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Trauma And Effects Of Being Raised By A Parent With Bipolar I Disorder: A Theoretical Approach Utilizing Internal Family Systems

Daniella Vasquez

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Daniella M. Vasquez, MA, LMHC

The Florida School of Professional Psychology at National Louis University

Christina D. Brown, Psy.D.
Chair

Kathie Bates, Ph.D.
Member

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CERTIFICATE OF APPROVAL

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Daniella M. Vasquez, MA, LMHC

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Examining Committee:

Committee Chair: Christina D. Brown, Psy.D.

Kathie Bates, Ph.D.

Member: Kathie Bates, Ph.D.

Abstract

Bipolar I disorder (BD) is a somewhat rare mental health disorder that impacts not only the person diagnosed but also their family (Chang et al., 2001; Cook et al., 2005; Wearden et al., 2008). Children of parents with BD may experience complex trauma as inconsistencies in parenting, conflict within the household, and possible neglect or abuse may be present (Chang et al., 2001; Rusner et al., 2009; Wearden et al., 2008). Multiple developmental areas can be impacted for individuals who have endured complex trauma to include attachment, somatic distress, affect regulation, biology, behaviors, cognition, and identity (Cook et al., 2005; Courtois & Ford, 2014). As such, this literature review identified ways in which children of parents with BD may meet criteria for complex posttraumatic stress disorder (Cook et al., 2005; Herman, 1992). Internal Family Systems is a treatment modality and theory which can be utilized for individuals with trauma symptoms (Foundation for Self Leadership, 2015; Schwartz, 2021; Schwartz & Sweezy, 2020). This literature review utilizes a hypothetical case of an individual raised by a parent with BD to answer the following research questions: 1. What kind of trauma may be experienced from being raised by a parent with BD? 2. How can offspring of parents with BD be conceptualized through the lens of IFS? 3. How can IFS treatment be applied for individuals raised by a parent with BD? Future research and clinical implications are addressed.

TRAUMA AND EFFECTS OF BEING RAISED BY A PARENT WITH BIPOLAR I DISORDER: A THEOETICAL APPROACH UTILIZING INTERNAL FAMILY SYSTEMS

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Introduction and History

Bipolar I disorder is a somewhat rare mental health disorder that not only deeply impacts the person diagnosed, but also can have a negative potential impact on others around them, including their offspring (Chang et al., 2001; Cook et al., 2005; Wearden et al., 2008). Those who are diagnosed with bipolar I disorder may experience fluctuating states of self-esteem, impulsivity, and strained interpersonal relationships (Knowles et al., 2007; Muralidharan et al., 2010). Those within this population may have a profound tension within their experiences and feelings, which play a role in creating chaos in their lives (Rusner et al., 2009). The chaos is not only experienced by the person with bipolar I disorder, but by those within their direct environment. Individuals who are raised by parents diagnosed with bipolar I disorder may experience trauma throughout childhood due to inconsistent parenting, conflict within the household, and possible neglect or abuse (Chang et al., 2001; Wearden et al., 2008). The inconsistencies, conflict, and lack of safety can influence the child's attachment to the parent (Chang et al., 2001). Research has demonstrated negative effects in children of parents with bipolar I disorder, such as poor interpersonal functioning within different settings including work, school, and intimate relationships; an impaired sense of self or identity; and mood disorders (Chang et al., 2001; Cook et al., 2005; Madey & Rodgers, 2009; Schore & Schore, 2008; Simeon et al., 2003).

Bipolar I Disorder

Criteria for bipolar I disorder (BD) as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5;* American Psychiatric Association*,* 2013) include evidence of at least one manic episode, which is defined as:

> "a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary)" (p. 124).

Throughout the mood disturbance three or more of the following symptoms are present: inflated self-esteem or grandiosity; decreased need for sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing; distractibility; increase in goal-directed activity or psychomotor agitation; or excessive involvement in activities that have a high potential for painful consequences. The mood disturbance is severe enough to cause disturbances within social or occupational settings or requires hospitalization to prevent harm to self or others. The episode is not the result of substance use or due to another medical condition (American Psychiatric Association, 2013).

According to the *DSM-5* (2013), the 12-month prevalence of BD has varied from 0.0% to 0.6% across 11 countries; however, the prevalence of the disorder may be underrepresented, as many individuals do not seek treatment and are therefore not diagnosed. The *DSM-5* (2013) has not provided updated information about the 12-month prevalence for those within the United States, relying on the *DSM-IV* (2000) prevalence of 0.6%. These statistics have increased since the publication of this book and has reached about 3-4% of the population

(Muralidharan et al., 2010). According to Merikangas et al. (2011), there is a lifetime prevalence rate of 0.6% for BD and 0.4% for bipolar II disorder (BDII). The United States earned the highest percentages with 4.4% and 2.8%, respectively (Merikangas et al., 2011).

Comorbid Diagnoses and Issues Experienced by Bipolar Parent

Those with BD had comorbid disorders at the rate of 88.2% (Merikangas et al., 2011). According to Muralidharan et al. (2010), individuals with BD are prone to emotion dysregulation in the form of anxiety and adjustment disorders, which could develop into further mood episodes. One common, but not required, aspect of BD is the presence of major depressive disorder (MDD) episodes. These severe depressive episodes experienced are likely to increase utilization of negative coping mechanisms, such as substance use (Chen & Kovacs, 2013). According to research, 36.6% of those with BD experience substance use issues (Mowbray & Mowbray, 2006). Mowbray and Mowbray (2006) conducted a study that examined experiences of adult offspring of a bipolar parent (OBD). Within this study, 40-50% of participants experienced abuse, parental alcohol or drug abuse, or physical illnesses within the family. Depressive episodes were noted to also result in considerable financial and interpersonal difficulties, thus causing further utilization of substance use and continuing the cycle (Chen & Kovacs, 2013). These findings are especially important when considering OBD, as research has suggested those who abuse substances have a higher risk of becoming more violent towards others, which could impact children in the household (Van Brunt et al., 2016).

In addition, those with BD experience a higher risk of suicide compared to the general population, with one in every four persons with BD indicating suicidal attempts (Chen & Kovacs, 2013; Merikangas et al., 2011; Muralidharan et al., 2010). It is important to consider

the aspect of having more energy during manic episodes, which could present with a greater chance in attempting suicide (Merikangas et al., 2011). This risk of suicide may also present further challenges for OBD, as these attempts may result in self-blame and confusion in addition to possibly not understanding social cues or doubting their own abilities to understand others (Muralidharan et al., 2010).

Symptoms experienced by those with BD also likely impact their careers, as interpersonal relationships are difficult to maintain and symptoms are severe at times, resulting in job instability (Schoeven et al., 2011). Additionally, deficits in detection and interpretation of social cues within bipolar individuals and first-degree relatives are also present, possibly creating further difficulties within jobs and relationships (Muralidharan et al., 2010). As such, individuals with BD may experience higher rates of disability, receiving financial assistance through the government (Schoeven et al., 2011). In addition, those with BD may exhibit more risky behaviors throughout manic episodes, such as spending money, increasing sexual activity, and substance use (American Psychiatric Association, 2013). These risky behaviors may further impact job and relationship stability. The importance of managing the impact of those with BD is high, as society and government resources are often costly when managing mood and psychotic disorders (Sandstrom et al., 2020).

Those who have BD may experience symptoms from a young age, which contributes to a delay in receiving services and higher comorbidity rates (Muralidharan et al., 2010). Further stressors could include the family climate, parenting style, and the inability to process socioemotional triggers in the environment. As these deficits may be present within families with BD, the potential risk for further comorbidity is high (Muralidharan et al., 2010).

Difficulties with Treatment for Parent with BD

Van Brunt et al. (2016) argue that studies and media portraying mental illness contribute to biases about mental illness, which can also impact parents and their reluctance to receive help. Individuals with mental illness who are focused on in the media can result in others in the community generalizing those with mental illness. Due to this portrayal, the role of stigma can become a deterrent for obtaining mental health treatment. Some parents may feel it is difficult to disclose problems to mental health professionals due to the stigma of BD and how this can impact a person's view of their parenting skills (Diaz-Caneja & Johnson, 2004; Fox, 2009). In fact, parents with BD have reported hesitancy in telling professionals about their mental illness for fear of losing custody of their children due to this stigma (Diaz-Caneja & Johnson, 2004). The fear of reaching out to professionals and others for help can limit the parent's support systems and socialization, in turn impacting the children and their own functioning (Diaz-Caneja & Johnson, 2004).

A study by Diaz-Caneja and Johnson (2004) reported that mothers with BD identified their children as being a motivator to receive treatment in order to maintain child custody; however, they reported that others viewed them as being incompetent and incapable of providing adequate parenting, resulting in lower self-esteem in skills and avoidance of asking for support. Without this support to help care for their children, experiencing severe symptoms could result in the welfare agencies becoming involved in the family dynamics and possible removal of children. The study also indicated feelings of concern and worry were experienced while parents with bipolar disorder (BDP) were in the hospital due to their children possibly

being placed in foster care when they did not have others to help support them (Diaz-Caneja & Johnson, 2004).

Medication was also perceived by those with BDP as reducing their ability to perform duties and focus, in addition to caring for their children (Diaz-Caneja & Johnson, 2004). These views about medication and side effects, which can be present at times, may result in further treatment non-compliance. Parents reported experiencing difficulties in keeping appointments for their mental health due to a lack of support in parenting and childcare, suggesting further complications to receive proper treatment (Diaz-Caneja & Johnson, 2004).

Experiences of Bipolar Parent

Knowles et al. (2007) discussed compelling evidence that abnormal self-esteem is implicated in bipolar disorder. Parents with BD may feel worthless when depressed and have grandiose beliefs about self when manic, resulting in a discrepancy between self-descriptions and ideals, which is more prevalent during a depressed state, but also present throughout remission periods as well. Knowles et al. (2007) suggested the possibility of inflated self-esteem may be due to an avoidance of the ingrained negative feelings an individual experiences. As such, individuals with BD live with a profound intensity and tension that is expressed in their feelings and experiences, which consist of different elements that create chaos in their lives (Rusner et al., 2009). Some of these individuals have described this phenomenon as "being in an ongoing struggle to keep contact with oneself and to be able to have a life that corresponds to how one perceives oneself to be" (Rusner et al., 2009, p. 162).

Rusner et al. (2009) conducted a phenomenological study to further understand the experience of living with bipolar disorder. Ten individuals with BD were asked to participate

in the study. These participants identified being unable to understand their experience, causing more confusion and conflict within themselves and an inability to effectively communicate with others. The reported confusion also contributes to a lack of self-confidence to make life decisions. These individuals identified feelings of being misunderstood, as their pace of life changes frequently without the words to explain their experience. The intensity that is experienced in living with BD was described as being debilitating, which can affect the ability to think or perform simple tasks. “The illness is intertwined with one’s whole being and indivisible from one’s identity” (p. 165). Relationships were also described as suffering due to the instability and anger that can often be present, possibly causing those with BD to experience suicidal ideation due to guilt of harming those around them. The person may struggle to keep a job due to interpersonal problems at work, as well as not managing symptoms properly (Rusner et al., 2009).

When exploring self as a parent with BD, mothers in a study expressed fear that their children would also become ill with mental health problems (Diaz-Caneja & Johnson, 2004). As discussed previously, there is an increased risk in BDPs possibly losing custody of their children due to instability and lack of support from their environment and professionals. When experiencing these situations, mothers were noted to experience a “severe blow” to their ego when losing custody of their children, thus continuing the cycle of low self-esteem and tension within themselves (Diaz-Caneja & Johnson, 2004, p. 477).

Melinda Fox (2009) provided a first-hand view of a mother with BD. She discussed clinicians and doctors not valuing her role and identity as a mother, which resulted in her not being in her children’s lives. Fox stated she felt as though she could not live up to the

expectations of others with her mental illness stigmatization. As such, many parents with BD may not seek out programs which could be beneficial in parental training due to the fear of having others being overly involved in their family structure and stigma that accompanies the disorder (Fox, 2009). Even with an online structure, parents with BD may struggle to complete training and maintain treatment, suggesting further instability (Jones et al., 2017). When taking all of these factors into account, a bipolar parent would be known to blame self for not fulfilling duties as a parent and not being there for their kids in a secure manner (Fox, 2009).

Additionally, BDPs expressed they worried that their children were taking on tasks that children should not be concerned about and indicated there is "a need to shield children from the burden of seeing the mother at their worst" (Diaz-Caneja & Johnson, 2004, p. 476). Some mothers described difficulties in caring for their children while experiencing more severe mental illness symptoms, indicating a sense of being overwhelmed. This experience for the BDP may push the children further to take on the role of caregiver and assuming more tasks in the household, contributing to the parent's guilt and concerns. Mothers with BD indicated their children provided love for them, which can be viewed as a positive aspect for the parent; however, may also be a negative factor for the child, as this can place an extraordinary amount of pressure for the child to fulfill this need (Diaz-Caneja & Johnson, 2004).

Overall, individuals with BD are more likely to experience comorbidity to include substance use, anxiety, and further mood episodes (Mowbray & Mowbray, 2006; Muralidharan et al., 2010). Symptoms those with BD experience and other mental health disorders may also impact their treatment compliance and functioning within jobs, interpersonal relationships, and familial relationships (Diaz-Caneja & Johnson, 2004; Muralidharan et al., 2010; Schoeven et

al., 2011). BDPs may experience stigma regarding their mental health illness, which can further impact their functioning and negative views of self (Diaz-Caneja & Johnson, 2004; Fox, 2009; Knowles et al., 2007). The negative views of self and mood instability may impact a BDP's parental skills which can affect their offspring.

Offspring of Bipolar Parent

Offspring of individuals with BD (OBD) are at a higher risk for experiencing BD or mood disorders within their lifetime, with distinct mood symptoms such as depression, irritability, affective lability, and mood regulation problems, compared to those of families without a parent with mental illness (Chang et al., 2000; Goetz et al., 2017; Moron-Nozaleda et al., 2017; Topal et al., 2021; Vance et al., 2008). After a 2-year follow-up in a longitudinal study, the prevalence of mental health disorders in OBD was reported to be 42.2% (De la Serna et al., 2021). In regard to heritability of BD, female OBD indicated a higher chance of at-risk BD in later life, while male OBD were more likely to exhibit externalized disorders such as attention-deficit hyperactivity disorder (ADHD) or personality disorders (Oquendo et al., 2013). While research has suggested affective lability within childhood may predict a future BD diagnosis in adulthood, it is important to take into account the culture of a family, relationship dynamics, and possible other mental health diagnoses which may impact the lability of affect (Zwicker et al., 2020).

In addition to the risk of inheriting BD, offspring are also at risk of being diagnosed with further diagnoses, with 86% of OBD experiencing at minimum one diagnosis (Goetz et al., 2017; Moron-Nozaleda et al., 2017). Chang et al. (2000) explored these diagnoses further through the use of 60 participants from 37 different families. The adult participants who were

interviewed had a child between 6 and 18 years old. The families consisted of one parent who had been diagnosed with BD or BDII, with a majority of families including a mother with BD. Parents of participants in this study were assessed by a licensed psychologist via a clinical interview to identify criteria for BD and past diagnoses or symptoms of attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), and conduct disorder (CD). Children of these families participated in a semi-structured interview which emphasized affective symptomology in addition to parental self-report measures. The sample of children in the study were diagnosed with the following diagnoses per *DSM-IV* criteria: MDD, ADHD, dysthymia, BD or cyclothymia, ODD, obsessive-compulsive disorder (OCD), tics, and other anxiety disorders. Of these children, 88% of those diagnosed with BD also had a comorbid diagnosis of ADHD, which was exhibited to be more common in the male sample, while 45% of this population did not meet criteria for any diagnosis (Chang et al., 2000). Additional studies have also suggested OBD have a higher chance of mood disorders as well as ADHD when compared to offspring from healthy families (De la Serna et al., 2021).

Anxiety has also been reported to be more prevalent within the OBD population (Goetz et al., 2017; Raouna et al., 2018). A systematic review conducted by Raouna et al. (2018) identified a significant chance of OBD experiencing anxiety disorders and OCD. In addition, panic disorder was found to be correlated with early onset BD (Raouna et al., 2018). These symptoms of anxiety may be due to the higher rates of internalization OBD experience, which can additionally impact attention and mood (Oquendo et al., 2013; Sandstrom et al., 2020). While anxiety is likely to be linked to a future BD diagnosis, it is important to note these symptoms may also be related to the trauma effects from living with a BDP (Chang et al.,

2001; Nery et al., 2020). Topal et al. (2021) suggested disruptive mood dysregulation disorder (DMDD) may also be present within the OBD population; however, these symptoms may mimic trauma symptoms within children. In addition, OBD are also more prone to experience an impairment in emotional and cognitive domains, which can be attributed to these symptoms of DMDD and being unable to express feelings appropriately (Topal et al., 2021).

OBD may be more prone to develop mental health disorders such as depression, anxiety, BD, ADHD, DMDD, ODD, and substance use when compared to offspring of families who do not have a parent with mental illness (Chang et al., 2000; Goetz et al., 2017; Oquendo et al., 2013). While OBD may experience mental health issues which resemble the aforementioned disorders and symptomology, one may argue these symptoms represent trauma responses a child may exhibit.

Trauma and Complex Trauma

According to the *DSM-5* (2013), posttraumatic stress disorder (PTSD) is defined as an exposure to actual or threatened death, serious injury or sexual violence in one or more of the following ways: directly experiencing the traumatic event; witnessing in person the event as it occurred to others; learning that the traumatic event occurred to a close family member or close friend, which must have been violent or accidental; or experiencing repeated or extreme exposure to aversive details of the traumatic event(s). The *DSM-5* also requires the presence of one or more of the following intrusion symptoms associated with the traumatic event, beginning after the traumatic event occurred: recurrent, involuntary, and intrusive distressing memories of the traumatic event(s); recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s); dissociative reactions in which the

individual feels or acts as if the traumatic event(s) were recurring; intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s); or marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s). Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one of the following: avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events; or avoidance of or efforts to avoid external reminders that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: an inability to remember an important aspect of the traumatic event; persistent and exaggerated negative beliefs or expectations about oneself, others, or the world; persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others; persistent negative emotional state; markedly diminished interest or participation in significant activities; feelings of detachment or estrangement from others; and persistent inability to experience positive emotions. Marked alterations in arousal and reactivity associated with the traumatic event by two or more of the following: irritable behavior and angry outbursts typically expressed as verbal or physical aggression toward people or objects; reckless or self-destructive behavior; hypervigilance; exaggerated startle response; problems with concentration; or sleep disturbance. The symptoms would need to be present for one month and cannot be due to substance use or a medical condition. The symptoms also need to

cause clinically significant distress in social, occupational, or other areas of functioning. One must also specify if there are dissociative symptoms through depersonalization or derealization. Depersonalization is the persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body. Derealization is the persistent or recurrent experiences of unreality of surroundings (American Psychiatric Association, 2013).

While the *DSM-5* (2013) definition of PTSD identifies the distress an individual experiences after living through trauma, as well as the dissociation symptoms that may occur, the definition clearly states there needs to be an "actual or threatened death, serious injury or sexual violence" (p. 271) in order to meet criteria. This definition excludes those who experience chronic and persistent emotional and relational trauma, such as those who live within a traumatic childhood environment but who did not experience actual or threatened physical or sexual harm. In addition, this definition does not take into account emotional dysregulation, processing of perceived threats, physical issues, or feelings of being unable to connect to oneself or others (Courtois & Ford, 2014).

Those who experience childhood trauma may have experiences that are more complex than the criterion required for a PTSD diagnosis. The definition of complex posttraumatic stress disorder (CPTSD) within the *ICD-11* (WHO, 2018) is arguably more suitable for the offspring of those with BD, as these individuals may experience prolonged childhood trauma, including emotional abuse or neglect, within their home environment (Chang et al., 2001). Mowbray and Mowbray (2006) indicated 25% of OBD experienced domestic violence within the family environment, which may further contribute to complex trauma. CPTSD was

proposed to include all symptoms of PTSD, in addition to severe and persistent problems in affect regulation; beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt, or failure related to the traumatic event; and difficulties in sustaining relationships and in feeling close to others (WHO, 2018).

While being raised by a parent with bipolar disorder does not necessarily allow OBD to meet criteria for PTSD, this unique experience is hypothesized within this literature review to be a complex trauma as evidenced by symptomology present within offspring. Although there is a higher heritability rate of BD within offspring, one may question what the symptoms are actually representing, as trauma can present itself in ways that resemble BD or other mood disorders (Herman, 1992). Those who experience adverse childhood experiences may develop severe mental health disorders based on the amount of trauma and level of abuse, as children who suffer from trauma are more susceptible in having brain matter changes which contribute to the etiology of disorders (Pietrek et al., 2013). Prior research indicated those who have CPTSD symptoms display unmodulated affect, behaviors, and interpersonal struggles (van Dijke et al., 2015).

