs of family members will prove valuable for all those concerned with easing the burden of mental disorder. There is no doubting that it is a time of enormous challenge and enormous opportunity with respect to multiple fronts in the battle against mental illness, particularly bipolar disorder, and I believe that narrative accounts and scientific progress go hand in hand.

REFERENCES

- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Anthony, E. J. (1974). Introduction: The syndrome of the psychologically invulnerable child. In E. J. Anthony & C. Koupernik (Eds.), *The child in his family: Children at psychiatric risk* (Vol. 3, pp. 3–10). New York: Wiley.
- Beardslee, W. R. (2002). *Out of the darkened room: When a parent is depressed: protecting the children and strengthening the family*. Boston: Little, Brown.
- Beardslee, W. R., Versage, E. M., & Gladstone, T. G. (1998). Children of affectively ill parents: A review of the last 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 1134–1141.
- Beardslee, W. R., Wright, E. J., Gladstone, T. R., & Forbes, P. (2007). Long-term effects from a randomized trial of two public-health preventive interventions. *Journal of Family Psychology*, 21, 703–713.
- Beauchaine, T. P., Hinshaw, S. P., & Gatzke-Kopp, L. (2008). Genetic and environmental influences on behavior. In T. P. Beauchaine & S. P. Hinshaw (Eds.), *Child and adolescent psychopathology* (pp. 58–90). Hoboken, NJ: Wiley.
- Blader, J. C., & Carlson, G. A. (2008). Bipolar disorder. In T. P. Beauchaine & S. P. Hinshaw (Eds.), *Child and adolescent psychopathology* (pp. 543–574). Hoboken, NJ: Wiley.
- Byng-Hall, J. (2008). The significance of children fulfilling parental roles: Implications for family therapy. *Journal of Family Therapy*, 30, 142–162.
- Carlson, G. A., & Goodwin, F. K. (1973). The stages of mania: A longitudinal analysis of the manic episode. *Archives of General Psychiatry*, 28, 221–228.
- Cicchetti, D. (2006). Development and psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 1. Theory and method* (2nd ed., pp. 1–23). Hoboken, NJ: Wiley.
- Cicchetti, D. (2008). A multiple-levels-of-analysis perspective on research in development and psychopathology. In T. P. Beauchaine & S. P. Hinshaw (Eds.), *Child and adolescent psychopathology* (pp. 27–57). Hoboken, NJ: Wiley.
- Cicchetti, D., & Valentino, K. (2006). An ecological-transactional perspective on child maltreatment: Failure of the average expectable environment and its influence on child development. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed., pp. 129–201). Hoboken, NJ: Wiley.
- Corrigan, P. W. (2005a). Mental illness stigma as social injustice: Yet another dream to be achieved. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (pp. 315–320). Washington, DC: American Psychological Association.
- Corrigan, P. W. (Ed.). (2005b). *On the stigma of mental illness: Practical strategies for research and social change*. Washington, DC: American Psychological Association.
- Corrigan, P. W., Markowitz, F. E., & Watson, A. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, 30, 481–491.
- Corrigan, P. W., Watson, A. C., Heyrman, M. L., Warpinski, A., Gracia, G., Slopen, N., et al. (2005). Structural stigma in state legislation. *Psychiatric Services*, 56, 557–563.
- Du Rochler Schuldich, T. D., Youngstrom, E. A., Calabrese, J. R., & Findling, R. L. (2008). The role of family functioning in bipolar disorder in families. *Journal of Abnormal Child Psychology*, 36, 849–863.
- Garno, J. L., Goldberg, J. F., Ramirez, P. M., & Ritzler, B. A. (2005). Impact of childhood abuse on the clinical course of bipolar disorder. *British Journal of Psychiatry*, 186, 121–125.

