Clinical Sociology Review

Volume 11 | Issue 1 Article 7

1-1-1993

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ABSTRACT

This article reports on the predominant emotions experienced by members of an education/support group for the relatives and partners of individuals with bipolar manic-depression. Identified are the specific types of emotions experienced as well as the situational, definitional, and behavioral frameworks in which particular emotions or combinations of emotions were generated, experienced, interpreted, expressed, and managed. Special attention is focused on emotional uncertainty, mixed and fluctuating emotions, the erosion of positive by negative emotions, and emotional stalemates. In addition, the personal and social consequences of members' adopting particular emotion management roles are examined. Finally, the article outlines the education/ support group contexts and processes through which members were able to normalize, alter, or reduce a number of particularly distressful emotions and create or reinforce specific positive emotions.

*Dr. Cuthbertson-Johnson would like to thank all the members of the bipolar family support group who so trustingly and generously shared their life experiences with her.

A number of researchers have noted the problems encountered by relatives and partners of individuals diagnosed with serious psychiatric disorders (Bernheim 1989; Fadden, Bebbington, & Kuipers, 1987; Francell, Conn, & Gray, 1988; Gubman & Tessler, 1987; Mayo, O'Connell, & O'Brien 1979; Noh & Turner, 1987). In their discussions they call attention to what Gubman and Tessler refer to as the subjective dimension of psychological distress among family members. It is the purpose of this article to expand the concept of the subjective dimension of psychological distress among family members by presenting a sociology of emotions approach to the experiences of members of a long-term support group for the relatives and partners of individuals with bipolar manic-depression.[1] Identified are group members' predominant emotions and the contexts, interpretations, and behaviors intricately linked to those emotions. Also reported upon is the support group ambience and processes through which members' identified, understood, and legitimated or altered important emotional patterns and processes.

The Group

The bipolar family education/support group was initiated in the department of psychiatry outpatient clinic of a major metropolitan hospital and medical center. Its purpose was to provide the relatives and significant others of bipolar individuals with the opportunity to gain, within a professional setting, information about bipolar disorder; to correct misinformation; to share experiences common to families and friends of individuals with bipolar disorder; and to develop new ways of adapting to their situations.

The group met weekly for the 18 month period, and group sessions, lasting for 1½ hours, were led by a clinical sociologist assisted for 7 months by a psychiatric social worker and for 11 months by a psychiatric resident. The group was comprised of 12 adults, 8 men and 4 women, who attended from 9 to 49 sessions.

Extensive notes were recorded on the proceedings of each group session and were analyzed for major themes and issues by the clinical sociologist group leader as well as an independent, outside sociological researcher. The clinical sociologist group leader also conducted numerous in-depth interviews and counseling sessions with family members and their bipolar relatives.

Identifying Typical Emotions

The Revelation of Emotional Experiences

During initial group meetings, members primarily discussed the type, frequency, and severity of manic or depressive episodes experienced by bipolar relatives or partners. Sharing these accounts provided a communal basis for revealing important personal concerns relative to living with and relating to bipolar individuals.

Anxiety

A predominant emotion revealed by group members was continuing anxiety. Anxiety was experienced in relation to the ever-present possibility that bipolar individuals would have a manic episode, especially an episode that would result in disastrous consequences for the bipolar individuals, their families, or others. The greatest anxiety occurred when members knew an episode was underway but could not determine the whereabouts of the bipolar individual. During those times, family members felt helpless, unable to play any role in preventing a possibly tragic outcome. Group members also discussed experiencing anxiety during bipolar individuals' depressive stages, primarily in relation to the lurking threat of a suicide attempt. Concern for the future also evoked anxiety. Parents worried about who would care for their sons and daughters after their death. A sibling was intensely anxious about how she would manage her brother if their father, with whom her bipolar brother lived, became ill or died.

Uncertainty and Fluctuating Emotions

Group members expressed considerable uncertainty in regard to bipolar individuals, themselves, and the relationship between them. Who was the authentic bipolar individual? What was the true cause of his or her behavior? Particularly troubling was their inability to make definitive interpretations of bipolar individuals' standpoints towards them. How did their sons, daughters, siblings, spouses, or partners really view them or feel about them? At times, members would feel they were the "best buddies" of bipolar individuals. On the other hand, when turned against during raging outbursts, they would question the veracity of their stand-

points. They were especially concerned about bipolar individuals' true feelings. Were the remarks made and behaviors displayed during outbursts or episodes indicative of the others' real feelings or just expressions of disordered states.