In addition to potential diagnoses of other mental health disorders, such as ODD, conduct disorder, anxiety, and ADHD, children with CPTSD may experience further issues encompassing sleep, eating, and communication (Cook et al., 2005). Additionally, OBD were also found to have a greater risk of experiencing a substance use disorder (Oquendo et al., 2013). OCD type behaviors may become present in those with complex trauma (Cook et al., 2005). Cook et al. (2005) argue these individual diagnoses are fragments of what a child is fully experiencing due to trauma. Research has demonstrated a lack of effective evidence-

based treatments when working with complex trauma that involves dissociation and an altered sense of self (Cook et al., 2005). Furthermore, the anxiety OBD may possess could arguably be present due to trauma symptoms and feeling unease within the home of a parent with BD (Goetz et al., 2017).

Chang et al. (2000) indicated that depressed mood, irritability, anger, and mood reactivity were associated with genetics; however, observations of mood reactivity and problems with mood regulation did not take into account the reactions to a BD parent or the family environment. These symptoms could be viewed as trauma reactive symptomology as the home environment can be chaotic and behaviors adopted may be viewed as a way to protect oneself. Chang et al. (2001) suggested families with more children had the perception of increased conflict within the home; however, those with a BD parent indicated significant differences from average families in "less cohesion and organization, and more conflict and control" (p. 76). Researchers concluded that those families that have a BDP may present with less cohesiveness and decreased perception of support, possibly contributing to further complex trauma (Chang et al., 2001; Lau et al., 2018).

To further understand the relationship between childhood complex trauma and CPTSD, van Dijke et al. (2015) conducted a study that included 450 adults from outpatient treatment centers, hospitals, and day treatment facilities. A structured interview was utilized to measure CPTSD symptoms and assess the domains of "dysregulated affect, impulses, bodily integrity, dissociation, somatization, altered self-perceptions, relationships, and sustaining beliefs" (p. 431). CPTSD symptomology was noted to be significantly related to childhood complex trauma and psychoform (cognitive) dissociation. van Dijke et al. (2015) indicated there is a

significant possibility of other factors contributing to CPTSD symptomology outside of dissociation, such as parental conflict and family environment.

In a study conducted by Ostiguy et al. (2009), participants were gathered from an ongoing study that included parents with BD and their offspring. Participants included 70 OBD who were recruited from hospitals and consumer groups. The interviewers identified the "episodic life events" that the participants experienced in the last year. OBD were noted to experience significantly higher levels of stress when accounting for family environment, financial health, and physical well-being. OBD also demonstrated a higher likelihood of experiencing a severe life event in contrast to the healthier controls from the study (Ostiguy et al., 2009).

OBD's experiences appear to meet the criteria for a CPTSD diagnosis as they are likely to experience prolonged childhood trauma due to the instability of their home environment and parental upbringing (Chang et al., 2001; Mowbray & Mowbray, 2006; WHO, 2018). Individuals raised by BDPs may experience parental conflict within the family environment which can result in mental health issues and an altered sense of self, a criterion of CPTSD (Cook et al., 2005; WHO, 2018). While OBD's symptoms exhibited in childhood could be indicative of a mental health disorder, these symptoms may also be behaviors adopted to protect oneself from further emotional harm within a chaotic household (Chang et al., 2000). Taking the family environment and culture into consideration, complex trauma may be more relatable to the experience of a child with a bipolar parent, as these experiences are more likely to contribute to insecure attachments and a poor sense of self (Kong et al., 2017; Madey & Rodgers, 2009; Ostiguy et al., 2012; Wearden et al., 2008).

Attachment

Attachment theory was first designed to be an alternative to psychoanalytic theory and strove to identify the reason for anxiety experienced in young children when separated from caregivers (Bowlby, 1988; Fitton, 2012). It was also an attempt to explain the structure of social behavior from infancy that eventually affect an individual's personality in a negative manner (Fitton, 2012). Attachment is viewed as being a drive for human beings, which if not met can lead to changes in personality. Attachment may be a way for a child to survive within their world, as becoming attached to a caregiver may result in having these needs met in life (Bowlby, 1988; Fitton, 2012). Mary Ainsworth conducted research and developed experiments, such as the Strange Situation, to further understand the intimate connection with the primary caregivers, considering this relationship is the first experience a child has to form a sense of self and others (Ainsworth & Bell, 1970). Attachment was defined by Ainsworth and Bell (1970) as "an affectional tie that one person or animal forms between himself and another specific one – a tie that binds them together in space and endures over time" (p. 50). The research suggested primary caregivers should be a secure base for infants and serve as a safe haven, providing comfort and soothing responses to a child's distress. If a child was scared or frightened and felt safe with their caregiver, they would seek comfort from them. Children whose parents were viewed as being safe were more emotionally stable and developed normally (Ainsworth & Bell, 1970). However, research conducted demonstrated not all children responded in a manner of seeking comfort.

Three different categories were identified for children through the Strange Situation study: secure, anxious/avoidant, and anxious/ambivalent (Ainsworth & Bell, 1970). Secure

attachment suggested mothers were emotionally responsive with their child, as the infant would cry when the mother would leave and sought comfort from her when she returned. Anxious/ambivalent attachment indicated the primary caregiver was inconsistent with parenting and unresponsive to the child's needs, resulting in the infant not expecting others to be responsive to their needs. The children who displayed an anxious/avoidant attachment, had caregivers who were cold and unresponsive to the child's needs, contributing to the perception others would also not be able to meet their needs (Ainsworth & Bell, 1970). In addition, if a parent has not resolved their own issues with attachment to their caregivers, this may result in further insecure attachment (Fitton, 2012).

In further research conducted by Main and Solomon (1986), another category was identified as disorganized/disoriented. These infants had caregivers who were disoriented and conflicted, which could be caused from a caregiver's mental state and abuse (Hesse & Main, 2000). "Disorganized/disoriented behavior is expectable whenever an infant is markedly frightened by its primary haven(s) of safety, i.e., the attachment figure(s)" (Hesse & Main, 2000, p. 1102). Those who are maltreated or abused by these attachment figures are more at risk to develop a disorganized attachment. Parental trauma and their own attachment patterns are also likely to impact their offspring, as these patterns are present in most relationships. Hesse and Main (2000) also hypothesized those who did not report abuse or trauma as a child but displayed disorganized behaviors may be dissociating from these painful memories, resulting in lower self-report of trauma. Childhood attachment theories were expanded into adulthood as they shape the individual's experiences with others early on, taking on new category names: anxious/ambivalent became known as preoccupied, anxious/avoidant was

identified as dismissing attachment, and disorganized was described as fearful attachment (Hesse & Main, 2000).

In order to develop a secure attachment, caregivers need to show their children positive affect (DeMulder & Radke-Yarrow, 1991; Schore & Schore, 2008). Attachment experiences are translated into an internal working model that verifies affect regulation and behaviors that are present in unconscious acts (Bowlby, 1988; Schore & Schore, 2008). When viewing the world around them, individuals with an insecure attachment also attribute negative events to themselves more than positive events (Knowles et al., 2007).

A study measuring attachment conducted by Radke-Yarrow et al. (1985) included offspring of those who had a parent with BD, MDD, or minor depression in comparison to healthy controls. The researchers utilized the Strange Situation study to observe children's reactions to separation from their parents and to assess their attachment style. The mother's affect was observed during the evaluation, in addition to self-report questionnaires inquiring about the mother's mood and functioning. Those who were offspring of parents with BD and MDD demonstrated higher levels of insecure attachments, primarily within OBD. Researchers found that a mother's affect towards their child significantly impacted the attachment of the offspring; however, social support was also noted to be of great impact for the offspring, such as having a healthy parent in the environment (Radke-Yarrow et al., 1985).

While the strange situation study revealed important information in regards to attachment and paved the way for further studies and theory development, it is important to also recognize the lack of diversity within these studies as the families mainly consisted of White, middle-class individuals (Ainsworth & Bell, 1970). Although further studies have

attempted to include more diverse samples in their studies, there are other aspects that can impact attachment further or alter the "norm" within a culture such as sexual orientation, gender identity, and socioeconomic stressors.

Object Relations Theory

Object relations theorists such as Melanie Klein and Otto Kernberg also explored early formation and inner concepts of the self and others. An object within this theory refers to a person to whom an action is directed (St. Clair, 1987). Representation refers to how a "person psychically represents an object" (St. Clair, 1987, p. 5). When a child is in early stages of life, they are unable to fully distinguish others from their self, as this higher level of thinking is not yet established. Object relations are considered to be intrapsychic structures, which an infant can start to utilize in developing the self. If an object or caregiver in their life is viewed as being unpleasant or bad, then this representation becomes ingrained in the self as well, thus resulting in the child as viewing themselves as being bad and aiding in further developing a negative internal working model. These structures they form are then present in future interpersonal situations as self-representations, which affect how one relates to others and the world (St. Clair, 1987).

Internal Family Systems (IFS)

Internal Family Systems (IFS) is a theory developed by Richard Schwartz that was built around the concept of self-acceptance, a concept which is emphasized within other theories such as dialectical behavioral therapy, acceptance and commitment therapy, and person-centered theory (Schwartz, 2021; Schwartz & Sweezy, 2020). The National Registry for Evidence-based Programs and Practices (NREPP) was a database maintained by the Substance

Abuse and Mental Health Services Administration (SAMHSA) before being discontinued in 2018 due to lack of government funding (Green-Hennessy, 2018). Prior to the NREPP being discontinued, IFS had been considered an evidence-based practice since 2015 (Foundation for Self Leadership, 2015). IFS was introduced as an evidence-based practice based on a longitudinal study conducted by Shadick and Sowell in 2013 was reviewed. This was a randomized trial study of 79 participants with rheumatoid arthritis (RA) recruited from an arthritis center in Boston. IFS treatment proved beneficial for overall pain and physical functioning. In addition, these results were consistent after a 1-year period, with indications of decreased depression and increased compassion for self (Shadick & Sowell, 2013). SAMHSA indicated IFS is effective for overall well-being of individuals and can be used in the treatment of anxiety disorders, physical conditions, depression, and self-concept (Foundation for Self Leadership, 2015).

According to Internal Family Systems, individuals are theorized to have different parts which make up their internal system (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). These parts are split into three types: the exiles, proactive protectors or managers, and reactive protectors or firefighters. Additionally, every individual has a Self, which is an innate part everyone is capable of experiencing. The Self is compassionate and provides unconditional love for the other parts. Exiles are considered to be parts of self which are considered vulnerable or even shameful, requiring the internal system to have them shunned or locked away. Managers are utilized to ensure the overwhelming feelings exiles experience do not upset the balance within the system. These parts can be controlling or even cause physical symptoms to protect the exiles and manage the overall feelings a person

experiences. Firefighters are parts which are enacted when managers are not able to stop exiles' feelings and trauma from resurfacing. They attempt to put the fire out when emotions are high, often engaging in self-harm behaviors, risky behaviors, and substance use to take attention away from the pain the exiles may experience (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

The goal of IFS is to access the Self within a client so there can be empathy and curiosity about the different parts before accessing these parts and unburdening them from their emotions or trauma (Anderson et al., 2017; Schwartz et al., 2014; Schwartz & Sweezy, 2020). Just as in a trauma informed treatment approach, IFS therapists are aware of clients needing to feel safe before accessing trauma. There are steps within the treatment to achieve this main goal. The first step is to help clients differentiate the parts which keep them protected. The second step involves having clients acknowledge these protectors while obtaining a relationship with them, which allows the client to ask their protectors to help the exiles or parts which are still in pain. In the third step, clients befriend their exiles and bear witness to the emotions and experiences the exiles have endured. The client is an active participant in helping their exiles to release these emotions and move forward. Unburdening exiles and protectors helps the client to find new roles for these parts of self and feel more whole and cohesive, often recognizing the pain and a part of self as no longer being in control. Once these steps are accomplished, clients are able to reintegrate, and the Self is now identified as being the part in charge. The Self is viewed as comforting and wants parts to be unburdened in a safe way, which helps the client to feel in control of the process (Anderson et al., 2017; Schwartz et al., 2014; Schwartz & Sweezy, 2020).

IFS theorists believe this treatment is useful for treating complex trauma and theorize every person develops parts of themselves without them becoming completely dissociated (i.e., dissociative identity disorder; Schwartz, 2021; Schwartz et al., 2014; Schwartz & Sweezy, 2020). Those with trauma histories may be prone to experiencing dissociative states, as mentioned in the diagnostic criteria for PTSD (American Psychiatric Association, 2013). Prior research has implied that individuals who have suffered from childhood traumatic experiences, particularly complex and relational trauma, may experience dissociation states, whether through psychoform (cognitive) or somatoform (bodily) symptoms (Chiu et al., 2018; Simeon et al., 2003; van Dijke et al., 2015; Watson et al., 2006). Attachment insecurity has been linked to adult dissociation symptoms, suggesting childhood trauma and inconsistent parenting may influence how a person actually obtains their parts of self (Kong et al., 2017). Research also suggests emotional neglect in childhood is significantly related to dissociative symptoms as dissociation may be present within those who have experienced complex childhood trauma (Simeon et al., 2003; van Dijke et al., 2015).

Hogdon et al. (2021) completed a study with individuals who had a history of two forms of trauma before the age of 18. The researchers hypothesized participant's symptoms would decrease after the utilization of IFS treatment for 16 weeks with 90-minute sessions. The researchers recruited 17 adults between the ages of 28 and 58, with a majority being female (76%) and White (89%). A depression inventory screener was given in addition to a self-report questionnaire which identified functioning in dissociation, somatization, affect regulation, and disrupted self-perception. Participants were also given a questionnaire to assess for level of self-compassion and bodily sensations. These questionnaires were given at the beginning of

treatment, after 8 sessions of IFS, after the 16th session, and 1month after completing IFS therapy. Baseline scores displayed moderate, clinically significant PTSD symptoms in addition to depression levels that were clinically significant. Multilevel growth curve modeling was utilized to gather data. Results indicated a significant reduction in both depression and trauma symptoms. One month after ending treatment, 92% of the participants were no longer meeting full criteria for PTSD. Hogdon et al. (2021) did identify limitations of the study to include small sample size and lack of diversity, which impacts generalizability.

In 2017, Haddock et al. conducted a study to identify the effectiveness of Internal Family Systems treatment (IFS) when treating clients who experience depression. Their hypothesis was that the clients who were treated with IFS would have a decrease in depressive symptoms equal to or more than clients being treated by "gold-standard" therapy techniques, including cognitive-behavioral therapy and interpersonal therapy. The study consisted of 32 female college students between the ages of 18 and 27 who experienced moderate to severe depression, with 26 of the participants being White. The authors reported the population of female college students was utilized due to difficult transitional periods within college and the prevalence of depression among women. The different issues young women experience during this time, such as lack of support, feelings of self-doubt, and low self-worth, were used to better justify the use of female college students for the study. Participants were not able to be involved in the study if there was a diagnosis of BD, current symptoms of PTSD, eating disorders, substance use disorders, prior suicidal attempts, or current suicidal ideation. The participants were randomly placed into blocks of participants to either receive IFS treatment or CBT/interpersonal therapy, which was referred to being treatment as usual (TAU). The

individuals participated in a clinical interview to obtain baseline data as well as completing weekly and by-session questionnaires and a posttest survey. The treatment was planned as 16 sessions for 50 minutes per session. The authors decided to utilize a series of growth curve models to identify changes within an individual in regards to depressive symptoms (Haddock et al., 2017). This model looks at time points within a given individual and includes a starting point and rate of change to smooth over changes within the curve. A multilevel framework was used to further gain data. The authors also used a regression model to assess the effects of treatment (independent variable) at sessions 6, 11, and 16 and to examine how the depression symptoms (dependent variable) regressed at these points of time (Haddock et al., 2017).

Findings suggested there were not statistically significant differences between the two groups after about 16 sessions, however both IFS and the TAU groups showed a decrease in depressive symptoms (Haddock et al., 2017). The authors strived to convey the importance of further exploring IFS treatment, concluding that it could be as effective as evidence-based practices (Haddock et al., 2017). While the models utilized by the authors appeared to be appropriate to use within this context, a correlation could have been utilized to identify the progress within therapy treatment for these groups. A repeated measure ANOVA to compare means across variables over periods of time could have also been utilized. In addition, the authors used data from all clients, however not all clients were present for 16 sessions, which could have impacted the study design further (Haddock et al., 2017).

In the TAU condition, it was easier to gain access to more competent therapists and psychologists, as training in evidence-based practices is prevalent within graduate school (Haddock et al., 2017). In the TAU condition, there were 10 female clinicians and 1 male

clinician, which may have impacted the work with female college aged students exploring parts of themselves. The IFS providers were not reported to be male or female, and the authors did not explain why they were inconsistent in reporting for both conditions. While the other diagnoses were viewed as being appropriate for exclusion, the exclusion of those who have had past suicidal ideation may have been more limiting for data, as severe depression can result in these ideations. In addition, the random assignment of the participants into blocks, may have been limiting on having a pure response to treatment, which was identified by the authors within their summary. The majority of the participants (26) were White, which also gives a limited view on how this study could benefit others from a more diverse background. While the authors addressed this within their summary, it is important to consider within the data, as it is not representative of those from other cultures and beliefs, thus resulting in possible impact on effectiveness of the treatment studied (Haddock et al., 2017).

The research utilizing IFS treatment and prior evidence-based treatment recognition has suggested IFS can be effective in treating trauma, anxiety, depression, and problems with self-concept (Foundation for Self Leadership, 2015). These symptoms may be present within individuals who meet criteria for CPTSD (Chang et al., 2001; Cook et al., 20015; Mowbray & Mowbray, 2006; WHO, 2018). As such, IFS may be a useful therapy modality to utilize in treating OBD as their experience within childhood can result in CPTSD symptomology (Kong et al., 2017; Ostiguy et al., 2012; Wearden et al., 2008).

Hypothetical Case Example

For the purpose of this study, a hypothetical case example will be utilized to best understand the phenomenon of trauma within OBD. Chase is a 25-year-old man who was

raised by a single mother diagnosed with BD. Throughout his childhood, Chase was aware of his mother's unstable and shifting moods but was not able to predict them or gain understanding of why the mood shifts happened. As a child, he often felt he was to blame for negative moods and feelings. He never felt safe in his home environment, consistently experiencing anxiety as he was uncertain of when his mother's mood would shift. Chase was belittled and often times left alone for days at a time, being left in charge of taking care of his 2 younger siblings. His mother struggled with holding jobs or maintaining relationships, likely influencing Chase having inconsistent housing and adult relationships in his life. As Chase grew older, he also struggled with maintaining intimate relationships, often pushing others away. His view of himself was negative, feeling unworthy of other's love or attention. Chase felt there was nobody to protect him in the past and still believes this to be true. In order to protect himself, Chase limited his relationships and became rigid with his schedule and life, taking comfort in this consistency and predictability.

Statement of the Problem

Bipolar I disorder impacts those diagnosed in profound ways, ranging from issues with self-esteem, strained interpersonal relationships, career problems, unbalanced sense of self, and impulsivity; all contributing to chaos within an individual's life (Knowles et al., 2007; Muralidharan et al., 2010; Rusner et al., 2009). In addition to the consequences a person with BD experiences, others in their life may also be impacted, such as their offspring. Parents with BD may not provide a secure attachment for their children due to the inconsistent moods and conflict one experiences within this disorder (Chang et al., 2001). The lack of attachment and unstable home environment provided for a child in this circumstance may be categorized as a

complex trauma due to the prolonged exposure to the unstable environment, low self-esteem associated with this trauma, and experiencing a poorly developed sense of self (Kong et al., 2017; Madey & Rodgers, 2009; Ostiguy et al., 2012; Wearden et al., 2008). Research has suggested individuals who grow up with a bipolar parent may also struggle with their own interpersonal relationships later in life (Chang et al., 2001; Madey & Rodgers, 2009; Simeon et al., 2003). Past research has suggested those who experience prolonged trauma in childhood may experience some form of dissociation in order to protect themselves from the instability and psychological insults (Chiu et al., 2018; Kong et al., 2017; Simeon et al., 2003; van Dijke et al., 2015; Watson et al., 2006). Internal Family Systems is utilized in this literature review to help conceptualize the offspring of those with bipolar disorder as this theory identifies different parts of Self which are present after experiencing trauma (Schwartz et al., 2014; Schwartz & Sweezy, 2020). The treatment is theorized to be beneficial for this population, as it is useful in treating those with complex trauma histories (Schwartz, 2021; Schwartz & Sweezy, 2020).