- Geller, B., Williams, M., Zimmerman, B., Frazier, J., Beringer, L., & Warner, K. L. (1998). Prepubertal and early adolescent bipolarity differentiate from ADHD by manic symptoms, grandiose delusions, ultra-rapid or ultradian cycling. *Journal of Affective Disorders*, *51*, 81–91.
- Goffman, E. (1961). *Asylums: Essays on the social situations of mental patients and other inmates*. New York: Doubleday.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.
- Gonzalez, J., Perlick, D., Miklowitz, D. J., Kaczynski, R., Hernandez, M., Rosenheck, R. A., et al. (2007). Factors associated with stigma among the caregivers of patients with bipolar disorder. *Psychiatric Services*, *58*, 41–48.
- Goodman, S. H., & Gotlib, I. H. (Eds.). (2002). *Children of depressed parents: Mechanisms of risk and implications for treatment*. Washington, DC: American Psychological Association.
- Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness: Bipolar disorders and recurrent depression* (2nd ed.). New York: Oxford University Press.
- Grob, G. N. (1994). *The mad among us: A history of care of America's mentally ill*. New York: Free Press.
- Harter, S. (2006). Self-processes and developmental psychopathology. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 1. Theory and method* (2nd ed., pp. 370–418). Hoboken, NJ: Wiley.
- Harvey, A. G., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment*. Oxford, UK: Oxford University Press.
- Haslam, N. (2000). Psychiatric categories as natural kinds: Essentialist thinking about mental disorder. *Social Research*, *67*, 1031–1058.
- Hinshaw, S. P. (2002). *The years of silence are past: My father's life with bipolar disorder*. New York: Cambridge University Press.
- Hinshaw, S. P. (2004). Parental mental disorder and children's functioning: Silence and communication, stigma, and resilience. *Journal of Clinical Child and Adolescent Psychology*, *33*, 400–411.
- Hinshaw, S. P. (2006). Stigma and mental illness: Developmental issues. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed., pp. 841–881). New York: Wiley.
- Hinshaw, S. P. (2007). *The mark of shame: Stigma of mental illness and an agenda for change*. New York: Oxford University Press.
- Hinshaw, S. P. (Ed.). (2008a). *Breaking the silence: Mental health professionals disclose their personal and family experiences of mental illness*. New York: Oxford University Press.
- Hinshaw, S. P. (2008b). Closing thoughts: The power of narrative. In S. P. Hinshaw (Ed.), *Breaking the silence: Mental health professionals disclose their personal and family experiences of mental illness* (pp. 347–360). New York: Oxford University Press.
- Hinshaw, S. P. (2008c). Developmental psychopathology as a scientific discipline: Relevance to behavioral and emotional disorders of childhood and adolescence. In T. P. Beauchaine & S. P. Hinshaw (Eds.), *Child and adolescent psychopathology* (pp. 3–26). Hoboken, NJ: Wiley.
- Hinshaw, S. P., Hoagwood, K., Jensen, P. S., Kratochvil, C., Bickman, L., Clarke, G., et al. (2004). AACAP 2001 Research Forum: Challenges and recommendations regarding recruitment and retention of participants in research investigations. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*, 1037–1045.
- Hinshaw, S. P., Owens, E. B., Wells, K. C., Kraemer, H. C., Abikoff, H. B., Arnold, L. E., et al. (2000). Family processes and treatment outcome in the MTA: Negative/ineffective par-

- enting practices in relation to multimodal treatment. *Journal of Abnormal Child Psychology*, 28, 555–568.
- Jamison, K. R. (1993). *Touched with fire: Manic–depressive illness and the artistic temperament*. New York: Free Press.
- Jamison, K. R. (1995). *An unquiet mind: A memoir of moods and madness*. New York: Free Press.
- Jensen, P. S., Hoagwood, K., & Zitner, L. (2006). What's in a name? Problems versus prospects in current diagnostic approaches. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 1. Theory and method* (2nd ed., pp. 24–40). Hoboken, NJ: Wiley.
