A POSTMODERN, COLLABORATIVE APPROACH TO THERAPY USING A NARRATIVE LENS WITH INDIVIDUALS DIAGNOSED WITH BIPOLAR DISORDER

By

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This study has taught me how important it is for significant others and professionals to collaborate. Post modernism is groundbreaking in that it allows everyone in the collaborative process to respect one another's reality. Bringing collaboration into the therapeutic process makes it much easier for everyone to understand one another and thus may allow for a better therapeutic outcome for people with mental illness and their significant others.

DECLARATION

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ABSTRACT

Bipolar disorder affects nearly 60 million people worldwide. It is a debilitating mood disorder that severely impacts on the functioning of those diagnosed as well as their significant others. Psychotherapies such as cognitive behavioural therapy and family orientated interventions have been used in conjunction with pharmacological treatment to reduce symptom severity, limit time spent in depressive or manic states and increase the duration between relapses, with these treatments showing varying degrees of success. Recently, there has been a focus on perceived quality of life as a measure of improvement for those with mental disorders, as opposed to symptom reduction alone. Collaboration, a technique employed by postmodern clinicians, can be defined as a philosophical stance to therapy that involves working with the client towards a mutually agreed outcome and can be extended to include other professionals and significant others chosen by the client. Collaborative approaches to therapy have been used increasingly in recent years, however they do not feature extensively in the literature and their effectiveness is not yet well-documented. To determine the effects of collaboration on the quality of life of those with bipolar disorder as well as their significant others involved in the therapeutic process, the researcher conducted three semi-structured interviews with three participant dyads. Each pair comprised a young adult (aged 16 to 23 years) who had been diagnosed with bipolar disorder and his/her significant other. Each dyad was currently receiving therapy or had completed therapy with a postmodern narrative practitioner making use of collaborative techniques. Data were collected using grounded theory research methods and analysed using the Gilligan's Listening Guide. Ten dominant themes emerged from the data, viz. early-onset bipolar disorder, comorbidity, helping others, relevance of diagnosis, illness management, relationships, collaboration, stigmatisation, overshare and difficulty of being the significant other of an individual with bipolar disorder. These themes are discussed in terms of the study's conceptual framework and research implications are considered. Collaboration resulted in improved quality of life and overall functioning for those involved in the study and has potential to be used in a range of settings with a variety of mental disorders.

Key Words: bipolar disorder; collaboration; narrative therapy; post modernism; quality of life; social constructionism

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ABBREVIATIONS AND ACRONYMS

ADHD	Attention-Deficit / Hyperactivity Disorder
AD / DD	Attention Deficit Disorder Dilemma
AUD	Alcohol Use Disorder
BD	Bipolar Disorder
BD-NOS	Bipolar Disorder Not Otherwise Specified
BPD	Borderline Personality Disorder
CBT	Cognitive-Behavioural Therapy
CCP	Collaborative Care Programmes
CLS	Collaborative Language Systems
DMDD	Disruptive Mood Dysregulation Disorder
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EOBD	Early-Onset Bipolar Disorder
FFT	Family-Focused Therapy
GAD	Generalised Anxiety Disorder
HRQoL	Health-Related Quality Of Life
MDD	Major Depressive Disorder
NMHPF	National Mental Health Policy Framework
NT	Narrative Therapy
ODD	Oppositional Defiant Disorder
PBD	Paediatric Bipolar Disorder
QoL	Quality of Life
SMD	Stereotypic Movement Disorder
STEP-BD	Systematic Treatment Enhancement Program for Bipolar Disorder