Research Questions

1. What kind of trauma may be experienced from being raised by a parent with BD? In order to answer this question, past research concerning complex trauma, attachment, and bipolar disorder will be summarized and applied to this population.
2. How can offspring of parents with bipolar I disorder be conceptualized through the lens of Internal Family Systems? Books and articles obtaining further information about the theory of IFS will be consulted and utilized to form an in depth understanding of conceptualization through this theory. The case vignette provided within the literature review will be utilized throughout the paper and will be fully developed to

conceptualize using IFS. Trauma and effects from research question one will be considered to gain a better understanding of the issues which may be present for conceptualization.

3. How can Internal Family Systems treatment be applied for individuals raised by a bipolar parent? Information from research question one and two will help to inform the process of treatment using IFS in addition to treatment manuals, books, and articles addressing treatment. The case vignette will also be discussed in this section to further develop an understanding of a real-life example. Step by step treatment will be developed and discussed.

Research Procedure

Books exploring the topic of IFS were utilized in order to understand the original theory from founding theorists/authors. This included textbooks and treatment manuals by the authors who developed IFS, including resources that explained how to use this theory for treatment. Utilization of PsychInfo database, Research Gate, and Google Scholar, helped in obtaining information and past research about the topics discussed. A combination of search terms was utilized and varied, including bipolar disorder, bipolar parent, children of bipolar parents, attachment, Internal Family Systems, dissociation, trauma, relational trauma, interpersonal trauma, complex trauma, and protective factors in children with bipolar parent. The articles chosen for the purpose of the literature review were thoroughly reviewed to identify appropriateness and applicability for the research questions proposed. Articles were published in peer-reviewed journals and were in the English language. The articles were obtained from journals in the United States, Canada, and the United Kingdom. Research took

place in New Zealand, China, Korea, Taiwan, the United States of America, Australia, Canada, Spain, Norway, the Netherlands, and the United Kingdom.

Articles regarding attachment theory included a wider range of dates, as attachment concepts are theory-based and older articles are relevant in defining this topic. Articles exploring BD and trauma range within the last 10-20 years in order to include prior theories about trauma and research exploring trauma related to bipolar disorder. IFS articles are mostly recent within the last 15 years; however, some older articles were utilized to understand initial development of theory. After selecting articles relevant to the topic, articles were categorized by topics, read, and summarized to be included in the final literature review.

CHAPTER II: COMPLEX TRAUMA AND EFFECTS ON OFFSPRING OF A PARENT WITH BIPOLAR DISORDER

Emotional abuse or neglect may not constitute a definition of a traumatic event as listed in the *DSM-5*; however, these experiences can impact a child's overall well-being and distress levels as there is an "internal threat" due to being unable to manage or monitor their own internal affective and emotional states (Courtois & Ford, 2014, p. 17). When experiencing childhood trauma, multiple developmental areas are impacted, including attachment, somatic distress, biology, affect regulation, behavioral regulation, cognition, and self-concept (Cook et al., 2005; Courtois & Ford, 2014). These impairments are related to complex trauma symptomology, which can be defined as "the dual problem of children's exposure to multiple traumatic events and the impact of this exposure on immediate and long-term outcomes" (Cook et al., 2005, p. 4). Furthermore, Courtois and Ford (2014) describe complex trauma as involving "not only the shock of fear but also, more fundamentally, a violation of and challenge to the fragile, immature, and newly emerging self" (p. 16). Those who have complex trauma may view themselves as not being sufficient, often feeling as though they are not competent in life (Cook et al., 2005). They are also more likely to identify with negative affect when they are presented with self-recognition. These fundamental changes within a child after experiencing trauma would require a diagnosis of CPTSD to best aid in treatment and conceptualization (Cook et al., 2005; Herman, 1992). As such, this chapter will explore how OBD meet criteria for CPTSD and the extent of the complex trauma they may experience. This chapter will delve deeper into the biological and neurological effects trauma may have on the

body. The experience of living with a BDP and the trauma that may impact attachment, aspects of identity, and dissociation will also be explored.

Biological and Neurological Effects

Individuals who experience complex trauma develop biological alterations that can better explain the response one may have when faced with stressors (Kolb et al., 2016). The biological response to stress has been theorized as a means for survival. Historically, humans were presented with many different threats, including illness, dangerous animals, and environmental elements. In order to stay safe from these threats, the human brain developed the capacity for emotions, such as anxiety, which help humans survive by alerting them of danger present (Kolb et al., 2016). When one experiences traumatic incidents, stress hormones are released in a large capacity, which can continue to be secreted after a considerable amount of time has passed from the actual event (van der Kolk, 2014). Bessel van der Kolk (2014) discussed this phenomenon in which people who have lived through chronic trauma can fail to learn how to manage the release of this stress hormone, as some of the reaction is necessary for survival but can be experienced in excess.

Several parts of the central nervous system are involved in the stress response traumatized individuals experience (Kolb et al., 2016). The thalamus receives information from a person's sense organs, which then travels to the frontal lobe and the amygdala. The pathway to the amygdala from the thalamus may send sensory information quickly to assess for dangerous stimuli, which can result in an exacerbated emotional response compared to a rational one, often identifying danger before it is actually perceived. The amygdala is the area of the brain which sends information to an individual about the level of danger one may be in

and can activate their stress hormones. Those who have experienced prolonged and chronic trauma may be triggered easily by something which reminds them of their past experiences, resulting in prematurely activating the amygdala, even if there is not actual danger (Kolb et al., 2016).

Without having rational understanding during times of stress, one may feel as though their trauma has been reenacted and danger is present (Kolb et al., 2016; van der Kolk, 2014). This activation is responsible for prompting stress hormones to spike, often being unable to return to baseline in a normal manner. When individuals experience an intense surge of these hormones, they may freeze and be unable to respond. Trauma may continue to be expressed in a person's life as they organize their mind and reactions around these experiences to best avoid the harm the trauma has caused. "After trauma, the world is experienced with a different nervous system" (van der Kolk, 2014. p. 53). For example, basic body functions and time clocks within the human body may be disrupted for a person who experiences abuse or neglect in childhood as there is little consistency within their world, often relying on others to provide guidance (Herman, 1992). These biological disruptions can result in a number of physiological complaints and diagnoses, such as gastrointestinal issues, sleep disorders, and tension (Courtois & Ford, 2014; Herman, 1992).

Additionally, prior research identifying how trauma affects individuals neurologically indicated possible dysfunction within the prefrontal areas for both children and adults. Beers and De Bellis (2002) aimed to understand the cognitive functioning of children who were maltreated in comparison to those similar in background who had not experienced trauma. They recruited 14 children who had PTSD due to maltreatment within their home and 15

mentally healthy children. Children who had experienced a trauma performed lower than healthy participants in four out of six cognitive areas. They struggled with overall attention and sustained visual attention, problem solving, abstract reasoning, and executive functioning. It is important to note, Beers and De Bellis (2002) indicated there is a chance their results may have measured anxiety in these children rather than PTSD symptoms, as one could debate the anxiety symptoms these individuals experienced may have been a complex trauma response. Further research has suggested when children experience stress, they suffer from decreased brain functioning, such as not being able to regulate thoughts during stressful situations, decreased ability to problem solve, and a decrease in attention and abstract reasoning (Cook et al., 2005).

Not only do those who experience trauma have continuous biological effects out of their control, there is also a possibility that those who are used to traumatic and chronically stressful environments seek out similar environments in the future, as this is something they feel more comfortable or familiar with (van der Kolk, 2014). Many theories discuss different reasons for this behavior, such as wanting to have a different ending to the original trauma. Whatever the reason may be, the continuous experience of stress can be related to CPTSD. For example, prolonged exposure to trauma may have resulted in feelings of failure related to the traumatic experience (van der Kolk, 2014).

Trauma symptoms may be exhibited differently in all individuals; however, the response within the body may be more similar in nature as the process of releasing hormones and engaging different parts of the brain is a normal human experience (Kolb et al., 2016). When these biological effects are in place, those with complex trauma may not be able to

understand when they are in danger. As such, trauma responses may occur in everyday normal occurrences, altering a person's ability to function (Kolb et al., 2016). Somatic symptomology is often present, resulting in physical health issues as well as possible lack of proper diagnosis (Herman, 1992).

Attachment and Trauma

The attachment a child develops from infancy is also correlated with the formation of an individual's neurological makeup and potential (Fitton, 2012). Schore and Schore (2008) discussed the core relationship with the caregiver as being crucial in offspring learning to regulate their emotions. As the emotions of an infant are more heavily regulated by those within their proximity, their ability to learn techniques for coping and stress relief is present from an early time, with caregivers providing this stability. Knowledge gained about emotions is considered to be based off the response of their caregiver, thus resulting in neural pathway changes and behavioral assumptions that can impact future relationships and coping (Schore & Schore, 2008). Cook et al. (2005) suggested when a child is not cared for in a consistent manner, they do not gain feelings of safety and security, often resulting in survival mode. Without a secure attachment, children are unable to adequately develop ways to regulate their own emotions. As such, offspring may begin to try and gain control over their lives because this helps with their survival, which can impact the connection between self and others, including disengagement (Cook et al., 2005; Schore & Schore, 2008).

Children who have present and supportive parents or caregivers are less likely to be impacted by their environment and associated resource deficiencies (Leventhal & Brooks-Gunn, 2000). However, when parents are experiencing environmental stressors, these stressors

may impact the mental health of a parent, resulting in possible dysfunction in the children. Those communities where families lack resources are correlated with a high risk of child neglect or abuse in addition to insecure attachments (Leventhal & Brooks-Gunn, 2000).

Attachment and Bipolar Parents

Households with a bipolar parent are likely to display less cohesion and more conflict, which influences attachment as safety and stability may not be consistent (Chang et al., 2001). OBD may often experience anxious attachment due to inconsistent parenting and leaving the child uncertain of their own worth (DeMulder & Radke-Yarrow, 1991; Ostiguy et al., 2012; Wearden et al., 2008). In a study conducted by DeMulder and Radke-Yarrow (1991), the researchers aimed to assess affect and control with BDPs utilizing the strange situation method, which identifies attachment styles by viewing the way a child responds to their absent parent after being left alone in a strange environment. DeMulder and Radke-Yarrow's (1991) study included 112 mothers and children between the ages of 15 and 52 months. These families were recruited through community clinicians, daycares, parental support groups, and the newspaper. In order to qualify for the study, the mothers were administered a psychiatric interview in person. Of these mothers, 24 were diagnosed with BD, 43 were diagnosed with MDD, and 45 did not have a past or current psychiatric disorder. Participants who met criteria for alcohol abuse, schizophrenia, or antisocial personality disorder were excluded. It is important to note the majority of the sample was middle and upper middle class, with 84% identifying as White, 14% Black, and 2% Hispanic. The families were placed in a furnished apartment with their children during the study to help create natural interactions typically experienced at home. They were observed for two half-day sessions that were separated by 1-2 weeks. The families

were observed completing everyday activities, such as making meals, cleaning, and playing, and a stranger was present at different times. The child's emotional responses toward the mother were evaluated when separated and reunited (DeMulder & Radke-Yarrow, 1991).

Control in the study was defined as the parent trying to "regulate the child's behavior," such as influencing the way a child behaved and having a desired outcome (DeMulder & Radke-Yarrow, 1991, p. 232). The rating of attachment concerned the following areas: "Immediate Maternal Success, Ultimate Maternal Success by Persuasion, Ultimate Maternal Success by Enforcement, Compromise, and Ultimate Maternal Failure" in which the child did not comply with the request (p. 232). The researchers also took into account the behaviors exhibited by the children in the following areas: "Passive Noncompliance, Direct Defiance, Simple Refusal, and Negotiation" (DeMulder & Radke-Yarrow, 1991, p. 232).

Sixty-seven percent of OBD were categorized as having an insecure attachment with their BD mother, primarily categorized as disorganized, compared to the 42% of children with a depressed or healthy mother who were identified as insecure (DeMulder & Radke-Yarrow, 1991). BDP were also identified as being more likely to have higher levels of impairment compared to children of a depressed parent; however, the relationship between attachment and severity of functioning was not statistically significant. Mothers were also more likely to have success with interactions with the female children (62%) than the male children when a secure attachment was present; however, no gender difference was present in the rates of insecure children. Mothers without a mental health diagnosis were also noted to compromise more with their children compared to bipolar and depressed mothers ($M = 10\%$, $p < .01$). Parents of insecure children were described as being more "downcast" in affect and they also had a higher

tendency to experience anxiety. Mothers of secure children were more likely to express affection than those with insecure children. Lower levels of parental affection were exhibited within the insecure group and higher levels of anger were observed in comparison to those parents with secure children (DeMulder & Radke-Yarrow, 1991).

This study did not represent a varied population sample, limiting the generalizability to all families with a BDP (DeMulder & Radke-Yarrow, 1991). Additionally, the researchers did not address possible pathological symptoms mothers may have been experiencing during the times of observation, as their psychiatric interview was conducted months prior to the experiment. Fluctuations mood of symptoms may have further impacted the interactions between the mother and child, which may not best represent typical daily interactions (DeMulder & Radke-Yarrow, 1991).

Morriss et al. (2009) hypothesized that those with BD would be more likely to display an insecure attachment. They gathered 107 BD participants through four state-run and one private facility in Northwest England in addition to recruiting outpatient individuals via psychiatrists and mental health workers. They advertised the study through brochures placed in outpatient facilities, day hospitals, and a magazine geared towards BD. Controls without mental illness were recruited through libraries, universities, and hospitals. Of the 107 participants, only eight were of South Asian descent and two were Hispanic, with the majority being of British origin. The researchers did not indicate if British origin included individuals who are not White (Morriss et al., 2009).

A structured clinical interview was utilized to obtain participants, in addition to a depression and mania self-report screener (Morriss et al., 2009). Once selected, the participants

completed the Bartholomew-Horowitz Relationship Questionnaire to assess for attachment styles (Bartholomew & Horowitz, 1991). Their study indicated all 107 of their participants diagnosed with BD reported an anxious attachment compared to healthy individuals. Those with mania and depression also demonstrated a higher chance of preoccupied attachment, which can be related to the lower self-esteem and dependency those with an insecure attachment may possess. Anxious attachment traits were found to be unaffected by the episode (i.e., manic or depressed) an individual was experiencing (Morriss et al., 2009).

Results of this study suggest that individuals who have BD are likely to not experience a secure attachment, which can also impact the attachment styles of future generations (Morriss et al., 2009). However, these findings were derived from a self-report questionnaire, which may not always be reliable as individuals may not be truthful with their answers. Additionally, only one self-report measure was given in this study. While the questionnaire may be valid, additional data could have been gathered to best have an understanding of a person's attachment style. The current mood of the participant while completing this questionnaire was also not taken into account, which may impact the response pattern and truthfulness (Morriss et al., 2009). As parents with bipolar disorder may develop an insecure attachment in childhood, this style of attachment is likely to disrupt their own parenting skills and further perpetuate the cycle of insecure attachment throughout generations (Kucuk Ozturk & Cam, 2017; Morriss et al., 2009).

When attachment is not secure due to parental mental health issues, there is a "lag in their [child's] ability or inclination to explore the emotions of internal states of others," which may also suggest a lack of understanding of one's own internal states and emotions (Zahn-

Waxler et al., 1984, p.83). The parents' possible negative affect and inability to provide stable caregiving may also be a determinant of this behavior as the child may not be taught the appropriate manner in which to empathize with others and show these emotions (Schore & Schore, 2008; Zahn-Waxler et al., 1984). The instability present within the home may translate to complex childhood trauma contributing to a more fearful or anxious attachment and a lack of positive coping mechanisms within offspring (Simeon et al., 2003).

Attachment and Effects on Interpersonal Relationships

Research has found that children with a bipolar parent do not obtain the secure attachment that is needed for positive and healthy relationship patterns (Bowlby, 1988; Ostiguy et al., 2012). BDPs may create stressful and chaotic environments due to their neuroticism, leading to their children internalizing and externalizing problems, which can predict negative interpersonal functioning for the children as well (Ostiguy et al., 2012). Ostiguy et al. (2012) hypothesized that parents with high levels of neuroticism would be predictive of interpersonal difficulties within their offspring. They conducted a longitudinal study to test this hypothesis and recruited 62 males and 62 females from 78 different families to include a parent with BD or a healthy control parent. These individuals were sought out through psychiatric outpatient clinics, support groups, doctor's offices, and community events in Montreal, Canada. The sample included mostly White participants who were noted to be French speaking with middle class SES. Of the 124 children, 35 met criteria for a *DSM-IV* diagnosis to include anxiety disorders, mood disorders, substance-related disorders, ADHD, eating disorders, Tourette's syndrome, or hypochondriasis. During the timeframe when children were ages 4 to 12 years old, Ostiguy et al. (2012) had parents complete a self-report questionnaire to assess for traits of

neuroticism, extraversion, agreeableness, openness, and conscientiousness. They were also asked to complete a form that evaluated their child's internalizing and externalizing behaviors. During the second timeframe when the children were between the ages of 15 and 27 years old, the offspring completed a diagnostic interview in addition to an interview that assessed life stress.

The findings of Ostiguy et al.'s (2012) study indicated neuroticism, which includes angry and irritable moods, may be higher in parents with BD, which may in turn impact their parental functioning. Neuroticism can be viewed as showing less warmth and negative affect towards offspring. BD parents who exhibit higher levels of neuroticism may impact how their offspring react to stress, with OBD possibly experiencing neurotic traits themselves as well as internalizing problems. These tendencies are not only partly genetically inherited, but they are also modeled for the OBD, resulting in insecure attachment patterns and possible affective disorders. In this study, internalization of problems predicted difficulties in future interpersonal functioning regardless of having a BDP or a healthy parent. Additionally, offspring who had a mental disorder experienced significantly more interpersonal difficulties compared to those with no mental disorder. The researchers addressed genes as being a possible explanation for some of the findings as well as external factors, to include environment and peer influence (Ostiguy et al., 2012). An important aspect of the study to note is the use of self-report measures and parental report measures, which may be skewed and biased in providing responses. Additionally, offspring with a mental disorder may also have difficulties with interpersonal functioning due to the nature of their disorder, which could impact their self-report and data collected (Ostiguy et al., 2012).

McCarthy and Maughan (2010) aimed to explore adverse childhood experiences and how the processing of these experiences may correlate to psychosocial functioning as an adult. They hypothesized that women with insecure attachment would experience negative interpersonal functioning as an adult compared to those who had a secure attachment as a child. They also hypothesized women with satisfying adult love relationships would be able to discuss negative childhood experiences in a clearer manner than those with poor love relationships. McCarthy and Maughan (2010) were cautious in their approach to their study, as they conceded that retrospective reports of childhood experiences may not be clear when completing a self-report questionnaire. They also addressed current mood states and how this impacted scores, which was not present within the studies discussed previously. Participants were gathered from a 20-year follow-up of a sample who were first studied at the age of 10 as well as participants from a family-reared group who were interviewed in a previous study on women raised in institutional care settings. All participants were of white British ethnicity. A group of 34 women between the ages of 34 and 44 were interviewed in respect to their childhood and adult relationships, which explored parental warmth, discipline, and involvement or communication; adult love relationships; depression via a depression screener; and adult attachment through the use of the Adult Attachment Interview (AAI; George et al., 1985. They found that the functioning of an individual's intimate relationship(s) exhibited a strong relation to the classification of childhood attachment, with a majority experiencing insecure attachment (68%). Maternal care was linked to the probability of having a more satisfying relationship, suggesting this attachment may be crucial to the development of relationship behaviors; however, relationships outside of the parental caregiving roles have

also been found to impact attachment in adult life (McCarthy & Maughan, 2010; Wearden et al., 2008). The current mood a participant was experiencing was not significantly correlated with coherence of attachment and parental scales. Furthermore, attachment was not significantly correlated to SES; however, those with love relationships in higher SES categories demonstrated higher satisfaction levels compared to those with poor love relationships.

Madey and Rodgers (2009) hypothesized that those who obtained a secure attachment in childhood would display lower difficulties within interpersonal relationships, while those with insecure attachment would be consumed by worries and doubts. They tested their hypothesis by recruiting 55 university students to include 15 males and 40 females. The majority of this sample identified as white (91%) with 6% being African American and 2% identifying as Asian American. Participants were required to be in a romantic relationship at the time of the study, completing an attachment style questionnaire, Sternberg's Triangular Love Scale (Sternberg, 1988), and a relationship satisfaction questionnaire. Their research suggested those who have a secure attachment may experience more intimacy and commitment within their relationships than those with an insecure attachment, which can result in greater relationship satisfaction and less doubts about the state of the relationship or their partner's involvement (Madey & Rodgers, 2009).