- Johnson, D. L. (1989). Schizophrenia as a brain disease: Implications for psychologists and families. *American Psychologist*, 44, 553–555.
- Johnson, S. L. (2005). Life events in bipolar disorder: Towards more specific models. *Clinical Psychology Review*, 25, 1008–1027.
- Keck, P. E., & McElroy, S. L. (2007). Pharmacological treatments for bipolar disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 323–350). New York: Oxford University Press.
- Kendler, K. A. (2005). “A gene for . . .”: The nature of gene action in psychiatric disorders. *American Journal of Psychiatry*, 162, 1243–1252.
- Kim, E. Y., & Miklowitz, D. J. (2004). Expressed emotion as a predictor of outcome among bipolar patients undergoing family therapy. *Journal of Affective Disorders*, 82, 343–352.
- Kim-Cohen, J., Moffitt, T. E., Caspi, A., & Taylor, A. (2004). Genetic and environmental processes in young children's resilience and vulnerability to socioeconomic deprivation. *Child Development*, 75, 651–668.
- Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatization: The functions of social exclusion. *Psychological Bulletin*, 127, 187–208.
- Lefley, H. P. (1989). Family burden and family stigma in major mental illness. *American Psychologist*, 44, 556–560.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–385.
- Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed., pp. 739–795). New York: Wiley.
- Luthar, S. S., & Brown, P. J. (2007). Maximizing resilience through diverse levels of inquiry: Prevailing paradigms, possibilities, and priorities. *Development and Psychopathology*, 19, 931–955.
- Luthar, S. S., Cicchetti, D., & Becker, B. (2000). The construct of resilience: A critical evaluation and guide for future work. *Child Development*, 71, 543–562.
- Maier, E., & Lachman, M. E. (2000). Consequences of early parental loss and separation for well-being in midlife. *International Journal of Behavioral Development*, 24, 183–189.
- Masten, A. S., Burt, K. B., & Coatsworth, J. D. (2006). Competence and psychopathology in development. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology: Vol. 3. Risk, disorder, and adaptation* (2nd ed., pp. 696–738). New York: Wiley.
- Mehta, S., & Farina, A. (1997). Is being “sick” really better? Effect of the disease view of mental disorder on stigma. *Journal of Social and Clinical Psychology*, 16, 405–419.
- Miklowitz, D. J. (2004). The role of family systems in severe and recurrent psychiatric disorders: A developmental psychopathology view. *Development and Psychopathology*, 16, 667–688.
- Miklowitz, D. J. (2008). *Bipolar disorder: A family-focused treatment approach* (2nd ed.). New York: Guilford Press.

- Miklowitz, D. J., & Craighead, W. E. (2007). Psychosocial treatments for bipolar disorder. In P. E. Nathan & J. M. Gorman (Eds.), *A guide to treatments that work* (3rd ed., pp. 309–322). New York: Oxford University Press.
- Neria, Y., Bromet, E. J., Carlson, G. A., & Naz, B. (2005). Assaultive trauma and illness course in psychotic bipolar disorder: Findings from the Suffolk County mental health project. *Acta Psychiatrica Scandinavica*, *111*, 380–383.
- Ochs, E., & Capps, L. (2001). *Living narrative: Creating lives in everyday storytelling*. Cambridge, MA: Harvard University Press.
- Peris, T. S., & Emery, R. E. (2005). Redefining the parent–child relationship following divorce: Examining the risk for boundary dissolution. *Journal of Emotional Abuse*, *5*, 169–189.
- Perlick, D. A., Rosenheck, R. A., Miklowitz, D. J., Chessick, C., Wolff, N., Kaczynski, R., et al. (2007). Prevalence and correlates of burden in caregivers of bipolar patients enrolled in the Systematic Treatment Enhancement Program for Bipolar Disorder. *Bipolar Disorders*, *9*, 262–273.