WHO	World Health Organization
WMH	World Mental Heatlh

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1. CHAPTER 1 – INTRODUCTION

1.1. Background to research problem

Bipolar disorder (BD) affects nearly 60 million people globally (Bahrer-Kohler, 2016), and is characterised by repeated episodes of major depression and mania or hypomania. BD is frequently linked to other mental disorders (Grant et al., 2005; Roshanaei-Moghaddam, Katon & Russo, 2009; Vancampfort et al., 2013; Weber et al., 2011; Zhang et al., 2018) and to alcoholism and substance misuse in particular (Balanza-Martinez, Crespo-Facorro, Gonzalez-Pinto & Vieta, 2015). According to the *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition, DSM-5) (American Psychiatric Association, 2013) the criteria for a major depressive episode are the same for both unipolar and bipolar depression, but Grande, Berk, Birmaher and Vieta (2016) observe that most patients with BD present with a depressive episode that "*differs subtly from unipolar depression.*" (p.1563). Elevated mood states with increased motor drive that occur for a specific length of time are referred to as manic or hypomanic episodes, and can differ in terms of both duration and severity (Grande et al., 2016). Impaired judgement, agitation and poor concentration are the main symptoms of hypo/mania (Simon, 2003).

Mood disorders, including BD, rank among the most commonly diagnosed mental disorders and in developing countries are often among the most under-treated group of disorders (WHO, 2013). Mood[1] has a substantial impact on how the world is perceived, how one interacts with others and one's personal sense of well-being (Sue et al., 2014). The risk of suicide, and the immense suffering frequently experienced by those diagnosed with a mood disorder, make it vital that diagnosis is accurate so that effective interventions can be swiftly implemented (Novick, Swartz & Frank, 2010).

The World Health Organization (WHO) (2013) lists BD as one of the leading causes of disability worldwide. BD and other mental health disorders cause widespread suffering to the individuals affected as well as to their social networks, families and society (Bahrer-Kohler, 2016). This lifelong episodic illness regularly causes

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[1] Mood can be defined as "*our emotional state or prevailing frame of mind*" (Sue, Sue, Sue & Sue, 2014, p. G-6).

cognitive and functional impairment and a reduction in quality of life (Grande et al., 2016; Martinez-Aran et al., 2004). BD is ranked as the illness with the second greatest effect on days out of role as per the WHO's World Mental Health surveys (Alonso et al., 2011), and as it is generally diagnosed in young adulthood, BD affects the economically active population and carries a high cost to society (Gardner et al., 2006). Kolostoumpis et al. (2015) assert that "*the chronicity and recurrent nature of manic and depressive episodes in bipolar disorder render it a major public health problem*" (p. 290).

Although individuals diagnosed with BD experience periods of remission, recurrence is considered to be a typical part of the illness (Grande et al., 2016). It is widely acknowledged that BDs are a leading cause of disability, and consequences of the disorder include long-term unemployment, comorbid medical illness, and suicide (Berk et al., 2013; Chen & Dilsaver, 1996; Dalton, Cate‑Carter, Mundo, Parikh & Kennedy, 2003; Zimmerman et al., 2010). Research indicates that Bipolar I Disorder (refer to Chapter 2, section 2.2) causes severe psychological and financial strain on public health care administration systems, those diagnosed with the disorder, and their family members (Park & Park, 2014). Chang et al. (2011) conducted a registry-based study in the UK and found that the life-expectancy of those diagnosed with BD is 10 years less than the national average. Effective long-term treatment for BD is paramount to decrease the loss of productivity and the increased medical costs associated with BD (Soares-Weiser et al., 2007).

1.2. The South African context

In South Africa the number of people who have mental illness runs into the millions and as many as one in four people are affected by, or experience mental illness (Madzhie, Mashamba & Takalani, 2014). Between 1% and 3% of South Africans are likely to need hospitalisation due to mental health issues while only approximately 45% of those with mental illness will seek treatment in a timeous fashion. Contributing factors with regards to mental illness in South Africa include poverty, political violence, substance abuse, the waning of traditional value systems, and disease (Madzhie et al., 2014). In a systematic review of the literature regarding the epidemiology and burden of BD in Africa, Esan and Esan (2016) found that despite mental health disorders being a significant issue in Africa, there is limited information about the economic, social, clinical and epidemiological load it places on society.