These findings about attachment and relationships are important when considering the OBD population. OBD with insecure attachments may feel as though they are not safe within relationships, resulting in avoidance and isolation (Madey & Rodgers, 2009; Kucuk Ozturk & Cam, 2017). This avoidance of relationships may result in an individual not getting their needs

met, and cognitive schemas could become more ingrained, providing further negative experiences and thoughts (Wearden et al., 2008). When a person becomes overly self-reliant due to inconsistent parenting, this can cause further avoidance of relationships with others (Herman, 1992).

Those who display an insecure attachment style may also be more prone to experience depressive episodes, as interpersonal conflict can trigger prior abuse and trauma response symptoms (Morriss et al., 2009). Due to insecure attachment with early caregivers, criticism of others can be present within relationships accompanied by possible negative behaviors that result in reinforced self-criticism created from the significant other's responses. Further conflict may arise as individuals who have an insecure attachment are less capable of managing their own emotions in stressful situations (Muralidharan et al., 2010).

Conflict within interpersonal relationships has been found to likely be higher within the BD population (Narayan et al., 2015). As a result, OBD may struggle more with conflict resolution, as the modeling for this behavior may not have been present within the hostility and negative affect being prominently displayed toward the OBD (Muralidharan et al., 2010; Narayan et al., 2015). BD parents are also viewed as being more negative when OBD were experiencing interpersonal struggles (Vance et al., 2008). Narayan et al. (2015) conducted a study that included 120 children from 61 married families with mothers who were diagnosed with depression, BD, or were healthy controls. These participants were from a larger longitudinal study, which included divorce throughout the years of assessment; however, this study only focused on the 61 married families remaining. BD mothers demonstrated a higher chance of involvement in physical violence perpetration when contrasted with depressed

mothers. OBD also displayed aggression when mothers were perpetrators of physical violence against their husbands/partners. It is important to note these families consisted of mostly White parents who were still married. In addition, parents may be less likely to endorse domestic violence as this could impact their parenting status and they may fear repercussions, especially during the timeframe the data was collected from 1979-1993 (Narayan et al., 2015).

Overall, OBD's experiences with their BDP, such as instability of moods, inconsistent parenting, and parentification of the OBD may result in an insecure and anxious attachment (DeMulder & Radke-Yarrow, 1991; Morriss et al., 2009). This insecure attachment can result in OBD struggling to integrate or understand their own emotions as they were not able to understand their BDP (Muralidharan et al., 2010). This lack of understanding and possible feelings of not being safe within their parental relationship can result in interpersonal difficulties as well (Goetz et al., 2017; Madey & Rodgers, 2009; Kucuk Ozturk & Cam, 2017; Ostiguy et al., 2012). Conflict within relationships may be present due to the OBD possibly not having healthy relationship behaviors modeled as well as internalization of problems (Morriss et al., 2009; Narayan et al., 2015).

Home Environment with BDP

Research has indicated that families with a BD parent displayed a higher amount of conflict within the home, significantly less expressiveness, lower levels of family cohesion, and lower organization (Barron et al., 2014; Romero et al., 2005). There may also be difficulties in solving conflict within the family, which can impair family functioning, especially within larger families (Du Rocher Schudlich et al., 2008). An increase in family conflict is likely to be more present when children's negative behaviors are increased, as the

relationship between parent and child can become further strained. Families with both parents being diagnosed with a mood disorder are also correlated with functional impairment, more so than families where only one parent is diagnosed with BD. Additionally, conflict may increase when a child in the home is diagnosed with BD, resulting in further decreased levels of family cohesion (Du Rocher Schudlich et al., 2008).

"Family cohesion is defined as the emotional bonding between family members that seeks balance between independence and togetherness of its members" (Lau et al., 2018, p. 13). Lau et al. (2018) studied areas of dysfunction and symptomology within families with a BD parent. Lau et al. (2018) hypothesized that offspring at a higher risk of being diagnosed with BD in the future would exhibit more internalizing and externalizing behaviors than their healthy counterparts; OBD and the parents would identify low levels of family cohesion and parental warmth with overprotectiveness being present; offspring who viewed their home as having little cohesion and parental bonding would be predictive of externalization and internalization; and the cohesiveness of a family in addition to bonding would serve as a mediator between OBD mental health and parental BD (Lau et al., 2018).

This study (Lau et al., 2018) was part of data collection conducted in the beginning of a longitudinal study at the University of New South Wales assessing bipolar children and their siblings. Participants were between the ages of 12 and 21 years old and recruited through bipolar research clinics, previous engagement in a genetics study, mental health organizations, and advertisements in papers and online sources. High-risk offspring (n = 90) were identified as having one parent with BD. The study included 56 control participants whose parents did not have psychiatric histories. All parents involved were administered the Diagnostic Interview

for Genetics Studies Version 4 to confirm the diagnosis of BD in one parent (DIGS v. 4; Nurenberger et al., 1994). A self-report measure assessing family cohesion was given to both the parent and child. The parents completed measures to identify adult and child behaviors for their children in addition to the offspring providing self-report measures about their parent's functioning and their own behaviors.

Lau et al. (2018) tested hypothesis one and two through the use of an Analysis of Covariance and utilized a multi-level mediation analysis to test hypotheses three and four. High-risk offspring verbalized a greater level of importance in receiving care and empathy from parents and experienced internalization of problems in response to low levels of parental care than did control offspring. High-risk offspring were also noted to internalize their problems as well compared to the control group, noting dissatisfaction with their physical health, mental health, social functioning, and view of self; however, their parent reports indicated externalization problems (Lau et al., 2018). There were no significant differences between groups regarding family cohesion and bonding as being mediators. While Lau et al.'s (2018) study indicated family cohesion with a BDP was not significantly different from control groups, the researchers suggested the recruitment of high functioning BDP families may have impacted these scores (Lau et al., 2018). Race, SES, and external family or other stressors were not taken into account within this study, and therefore results cannot be generalized to the broader BD population. Additionally, the severity of BD within the parent and the functioning of a possible second parent was not addressed, which may present as mediators within the research (Lau et al., 2018).

Past research about OBD's home environment suggested possible internalization of problems experienced by the OBD, especially when family cohesion is low (Du Rocher Schudlich et al., 2008). This internalization can impact the overall well-being of the OBD, influencing their physical health, self-esteem, and interpersonal effectiveness as well (Goetz et al., 2017; Lau et al., 2018). Conflict within the home was discussed as possibly increasing the risk of OBD externalization of problems (Lau et al., 2018). The study did not fully account for second parents or caregivers who would be considered healthy, suggesting further research would be necessary to examine this phenomenon.

Offspring's Experience of Being Raised by Bipolar Parent

Much of the research exploring the experience of being raised by a BDP has varied in data collection techniques; however, many of the prior studies have gathered data exclusively from the parental view, which can be significantly skewed in comparison to the child's experience. As such, it is imperative to review qualitative research from the perspective of the OBD to best understand the possible complex trauma symptoms experienced.

A qualitative study that utilized in-person interviews with offspring of bipolar mothers was conducted via a semi-structured interview schedule containing open-ended questions with children ages 10-15 (Venkataraman, 2011). The study aimed to identify both strengths and challenges in having a mother with BD. The participants were from a small urban town located in the Midwest of the United States of America. Three families were recruited from a larger study and four children from these families were interviewed. The participating mothers were in their late 30's and early 40's and were single mothers. All mothers were noted to have obtained at least a General Equivalency Diploma (GED) with their SES status ranging from

lower to middle class. The OBD participated in an initial interview with a clinician without their parent present. The children were later involved in a follow-up interview to confirm themes and content they had described in their initial interviews. Clinicians provided the children with a short summary of their previous responses to clarify the accuracy. The OBD were noted to have agreed with their statements during their follow-up interviews (Venkataraman, 2011).

OBD within the study viewed their mothers as helpful by providing encouraging words at times and getting things they wanted (Venkataraman, 2011). The mothers in this sample were also viewed as setting limits, which can be considered as responsible parenting skills; however, the extent of the limits was not reviewed. Some OBD reported needing to engage in approaching their mother with a sense of humor in order to lighten the mood when the mother was feeling angry, resulting in some relief for the OBD. While this strategy was viewed as being a strength, it may also be considered an adaptive skill necessary for survival (Venkataraman, 2011).

When considering challenges, children within the study reported a sense of needing to be the caregiver for the home, especially when their mother slept throughout the morning (Venkataraman, 2011). Those who were in more of a caregiver role appeared to be conflicted with their feelings regarding their mother's behavior and how it impacted them, oscillating between resentment and pride. One 15-year-old daughter stated "It doesn't really bother me, just feel like I have a lot of responsibilities sometimes… I think that I would like to have responsibilities because I feel like needed but sometimes it is just like wow!" (Venkataraman, 2011, p. 101). Anger issues and screaming were discussed as additional challenges within the

household. One child from the study identified unpredictable moods as being a stressor, needing to be actively aware of her mother's mental health state. The children interviewed appeared to understand their mother's illness, if they were aware of it, and were more tolerant of the behaviors, often seemingly defending their mothers. Two children from the study also identified feeling somewhat fearful of the possible genetic inheritance of BD and what this would mean for them (Venkataraman, 2011).

While these views expressed within the study were useful in understanding what a child may perceive during childhood, the study was small in size and included mainly medicated, single mothers (Venkataraman, 2011). In addition, there was a possibility of the interviewed children shielding and protecting their mothers, as this strategy not only protects the family, but also protects the image the child has of their main caregiver. Because these families were from a small town in the Midwest region, it is possible verbalizing issues within the family may have been viewed as more damaging, as the stigmatization and fear of repercussions may have been present. Race was not discussed in the article, which diminishes the ability to generalize to the BD population. Larger sample sizes would need to be studied to both replicate and generalize these findings within this population. (Venkataraman, 2011).

In a qualitative study conducted in the United Kingdom, researchers Backer et al. (2017) discussed the importance and validity of looking at the child's experience instead of only gaining information from parents. The study aimed to understand how having a bipolar parent impacted the experience of family life for the children and their emotional health. The study consisted of 1 father and 5 mothers, all reportedly White. Three of the parents were considered to be single parents with the other 3 having a two-parent household. Four out of the

6 BDPs had been hospitalized prior to the study with five taking psychotropic medication. Six parents with BD were recruited through the use of a BD organization ad. The ages of the 10 children interviewed ranged between 4 and 12 years old, consisting of 9 male and 1 female child. Two children were identified as being diagnosed with Asperger's syndrome and 1 with ADHD. Additionally, one of the children was identified as being delayed in regard to emotional and social skills (Backer et al., 2017).

Interviews were conducted in the home environment, and terminology used within the varying home settings was adopted by the interviewers (Backer et al., 2017). Two of the 10 parents did not allow the researchers to discuss bipolar related questions due to the children not being informed of their diagnosis. The researchers utilized the assessment tool "In my Shoes" (IMS), which is considered to be a semi-structured interview process. The process involved children being asked to consider specific times in which they experienced a range of emotions and identifying the family member or individual present for these experiences. The children were able to express their own phenomenon of living with a BD parent. Backer et al. (2017) indicated they provided detailed documentation in order to have a reliable and sound attempt at constructing themes, indicating there was more than 70% agreement in regards to the themes extracted from the transcripts.

Four themes were identified from the data gathered, including "perception of parents, knowledge and awareness of BD, managing life with BD parent, and living in a family with BD" (Backer et al., 2017, p. 217). The perception of parents suggested the children of BD parents were able to identify many moods their parent experiences, such as "depressed, sad, happy, giddy, irritable, angry, worried, stressed, 'funny face,' and 'naughty'" (p. 217). Some

children blamed themselves for their parent's feelings, others were unsure, and some thought they happened without cause. In this study, it appeared the younger the child, the more self-blame was inflicted, which can negatively impact a child's developing sense of worth. Behaviors such as shouting and "telling their children off" were also noted (p. 217). Those in two-parent households identified times in which there was stability and consistency with the parent who was "well" and how this had a positive impact on the children. However, there were also times in which the healthy parent felt they were an only parent while their partner was "sick," resulting in stress and possible conflict within their relationship with their child. Researchers also discussed the "well" parent taking on multiple roles, such as being the disciplinarian, which may contribute to further conflict within the household (Backer et al., 2017).

The second theme regarding knowledge and awareness of BD discussed communication of the disorder between parents and children (Backer et al., 2017). Many of the older children who were interviewed about BD symptoms indicated they could not remember having a talk with their parents about their diagnosis of BD; however, some reportedly did find it helpful to know. Older children appeared to be more curious about the disorder and they experienced confusion and uncertainty about how to verbalize aspect of their parent's illness. Although some children reported they were unsure of their knowledge, they were able to describe the symptomology of BD (Backer et al., 2017).

The theme of "Managing life with a BD parent" explored the emotional effects on the child. Researchers indicated the main emotions expressed within the children were sadness and anger (Backer et al., 2017). Over half indicated they felt sadder when their BD parent was

experiencing symptoms compared to when they were euthymic. Anger experienced in the children was exhibited differently, with younger children experiencing behavioral problems and older children expressing annoyance towards the shifts in moods. Some were unsure of how the parent affected them, expressing some difficulties in separating self and personal impacts from their BD parent. The older children were described as taking on a more parental role in helping their BD parent around the home, even going to the store for their parent. Some described feeling happiness helping their parent as they liked to be useful and felt it contributed positively to their parent's mood. Backer et al. (2017) indicated the children in the study may not have been old enough to truly understand how parentification impacts them, stating the children were proud of their helpful roles. The themes did not take into account the parental attention and approval when the children do take on more helpful roles. These responses and approval might be viewed as positive affirmations at a younger age as these children are more desiring to achieve and gain an understanding of their selves in relation to others (Backer et al., 2017).

Many children were not aware of what they felt they needed for support, however sources of support through external family members and pets were considered to be important and focused on often (Backer et al., 2017). Being with friends was also another way children gained additional support. In regards to living in a family with a bipolar parent, the children interviewed described positive and negative aspects of family life; however, many of the aspects discussed were similar to those present in most families such as fighting with siblings and being punished for negative behaviors. The researchers reported some children of BD

parents referenced some avoidance of their parents “when they were angry, sad, or irritable” (Backer et al., 2017, p. 222).

While this research contributed to understanding the OBD’s view of living with a BDP, there were some limitations present. All of the participants in the study were identified as White, which does not take into account other races and social factors which can contribute to stressors and moods in addition to cultural norms within households. Three of the children were also diagnosed with a mental health disorder, which can impact the relationship with their parent as further attention may be needed and additional stressors can be present. One child who exhibited delays in social and emotional skills may have a skewed perception of their relationship with their BDP and could possibly be treated in a different manner than other children in the household. The sample size of this study was small and is not able to be generalized to the BD population.

Depression in BD households

Those who are diagnosed with BD may also experience depressive episodes, which can influence parenting, as depressed mothers are likely to display more difficulties in fulfilling parental duties and maintaining their behaviors (Lovejoy et al, 2000). Lovejoy et al. (2000) reviewed literature regarding depression in mothers and identified that depressed states result in higher levels of irritation and hostility toward their offspring compared to when the mothers are not depressed. The possibility of this effect was noted as being even greater for children who are younger, as these children desire more contact and initiation to learn and feel safe in their environment (Lovejoy et al., 2000). When families have two BDP or depressed parents, there may be a “decrease in fostering of independence” within the offspring (Chang et al.,

2001, p. 76). Parents suffering from bipolar disorder who exhibit negative affect due to periods of depression may also create stressful life events, which are then imposed onto their children (Ostiguy et al., 2009). Additionally, children who are raised by a parent who suffers from depression are considered to have a higher chance of experiencing childhood emotional abuse, physical abuse, sexual abuse, or neglect in addition to difficulties within relationships and academics (Chen & Kovacs, 2013; Oquendo et al., 2013).

Calam et al. (2012) hypothesized that depression in parents results in higher levels of hands-off parenting, higher levels of activation and chaos, and frequent child behavioral issues when parents are unstable and depressed. Calam et al. (2012) recruited 52 parents via advertisement online and in practices located in the United Kingdom; however, only 48 families were utilized due to lack of participation from four families. The 48 parent participants included 45 mothers, two fathers, and one stepmother. The children consisted of 29 male and 19 female children ranging from ages 2 to 10. Eight of the children were seeking professional help at the time of the study due to anxiety, ADHD, mood disorders, and behavioral problems. The researchers did not identify exclusion criteria, but the parents were only able to discuss one child if more than one was present in the household (Calam et al., 2012).

The Mood Disorders Questionnaire (MDQ; Hirschfeld et al., 2000) was utilized to aid in identifying BD in the parents in addition to a self-report questionnaire that assesses manic and depressive symptoms. A depression self-report measure was utilized to detect current depression symptoms. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 2001) was utilized to assess emotional symptoms, conduct problems, hyperactivity, peer problems, and prosocial behaviors in the children. Parents were also administered a self-report

questionnaire to determine their discipline styles as a parent. All questionnaires were completed online by the parents.

Calam et al. (2012) found that when considering child emotional and behavioral difficulties in families with a depressed parent, a larger percentage of the sample fell within the borderline or abnormal adjustment. Parents who were diagnosed with BD, were not currently manic, and were experiencing depression endorsed high dysfunction within parenting styles and difficulties within the household. It was also suggested that depression was correlated with overreactivity in parents; however, depression was not significantly correlated to OBD's emotional difficulties. Activation of restlessness and impulsivity showed a positive correlation with emotional issues a child experienced but was not significantly associated with parent overreactivity. Disorganization of BDP's emotions was noted to possibly result in more parenting difficulties and child adjustment problems (Calam et al., 2012).

While Calam et al.'s (2012) study discussed pertinent information, it is important to note the majority of the subjects within the study identified as being White (78%) and only 8% of the families considered themselves to be struggling financially, indicating a lack of diversity within the sample (2012). Depressed mothers who have a lower socioeconomic status (SES) may exhibit a decrease in positive parenting behaviors due to economic stressors, which could significantly impact the information gathered for this demographic and may be f a representation for those who suffer from BD (Lovejoy et al., 2000). In addition, the study primarily considered the perspective of the parent, which can likely lead to bias and skewed perceptions of the child. The BDP may also have chosen their most perceived "problematic" child in the home or could have also chosen a "non-problematic" child to avoid judgment or

scrutiny from the researchers given that prior research has identified bias towards parents with mental health struggles (Calam et al., 2012).

Anderson and Hammen (1993) included the perspective of children with mothers who suffered from unipolar depression, bipolar disorder, chronic medical illness, and mothers without psychiatric disorders. Anderson and Hammen (1993) conducted a longitudinal study in which families were contacted by the researchers every 6 months over a period of 2 years. Data gathered during contact focused on offspring's academic performance, behaviors present both at home and in academic settings, and social competence. Participants were recruited from inpatient and outpatient facilities in addition to referrals from private sources. The study included 96 children ranging from ages 8 to 16 when the study first began, with 10 children dropping from the sample during the first year and six children leaving during the second year. Of the children involved in the study, 22 were offspring of mothers with MDD, 18 were OBD, 18 were children of mothers with medical illnesses, and 38 were offspring of mothers who were not diagnosed with a mental health or medical disorder. Most of the families were White; however, there was a small percentage of African American and Hispanic women (Anderson & Hammen, 1993).

The families were not interviewed until mothers with mental health disorders had not been hospitalized for at least 3 months (Anderson & Hammen, 1993). The mothers were initially interviewed alone to gain information into their symptoms and view of the family. Children were then interviewed in addition to the mother 2 - 4 weeks later. During each of the 6-month follow-up sessions, school records were requested, and mothers completed a behavior

checklist to assess for severity of behavior problems within the offspring. Each year a teacher rating scale was completed as well (Anderson & Hammen, 1993).

Results of their study indicated lower scores in behavioral problems and social competence in children of bipolar mothers than in children of mothers with unipolar depression. Additionally, offspring of depressed mothers had higher rates of internalized behavior scores, school behavior scores, and academic performance scores compared to all other groups. No significance was found between bipolar and healthy mothers in regards to behavior problems, academic performance, and social competence (Anderson & Hammen, 1993).