Inundated by uncertainty, members found it difficult to select appropriate roles and behaviors for themselves as well as bipolar individuals. Unmarried partners wondered if they should make a full commitment to their relationships, and spouses questioned whether they should remain in their marriages. Questions relating to parenting abilities were of special concern. Would the bipolar individual be able to function as a mother or father? Furthermore, if the disorder had genetic components, would their children inherit the problem? One young man, newly married, was deeply confused over the extreme contrast between his normal-acting and episodic wife. Questions relating to her true identity were a primary topic of concern, and he constantly fluctuated between fearing and desiring the relationship. Similar to other partners, he could make no definitive sense of who his bipolar wife was or what he could expect of her from one day to the next. Even members long accustomed to bipolar individuals' changing moods struggled with feelings of uncertainty, especially in regard to the cause of bipolar behavior. Were episodes the result of an uncontrollable biological disease, for example, or were they merely manipulative emotional displays? Not having definitive answers to these and similar questions hindered members' knowing what they should expect of their relatives or partners in regard to education and career goals or social relationships.

Confusion also existed among group members over the legitimacy or appropriateness of their experiencing or expressing certain emotions. For example, if a bipolar son was unwilling to work and was using episodes as an effective excuse, a parent could legitimately experience or express anger. If the son was unable to work because of a biological disorder and its ramifications, however, experiencing or expressing anger might be inappropriate, even damaging. In general, family members had considerable difficulty taking the role of their bipolar others. Accordingly, they experienced uncomfortable confusion as to the appropriateness and justification of a particular emotional standpoint or expression.

Frustration, Irritation, and Anger

Frustration, irritation, and anger were prominent emotions among group members. A constant source of irritation, for instance, was having to deal with continual anxiety and uncertainty. What was defined as "adolescent behavior" on the part of bipolar individuals was another major source of irritation, and, at times,

considerable anger. Members reported that bipolar individuals, even when not experiencing a manic or depressive episode, often reacted angrily to minor occurrences, subjecting relatives and partners to tirades of blame and sarcasm. Several partners and spouses expressed self-anger as well as chagrin at not having recognized the severity of bipolar individuals' problems before becoming seriously involved with or married to them. They also expressed anger at not having been informed, before initiating close relationships, of the gravity of the situation by bipolar individuals' relatives and friends.

Anger was often combined with other emotions. Anguish as well as anger was experienced over social stigmatization issues. These feelings were coupled with anxiety as members debated whether or not to tell friends, co-workers, or relatives of the problems they were experiencing or of the need to have a bipolar relative or partner hospitalized. In addition, they often agonized over the possible repercussions of explaining to a bipolar individual's employer that a psychiatric hospitalization had been the true reason for his or her prolonged absence from work.

Guilt and Self-Reproach

Feelings of guilt and self-reproach were also revealed by relatives and partners. At times parents agonized over their possible genetic or environmental contributions to offspring's bipolar problems. Members were also concerned about perceived deficits in their personal emotion management strategies. Two male group members with female bipolar partners, for example, consistently expressed guilt and remorse for having sometimes allowed their anger to escalate to the point of using physical force to deal with bipolar partners' behaviors. Also, a father felt guilty about continually displaying anger not only at his bipolar son but at his wife for tolerating verbal abuse during their son's episodes. In another case, a sibling discussed feeling guilty because she had not developed bipolar disorder. She also stated that in relation to feeling guilty in regard to what her brother did not have or had not accomplished, she often failed to mention or played down, especially during family discussions, important personal accomplishments or satisfying social relationships.

Positive Emotions

All members expressed deep feelings of love for bipolar relatives or partners. They also displayed pride when describing bipolar individuals' intelligence,

talents, and creativity. In addition, members recounted numerous rewarding interpersonal experiences. Unfortunately, the existence of positive emotions and experiences seemed to increase members' confusion over the true nature of their relationships with bipolar individuals. Furthermore, strong beliefs in bipolar individuals' potential amplified feelings of disappointment and anguish over disrupted careers, failed relationships, or low accomplishments.