A study conducted as part of the WHO World Mental Health (WMH) Survey Initiative found that South Africa has a comparatively high 12-month prevalence of mood and anxiety disorders (Herman et al., 2009). One in six South Africans had a history of a diagnosable mental disorder, as per DSM-IV, in the previous 12 months. Geographical differences in the 12-month and lifetime prevalence rates across provinces were also noted, with the Western Cape having the highest prevalence of mental disorders. Kleintjes et al. (2006) found a 1% annual prevalence rate for BD in adult and child populations in the Western Cape. In contrast, the Eastern Cape was the region with the lowest rates of mental disorders. In general, rural areas appear to have lower rates of mental disorders, although this may be misleading as there may be poorer access to health services that result in lower rates of diagnosis in rural areas (Herman et al., 2009). The results of this study indicate that mood disorders, such as BD, are more common amongst women in the 18–34 year old age range who hold a primary and high school education. Individuals who are divorced, separated, or widowed also appear to be at higher risk.

The South African Stress and Health Study (2014) showed a 75% treatment gap of mental health disorders nationally. Egbe et al. (2014) found that stigma around mental health disorders causes South Africans to delay seeking help. In addition, many individuals will consult traditional and religious healers first (Burns & Tomita, 2015). In South Africa, as well as in numerous other African countries, traditional belief systems view mental health issues as being the result of bewitchment or a consequence of interference by the individual’s ancestors (Sorsdahl, Flisher, Wilson & Stein, 2010). Traditional healers hold numerous explanatory models for both non-psychotic and psychotic disorders, and non-psychotic illnesses are typically not viewed as pertaining to mental health (Sorsdahl et al., 2010).

1.3. Overview of treatment for BD

Antipsychotics and mood stabilisers are widely used for the acute management of bipolar mania and depression (Grande et al., 2016). A combination of medications is typically used for management of BD including lithium, lamotrigine, olanzapine, aripiprazole and valproate as maintenance treatments and second generation antipsychotics (SGA's), valproate, extended release carbamazepine and lithium for acute episodes of mania. Effect prophylaxis of BD remains challenging due to efficacy of available treatments and poor adherence due to adverse side-effects (Baldessarini, Tondo & Vázquez, 2019). Even with stable pharmacology, recurrence rates remain high. Sylvia et al. (2015) note that close to 40% of individuals experience an episode recurrence within one year, and over 70% experience recurrence within five years.

Guidelines for treatment invariably suggest an integrated use of pharmacotherapy and targeted psychotherapy for the optimum management of BD. Psychological approaches are based on evidence that psychosocial stressors are associated with relapses and worsening symptomatic states (Geddes & Miklowitz, 2013). These stressors may include excessive family discord or distress, negative life events, or events that disrupt sleep or accelerate goal attainment. Adjunctive psychotherapy can be extremely beneficial as it "*targets areas that medications do not address, such as teaching individuals about illness, providing skills to control their mood fluctuations, coping with stressful life events, improving social rhythms, sleep patterns, and interpersonal skills*" (Sylvia et al., 2015, p. 454). According to Parikh et al. (2012) the use of pharmacology treatment plus psychotherapy for BD outperforms either treatment on its own. A review of 18 randomised trials of psychotherapy, showed that adjunctive psychosocial treatments were linked to a 30 to 40% reduction in rates of relapse over a 12 to 30 month period including more functional improvements, compared to treatments that relied solely on pharmacological treatments (Miklowitz, 2008a). Despite this, psychotherapy is underutilised (Evans-Lacko et al., 2011; Sylvia et al., 2015; Weiss et al., 2000), and some authors question its value. Soares-Weiser et al. (2007) consider that psychosocial therapies have not been investigated thoroughly, although they concede there is evidence that group psychoeducation, cognitive-behavioural therapy (CBT) and family therapy might be beneficial as adjuncts to pharmacological maintenance treatments. In a study examining the characteristics of those with BD who entered into psychotherapy versus those who did not, Sylvia et al. (2015) found that individuals who did attend therapy had a greater illness burden and that psychotherapy did not tend to improve outcomes.