Anderson and Hammen (1993) suggested major depression had more of an impact on the child-parent relationship than parents with BD or no mental illness. However, their findings did not take into account the possible inconsistency within the bipolar parent relationship or the "parental role" a child may take on, which can result in children striving to do well in school or in external relationships. The parent's scores may also fluctuate as the moods they experienced can be labile in nature. Additionally, children at younger ages may be unaware of the impact their parental relationships may have had, resulting in less drastic behaviors and under reporting. Results did conclude that having a mother with an illness, either medically or psychiatric, does have an impact on a child's behavior and functioning. In addition, the study indicated that those with lower SES fell in the unipolar depressed group as this population was noted to need more financial assistance while having a disability. As such, it would be beneficial to understand how the lower SES status impacted these additional symptoms the mother had experienced, as well as the children. Those within the unipolar and bipolar groups

as well had higher rates of being unmarried, which may be attributed to interpersonal issues that can be experienced with serious mental illness and can contribute to further financial stressors (Anderson & Hammen, 1993).

A study conducted by Fear et al. (2009) strove to identify how children of depressed parents experience internalized and externalized symptoms in addition to how self-blame for interparental conflict may significantly impact these symptoms. Participants were recruited via mental health clinics, medical professionals, advertisements in newspapers and television ads, university recruitment, schools, and community centers. The participants included 204 children aged 9 to 15years old from 152 families with parents who had a history of depression (108). Parents were mostly White (87%), 8% African American, 3% Hispanic and 2% of mixed racial identity. Parents with BD were excluded, in addition to those with Schizophrenia. Children who met criteria for CD, substance abuse, intellectual disability, and autism were excluded. Parents completed a depression screener, a behavior checklist for the offspring, and Responses to Conflict Questionnaire (RSQ; Connor-Smith et al., 2000). Offspring of the parents also completed the RSQ and a questionnaire which assesses self-blame in relation to parental conflict (Fear et al., 2009).

Conflict within the household between parents was identified as having a negative effect on a child's functioning, resulting in an increase of anxiety, aggression, and depressive symptomology (Fear et al., 2009). In addition, when offspring of depressed parents blamed themselves for their parent's maladaptive behaviors and moods, their symptoms were exacerbated. When self-blame is present, secondary control coping strategies were noted to not be engaged, which is consistent with other research about depressed parents and family conflict

(Fear et al., 2009). Research also suggests children who are living in a family environment characterized by conflict due to parental depression will often times utilize "disengagement coping," which consists of avoidance of the stressor, social isolation, and avoidance of conflict (Langrock et al., 2002; Lovejoy et al., 2000).

Parentification

Blame may become a primary thought process within children of abuse, due to the glorification of the parent and needing them to be "good," resulting in innate feelings of being bad or not good enough (Wells & Jones, 2000). To make up for this perceived sense of being bad, children may begin to take on extra roles for their parent's approval, such as taking care of the household, parental health, or becoming a caregiver themselves (Herman, 1992). As suggested previously, children who live in a household with a BDP are more likely to take on these roles outside of their developmental level due to a possible decrease in parental functioning (Wells & Jones, 2000). In one study, female participants who had a mother with BD indicated a higher chore load within the household than in families with no mental health disorders, causing more tension and responsibilities (Kucuk Ozturk & Cam, 2017). Those with a father with BD reportedly needed to support the family financially in some situations (Kucuk Ozturk & Cam, 2017).

When children take on a parentified role in their childhood, there is a disengagement from their possible self, sometimes becoming overly invested in this role as this is their source of love and acceptance within the family construct (Wells & Jones, 2000). A child may feel as though their own true self is not valued, resulting in the concept of shame and denouncement of self. Wells and Jones (2000) described shame as being the inability to reach an expected

sense of self others may place on us, such as caregivers, and viewing this failure as a part of self. These researchers conducted a study that indicated shame is a trait that is more prone to be experienced in those who have been parentified; however, guilt was not something that was related. This finding suggests there is more of an internalization process of not being able to live up to parental expectations, resulting in further psychopathology within offspring such as possible narcissistic and masochistic traits in later life (Wells & Jones, 2000).

OBD may experience mental health symptoms in relation to the level of conflict within the home (Fear et al., 2009). BDP's may present with unpredictable moods which can present as self-blame in OBD and lower levels of self-worth (Venkataraman, 2011). Additionally, the possible self-neglect within BDP and inability to manage daily tasks when depressed or manic can result in parentification of the OBD (Lovejoy et al., 2000; Venkataraman, 2011). When parentified, OBD can gain a sense of worth in the household; however, have more responsibilities placed on them which can create confusion and lack of self-identity. If OBD's are criticized, regardless of the roles they take on, there can be shame present which can manifest in personality dysfunction (Wells & Jones, 2000).

Complex Trauma and Identity

Children of trauma are also tasked with forming an identity without a secure attachment. Cook et al. (2005) identified the right hemisphere of the brain as being the central area for individuals to gain a sense of self; thus, when this hemisphere is not adequately developed, there is a lack of a cohesive self. Additionally, social learning from parents and caregivers who are unstable may result in children not being able to understand their own emotions, as these can be viewed as inconsistent as well (Cook et al., 2005). According to

attachment theory, if children do not have consistent parenting, there may be a decrease in self-worth and an internal working model, which conveys that they are not worthy of love (Ainsworth & Bell, 1970; Herman, 1992). These views of self are further exemplified within households who have a BDP as parenting may not be consistent, with possible overreactions when disciplining (Calam et al., 2012; Knowles et al., 2007).

A study focused on self-concept within OBD was conducted in Turkey and included 131 OBD between the ages of 15 and 25 who were offspring of BDPs receiving inpatient mental health treatment (Kucuk Ozturk & Cam, 2017). The researchers used a self-concept scale in addition to gathering information about the OBD's support system outside of the caregiver, striving to understand how the BDP affected their daily lives. Compared to offspring of those who do not have a parent with BD, OBD identified having a lower self-concept; however, those who had identified support from grandparents and other family members scored higher than other OBD in regards to self-concept. Those who were lower SES also indicated lower self-concept, suggesting further external influence on an individual's functioning and view of self (Kucuk Ozturk & Cam, 2017). These factors can also be mediated by the offspring's behaviors and diagnoses in addition to the supportive and other protective factors involved (Shalev et al., 2019). The study conducted by Kucuk Ozturk and Cam (2017) did not discuss racial identity, which impacts generalization of their findings. Additionally, while the participants were noted to not have a mental health disorder, the age range of the participants should be considered as mental health episodes may have a later onset. The OBD in this study may also display fewer symptoms of their own mental health struggles to avoid further conflict in the family (Kucuk Ozturk & Cam, 2017).

Overall, OBD may be more at risk for experiencing lower self-esteem and not having a stable sense of self due to the inconsistent parenting they may receive in addition to lack of secure attachment (Calam et al., 2012; Herman, 1992; Knowles et al., 2007). While insecure attachment in OBD has been linked to lower self-concept and lack of identify, there are also protective factors which can aid in improving the sense of self, such as having healthy external caregivers and grandparents (Kucuk Ozturk & Cam, 2017).

Dissociation

When one is unable to adequately provide safety for themselves outside of the caregiver attachment, a person may begin to try and develop a part of self who can provide this stability (Herman, 1992). “Repeated trauma in adult life erodes the structure of the personality already formed, but repeated trauma in childhood forms and deforms the personality” (Herman, 1992, p. 96). Judith Herman (1992) discussed the concept of children needing to develop their own defenses in order to maintain their sense of stability and safety in an otherwise unsafe environment. Coping mechanisms are adapted in order to understand the caregiver, as it can be difficult for the child to associate their primary caregiver and main source of survival as being “bad” (Herman, 1992; St. Clair, 1987). To achieve this, an individual may “split off” negative experiences and abuse to best alter the painful reality it can inevitably present (Herman, 1992).

Dissociation is at times utilized by survivors of abuse or trauma, as the avoidance of the present moment may be a safe way to absolve the caregiver of these negative views and feelings (Herman, 1992). Dissociation does not always progress into alters of a person, in which each alter has their own personality, rather individuals may have parts of themselves that are emotionally stunted and frozen. Judith Herman described this as fragmentation, which is

when “the inner representations of the self prevents the integration of identity” (1992, p. 107). She further discussed the possibility of dissociating to a degree of not being able to feel connection to self, but also to others in life, resulting in further complications and views of self. When feeling disconnected from the self, there may be a tendency to participate in self-injurious behaviors to feel something. Not being able to differentiate how they are feeling or what they are experiencing can also result in dissociation in order to avoid emotions and situations (Herman, 1992).

While some survivors of trauma may rely on substances, self-mutilation, or reenactment of trauma to help cope with the pain they had experienced, it can also be hypothesized some survivors may become overly protective of themselves, often wanting full control at all times, resulting in dissociation (Herman, 1992; Schwartz & Sweezy, 2020). When understanding dissociation, it is important to identify the different levels that play a role in the overall functioning of this phenomenon. Dissociation can take place within higher cognitive functioning and at the lower base levels of basic sensory and motor activity (Chiu et al., 2018). The *DSM-5* defines dissociation as the “constellation of symptoms characterized by a disruption of ordinarily integrated functions in mental processing” (American Psychiatric Association, 2013, p. 291). Dissociation can often be seen in multiple mental diagnoses within the *DSM-5*, such as PTSD, Borderline Personality Disorder (BPD), or other dissociative disorders. While dissociative episodes often are viewed as being evidence of dissociative identity disorder, there are multiple forms and severity of dissociation (American Psychiatric Association, 2013). Many studies have looked at the relationship of dissociation in relation to those who suffer from BPD, as this can be a diagnostic marker; however, these studies also

discuss and identify the varying arenas of trauma and how these adverse events contribute to the possibility of dissociative episodes. Cook et al. (2005) discussed the concept of dissociation in the aftermath of complex trauma, stating dissociation "is the failure to take in or integrate information and experiences" (p. 5), which can result in a person not being able to fully connect past experiences, feeling, and thoughts.

Dissociation has been considered to be experienced at a higher level when there is a history of childhood abuse and may be used as a defense tactic to best handle high levels of anxiety a person may feel (Chiu et al., 2018; Cook et al., 2005; Watson et al., 2006). As children within traumatic environments may continue to experience chronic and prolonged stressors, this defense may be utilized more often, resulting in continued dissociative tendencies throughout adulthood. When individuals experience traumatic incidents or prolonged trauma, there may be an overwhelming feeling of wanting to avoid the emotions and physical reactions linked to these events (van der Kolk, 2014). Not only does this help a person feel more in control of their outcome to the experience, but they can also avoid unpleasant feelings and memories (Herman, 1992; van der Kolk, 2014). This "freeze" aspect of trauma can be viewed as the depersonalization criteria associated with dissociation in the *DSM-5* (American Psychiatric Association, 2013).

Chiu et al. (2018) sought to find predispositions for dissociation symptoms, including childhood interpersonal and relational trauma. Current stress and prior stress, including childhood trauma, were hypothesized to impact the dissociation process. As Chiu et el. (2018) discussed, "71% to 63% of psychiatric patients with a dissociative disorder reported childhood physical and sexual abuse" (p. 2). The researchers suggested childhood relational trauma may

not be well represented in prior research involving dissociation, as the areas of abusive relationships in childhood were not determined in many studies.

Simeon et al. (2003) strove to better understand how childhood trauma impacted those with BPD, including the potential presence of dissociative episodes. Twenty individuals diagnosed with BPD from the community and 24 healthy controls were utilized in this study. The researchers assessed for dissociation, trauma, temperament, defenses, cognitive schemas, and attachment style through the use of self-report measures. Simeon et al. (2003) found that within their sample, childhood trauma and dissociation were positively correlated, with dissociation being most significantly correlated with an emotional neglect type of trauma or abuse. A significant correlation was present between dissociation and a fearful attachment style in addition to immature defenses. It is important to note the small sample size utilized in this study while also considering the possible underreporting of abuse and symptomology, as those who experience dissociation may not be cognitively aware or are unable to access their emotional trauma easily. Race and other stressors such as SES were also not taken into account, which could impact the data being generalizable. In addition, those with BPD may have different cognitive schemas and processing styles than the OBD referred to in this literature review, suggesting differences in dissociation levels. The way in which an individual processes information may also moderate the degree of relational trauma a person experiences (Chiu et al., 2018). For example, Chiu et al. (2018) discussed the pattern exhibited within those who dissociate to include ignoring certain stimuli and experiencing an ability to move between mental states within a quick period of time to aid in this behavior. This atypical cognitive

process may contribute to a decrease in processing the childhood trauma a person experiences, which could also alternatively impact the dissociation processes (Chiu et al., 2018, p. 3).

Those with dissociation and trauma experiences from childhood may have difficulties in accessing certain self-representations, as they may have been unable to integrate all parts of self. Chiu et al. (2018) conducted research to identify if there is a correlation between self-referential processing and the dissociation one may experience. In addition, they strove to understand if "low accessibility to self-referenced representations may moderate the link between childhood relational trauma and dissociation" (p. 3). Participants were gathered from National Cheng Kung University in Taiwan, which included 182 college students. Researchers utilized the Dissociative Experiences Scale (Bernstein & Putnam, 1986) to gain understanding of the dissociation levels within participants; 27 displayed high scores, 29 medium scores, and 17 low scores. These participants then participated in a self-referential memory experiment which included viewing 144 Chinese adjectives to describe traits they thought described themselves and those which were socially desirable (Chiu et al., 2018).

Chiu et al. (2018) found dissociation was positively correlated with childhood relational trauma, in addition to maladaptive environments throughout childhood and negative parenting. Results from this study also suggested a relationship between dissociative episodes and lower levels of self-reference (the ability to understand self within personal history). This results in individuals with trauma lacking the ability to recognize past hurtful experiences while also impacting the way in which they process new information that is presented to them, thus resulting in fragmentation. However, the researchers also addressed the low levels of self-reference may in fact be a symptom of the dissociation experience (Chiu et al. 2018).

While dissociation has been reported to be present within those who have experienced trauma in childhood, theorists suggest trauma's effects may be modulated when there is a positive caregiver relationship (Kong et al., 2017). Kong et al. (2017) conducted a study in which they aimed to understand how attachment within adults who have experienced trauma is related to a specific form of trauma and possible dissociation. They also questioned whether those who have an anxious/insecure attachment would "mediate the relationship between each form of childhood trauma and dissociation" (p. 6). The researchers recruited 115 participants from an outpatient clinic in Korea which specializes in trauma treatment. The mean age of participants was 33.6 and more than half were female with 88.7% of participants found to be at an increased risk for PTSD. Participants completed an interview with a psychiatrist and completed measures which explored adult attachment, childhood trauma, and dissociation. Results from these measures suggested those who experienced childhood trauma had a significant likelihood of experiencing dissociation and this correlation could be mediated by anxious attachment. Those who were subjected to sexual abuse in particular, displayed dissociation as mediated by a fearful attachment. The concept of anxious attachment was more prevalent in the role of dissociation and identity integration in regards to childhood trauma. The findings also identified emotional neglect as being the most significant form of abuse in relation to dissociation when mediated by insecure attachment (Kong et al., 2017). The presence of resilience and other intrinsic factors should be considered, as they may impact the level of trauma a person experiences, resulting in less frequent chances of dissociation (Chiu et al., 2018).

OBD may experience varying levels of trauma while living with a BDP which could possibly result in dissociation or fragmentation (Chiu et al., 2018; Herman, 1992). When experiencing dissociation, OBD are not able to integrate experiences or information presented to them (Herman, 1992). The research suggested emotional neglect and abuse is more likely to result in this fragmentation of self (Chiu et al., 2018; Kong et al., 2017). Dissociation is viewed as being a way for individuals who have lived through trauma to protect themselves from further pain and trauma, protecting the vulnerable parts of self. However, there are protective factors which can mediate the experience of dissociation, such as other positive caregiver relationships to include external family (Kong et al., 2017).

CHAPTER III: CONCEPTUALIZATION OF OFFSPRING UTILIZING INTERNAL FAMILY SYSTEMS

Internal Family Systems (IFS) was founded by Richard Schwartz who wanted the theory to include the different aspects that contribute to a person's individual psyche, such as family, community, culture, and societal aspects (Schwartz & Sweezy, 2020). IFS theorizes all individuals have different parts of themselves, with varying levels of fragmentation. The exploration of these parts is useful for those who have experienced trauma in addition to depression, anxiety, and eating disorders (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). As such, IFS would be an appropriate theory to utilize when approaching individuals who were raised by a bipolar parent due to the possible trauma and fragmentation prior research has demonstrated may be present within this population (Chiu et al., 2018; Kong et al., 2017). This chapter strives to explain how offspring of parents with bipolar I disorder be conceptualized through the lens of IFS. The theory of IFS will be discussed and applied to a hypothetical case example.

Theory of Internal Family Systems

In an interview conducted by Pedigo (1996), Schwartz identified the hesitance in earlier days of psychology to understand the intrapsychic nature of human beings, as these systems and aspects were more difficult to measure and observe. Richard Schwartz was able to develop IFS, which included these different systems or "parts" within a person. "We all have what other theories have called archetypes, complexes, internal objects, ego states, or subpersonalities, what I call parts because that seems to be the most user-friendly term" (Pedigo, 1996, p. 271). Schwartz indicated an individual will switch personalities or parts

throughout the day without being aware of the transition (Schwartz, 2021; Schwartz & Sweezy, 2020). An example may be an individual "switching hats" throughout the day, such as being a manager of a store, being a mother, being a friend, and being a wife.

Schwartz indicated having multiple parts can be conceptualized in a family systems theoretical manner (Pedigo, 1996; Schwartz & Sweezy, 2020). For instance, homeostasis, a term which indicates a balance or norm within a family when change is present, is taken into account for internal systems (Nichols, 2009). Like a family, each part has their own state of functioning and role within the system, all contributing to the overall wellbeing of the individual (Pedigo, 1996; Schwartz & Sweezy, 2020). Just as in a family system, an internal system may resist change as this causes an imbalance in normal functioning or the homeostasis. In addition, the parts are viewed as having relationships with one another as a family would have. Schwartz identified a system as being "any entity whose parts relate to one another in a pattern" (Schwartz & Sweezy, 2020, p. 25). While some aspects of IFS can be viewed through a family systems lens, Schwartz stated that while developing IFS, he recognized some family system's theoretical views did not prove beneficial for internal change, such as when only focusing on external factors (Pedigo, 1996; Schwartz & Sweezy, 2020).

The overall goal of IFS therapy is for a client to provide love and security to all of their parts to bring balance and peace (Schwartz, 2021; Schwartz & Sweezy, 2020). It is believed within IFS there is an innate ability for every individual to have healthy internal and relational lives; however, access to these abilities can be affected by a multitude of issues, such as trauma and culture. IFS therapy can help a person to relieve themselves from these issues that have impacted their growth. Instead of viewing symptoms as being a sign of pathology, IFS takes

the standpoint of individuals having everything they need inside themselves but do not necessarily have access to (Schwartz, 2021; Schwartz & Sweezy, 2020). Schwartz discussed the concepts of balance, harmony, leadership, and development as being key within human systems (Pedigo, 1996; Schwartz, 2021; Schwartz & Sweezy, 2020). Balance was noted as being necessary for optimal functioning and to gain access to our innate resources. Harmony in the context of IFS suggests the different parts are working together, identifying what role is necessary and best for the internal system. In order to obtain balance and harmony within a system, leadership is necessary to facilitate these aspects. Development is the way in which an individual grows and gains access to their innate abilities when balance, harmony, and leadership are intact. When not in a balanced system, development can be restricted, often maintaining problematic views or values (Pedigo, 1996; Schwartz & Sweezy, 2020).

IFS' balanced system consists of three types of parts: exiles, proactive protectors or managers, and reactive protectors or firefighters (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). These parts are viewed as being equally important and helpful; however, they may be viewed as problematic at times as they have taken on roles which are more extreme in nature in order to protect an individual (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). Schwartz and Sweezy (2020) hypothesized that all individuals, even without trauma, experience these three main parts within, as individuals are asked to exile parts of themselves due to societal and other cultural expectations. The longer a person experiences traumatic incidents, the further out of balance their system becomes, and the more parts do not trust themselves to be in control (Schwartz & Sweezy, 2020).

Exiles

An exile is described as being a part which is closely related to trauma and abuse a person may experience throughout childhood (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). Exiles may contain extreme emotions, resulting in an individual banishing this part of self to avoid becoming too overwhelmed or flooded with pain/affect. Schwartz explored the idea of vulnerability within parts, often shunning parts that have experienced trauma and needing to protect these aspects of oneself, resulting in not displaying weakness (Pedigo, 1996; Schwartz, 2021). Resistance is viewed as necessary for some individuals as this is a way exiles can be protected (Pedigo, 1996). Exiles are viewed as being the parts of individuals who are shunned as their emotional instability and lack of appeal from others is viewed as distasteful from other parts within a person (Schwartz & Sweezy, 2020). The exiles are described as wanting "care and love," even if from abusers and those who victimize them further (Schwartz & Sweezy, 2020, p. 32).