Over the course of group sessions, several members also admitted to sometimes experiencing vicarious feelings of delight in bipolar individuals' outrageous behavior or aberrant social activities. They also mentioned that at times they felt entranced by an oddly enticing charisma present during bipolar individuals' manic phases.

Emotions Relative to Treatment Contexts

Emergent in discussions were a number of emotions that specifically related to the issue of hospitalization. Members reported considerable anguish over having to forcibly hospitalize a relative or partner. For several members hospitalization was a sign of personal failure. In one case, not preventing hospitalization resulted in a member experiencing severe guilt, and, ultimately, depression. In another case, believing that he had again failed to prevent his partner's hospitalization, a member contemplated suicide. All members reported it was incredibly agonizing to convince as well as demand a bipolar individual to enter the hospital against his or her will. Several members reported mixed feelings about hospitalization. They felt relieved that their relatives or partners were safely hospitalized; at the same time, they worried about the efficacy of the care they would receive. Discharge was an additional concern. Was the bipolar individual coming home too soon or not soon enough? These questions evoked, respectively, feelings of anxiety and guilt.

Members' intersections with the medical community generated both positive and negative emotions. On the one hand, professionals were considered a source of support, education, and assistance, especially in times of crisis. On the other hand, they and the facilities with which they were associated often motivated anger. Members did not hesitate to express anger in regard to long waits in emergency rooms, complicated hospitalization admission procedures, and bureaucratic coldness and inefficiency. They were particularly concerned about getting doctors or emergency room personnel to respect and validate family members' considerable knowledge of bipolar behavior. Members reported that their warnings of the imminent relapse of bipolar individuals were often discounted or refuted by

medical personnel, in a number of instances with serious consequences. Members also expressed concern over their lack of knowledge of psychiatric terminology and procedures. In addition, they displayed fear over appearing uneducated or intrusive by asking doctors "stupid questions" about the disorder and its treatment.

Additional Emotions

A number of other emotions were revealed. Several members stated that they had experienced occasional feelings of embarrassment over bipolar individuals' behaviors or manner of dress, especially during manic episodes. In addition, they discussed feeling a great deal of grief over the lack of normality in the lives of their spouses, sons or daughters, and siblings, especially isolation from friends or lack of progression through normal career paths.

In general, it became apparent from members' revelations that their lives were disorder-dominated and drained by continuing distress. Unable to alleviate continuing anxiety and uncertainty, they had little peace of mind. Within such a context, it is understandable that members experienced feelings of helplessness and hopelessness as well as serious health problems. One father, two male partners, and one mother had severe alcohol problems; two male partners and one mother experienced depression; and one father was on medication for an anxiety disorder. Another male partner was often depressed, sometimes suicidal, binged on food, and bought impulsively.

Altering Emotional Experiences

In the course of attending group sessions and coming to understand and discuss with each other and group leaders their emotions, group members were able to normalize, alter, or reduce a number of particularly distressful emotions and the definitions, situations, and behaviors to which they were related. The group also provided a context within which positive emotions were reinforced and created.

The Establishment of Feeling Rules

Group members established feeling rules (Hochschild, 1975, 1979) or group agreements about the legitimacy and appropriateness of experiencing or expressing particular emotions. By attending group sessions and listening to others' accounts

of bipolar-related incidents, for example, members normalized personal experiences and feelings. They found they were not alone in their anxieties and frustrations. Neither were they alone in their inability to come to definite interpretive standpoints regarding bipolar individuals' behaviors and feelings towards them as parents, siblings, spouses, or partners. All members had had difficulty establishing specific standpoints for selecting appropriate roles, behaviors, expectations, decisions, and commitments. Uncertainty was prevalent even as to the legitimacy of experiencing and expressing certain feelings. Normalizing these patterns and the specific situations that often generated them reduced overall anxiety. Confusion and uncertainty were no longer solely personal problems; they were group issues, and, as a result, less threatening and potentially more controllable.