Ngazimbi, Lambie and Shillingford (2008) argue for the use and efficacy of narrative therapy (NT) as an adjunct to pharmacology for various disorders, including mood disorders such as BD. Described by these researchers as a "*postmodern social constructionist theory, which focuses on client strengths, rather than deficits*" (Ngazimbi et al., 2008, p. 162), NT centres on the view that clients have problems and that these issues need to be separated from the client (Ngazimbi et al., 2008). Based on Rogerian principles of congruence, warmth, acceptance, and unconditional positive regard, the counselling relationship in NT is pivotal and aims to be different to other relationships clients have in their daily lives, in which they may feel judged due to their mental health issue. Once a rapport is established, the counsellor and client enter into a collaborative relationship (Winslade, Crocket & Monk, 1997). Research supports the value of NT when used with clients diagnosed with mood disorders (e.g., Havens & Ghaemi, 2005; Judd & Akiskal, 2003; Ngazimbi et al., 2008; Robertson, Jones, Haque, Holder & Craddock, 2005). NT will be described in-depth in chapter two.

There is evidence that adjunctive psychotherapies for the treatment of BD have a positive impact on functional and symptomatic outcomes (Gitlin, 2006; Jones, 2004; Miklowitz, 2008a). Counter arguments emphasise the need for more research to be done in this area (Sylvia et al., 2015) so that a stronger evidence base can be built. This disparity coupled with the dearth of literature pertaining to collaboration in a therapeutic setting was the inspiration for the current study.

1.4. Rationale and significance of the study

This study was conducted to provide a better understanding of how collaboration, using a postmodern approach (narrative therapy), can enhance the quality of life of clients diagnosed with BD. The limited literature regarding the treatment of BD using a postmodern, collaborative approach suggests an urgent need for more research.

Long term management of BD usually involves pharmacological intervention. However, a substantial proportion of individuals starting with maintenance treatment will have an episode within two years: Gitlin, Swendsen, Heller and Hammen (1995) suggest this figure is as high as 60%. Psychological interventions can reduce the rate of relapse and improve symptoms (Oud et al., 2016). There is a need to improve current therapeutic techniques as well as develop novel interventions for people with BD and their families within the therapeutic context. This is the purpose of the current study.

The research focuses on BD as it is one of the most common psychiatric illnesses (Aldinger & Schulze, 2017) and causes the loss of more disability-adjusted life years (DALYs) than all types of cancer and major neurological conditions, including epilepsy and Alzheimer’s disease (Merikangas et al., 2011). Aldinger and Schulze (2017) note that even in euthymic states, patients with BD may suffer from neuropsychological impairments, such as mnestic deficits and a reduced psychological capacity, negatively impacting their participation in daily life, social integration, and employment. Prevalence rates are also a cause for concern. Estimated lifetime prevalences are 0.6%–1.0% for bipolar I subtype; 0.4%–1.1% for the bipolar II subtype, and 2.4%–5.1% for subthreshold (spectrum) forms of the disorder (Berk et al., 2013) (see Chapter 2, Section 2.2. for further detail of the BD subtypes).

1.5. Conceptual framework

The effects of collaboration on the quality of life of those with BD as well as the impact it may have on their significant others’ lives is the topic of this study. Currently, literature mainly focuses on psychological interventions such as CBT, Family-Focused Therapy (FFT), the early warning approach and psychoeducation as adjuncts to pharmacological treatment. Limited attention has been given to the use of collaboration in a therapeutic setting.

The variables under study include collaboration and quality of life (Figure 1-1). The independent variable, collaboration, can take place between two individuals (the mental healthcare professional and the client), and it may also include other professionals in the medical field as well as family members or close friends of the client seeking treatment for BD. Collaboration involves a mutually agreed upon goal for intervention outcomes. Chapter two explores collaboration in greater detail.

Quality of life, the dependent variable in this study, is a broad concept but in general is understood to be subjective and refers to the evaluation of human experience (Costanza et al., 2007) and the way in which individuals perceive their position in life, taking into consideration contextual factors such as value systems and culture with regards to their goals and experiences (Martin-Subero et al., 2014). The concept of QoL is expanded upon in chapter three.

1.6. Research objectives and questions

The aim of this study was to determine whether a postmodern, collaborative approach to therapy would assist in improving the quality of life of patients presenting with BD, as well as their significant others. The study focused on a sample of clients who are currently seeking, or who have sought, therapeutic intervention from a narrative therapist. Their subjective experiences and perceptions of the therapeutic process comprise the data for the study.