Managers

The other two parts of self are viewed as being protectors. Schwartz (2013) hypothesized that those who have conflict within their inner dialogue experience these parts as a way to protect parts of themselves, "often frozen in time during earlier traumas or attachment injuries" (p. 805). Others around them and their behaviors may trigger feelings of hatred or shame they may have felt towards their own parts at one point. The proactive protectors or "managers" are utilized to help control the exiles from triggering too many emotions (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). This can be done by managers adopting coping mechanisms, which help to avoid emotion, often resulting in using

cognition in order to maintain a sense of stability. Some of these coping skills are often times negative, as they could result in shaming and criticizing self to further avoid pain and conflict (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

Managers are often in a constant mode of needing to ensure safety of the Self, thus fearing the exiles and their behaviors, which can cause more harm at times due to their influx of emotions (Schwartz & Sweezy, 2020). A manager can come in many forms to best protect a person, sometimes becoming critical of self or others to avoid intimacy and closeness. They may also take on the form of being in control of all emotions and interactions with others, so an exile is not triggered. Schwartz and Sweezy (2020) discussed the concept of success and how this can be beneficial for a manager to obtain, as being viewed as successful by others can result in decreased feelings of shame and an increased feeling of control within their environment. Managers are identified as being related to different symptoms such as panic, obsessions, and depression (Schwartz & Sweezy, 2020).

Firefighters

Reactive protectors or firefighters also want to banish the exiles, however, instead of protecting the individual from feeling pain, they are activated once an individual is flooded with memories or emotions from the exiles (Anderson et al., 2017; Schwartz & Sweezy, 2020). IFS theory describes firefighters as being the parts who are in charge of escaped exiles and the feelings which accompany these exiles. The firefighters are summoned to distract, which can be done in many harmful ways including self-harm, eating disorders, substance use, and risky behaviors. While these behaviors can be dangerous for the person, the firefighter is not conscious of the impact this has on the Self, as their main job is to “put the fire out” in regards

to the feelings expressed. These behaviors are viewed as being comforting, regardless of the consequences. Unlike the manager's controlled temperament, the firefighter can be irrational and impulsive in nature, which can cause conflict between the parts as well as within interpersonal relationships (Anderson et al., 2017; Schwartz & Sweezy, 2020).

The Self

In addition to the three parts discussed, an individual is also theorized as having the "Self," which is considered to be an innate part of all people that can be accessed once all other parts are differentiated or separated (Anderson et al., 2017; Schwartz & Sweezy, 2020). The Self is viewed as bringing harmony and balance within an individual, which is present through qualities such as curiosity and playfulness (Schwartz & Sweezy, 2020). The Self within IFS theory is described as having "all the necessary qualities of good leadership, including compassion, perspective, curiosity, acceptance, and confidence" which are innate since birth (Schwartz & Sweezy, 2020, p. 38). The Self is not considered to be a part, but rather can help parts collaborate and shows compassion, offering what is needed in the moment for parts to safely reconcile and differentiate from each other. The Self is calm and able to manage emotions the person feels and can handle past hurt, regardless of their own attachment style to caregivers or emotional lability (Schwartz et al., 2014). As relationships are repaired within the internal system, individuals gain more access to the Self, which can sometimes take longer to access (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

When being led by the Self, parts are free to be themselves without criticism, but rather with curiosity and love. Clients only need to desire looking inward at the different parts to access their innate Self. Additionally, the Self is viewed as being the client's main attachment

figure instead of needing validation and love from external sources such as parental figures (Schwartz, 2013; Schwartz, 2021; Schwartz & Sweezy, 2020). The Self is considered to be an innate part that everyone can have access to when other parts are separated and balance is displayed in the system; however, the Self can be difficult to access within the presence of trauma and other adverse events (Schwartz, 2021; Schwartz & Sweezy, 2020). Parts are viewed as a family unit with different functions (Hsieh, 2015). These parts may all have their own view and goal for the future, which can result in conflict within the Self (Hsieh, 2015). The Self's role is to ultimately accompany exiles back into times in which they were frozen from traumatic incidents and providing assistance to help them heal, resulting in a decrease of burdens and freely living in the present (Schwartz, 2021; Schwartz & Sweezy, 2020).

Burdens

As discussed in previous chapters, children are dependent upon their parent's love and acceptance, which can often times be withheld by parents in unstable households (Schwartz & Sweezy, 2020). IFS is similar to Object Relations theory, in that the protectors within a person will emulate the qualities of the rejecting parent, such as criticism. These parts are viewed as being "burdened managers" as their role becomes about "sacrific[ing] their inner relationships and their childhood to the cause of safety" (Schwartz & Sweezy, 2020, p. 37). Burdens can be intergenerationally passed, as the same patterns can be present throughout the family. Personal burdens are defined are developed through an individual's life experiences, which result in their own world views, beliefs, and emotions (Schwartz & Sweezy, 2020).

Schwartz (2021) indicated parts are not only affected by trauma but also narratives within the person's culture and societal demands. Legacy burdens are "absorbed from family,

ethnic group, or culture" (Schwartz & Sweezy, 2020, p. 55). Legacy burdens can include racism, patriarchy, and cultural aspects which can impact an individual's internal world and system in addition to the family system, which also exacerbates the internal messages one can receive. "Legacy burdens are communicated firsthand from parent to child but are secondhand in the sense that the origin of the belief (the reason that having a particular need or desire is a threat) comes from the experiences of someone else, someone who might have lived generations earlier" (Schwartz & Sweezy, 2020, p. 57). These burdens can be aspects of parts or can be considered as being their own part within someone's internal family system.

IFS and Trauma

Parts may be in conflict with each other as each part has their own views and values, with these viewpoints stemming from different timeframes. That is to say, some parts are created from a specific time in which trauma was experienced. Parts may be experienced as bodily sensations or symptoms, such as chronic tension. For example, a manager may create chronic fatigue to get needs met for another vulnerable part who needed rest. These symptoms may be a way to keep the exiles at bay and protect the person, while possibly causing physical pain and discomfort. A person's Self can become "overwhelmed by parts," which is referred to in IFS as blending (Schwartz & Sweezy, 2020, p. 43). When discussing a past client who had suffered from child abuse, Schwartz (2021) indicated one of her parts appeared to be "frozen in the past, just as many acting-out children are trapped in their roles" (p. 14).

Managers will often take on the views of abusers an individual's life or those who are absent, often exiling the parts who experienced the abuse as they are not desirable and present with too many emotional wounds (Schwartz & Sweezy, 2020). "Trauma can burden our

protectors with disdain for vulnerability and extreme beliefs about certain categories of people or the world in general" (Schwartz & Sweezy, 2020, p. 59). In response to abuse, a person may dissociate parts of themselves, which may also include exiling their Self as the Self can be viewed as important and crucial to well-being. When a person is abused and the beneficial parts of the Self are targeted, this alerts an individual's internal system to protect the Self at any cost.

Lucero et al. (2018) provides an example of this dissociation process in their study involving veterans' experiences of dual identities. The researchers indicated the military asks soldiers for obedience and dissociation, while the civilian lifestyle calls for a relational aspect. The contrast between the two results in difficulties. The part of dissociation within a veteran can be related to the "exile," which is identified within IFS as being the vulnerable part of an individual. The trauma veterans experience while in war may be "exiled" as it can be too painful of a memory to identify or process. The "manager" part is utilized as a way to avoid discussing exiles and to present to the world they are healthy and managing as a civilian. Stigma of seeking help for mental health may contribute to this behavior. Lucero et al. (2018) hypothesized IFS would be a beneficial form of treatment for combat veterans, as this approach enables the client to identify their own problem areas instead of being labeled or stigmatized. Due to the dual identities experienced by veterans, IFS may help veterans to feel all forms of their identity are acceptable and can cohabitate within, resulting in integration instead of dissociation and guilt. Individuals who experience physiological symptoms due to trauma would benefit from being made aware of these while identifying individual needs of different parts (Lucero et al., 2018).

When a person experiences a form of trauma, their internal family system is likely to become polarized, as their parts are injured and alone (Schwartz, 2021; Schwartz & Sweezy, 2020). The purpose of polarizing parts helps to ultimately protect the main balance of the system or the Self. These protectors, which are present after a state of trauma, may display themselves in ways typical trauma behaviors are often presented. For example, when the Self is not able to be present throughout a trauma, the exiles and traumatized parts will tend to become stuck within their time and developmental age. Individuals who are viewed as being safe and caring in a person's life may promote validation and less burdening, which results in the system feeling the Self is safe enough to lead. This concept could also be described as resiliency (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

IFS and OBD

When considering OBD within an IFS framework, it would be prudent to identify different parts which may be present due to the possible lack of parental stability and experience of complex trauma. One part which can be identified in OBD is the parentified child, which is viewed by IFS as being in charge of responsibilities, despite not wanting to, possibly resulting in "rigidity and extremity" (Schwartz & Sweezy, 2020, p. 34). Similar to exiles, the parentified child is viewed as desiring love, but feel they cannot exhibit this need (Lovejoy et al., 2000; Schwartz, 2021; Schwartz & Sweezy, 2020; Venkataraman, 2011). The manager may be viewed as the only way a person can continue functioning and is heavily relied upon at times, which can result in more responsibility and further symptomology (Schwartz, 2021; Schwartz & Sweezy, 2020).

Additionally, OBD may exile parts who they feel are not worthy of love (Ainsworth & Bell, 1970; Herman, 1992; Schwartz & Sweezy, 2020). Avoidance of these negative feelings may enact firefighters within due to disengagement coping tactics OBD can experience (Langrock et al., 2002; Lovejoy et al., 2000). Another part may need the role of being in control, as there may have been little stability and control when assessing parental moods and needs (Backer et al., 2017).

Hypothetical Case Study: Chase

Applying IFS to a hypothetical case example will help in further understanding trauma within the OBD population. His background was inspired by previous case studies and stories told by those who were raised by a bipolar parent. Chase, a 25-year-old, single, white male, was raised by a single mother who was diagnosed with BD. His father left the family when Chase was nine years old after many years of conflict with Chase's mother. His parents displayed chaotic behaviors, often including arguments which at times turned physical. Chase tried to mend the conflict between his parents, sometimes taking the role of being the mediator. His father was not present often when he was living in the home, typically spending days away from the family and leaving the children to the care of Chase's mother. Chase has two siblings who are six and seven years younger than him. Chase felt as though he did not have a connection with his parents, often feeling like a parent himself.

Chase's mother exhibited unstable and shifting moods. As a child, Chase experienced confusion as he was unable to predict her moods or understand the root cause of her moods. He often took the blame upon himself for her moods as they were sometimes directed towards him. After his father left the home, Chase's mother's behavior appeared to be more erratic. She

struggled to maintain employment, resulting in financial strains for the family. During times she experienced manic episodes, Chase would be responsible for the care of his siblings overnight. He began to take on a caretaker role, often feeding his siblings and cleaning the home. During his mother's depressive episodes, she would rely on him and ask him for help, leading to shame and guilt if he were to deny her requests. While this was strenuous for Chase, he also felt as though he had purpose and could somewhat help his mother. He began to prefer her depressive episodes to her manic episodes, which resulted in feelings of abandonment and anxious states worrying about his mother's safety.

His mother displayed more anger and frustration when manic, often yelling at the children, exhibiting neurotic behaviors, and expecting them to understand her needs. Chase's mother was hospitalized multiple times while experiencing manic episodes, leaving Chase and his siblings at home for days. He and his siblings would at times have family friends help them while his mother was in the hospital; however, these support systems were not always present. These hospitalizations terrified Chase as he often wondered if his mother would come back. He felt tremendous pressure being in control of his siblings' safety and wellbeing. His siblings began to depend on him for many aspects of their lives, consistently coming to Chase for their needs even when his mother was home. He began to be a parent for which he resented his mother; however, he desperately wished to gain her acceptance and love, following through on her demands and taking on the role.

His mother struggled to maintain consistent relationships or friendships; however, when in an intimate relationship, his mother often neglected the needs of her children, resulting in further parental duties for Chase. He struggled to maintain his own friendships and

extracurricular activities in school due to his role of caretaker. Chase found it difficult to manage his own grades at school while also taking on this role in his household but persevered with high grades. His mother was absent in his academic career, often minimizing his accomplishments when they were shared as she would have her own crisis to attend to. Chase felt as though he needed to continue accomplishing his goals in school to provide some sort of role model for his siblings. He had a few strong relationships with teachers in high school, who he viewed as mentors and encouragement to complete school. When he was accepted to college, he chose a school nearby so he could be present for his younger siblings; however, he was unable to visit home as much as he wanted, resulting in feelings of shame and guilt for leaving his siblings behind.

Chase's caretaking role was so overwhelming that he began to develop anxiety at a young age, carrying these symptoms with him well into adulthood. He exhibited signs of needing complete control over all aspects of his life. When traveling to a store or other places, he needed exact details and timing of the travel in order to feel less anxious. Chase was overly organized and became distraught when control was not engaged. In college, he was able to have more of this autonomy to be organized in the manner he yearned for but felt out of control whenever he returned home to disarray. He strove to succeed within school and his career, resulting in being the youngest senior accountant in his firm. Chase placed work above friendships and other social gatherings, leaving him without supportive relationships. He was viewed as being rigid with his acquaintances and work associates. Chase realized he was viewed by others as being rigid but could not stop the way in which he behaved. He believed others would not be able to provide security for him in life and were unable to manage

projects, identifying himself as the only person able to meet his needs. His symptoms presented were indicative of obsessive-compulsive personality disorder (OCPD).

Chase sought therapy due to experiencing intense anxiety symptoms in addition to some depressive episodes. His siblings were both enrolled in college and becoming their own people outside of his mother's home; however, this caused stress for Chase as he no longer had access or control of their decisions and lifestyle. He began to question his own career choices and his life. Chase was concerned about his lack of interpersonal relationships but was acutely aware of his role in this experience. He indicated feeling as though he was unable to understand other's feelings, which strained relationships he did try to develop. He was also worried about his mother now that she was alone and had nobody to help her during her times of need, even though a part of him felt as though she deserved to be alone. His consistently shifting feelings towards his mother was also something he wanted to explore while in therapy. Chase also indicated he had begun to drink alcohol more frequently within the last month, which had started to cause an imbalance of his structured and rigid lifestyle.

Case Conceptualization with IFS

According to IFS, individuals have everything they need inside themselves but cannot always access this part called the "Self." Chase particularly struggles to access his Self not only because of his exiles, managers, and firefighters in play but also because of his lack of self-worth and negative self-identity he has experienced throughout childhood. His mother's inconsistent parenting and unstable emotions resulted in an underdevelopment in Chase of a positive self-concept or feelings of adequacy. Additionally, Chase's lack of stable caregivers resulted in developing an anxious attachment, fragmentation, and lack of identity integration

(Kong et al., 2017). As he experienced complex trauma throughout his childhood, Chase internalized his emotions which contributed to this negative view of himself (Goetz et al., 2017; Lau et al., 2018). These can be viewed as personal burdens, including believing he is unlovable and can never do anything right, despite his successes in life (Schwartz & Sweezy, 2020). His burden was developed in response to his mother's harsh criticisms and inconsistent parenting.

Chase's intimate relationships may be viewed as being dangerous because his relationship with his mother made him feel unsafe in relationships (Kucuk Ozturk & Cam, 2017; Madey & Rodgers, 2009). As such, he developed managers which helped aid him in keeping his safety a priority. Whenever his relationships became too serious or vulnerability was experienced, his managers became enacted, protecting the child inside of himself who had been let down repeatedly by his mother. Chase began to distance himself from the relationship, often shutting down as he was unable to manage his own emotions in stressful situations (Muralidharan et al., 2010). Chase was used to seeing his parents verbally and physically abuse each other from an early age, suggesting these arguments were a step towards violence. Chase often felt blame for his parent's fights as he was pulled in as a mediator (Fear et al., 2009). When presented with intense emotions, Chase is reminded of his mother's reactions and own chaos which can often be present in those with BD (Rusner et al., 2009). In response, Chase developed a manager that is present within his interpersonal and intimate relationships (Schwartz & Sweezy, 2020). This manager's job within Chase's IFS is to become critical of others, so he does not become too intimate with another and feel hurt or pain.

Chase became angry about not having support from his caregivers and needing to care for his family at such a young age, robbing him of the childhood he had longed for. However, this anger was not something he could show to others as it would not have led to his needs being met and would have been viewed negatively by his caregiver (Schwartz & Sweezy, 2020). This young, angry part of Chase became exiled and managed by a part which exhibited the opposite type of behavior. This manager would display helpfulness and strongly took on the role of being an adult at a young age in order to gain that love and admiration from Chase's mother.

Other parts within Chase view his younger exiled part as being unappealing, as his vulnerable part strove for love and acceptance from his parents that could not be achieved, and thus this exile demonstrated weakness (Schwartz & Sweezy, 2020). When Chase was unable to gain love and safety from his mother or father, he needed to develop a part that could provide him with the stability he desperately needed (Herman, 1992). This parentification was a role or part he implemented in order to rectify the perceived sense of being bad, resulting in pushing his vulnerable child part down to meet the needs of his parents (Herman, 1992; Well & Jones, 2000). Chase's mother did not aid in exiling the part of him that helped take care of her and his siblings as she was getting a need met (Schwartz & Sweezy, 2020). While Chase was able to offer more emotionally, this part of Chase was criticized and exiled to protect from further trauma, which can also result in Chase's Self being exiled as his parts do not believe his Self has the ability to be in control. Chase may feel as though he cannot truly be himself as this vulnerable child part of him is not valued, thus resulting in his caretaker part being more present (Schwartz & Sweezy, 2020).

When his siblings and mother were not adequately cared for, Chase viewed himself as a failure and experienced feelings of shame. Shame may be an original feeling a person experiences to protect themselves, which is exhibited in daily life (Sweezy, 2011; Wells & Jones, 2000). As long as he feels shame, his exiles are not gaining control and his managers are able to protect him. The more Chase utilizes this manager in his internal system, the increase of responsibility is felt, which places him back in the traumatic emotional state he has endured since childhood and enacts the manager further to avoid the exile being present (Schwartz & Sweezy, 2020; van der Kolk, 2014). Chase's caretaking role can be considered a "burdened manager" as he is sacrificing his own inner relationships to be safe. This also results in self-criticism his own mother reflected to him as a child, which actually contributes to his feelings of being safe as he expects these behaviors and negative feelings (Schwartz & Sweezy, 2020). This sense of expectation helps Chase to feel as though he is in control. Chase's caretaking manager resulted in OCPD type behaviors, which were adapted to best help Chase meet his goals, protect himself, and gain some sense of control in his life (Cook et al., 2005; Herman, 1992; Schwartz & Sweezy, 2020). Chase being successful and in control of his environment helps contribute to a decrease in his feelings of shame as he is demonstrating strength, despite the circumstances in his life and trauma he experienced (Schwartz & Sweezy, 2020). This manager also aids in Chase protecting his young exile that felt as though he was not deserving of anything, proving to himself he can make it in the world.

Chase may experience depression as a way to help give his caretaking manager a break as there is an excuse to not be productive; however, the caretaking manager views his depressive manager as being a threat to the system due to the lack of productivity and

ultimately the lack of success it strives to achieve (Schwartz & Sweezy, 2020; Schwartz, 2021). This polarity experienced between these two parts results in his reactive manager, the firefighter who has been abusing alcohol, becoming more present as to not experience the vulnerable feelings these parts are trying to manage.

The recent changes within his family and his siblings leaving the home have thrown off the homeostasis for Chase, which has resulted in feeling unstable (Schwartz & Sweezy, 2020). His caretaker part is now unsure of what role to fill, as they are not needed. He has nowhere to put this caretaking energy and strives to do so at work, but this causes conflict and disrupts harmony in the system. Chase is not clear on who needs to be in the leadership position now that his role is changing, resulting in a lack of balance and harmony within his system and aiding in negative beliefs that contribute to his recent increase of alcohol use. As his system is not in balance, Chase's parts do not feel his Self is capable of managing his needs and being the part in control as his chronic trauma has impacted him tremendously (Schwartz & Sweezy, 2020).

Chase's parts have shunned his caretaker manager role as this part no longer has a purpose within his system but has been in control for a majority of his life. This results in firefighters being enacted to help with the feelings of being out of control. He currently does not have a part he can trust and feels weak in many regards. His inconsistent feelings toward others further upsets his system as this again shines light on his instability and provides additional feelings of shame for his lack of control.