- Pettigrew, T. F., & Tropp, L. R. (2000). Does intergroup contact reduce prejudice? Recent meta-analytic findings. In S. Oskamp (Ed.), *Reducing prejudice and discrimination: The Claremont Symposium on Applied Social Psychology* (pp. 93–114). Mahwah, NJ: Erlbaum.
- Phelan, J. C. (2005). Geneticization of deviant behavior and consequences for stigma: The case of mental illness. *Journal of Health and Social Behavior*, *46*, 307–322.
- Phelan, J. C., Cruz-Rojas, R., & Reiff, M. (2002). Genes and stigma: The connection between perceived genetic etiology and attitudes and beliefs about mental illness. *Psychiatric Rehabilitation Skills*, *6*, 159–185.
- Phelan, J. C., & Link, B. G. (1998). The growing belief that people with mental illness are violent: The role of the dangerousness criterion for civil commitment. *Social Psychiatry and Psychiatric Epidemiology*, *33*(Suppl. 1), S7–S12.
- Phelan, J. C., Link, B. G., & Pescosolido, B. A. (2000). Public conceptions of mental illness in the 1950's and 1960's: What is mental illness and is it to be feared? *Journal of Health and Social Behavior*, *41*, 188–207.
- Post, R. M., Leverich, G. S., Xing, G., & Weiss, S. R. B. (2001). Developmental vulnerabilities to the onset and course of bipolar disorder. *Development and Psychopathology*, *13*, 581–598.
- Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., et al. (2007). No health without mental health. *Lancet*, *370*, 859–877.
- Quinn, D. M. (2006). Concealable versus conspicuous stigmatized identities. In S. Levin & C. Van Laar (Eds.), *Stigma and group inequality: Social psychological approaches* (pp. 83–103). Mahwah, NJ: Erlbaum.
- Read, J., & Harre, N. (2001). The role of biological and genetic causal beliefs in the stigmatization of “mental patients.” *Journal of Mental Health*, *10*, 223–235.
- Richards, R. L., Kinney, D. C., Lunde, I., Benet, M., & Merzel, A. P. (1988). Creativity in manic-depressives, cyclothymes, their normal relatives, and control subjects. *Journal of Abnormal Psychology*, *97*, 281–288.
- Rutter, M., Moffitt, T. E., & Caspi, A. (2006). Gene-environment interplay and psychopathology: Multiple varieties but real effects. *Journal of Child Psychology and Psychiatry*, *47*, 226–261.
- Sartorius, N. (1998). Stigma: What can psychiatrists do about it? *Lancet*, *352*, 1058–1059.
- Sartorius, N. (1999). One of the last obstacles to better mental health care: The stigma of mental illness. In J. Guimon, W. Fischer, & N. Sartorius (Eds.), *The image of madness: The public facing mental illness and psychiatric treatment* (pp. 138–142). Basel, Switzerland: Karger.

- Simoneau, T. L., Miklowitz, D. J., & Saleem, R. (1998). Expressed emotion and the interactional patterns in the families of bipolar patients. *Journal of Abnormal Psychology, 107*, 497–507.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G., Perlick, D., Raue, P., Friedman, S., J., et al. (2001). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry, 158*, 479–481.
- Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist, 42*, 106–117.
- Struening, E. L., Perlick, D. A., Link, B. G., Hellman, F. G., Herman, D., & Sirey, J. A. (2001). The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services, 52*, 1633–1638.
- Tessler, R., & Gamache, G. (2000). *Family experiences with mental illness*. Westport, CT: Auburn House.
- Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford, UK: Oxford University Press.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Author.
- Wahl, O. F. (1995). *Media madness: Public images of mental illness*. New Brunswick, NJ: Rutgers University Press.
- Wahl, O. F. (1999). *Telling is risky business: Mental health consumers confront stigma*. New Brunswick, NJ: Rutgers University Press.
- Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55*, 738–748.