The objectives of this study were:

a) To explore the effects of collaborative therapy on the QoL experienced by individuals diagnosed with BD.
b) To explore the effects of collaborative therapy on the QoL of the significant others of those diagnosed with BD.
c) To explore the effects of collaborative therapy on communication between significant others and individuals diagnosed with BD.
d) To explore how involving other medical professionals in the therapeutic process facilitates change.

The main questions that directed the focus of this study were:

a) What is the impact of a postmodern, collaborative approach on communication between the client with BD, their significant others and/or the medical professionals involved?
b) Is a collaborative, postmodern approach to treatment effective in terms of enhancing the subjective QoL of those with BD?

1.7. Ethical issues

Due to the sensitive and deeply personal nature of the research, the following ethical issues were considered and addressed by the researcher as recommended by Alpaslan (2010): informed consent, confidentiality, and management of information, autonomy, nonmaleficence, beneficence and cultural context. Principles put forth by Emanuel et al. (2008) such as social value, fair selection of participants, scientific validity, ongoing respect for participants and study communities and favourable risk/benefit ratio were also adhered to during the course of this study (Wassenaar & Mamotte, 2012). An in-depth description of each of these ethical concerns is provided in Chapter three (Section 3.7).

1.8. Structure of the thesis

This thesis has been structured into six chapters and also contains appendices which provide additional information pertaining to the study.

Chapter 1: In this chapter the reader has been introduced to the study and its background as well as the main aim and objectives of the research. The research questions which directed the focus of the study were presented, as well as an outline of the thesis structure.

Chapter 2: This chapter includes a review of the literature pertaining to the study as well as a definition of BD, its effects and treatment. Also included are definitions of postmodernism, collaboration and a narrative orientation followed by an explanation of the chosen theoretical framework, ‘quality of life’ (QoL).

Chapter 3: The research design, sampling procedures, data collection and analysis methods and ethical considerations will be discussed in this chapter.

Chapter 4: The data findings are presented in this chapter.

Chapter 5: Here, an integration of the findings and literature will be provided and the implications of the findings for research, theory and application will be discussed.

Chapter 6: Included in this chapter are the concerns, recommendations and limitations of the study.

2. CHAPTER 2 – REVIEW OF THE LITERATURE

2.1. Introduction

This chapter explores the nature and scope of BD, its social impact, and available pharmacological and psychotherapeutic treatments for the condition. In addition, the concept of collaboration will be introduced and the value of narrative therapy with respect to collaborative interventions will be explored.

2.2. Bipolar disorder

BD, previously known as manic-depressive disorder, is a mood disorder that is typically diagnosed during young adulthood according to DSM-5 (American Psychiatric Association, 2013). Appendix A lists the criteria for diagnosis of BD. According to Johnson, Applebaum and Otto (2013) BD can be described and understood on the basis of manic symptoms that can differ in both duration and severity. The term BD is thus used to refer to a spectrum of difficulties with BD presenting in three main forms: Bipolar I, bipolar II and cyclothymic disorder. These three forms are distinguished by their diagnostic features. In this dissertation the term 'bipolar disorder' (BD) will be used to refer to the full spectrum of difficulties, unless otherwise specified by the particular subtype. The principal feature of a manic episode in Bipolar I disorder is a readily discernible period of time during which:

> there is an abnormally, persistently elevated, expansive, or irritable mood as well as persistently increased activity or energy that is present for most of the day, nearly every day for at least one week (or any duration if hospitalization is necessary) (American Psychiatric Association, 2013, p.127).

For a diagnosis of Bipolar II disorder, a major depressive episode lasting for at least two weeks and a hypomanic episode lasting at least four days, must be present. Cyclothymic disorder, sometimes referred to as subthreshold BD or bipolar disorder not otherwise specified (BD-NOS), includes enduring fluctuations between low and high moods that, due to a lack of severity, do not meet the criteria for depressive or hypomanic episodes but continue for two years, or one year in children and adolescents (Johnson et al., 2013; Van Meter et al., 2017).