Not having a consistent role and feeling out of control in regard to his family has resulted in firefighters being enacted due to his vulnerable exiled child threatening to be

present (Schwartz & Sweezy, 2020; Schwartz, 2021). The firefighter does not want his exile to be released, as this part is too vulnerable and seeks comfort from those who will hurt him. His firefighter is wanting to put out intense emotions as he is not only unsure of how to manage them, but they also dysregulate his rigid emotions and bring him back to a state of anxiety he consistently felt as a child. Trauma living within the body and having this exile present represents weakness, which is something his managers are trying to avoid (Cook et al., 2005; van der Kolk, 2014). He utilizes alcohol as a way to push back this exile and take control of how he is feeling. However, when this firefighter is enacted, the other parts become distressed due to responsibilities being in jeopardy, which Chase's main manager has tried to keep intact for a long period of time (Schwartz & Sweezy, 2020).

Summary

The hypothetical case example of Chase aids in understanding the phenomenon of living with a bipolar parent. His experiences have resulted in interpersonal and relational trauma which prior research of OBD has indicated can occur. Utilizing IFS for those who have experienced these types of relational traumas can be helpful as the parts become frozen in time, resulting in fragmentation or dissociation. Chase's fragmentation of self he exhibits is fitting for IFS therapy, as many of his parts have been frozen due to trauma, which can be safely explored through the IFS theory. Parts were also discussed and how they relate to a person's functioning and symptomology. This chapter explored the theory of IFS and how to apply theory to clients. Furthermore, IFS theory was applied directly to Chase's case example to aid in conceptualizing OBD trauma through this lens and to aid in treatment.

CHAPTER IV: TREATMENT OF OBD UTILIZING INTERNAL FAMILY SYSTEMS

According to Richard Schwartz and Martha Sweezy (2020), the three main goals for IFS therapy include "liberating parts from extreme roles so they can move on to preferred, valuable roles; restoring the trust of parts in the leadership of the Self; and re-harmonizing the system of parts such that they get to know each other and form productive collaborations" (p. 106-107). These goals are met through weekly sessions with a client (Schwartz, 2021; Schwartz & Sweezy, 2020). The length of treatment prescribed for a client to meet these goals is dependent upon each individual client as their traumas and symptoms can vary in severity. Additionally, parts may have varying degrees of resistance in letting parts move forward in new roles. It is the role of the therapist to meet a client where they are in their healing process and not push the client into healing that they may not be ready for. This chapter will further explore IFS treatment and how this can be applied for individuals raised by a bipolar parent. The hypothetical case example of Chase will be utilized to best understand what treatment can look like for an OBD person.

IFS Therapy Process

IFS is a collaborate approach in which therapists explain the process of IFS and parts to the client. The functioning of parts and the theory is divulged so the clients are able to best access different parts in a manner which does not feel overwhelming (Schwartz, 2021; Schwartz & Sweezy, 2020). IFS therapists are responsible for having the client "buy in" to the therapy model (Anderson et al., 2017; Schwartz & Sweezy, 2020). As such, there needs to be transparency and collaboration within the therapy relationship. Providing a space where clients feel comfortable is needed, as vulnerability is a necessity within this model (Hseih, 2015).

"Trailheads" are first identified when utilizing IFS, which can include a feeling, memory or emotion that ultimately leads to a part (Schwarts & Sweezy, 2020). It is the role of the therapist to then assess for parts and identify whether they are protective or an exile. When working with exiles, it is important to reiterate the therapist's role is not to overwhelm the person with emotions in order to make a change. This clarification may help protectors to relax and move away from their rigid role of stifling the negative emotions to make space for exploration (Schwartz & Sweezy, 2020).

IFS therapists begin the process of finding parts a client possesses before asking which part would best benefit from immediate attention (Schwarts & Sweezy, 2020). It is important to ask parts who they protect, as exiles can at times come across as being protectors. Asking can provide further clarification and help the process to run more smoothly. Schwartz and Sweezy (2020) identified six concepts which are used to help aid in treating protectors involved in an individual's internal family. These concepts include "find, focus, flesh out, feel toward, befriend, and explore fears" (p. 122).

Focusing requires reflection and turning inwards to best identify parts within the system (Schwartz & Sweezy, 2020). It is then the responsibility of the therapist to "flesh out" the part, which essentially is the process of verbalization and constructing the identity of this part or describing what their role is and does for the individual. The therapist validates the fears of different parts and identifies reasons for them being present, while offering to help and avoiding overwhelming feelings. A question Schwartz and Sweezy may typically ask a client in session is "How do you feel towards the part?" (2020, p. 132). This helps therapists to

recognize whether there is another part present that may be blended, or if the Self is activated in this area. If the Self is activated, curiosity and compassion towards the part will be exhibited.

If there is a reaction that does not exhibit the Self's core attributes, the therapist can then validate the reactive part or protector, as this can be another way of protecting, by letting the part know the therapist is wanting to help and not overwhelm (Schwartz, 2021; Schwartz & Sweezy, 2020). At times, protectors are too reactive, hindering the process of the Self helping the exiled parts or managers, which requires the therapist to use their own Self to lead and ask questions, otherwise known as direct access. It is important to note, Self-like parts are also present within some internal family systems, which includes a part that is reminiscent of the Self, wanting to be more in control of the system to avoid hurt and pain; however, is not the genuine Self (Schwartz & Sweezy, 2020).

It is important for the therapist to check in with firefighters as well to check for risk of self-harm, as becoming too close to certain parts and exiles may cause a firefighter to react and engage in risky and dangerous behaviors (Schwartz, 2021). The exiles or parts which are protecting the exiles are addressed and asked to not overwhelm the client, as this ultimately results in firefighters becoming engaged. "In IFS 'resistance' is a manager putting on the brakes" (Schwartz, 2021, p. 141). This resistance can result in firefighters being enacted as managers are not always able to control the negative feelings.

Instead of utilizing grounding techniques, IFS therapists will allow room for the part that is feeling overwhelmed (such as experiencing panic) and ask it to separate from the Self so it can be helped in a better way (Schwartz & Sweezy, 2020). This is accomplished by verbally asking the part if it feels comfortable in solely focusing on itself in order to understand the

thoughts and feelings the part feels without bias or engagement from other parts, which may cause confusion. It is the goal of the therapist to have the client understand parts are not dangerous and are able to be accepted and managed without suppressing them further with coping skills given in trauma work (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). An IFS therapist would then want to assess for the level at which the Self can be accessed within the client by observing if the client is able to speak to their parts and remain curious about the functioning. This curiosity is essential in unburdening and understanding the different parts, a crucial attribute the Self would possess (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

A client's Self is known to guide the client through the treatment goals, better known as "in-sight," as the individual's parts are being explored to best understand a person's psyche and functioning in response to prior experiences (Schwartz, 2021; Schwartz & Sweezy, 2020).When a client's Self is not able to be accessed for healing due to exiling the Self for protection, direct access may also be utilized, which involves a therapist accompanying parts during the unburdening process in order to help them heal. This not only helps parts be recognized and heard but also can provide guidance on how the Self can be present for parts, offering further trust in the Self (Schwartz, 2021; Schwartz & Sweezy, 2020). Individuals who have experienced trauma may have more difficulties in meeting these goals as the Self is not easily accessed and the different parts created to protect the individual can become blended, otherwise known as enmeshment in family systems theory (Minuchin, 1974; Schwartz, 2021; Schwartz & Sweezy, 2020).

Healing through use of the Self includes the following attributes: curiosity, calm, confidence, connectedness, clarity, creativity, courage, and compassion (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). Curiosity helps the Self to allow other parts to relieve their protective duties and explore without judgment which is crucial in helping parts to feel heard and validated. Calmness helps bring balance to unstable emotions which can be present within parts. Staying in a calm state of mind can help an individual explore their parts with curiosity and regulate emotions throughout the exploration. Yoga can be considered a way to become grounded both physically and spiritually through the Self, which can result in parts trusting the Self to manage the body more. Confidence is exuded within the Self, which helps parts to relax and manage burdened parts. Without confidence, an individual may not be able to trust their own journey or intuition in relation to parts and what is needed. Connecting and showing compassion for parts contributes to the Self's desire to connect with others. Without this compassion and connection, there may be little motivation in understanding the parts and thus unburdening them. The Self already possesses clarity; however, parts and their critical views of the person can cloud this clarity, as the Self is not in control. IFS therapists believe a person possesses the creativity needed to solve their own problems when the Self is accessed as they ultimately know what they need. When exiles are acknowledged and healed, the Self can become active, which results in further compassion for parts in addition to others (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

While these attributes are necessary to heal parts via the Self, there are difficulties experienced at times when trying to access them. Schwartz and Sweezy (2020) discussed these roadblocks, stating "When we are blended with protective parts, we lose access to curiosity.

Rather than being open to discovery, we fill up with the preconceptions, expectations, and visual distortions of our parts" (p. 51). As such, being blended with parts may result in taking on that part's view of the world, resulting in less curiosity to understand parts and other aspects of the Self (Schwartz & Sweezy, 2020).

Additionally, firefighters may react negatively when curiosity is engaged because they fear being exterminated (Schwartz, 2021; Schwartz & Sweezy, 2020). When an individual is curious about a part, there may be a resolution that does not involve needing a manager or extreme behaviors to help these parts. While the firefighters may become defensive, it is the goal of IFS to find a new role for them instead of eradicating the part, which can be discussed with the parts and Self prior to an unburdening (Schwartz, 2021; Schwartz & Sweezy, 2020). When working with firefighters, it is important to let them remain seen and heard as they feel they are in control. In addition, offering them relief and a different role can help the firefighter want to move forward (Schwartz, 2021; Schwartz & Sweezy, 2020). Asking parts to allow space for the target part to be explored and understand their role is important to provide certainty parts are feeling heard and being protected. Observing instead of ignoring parts can feel less overwhelming for individuals. Naming different parts may also be something which is beneficial for clients as they are able to identify what the part does for the Self and can describe these parts with more clarity (Pedigo, 1996; Schwartz, 2021; Schwartz & Sweezy, 2020).

Green (2008) discussed the concept of parts being meant to represent different aspects and experiences of a person's life, often striving to protect the Self from harm. These parts may no longer be functional for an individual, causing distress and dysfunction. When the Self is

the part in charge, individuals may feel as though they have reached peace both internally and externally. Green suggested that individuals who obtain access to the Self will develop healthier ways of communicating with their partners. In addition, healthier boundaries are in place as the Self is able to manage their own feelings without co-dependency from the partner. Having both partners working on gaining access to the Self will assist in their celebrating the progress of this access and sharing results in deeper levels of intimacy and self-actualization (Green, 2008).

Protectors

Having the protectors such as managers and firefighters talk to each other and identify their main goals can be achieved by having the therapist focus on obtaining the view from each protector and listening empathically to fully understand (Schwartz & Sweezy, 2020). This not only promotes trust, but also helps to explore the system further and what is being accomplished. Just like an actual family, the parts would benefit from learning how to live among each other in a harmonious way with clear roles and boundaries expressed. It is imperative that the therapist continues to approach the client from a state of curiosity and questions instead of guiding, as the Self is able to perform this job.

Trauma and Protectors

A “parent protector” is a part that helps the individual dismiss the concept of being unlovable by their caregiver or parents (Schwartz & Sweezy, 2020). IFS postulates those who are more Self-led and compassionate towards themselves can begin to unburden themselves from hurtful people in their lives, such as attachment figures or caregivers. Confronting an abusive person from the past takes time and may not be something the system actually needs to

more forward, as clients from abusive pasts may tend to seek out some form of love or care. Exiles tend to view themselves in the irrational manner that children tend to utilize, with all or nothing thought processes. When the Self is more active and clients begin to move forward, there is a period of grief as past hurts and trauma can be experienced and felt. It is imperative the therapist validate and normalize this experience, while also providing support throughout this grief (Schwartz & Sweezy, 2020).

Miller et al. (2006) discussed the utilization of IFS in addition to narrative therapy in working with those who have experienced childhood sexual abuse, identifying themes of shame, an inability to feel, and serious mistrust within those who have experienced this pronounced trauma. The authors discussed the importance of understanding the different burdens parts may carry and how these may at times be parts that are being ostracized from the others. Wilkins (2007) indicated trauma may also suppress aspects of the Self when one experiences childhood abuse, specifically if there is a diverse component, as a person's parts may not be helpful within society. They hypothesized IFS would be beneficial in working with women of color who suffered from childhood sexual abuse, as they would be able to display vulnerability within sessions they cannot exhibit in their daily environments.

Polarized and Blended Parts

The unburdening of protectors is similar to the concept of unconditional positive regard Carl Rogers developed as one of the necessary and sufficient conditions within a therapeutic relationship, except in IFS positive regard is provided by a client's Self (Rogers, 1992; Schwartz & Sweezy, 2020). The Self is responsible for providing the support and love the exile is in desperate need of (Schwartz & Sweezy, 2020). Without this love and compassion from the

Self, the exiles and protectors cannot trust, resulting in further polarization. A “do-over” is a way in which the Self can help the exile relive the traumatic moment they have been stuck in for years, in which a new, fulfilling ending is created. Sometimes it is necessary to unburden over many sessions, as freeing exiles from the past and witnessing this trauma can be overwhelming and difficult to manage (Schwartz & Sweezy, 2020).

Treatment can take longer with IFS when parts are extremely polarized and burdened to a high degree; however, it is important to remember “parts are not their burdens” (Schwartz & Sweezy, 2020, p. 61). Burdens are taken on from external relationships and situations, which have integrated themselves into the identity of parts. Legacy burdens can be difficult to unburden, as they were passed down from familial connections. At times, there is not a part that holds onto this burden, but rather may feel the impact from it. One way to address the burdens a part may be carrying would be to ask if the part would be willing to let go of the weight or burden that does not belong to them. This ultimately provides a choice in the situation while also demonstrating the two can be disconnected. This realization can help clients to feel more at ease with addressing burdens that have been a big part of their life and would still be considered safe and useful (Schwartz & Sweezy, 2020).

The therapist’s role in the unburdening process is to ask questions to unburden parts and polarizations; however, there is not as much redirection or interpretation provided as in other theories (Schwartz & Sweezy, 2020). Instead, validation of the parts’ feelings and the process of identifying their needs is the most important tool to utilize while unblending. The client is assumed to be the expert of their life and their Self is able to know what is needed, thus the questions pull from the individual’s Self and help to enact this part. The therapist

provides a safe environment and stability which helps a client feel all of their parts are welcome, despite some parts being exiled. When unblending parts, it can be helpful to place one part in another room or place that is deemed comfortable and safe, while other dangers or parts are managed. Addressing parts with the client and exploring the idea of letting the Self take control should also be practiced, as this can result in regression if a person is not ready to unburden from trauma. Once an exile is unburdened, other protectors may benefit from seeing the exile free from the trauma of the past. However, it can also present with feelings of dismissal or no longer being needed. This anxiety of being forgotten or left behind can be addressed through exploration of new roles in the system. Consistent reviews of the system after being unburdened is prudent in understanding how the system is continuing to experience the changes (Schwartz & Sweezy, 2020).

Therapist's Role in IFS

The role of the therapist is to help clients gain access to their Self while leading with their own Self, which is not something that can be done instantaneously, as burdens and protectors may resist the access of the Self (Schwartz, 2021; Schwartz & Sweezy, 2020). A therapist who is viewed as curious and calm can be scary for clients at first, but that is also what helps the client to gain their own sense of curiosity and access to the Self. The therapist is viewed as being the hopeful person who validates the sometimes pessimistic feelings a person may experience due to their past. In addition, this appears to help model this optimism for the client's Self to utilize. When an individual has suffered from trauma and exhibits a lack of trust in others, it is only rational to believe this would also include the therapist, as trust needs to be built and maintained (Schwartz, 2021; Schwartz & Sweezy, 2020).

It is imperative the therapist be aware of their own parts, as these can be activated by a client's parts (Schwartz & Sweezy, 2020). Parts of a therapist may at times contribute to the session and possibly hinder progress towards the identified target part being helped. When the therapist is aware of this, it is best to disclose this information to provide a trusting and collaborative environment. This process is similar to therapists with a psychodynamic theoretical background discussing countertransference; however, the activated part within the therapist is only one part and not their whole being, which is more easily detected and able to be addressed by the therapist's Self (Schwartz & Sweezy, 2020).

While utilizing IFS interventions, Deacon and Davis (2001) discussed the need for the therapist to be nonreactive when addressing a client's parts through direct access, which entails therapists to accompany parts in the unburdening process. Therapists may also integrate other techniques into the IFS approach to best serve the client such as sculpting, which may help a client physically envision their parts while setting clear boundaries and space (Deacon & Davis, 2001). Hsieh (2015) explored a "party" process, which entails the Self being the host and the parts being the guests. He suggested if all parts are separated, communication between the parts would be easily facilitated with the therapist role modeling these dialogues. Parts were suggested to also have their own chairs that the client can move between when discussing these roles. Being able to validate the feelings of these parts is beneficial and crucial for developing a cohesive sense of Self (Hsieh, 2015). Additionally, Lavergne (2004) suggested integrating both IFS and art therapy to help to create the distance from parts which are hurt, as physical representations may help clients view parts in an objective manner and can also represent the different phases of treatment.

Treatment of Case Study with IFS

In treating Chase with IFS, a therapist would need to have a discussion about the theory in a manner that would not feel overwhelming while also helping him to feel in control of his own emotions, parts, and healing journey (Anderson et al., 2017; Schwartz & Sweezy, 2020). Due to his higher level of ego and manager that exhibits the need for control and success, he would also need to "buy in" to the theory and treatment (Anderson et al., 2017). A therapist may be able to contribute to Chase's higher self-esteem by reminding him he is naturally aware of what he needs for himself, which is clearly evident by him coming to therapy to begin with (Anderson et al., 2017; Schwartz & Sweezy, 2020). He has been strong his entire life, which has helped him in many ways; however, sometimes people need new ways to cope and function as life progresses. Chase can be reminded parts of him were aware of the need for change, which led him to therapy, and that his therapist wants to help him make sense of these feelings and changes. Chase's parts can be described as being their own family system, which would need to be addressed, similar to acknowledging a family member who is in the same space as the individual. Not doing so may cause conflict and turmoil. Naming his parts is something that can help make them more real and able to be addressed without confusion. This also aids in the parts feeling as though they are being viewed as actual individuals within the system, possibly resulting in further comfort and vulnerability to divulge information (Anderson et al., 2017; Schwartz & Sweezy, 2020).

Chase's Self is a part which may be more difficult to access due to the trauma he experienced as a child, resulting in needing more guidance from the therapist (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). Chase's therapist would benefit from

helping him practice grounding as this may help the Self to utilize calmness and provide stability while exploring parts with the therapist. This process could help Chase learn to remain open and regulate his emotions that may arise from the experience. If there is a reaction while exploring exiles, Chase's protectors may become present. These would need to be explored with the therapist, identifying what their role is in the moment. His therapist would then ask these protectors what they are concerned about and if they would be able to provide space for the other parts to be heard and validated. Through the use of curiosity, Chase will be encouraged to utilize his Self to explore these parts which have their own roles and duties they feel attached to. The Self will be able to provide empathy for these parts, which can be further modeled through the therapist's reactions to Chase (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

Exploring and Unburdening

The therapist would provide the safe space in which Chase is still in control, as this is a major role of Chase's protectors. Chase can then be asked to explore some emotions or feelings which have contributed to his arrival in therapy (Anderson et al., 2017; Schwartz & Sweezy, 2020). In Chase's case, his recent downslide with work and feeling out of control with drinking alcohol is resulting in some anxiety and depression. These feelings are recognized as parts. A therapist can address this by asking if Chase's depressed part of himself is a protector, which is amplifying depression symptomology for a purpose, or if this is an exiled part of himself that is showing up in his life (Anderson et al., 2017). Chase may have both types of parts, an exile who is depressed and a protector (Anderson et al., 2017; Schwartz & Sweezy, 2020). It would be beneficial to first address the protectors as they ultimately help with unburdening exiles.

Chase's depressed protector part can be named "Blue" for this hypothetical case example. The therapist would address Blue by letting them know it is not the role of the therapist to overwhelm them but instead explore what may be happening for them. This mere act of expressing validation for their feelings and non-abrasive approach can be extremely useful in developing trust (Anderson et al., 2017; Schwartz & Sweezy, 2020). Chase can then be gently asked if he has any questions for Blue and how they function or what they need (Anderson et al., 2017).