The group also decided that feeling guilty over desiring to get a bipolar individual out of the house or having him or her hospitalized when manic was, under the circumstances, legitimate. The appropriateness of experiencing anger, and, more importantly, expressing and managing anger, was a more complex subject. Experiencing or expressing a certain amount of anger was considered beneficial. For example, one member discussed how replying with mild to moderate anger to a sarcastic comment by his bipolar partner did not alter his partner's behavior, but it did make him feel he had not just tolerated an inappropriate action. Preventing the escalation of anger into violent or abusive behavior, however, became a critical group goal. Accordingly, the group routinely assisted members who had difficulty controlling anger in themselves or their partners by "brainstorming" strategies for establishing personal boundaries and dealing with partners' provocations.

The Management of Emotion

The group also became a critical context for members' establishing strategies for what Hochschild (1979, 1983) has defined as emotion work. Realizing that ongoing anxiety in regard to the possible threat of a manic episode was a major but normal group problem facilitated members' exploring, with the assistance of group leaders, important means to reduce feelings of vulnerability and increase perceptions of control.

One strategy was to provide each other with stability and support when a crisis did occur. A second strategy involved utilizing members' predictive abilities or proficiencies in identifying signs of hypomanic[2] episodes in relatives and partners to devise and implement specific means for preventing the escalation of hypomania into mania. Jointly working on the prevention of episode escalation had important

consequences. Forestalling episodes came to be defined as a challenge not a burden or hopeless endeavor. Furthermore, as several members successfully utilized their predictive abilities and new tactics to assist in averting or lessening the severity of specific episodes, feelings of hopelessness and helplessness diminished and individual as well as group pride emerged. In fact, the group labeled one member, who became especially skilled at noting and preventing manic relapse in his bipolar partner, the "Manic-Depressive Detective."

A third emotion management strategy was taking advantage of the educational aspects of group membership. Members were free to clarify, without fear or embarrassment, any lack of knowledge or misunderstanding of bipolar disorder. Leaders provided information about diagnostic labeling, medications and their side effects, and important hospital procedures. Education relevant to the form and processes of social stigmatization also lessened members' anxieties and anger in regard to dealing with the public and facilitated their devising specific means to prevent or manage stigmatizing occurrences. Furthermore, members' feelings of efficacy increased as leaders disseminated important information to hospital personnel regarding relatives' and partners' evaluations of their facilities and procedures.

Finally, the group provided members with the opportunity to discuss particularly sensitive issues, including life beyond bipolar disorder. Members talked about personally rewarding events that they were usually cautious about revealing to bipolar individuals. Moreover, members came to feel comfortable discussing individual or marital problems not related to bipolar issues. One member, for example, reflected upon and resolved a work-related alcoholism problem; another member, with group assistance, developed ways to deal with an overcritical father and a past, traumatic divorce. In addition, an agreement was made to use the group as a safe place for members to express anger at bipolar individuals, inefficient facilities, uncaring professionals, and an uneducated or stigmatizing community. In general, these activities reduced overall distress and created an increased sense of well-being among group members.

The Identification and Alteration of Established Behavior Patterns

The Identification of Dysfunctional Patterns

Group-generated feelings of trust and common concern provided an optimum context for members' exploring, with the assistance of group leaders, established

ways they had been interpreting, responding to, and managing their own lives as well as the lives of bipolar individuals. They were also able to identify the psychological and social consequences of their behavior patterns.

Members began to recognize that, paradoxically, despite feelings of confusion and uncertainty, they had adopted general working standpoints from which to understand and respond to bipolar relatives and partners. Two major standpoints emerged:(1) a victimization standpoint in which any episodic or nonepisodic deviance or irresponsibility was generally defined as the result of a disease and not preventable by the bipolar individual; and (2) a manipulation standpoint in which episodes were basically defined as bipolar individuals' purposefully planned escapes from stressful situations. Both standpoints resulted in debilitating overconcern or overcontrol on the part of the family member.

The victimization standpoint placed the parent or partner in a responsible caretaker role; the manipulation standpoint put the parent or partner in a predominantly controller role. Caretakers continually expressed concern and anxiety over the well-being of bipolar individuals and provided them with constant watchful attention and solicitude. Controllers were also concerned about their bipolar relatives or partners but were primarily apprehensive over if and when the bipolar individual would "pull another stunt." Both types worried that stressors, even the everyday pressures of job situations or social relationships, would produce an episode. Therefore, like the episode-fearful spouses and family members of bipolar individuals discussed by Waters, Marchenko-Bouer, and Offord (1981), they avoided placing stress on their relatives or partners.