Blue may be feeling depressed to help alleviate some stress from needing to be perfect, which is helping another part while also enacting firefighters as this perfection manager is typically the part in charge (Anderson et al., 2017; Schwartz & Sweezy, 2020). Chase may not feel comfortable exploring this part at first, as it is a part that may cause shame, another part that can be explored. As such, it would be the role of the therapist to utilize direct access in speaking to a part while being nonreactive (Anderson et al., 2017; Schwartz & Sweezy, 2020). Considering the beginning of IFS treatment can be somewhat ambiguous or overwhelming for someone who needs to be in control, it may be beneficial to utilize the approach of visually seeing parts by placing them in different chairs in the room (Deacon & Davis, 2001). This can be done by placing a name on a whiteboard that sits in the chair. The therapist can add some content to the whiteboard for these parts, such as whether they are an exile or protector (Deacon & Davis, 2001). In this case of Blue, their board would read "protector" as they have been developed to relieve pressure for other parts. Blue's role is in direct conflict with one of Chase's parts which feels shame. Chase may be asked how he feels about Blue and what he would like them to do in his system (Anderson et al., 2017; Schwartz & Sweezy, 2020).

As Blue may not feel they can be relieved from their duty until the manager of perfectionism is relieved, Chase may benefit from exploring this part further which can be hypothetically named “Hero.” Hero can be asked about why they are part of Chase’s system, exploring their role through Chase’s Self and curiosity about his own inner workings (Anderson et al., 2017; Schwartz & Sweezy, 2020). Hero indicated they are protecting an exile who has been deprived of acceptance and love from their caregivers. This vulnerable exile can be viewed as “Young Chase.” The therapist and Chase’s Self can both validate the role as being helpful considering the traumatic experiences Young Chase has lived through. The manager Hero may divulge further information, indicating Young Chase was exiled because Hero was needed for Chase to feel a sense of worth. This was done through all of his successes in work; however, those successes have started to become unraveled, which has made Hero worried and more protective of Young Chase. Hero is more driven for success which not only includes control of Chase’s finances but also an inflation of ego, which is presented by being in higher positions. This fuels his self-esteem and can sometimes cause conflict as at times Chase needs to be more dependent on others to meet all of the tasks presented to him. When Hero is more in control, Chase may feel as though he has no choice but to complete all of the work and cannot delegate, causing further conflict and stress. He may also not be able to connect with others as this part is weary of having any type of emotional connection, disrupting his work relationships.

Hero may feel frustration and relief from having Blue around as there is some relief, causing Hero to feel worthless, a feeling Young Chase has felt often (Anderson et al., 2017; Schwartz & Sweezy, 2020). In order to fully address Hero, the therapist may ask if Blue can be

put into a different room to let Hero experience their feelings fully and without fear. Hero may then be validated further while commending the hard work they have done to protect Young Chase. The therapist can assure Hero their role would be beneficial elsewhere in the system, asking what they would like to do going forward. Once this role is decided, there may be less resistance in letting Young Chase be accessed. It is important to note this may take several sessions to fully obtain access, as managers can be ingrained and worried (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

When access to Young Chase is given, Chase's Self has the opportunity to explore how this part feels. Underneath there is a vulnerable child whose needs were unmet. The exile may show Chase traumatic incidents from the past which may include themes of worthlessness and helplessness (Anderson et al., 2017; Schwartz & Sweezy, 2020). This includes times in which his mother was hospitalized, and he was left alone. Words from his mother about his performance and negative comments may also be relived. Chase's Self has the ability to ask Young Chase what he can do to help them. This could be a simple solution such as hugging Young Chase and speaking up for him during these times of pain, offering the love and acceptance this part of him needed as a child. Accepting Young Chase can ultimately provide what may be needed, as they have been exiled for many years. Once this exile is able to experience peace, other parts may also begin to respond with curiosity, while some may become more defensive. Shame may also be something which can be somewhat alleviated as Young Chase is not viewed as being a burdensome exile, lifting some negative feelings toward this vulnerability.

It is necessary to remember the firefighter present in Chase's life, which has utilized alcohol as a way to cope with the negative feelings and polarity between parts (Anderson et al., 2017; Schwartz & Sweezy, 2020). Checking in with this part would be beneficial to validate needs and also explore how the parts have reconciled. As such, drinking alcohol is no longer necessary to aid in harmonizing the system. Once these two parts are able to experience some unburdening, Blue can then be addressed again. Hero and Young Chase can be part of this discussion with Blue to assure them the role can be shifted and is no longer necessary in the same capacity. At this time, Chase's Self would hopefully be more enacted in the process, as there will be more curiosity and empathy towards his parts. Chase may then be asked what other feelings are happening for him now that these parts have been successful in their process (Anderson et al., 2017; Schwartz & Sweezy, 2020).

Due to his interpersonal conflict and lack of intimate relationships, Chase may address another part who can be named "Love." Love is critical of others around them, often pushing them away when there is intimacy promoted. The feeling of vulnerability can be viewed as being weak and also dangerous. When Love is enacted, their main goal is to ensure Chase does not feel pain brought about by others in his life. Chase's negative self-image may also promote this manager to be present more. Not only is Love critical towards others, but also towards Chase himself. When asked who Love is protecting, they identify "Fear" as being an exiled part. This Fear was a part which was formed at a very young age and exiled due to the negative feelings towards Self it exhibited. Fear can be explored, and questions can be asked about why it was exiled or formed (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). Chase's parents and the domestic violence between them is shown to Chase's Self, urging for

help within this traumatic time period. Chase can help Fear to construct a new ending to the trauma and ways in which they would feel validated and supported. Once this is managed, Love can be asked to witness Fear's relief and find a new and more constructive role within interpersonal relationships (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

Additionally, Chase's therapist could help to relieve his caregiver or parenting protector. Chase's protector is helping the exiled part called "Anger" from being experienced. Through exploration and curiosity, his parenting protector identified Anger as being present after having to take on these roles at a young age, thus identifying with this part more instead of expressing underlying feelings which could be dangerous (Anderson et al., 2017; Schwartz & Sweezy, 2020). Chase may verbalize thoughts of fear and resistance in accessing Anger. "If the angry part comes out, there will be no stopping it. There is too much built up. Look how it is already affecting my life and depression." The therapist would aid in providing empathy and compassion towards his parental protector, further exploring the ambivalence and fear of letting their role go. This may prove to be more difficult, as this role has been enacted for many years through his time of caring for his siblings as a child. Additionally, Chase's recent lack of purpose in his sibling's lives may also be causing his parental protector to be more guarded and on edge, considering they have already been feeling obsolete. Chase's Self would need to be trusted more by other parts to help his unburdening of this exile. The therapist would also need to address their own feelings and hold space for this part to aid in guiding Chase's Self. Once access is granted, both roles can be further explored and new roles can be implemented (Anderson et al., 2017; Schwartz & Sweezy, 2020).

While these parts are hypothetical for this case study, the process demonstrates the need for Chase's Self to be accessed and the difficulties that may arise. The utilization of IFS for treatment helps Chase's parts learn to trust his Self to actively manage the others throughout his life (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). The ultimate goal for Chase is to reach this level of trust. If Chase's Self is able to be active in his internal family system, he is more capable to effectively manage future crises that may arrive while also having compassion for parts which may be triggered. Throughout this process, Chase will have interacting parts which work together to bring harmony and balance in a positive and effective manner (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020).

Summary

Throughout this chapter, IFS treatment was discussed and applied to a hypothetical case person, Chase, who was raised by a bipolar parent. As Chase struggled with control due to interpersonal and relational trauma, IFS would be beneficial in treating his symptoms. The use of IFS with Chase's case helps him to still have control while in session, setting the pace and tone for his treatment. With the collaborative approach the IFS therapist would endorse, Chase may feel as though he is not alone and has support, which was not present throughout most of his childhood. This collaborative concept and style appear to be a safe option for treatment that others with relational trauma could benefit from, including OBD.

CHAPTER V: DISCUSSION

The phenomenon of being raised by a bipolar parent is an area that has been researched over the years; however, still remains an area of concern. The purpose of this review was to identify possible experiences of trauma and the effects on the offspring of a bipolar parent, which included reviewing the diagnostic criteria for PTSD. The experience of OBD however does not always meet the full criteria for PTSD, which may not account for all aspects of interpersonal trauma a child experience (American Psychiatric Association, 2013; WHO, 2018). As such, CPTSD was proposed to conceptualize OBD to best capture the phenomenon due to the prolonged exposure to childhood trauma to include possible emotional abuse or neglect (Chang et al., 2001; Kong et al., 2017; Madey & Rodgers, 2009; Wearden et al., 2008; WHO, 2018). In order to treat this complex trauma, IFS was explored as a possible treatment for OBD due to the fragmentation of self that can be experienced after traumatic incidents (Herman, 1992; Schwartz & Sweezy, 2020). Through the use of IFS, it was hypothesized OBD clients would be able to gain access to their Self and heal their interpersonal trauma. This critical literature review project addressed the following questions related to the lived experience of being raised by a bipolar parent:

1. What kind of trauma may be experienced from being raised by a parent with BD?
2. How can offspring of parents with bipolar I disorder be conceptualized through the lens of Internal Family Systems?
3. How can Internal Family Systems treatment be applied for individuals raised by a bipolar parent?

Parents with Bipolar Disorder

Individuals who are diagnosed with BD struggle with maintaining their emotions, often experiencing fluctuating states of moods, which impact their self-esteem, impulsiveness, and interpersonal relationships (Knowles et al., 2007; Muralidharan et al., 2010). The tension within the lives of those with BD can result in feelings of chaos and instability, further causing conflict and instability within their household (Chang et al., 2001; Rusner et al., 2009). Due to this internal conflict and impulsivity which can be experienced, BDPs may experience other mental health disorders, at the rate of up to 88.2% (Merikangas et al., 2011). Some individuals with BD may experience substance use issues that can result in further strain within interpersonal relationships (Mowbray & Mowbray, 2006; Van Brunt et al., 2016). In addition to intimate relationships, those with BD are also more likely to experience conflict and difficulties within their work environments, resulting in more instability within their lives (Muralidharan et al., 2010).

BDPs may experience difficulties in receiving treatment for BD, as stigma and biases are present surrounding this disorder (Van Brunt et al., 2016). This can result in BDPs not seeking out the help or treatment they need as they may be concerned of the repercussions, such as fear of losing custody of their children (Diaz-Caneja & Johnson, 2004; Fox, 2009). Mothers with BD had indicated they had experienced doctors not providing support and felt judged by the clinicians who were providing treatment, deterring them from reaching out to a professional for help (Diaz-Caneja & Johnson, 2004; Fox, 2009).

OBD's Experience

Attachment is crucial in the development of an individual's sense of safety and development (Ainsworth & Bell, 1970; Bowlby, 1988). Those who are from a family with a BDP may experience more instability within their daily lives, resulting in an anxious attachment (DeMulder & Radke-Yarrow, 1991; Morriss et al., 2009). OBD may be less capable of managing their own emotions in stressful situations due to their inconsistent parenting and instability within their households (Muralidharan et al., 2010). When attachment is compromised within the parent-child relationship, this can also impact an individual's interpersonal functioning, as safety is not something experienced (Madey & Rodgers, 2009; Kucuk Ozturk & Cam, 2017; Ostiguy et al., 2012).

Disorganization within the BDP may also result in more parenting difficulties and child maladjustment (Calam et al., 2012). Research suggested there are lower levels of family cohesion within a BDP household, indicating less warmth and aiding in the development of an insecure attachment (Bowlby, 1988; Du Rocher Schudlich et al., 2008). There is likely a higher amount of conflict within a BDP home as well (Barron et al., 2014; Romero et al., 2005). Conflict within the home may also affect OBD's mental health, resulting in anxiety, aggression, and depression; however, it is important to identify if the mental health symptoms manifested are genuine symptoms or trauma responses due to the unstable household environment and relationships (Fear et al., 2009; Goetz et al., 2017). Research on OBD suggested 86% experienced at minimum one mental health diagnosis (Goetz et al., 2017).

OBD may be more likely to internalize their problems than healthy controls as they often have to manage high levels of stress within their family environment (Lau et al., 2018;

Ostiguy et al., 2009). Unpredictable moods of a BDP may be viewed by OBD as being a significant stressor in their daily lives that they may feel unable to speak to gain support within the household (Venkataraman, 2011). Self-blame can often be present in younger OBD when the bipolar parent's moods fluctuate, resulting in feelings of lower self-worth, which is a necessary criterion for CPTSD (Backer et al., 2017; WHO, 2018). Trauma within the OBD population can also be experienced within the body, causing alterations in the way one functions, resulting in health issues, attention and concentration problems, and hormonal imbalances; another necessary condition for a CPTSD diagnosis (Courtois & Ford, 2014; Herman, 1992; Kolb et al., 2016; WHO, 2018).

When the BDP is unable to care for self, the OBD may be more likely to be parentified, resulting in further conflict in feelings about their parent and self. A parentified role may be pleasing to the BDP when they are in need of assistance, which can help the OBD feel needed; however, needing to be in this role can also cause feelings of resentment (Lovejoy et al., 2000; Venkataraman, 2011). Shame can also be internalized when OBD do not feel as though their true self is valued, which can result in personality dysfunction in adulthood to gain control (Wells & Jones, 2000). Fragmentation can begin to occur within OBD as they may be unable to integrate all aspects necessary to form an identity, often having parts of themselves frozen in a time due to interpersonal and relational trauma (Chiu et al., 2018; Herman, 1992; Schwartz & Sweezy, 2020; van Dijke et al., 2015). While this can be considered dissociation, this does not mean individuals have alter egos but instead experience the fragmentation discussed (Herman, 1992). In order to keep themselves safe, OBD may want full control in their lives, resulting in possible further fragmentation (Herman, 1992; Schwartz & Sweezy, 2020). Emotional neglect

or abuse may also be correlated to dissociation as defenses may be immature from an insecure attachment present in the parental relationship (Simeon et al., 2003).

IFS Theory and Treatment

Internal Family Systems treatment developed by Richard Schwartz provides a theoretical base for working with individuals who experience anxiety disorders, physical conditions, depression, and problems with self-concept, all of which can be present within a CPTSD diagnosis (Schwartz & Sweezy, 2020; Shadick & Sowell, 2013; Foundation for Self Leadership, 2015). The National Registry for Evidence-based Programs and Practices (NREPP) considered IFS to be an evidence-based practice in 2015 (Green-Hennessy, 2018; Foundation for Self Leadership, 2015). The NREPP informed their decision by considering a longitudinal study which followed individuals who were diagnosed with rheumatoid arthritis (Shadick & Sowell, 2013). After a 1-year period, individuals participating in IFS treatment were experiencing less overall pain and greater physical functioning in addition to decreased depression in comparison to an education group (Shadick & Sowell, 2013).

IFS has been noted to take a more trauma informed treatment approach in which clients are needing to feel safe before accessing their trauma and parts that have been exiled from traumatic experiences (Anderson et al., 2017; Schwartz, 2021; Schwartz & Sweezy, 2020). While the research on IFS is limited, the theoretical foundation has been described as being useful for treating complex trauma, such as for those who have experienced interpersonal and relational trauma, as dissociation states and engagement of parts within oneself can be present (Chiu et al., 2018; Schwartz, 2021; Schwartz et al., 2014; Schwartz & Sweezy, 2020). IFS would be best suited to use with individuals who are more high functioning, as the concepts

and treatment can be abstract in nature. It is important to note this theory may not work for every individual's needs and treatment would need to be tailored as such. Additionally, IFS treatment could take longer to meet an individual's needs and goals which may not be suitable for those who have limited time for therapy sessions. IFS was utilized in this literature review to aid in conceptualization and treatment of OBD as this theory encompasses the different facets that may be present within this form of complex interpersonal trauma (Schwartz et al., 2014; Schwartz & Sweezy, 2020).

Limitations

As mentioned previously, the research on IFS treatment is limited in nature. The studies that were able to be accessed did present with diverse populations, which is helpful in generalizing the research. While the research concerning BDPs, their offspring, and complex trauma was extensive and well-rounded, the studies were not as diverse in nature, resulting in less generalizability in the BD population. This was an extreme limitation as diversity factors such as SES, race, and societal constructs also impact the BD population. For example, those with BD were reported to have a higher likelihood of receiving financial assistance through the government due to difficulties experienced within careers and jobs (Schoeven et al., 2011). Many of the studies either did not address the SES of the participants involved or recruited individuals who were more stable financially. Having a more diverse sample for these studies is crucial in understanding other elements and themes of what might be influencing a BDP's behaviors or thoughts in addition to OBD. Race may play a significant role in BDPs receiving treatment or help as some cultures may not view mental health treatment as an option. The stigma of being a person of color while also having a serious mental illness such as BD is also

something to consider. Would these individuals have more to add to this research if they felt comfortable sharing their lived experience? Geographical location is also something to consider, as individuals participating in a study in a small town may fear more stigma of self or repercussions for being open and honest. Their experience may also be vastly different than those who live in more urban areas with a plethora of resources to utilize.

Some studies regarding OBD and trauma did suggest MDD parents may have had more of an impact on their offspring; however, many studies did not take into account the inconsistencies in mood with a BDP, as their mood can be labile (Chang et al., 2018; Knowles et al., 2017). Additionally, depressive episodes can also be experienced by those diagnosed with BD as well (Anderson & Hammen, 1993).

The research also utilized multiple self-report measures, which can impact the results as individuals may be experiencing or viewing things in a skewed manner compared to the actual truth. Mania and grandiosity should also be taken into account when completing these measures, as current moods can impact the way in which an individual may perceive the questions and influence their responses. Many studies did not rule out participants for personality disorders, which could also impact the research and data. If a personality disorder is present within a BDP, there may be more dynamics to consider and ways in which the data could be skewed.

Additionally, the literature did not always take into account other sources of support for the OBD, such as second parents, grandparents, or external family members. While some studies did incorporate this into the research, many focused on only the BDP and the OBD's relationship. It is vital to understand all contexts of a person's lived experience to best

understand their functioning and thought processes. Furthermore, it may be important to recognize how different generations of individuals experience varying upbringings and societal demands. That is to say, some of the research was conducted in earlier years, which can have an impact on what is viewed as being traumatic, physical abuse, emotional abuse and so forth.

Clinical Implications and Future Research

Considering the vast amount of research regarding OBD and the trauma they may experience within their household when raised by a bipolar parent, it is crucial to understand this phenomenon as complex trauma to best aid these individuals in treatment. The OBD not only experience biological and neurological alterations, but there is also a possible lack of self-identity or fragmentation which can further cause problems in adulthood. It is imperative for mental health providers to be aware of these different experiences for OBD to best know how to manage an individual in therapy and be informed about the issues which may be present. Clinicians could also broaden their knowledge about the stigma placed on this population and understand how diversity issues may impact these stigmas further. It is imperative the clinician take into account these legacy and personal burdens through IFS treatment to best conceptualize a client and aid in parts work. It is recommended when conducting research with this population to include culturally diverse participants to get a more accurate and well-rounded understanding of this phenomenon. With this understanding providers may better be able to provide a framework to assess for complex trauma.

Having systems outside of the family and readily available resources put into place can greatly benefit and positively impact families who have a depressed or bipolar parent as protective factors are strengthened (Kucuk Ozturk & Cam, 2017). These positive relationships

can help to modulate dissociation when trauma is experienced in childhood (Kong et al., 2017). When taking into consideration the aspects of depression, such as loss of interest, sadness, and fatigue, it is realistic to envision a disruption in the parenting skills of a parent who suffers from depressive episodes. Irritability and bouts of frustration due to these negative symptoms could result in further alienation/decreased attachment between child and parent (Kong et al., 2017).

Attachment is linked to self-esteem and self-efficacy, which in turn can also impact resiliency levels (DeMulder & Radke-Yarrow, 1991; Morriss et al., 2009). Adults who are not main caregivers for children are viewed as being a potential source of protective factors, as these individuals may provide an outlet and further social learning (Kong et al., 2017; Kucuk Ozturk & Cam, 2017). Higher resiliency levels are often present when there is support both within and outside the family environment (Cook et al., 2005). Parental and familial education about mental illness and how this can impact children in the household would be appropriate and may also be beneficial in improving communication.

Future research could include more qualitative studies as well to better understand the lived experience of OBD and BDPs as an interview can provide a rich background of a person's experience. In regards to IFS research, more studies can be conducted with OBD to assess how IFS can be beneficial in treatment of this population. IFS research in general could be broadened to encompass complex trauma and identify the treatment outcomes. As IFS can be a longer treatment approach depending on the individual and level of resistance of parts, it may be beneficial for studies to be longitudinal in nature.

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