Caretakers carefully guarded their relatives or partners from unnecessary or unexpected occurrences. Controllers constantly supervised bipolar individuals moods and situations, attentive to any cues of the bipolar individual taking an "episodic way out." Both were apprehensive about leaving the bipolar individual unsupervised. Vacations were a special problem. Members were concerned about what would happen if they were traveling with bipolar individuals and, far from trusted doctors, therapists, or hospital facilities, an episode occurred. Parents were especially reluctant to take vacations. One couple had taken only one vacation in 25 years, and, on that occasion, their bipolar son had unexpectedly arrived to join them on their second day at a resort. Furthermore, when an adult bipolar son or daughter went on a business trip or vacation, parents experienced constant anxiety unless continually notified of their offsprings' safety.

Controllers were constantly suspicious of bipolar individuals' motives. Although angry over relatives' and partners' alleged inclinations to be irresponsible,

they were hesitant to give them opportunities to be responsible. Simultaneously experiencing anger and anxiety, they became locked in emotional stalemates or standpoints in which the experience of two equally distressful emotions prevented their taking a distinctive behavioral role. Caretakers often experienced sadness over the menial jobs held by relatives or partners; at the same time, they worried how bipolar individuals would be able to handle the pressures of more demanding opportunities. They, too, were locked in emotional stalemates.

Caretakers displayed a reluctance to upset bipolar individuals. They were apprehensive about the consequences of disagreeing with bipolar individuals or not complying with their requests. Controllers continually looked for manipulative maneuvers, responding with frustration and anger when they perceived what they felt was a manipulative behavior. They also concentrated on preventing circumstances or contexts conducive to bipolar manipulation. In general, both caretakers and controllers were constantly on the alert, guarded, doing everything in their power to forestall critical events, often with the consequence of impeding their own emotional ease and positive life fulfillment as well as others'. One group member, a long-term male partner of a female bipolar individual, for example, waited 3 weeks before informing her that he had been fired from his job. With assistance from the group, however, he eventually told her about his dismissal, gaining, to his surprise, considerable support and compassion.

The Alteration of Dysfunctional Patterns

As members focused upon established caretaker or controller roles, they began to recognize and, eventually, debate the belief systems on which the roles were based. They also began to examine the personal and social consequences of taking caretaker/controller roles. Members began to discuss, for instance, the fine line between responsible concern and debilitating overcontrol. They also reflected upon the consequences of viewing bipolar disorder as purely a biological disease, controlled only by medication, or simply a manipulation, brought about by purposeful motive. In the process of reflection, they came to explore a number of factors relevant to the emergence and escalation of episodes, such as genetically based vulnerability, specific individual experiences and interpretational styles, interpersonal relationship patterns, and general social beliefs and values. Also, as members focused upon bipolar disorder as a multifaceted problem that involved genetic, biological, psychological, and social factors, they transformed entrenched definitions of themselves as the burdened caretakers of helpless victims or the

designated controllers of purposeful manipulators. Instead, they came to view themselves as persons who lived with and adapted to a major life challenge. These changes among group members had healthy emotional consequences.

Alterations of perspective, carried out in a supportive group ambience, also had positive consequences for bipolar individuals. As family members stopped overly focusing on bipolar individuals and reduced their level of anxiety-ridden caretaking or frustration-laden attributions of intended manipulation, bipolar individuals felt more comfortable, less patronized, and able to reflect upon and attempt to alter dysfunctional behaviors. Also, as family members set personal and social boundaries without fear of severe repercussions or frustration over imputed manipulations, they facilitated bipolar individuals' learning to accept and appropriately respond to reasonable limits.

Summary and Discussion

Exploring the subjective dimension of the bipolar family support group from a sociology of emotions perspective revealed patterns and processes not possible to be discerned through viewing emotion primarily as psychological distress. First of all, it pointed out the importance of identifying the range of emotions of specific individuals as well as groups, that is, the specific types, intensities, and durations of particular emotions experienced. It also established the relevance of individuals not being able to establish particular emotional standpoints. Emergent as highly important were the processes through which individuals took into account and attempted to make sense of the experience, expression, and management of their own emotions as well as the emotions of others. Found critical to examine were the situational as well as interpretive frameworks through which particular emotions or combinations of emotions were generated and maintained. Identifying the intersection of emotions on a personal and interpersonal level was also found to be highly relevant. What negative emotions eroded positive emotions, for example, or how did one individual's emotional patterns intersect with or impact those of another? Studying the general social values and themes involved in particular emotional standpoints also shed light on emotional patterns and processes, as did the examination of specific community contexts to determine what positive or negative emotions were influenced by their formats and practices. Especially relevant was understanding the group contexts and processes in which emotions were reflected upon as to legitimacy and appropriateness in experience or expres-

sion, negative emotions were altered or reduced in intensity, positive emotions were created, and emotion management patterns were devised and carried out for controlling negative emotions in the self and others.

Taking a sociology of emotions perspective on the professionally facilitated bipolar education/support group enabled a fuller understanding and appreciation for the group's positive contributions. It validated the significant benefits to family members of education and information, as pointed out in studies by Kurtz (1988) and Bernheim (1989). It confirmed the importance of investigating the influence of the family environment on the course of bipolar disorder, as suggested by Miklowitz, Goldstein, Nuechterlein, Snyder, and Doane (1986), and the relevance of family members considering their own roles in bipolar situations. It made clear the need for professionals to be cognizant and respectful of family members' knowledge of the bipolar individual, available during times of crisis (Bernheim, 1989), and willing to help relatives and partners participate in treatment and recovery (Bernheim, 1989; Fadden, Bebbington, & Kuipers, 1987). It also suggested the importance of focusing on a multifactorial, integrated approach to psychiatric disorder that is based on the critical intersection of genetic, biological, psychological, and social factors and "that neither places the burden only on the family's shoulders nor dismisses the notions of family and societal responsibility altogether" (Bader, 1989, p. 48). In addition, it supported the practice of having interdisciplinary group leadership, such as a clinical sociologist, psychiatric resident, and social worker, bringing their respective disciplinary knowledge and skills to the group setting.

The group had definite effects on the emotions of relatives and partners. Uncertainty and mixed or conflicting emotions were reduced through the group's creations of joint interpretive standpoints from which to understand and adapt to bipolar disorder. Redefinitional processes, initiated and carried out within a secure group setting, assisted members in identifying and altering dysfunctional interpretations and related roles. Providing an arena for members to experience, express, interpret, and learn to manage negative emotions as well as experience and discuss positive emotions was another group contribution. Emotions like frustration, guilt, anxiety, and anger were safely expressed and discussed. Frameworks for normalizing the experience or expression of negative emotions were established and strategies devised for managing explosive and possibly harmful emotional outbursts in themselves and bipolar individuals.

Although group members continued to experience considerable problems and realized that, in some cases, they would never be able to completely allay feelings of grief, disappointment, frustration, anger, or anxiety, they received considerable

group understanding and support for their personal hardships. In addition, ongoing negative emotions were neutralized through group-generated pride and hope, and intolerable distress levels were lessened through the sharing and resolving of non-bipolar-related difficulties.

It is hoped that clinicians and mental health facilities will establish bipolar family support groups as an important adjunct to traditional treatment programs. Through the establishment of support groups, they can assist relatives and partners in reducing feelings of threat and vulnerability; increase hope, empathy, and pride; and achieve the sense of mastery noted by Noh and Turner (1987) as especially important in individuals living with psychiatric patients. It is also hoped that mental health personnel will begin to utilize a sociology of emotions approach for understanding the subjective dimension of psychiatric disorder and its treatment.

NOTES

1. A diagnosis of bipolar disorder is made when a patient has a history of mania or hypomania. Key diagnostic features of mania are a distinct period of elevated, expansive, or irritable mood accompanied by increased activity, pressure of speech, flight of ideas, grandiosity, decreased need for sleep, and/or distractibility (Talbott, Hales, & Yudofsky, 1988).

2. According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1987, p. 218), the essential feature of a hypomanic episode is a distinct period in which the predominant mood is either elevated, expansive, or irritable, and there are associated symptoms of a manic syndrome. The disturbance is usually not severe enough to cause marked impairment in social or occupational functioning or to require hospitalization.

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