For Bipolar I disorder, the mean age at onset of the first depressive, manic, or hypomanic episode is 18 years of age. The average age of onset for Bipolar II disorder is the mid-20’s but onset can be in the later stages of adolescence or during the course of adulthood (American Psychiatric Association, 2013). When diagnosed at an earlier age, it has been found that the course of BD is more severe and that there is a higher risk for suicidality (Perlis et al., 2004).

For a diagnosis of Bipolar I disorder, the criteria for a manic episode have to be met; major depressive or hypomanic episodes are not required (American Psychiatric Association, 2013). The distinctive period of time during which the individual displays an abnormally, persistently elevated, expansive, or irritable mood together with persistently increased activity (American Psychiatric Association, 2013) is the key characteristic of a manic episode. During this time, the individual is likely to not recognise the need for treatment and may even strongly oppose treatment efforts. In a manic episode, individuals may alter their physical appearance to a more ostentatious or sexually suggestive style, experience an increased sense of vision, hearing or smell and a decreased need for sleep. S/he may display poor judgement, and speech is often noticeably rapid, loud and pressured. Self-esteem is frequently exaggerated and can extend to delusional levels. While experiencing a manic episode, the person with BD may have an increased sense of sociability and a tendency to disregard the demanding nature of these interactions, whether it be with strangers, work colleagues or old friends. The individual is also likely to engage in activities such as shopping sprees, unsafe sexual relations and ill-conceived business ventures, despite the possibility of disastrous consequences (American Psychiatric Association, 2013). Bipolar I disorder affects males and females equally whereas Bipolar II disorder is more common in women (Grande et al., 2016). Known risk factors influencing the prognosis of BD include stress-inducing life events and experiences, family history, severe childhood abuse, and substance abuse comorbidity (Burgin & Gibbons, 2016).

Depressive disorders and BD are significantly different although depressive symptoms can occur in BD (Michalak, Torres, Bond, Lam & Yathan, 2013). One such difference is that BD has a notable genetic element, and evidence points toward a shared biological etiology with schizophrenia, a mental health disorder which includes a loss of contact with reality as one of its most prominent symptoms

(Leonenko et al., 2018). While the peak age of onset for depressive disorders is usually in the late twenties, the onset of BD can occur earlier, around the teens and early twenties. Depressive disorders occur considerably more frequently than BD. Finally, according to Merikangas et al. (2011) those diagnosed with BD respond to medications that have minimal effect for those with depressive disorders.

After a clinical assessment has confirmed the presence of either manic or hypomanic symptoms, a diagnosis of BD can be made (American Psychiatric Association, 2013; See Appendix A). Michalak et al. (2013) argue that the clinician needs to make enquiries into the severity and pattern of depressive symptoms as these are regularly the most incapacitating feature of BD. By reviewing the pattern of mood changes as well as the intensity of manic/hypomanic and depressive symptoms, the clinician is able to distinguish between the BD diagnostic categories. Berk et al. (2013) suggest that depression is the main phase in BD and causes the most psychosocial disability, with people generally spending three times as long experiencing a depressive episode than they do experiencing a manic one.

A complex disorder, BD encapsulates the extremes of mania and depression and often occurs together with other conditions (Johnson et al., 2013). Those diagnosed may experience a range of challenges with professional and personal issues. Risk of relapse is high even after remission, and suicide rates are significantly higher than for the general population (Pompili et al., 2013). Appendix A summarises the diagnostic criteria for BD, and the following sections describe the prevalence of the condition, the functional impact of BD and associated comorbidities.

2.2.1. Prevalence of bipolar disorder

According to DSM-5 the 12-month prevalence estimate of bipolar disorder I in the continental United States is 0.6% (American Psychiatric Association, 2013). Across eleven countries, the 12-month prevalence fluctuated from 0% to 0.6% (Merikangas et al., 2011). The lifetime male : female prevalence ratio is in the region of 1.1:1. The 12-month prevalence for Bipolar II disorder is 0.3% and 0.8% in the United States (American Psychiatric Association, 2013).

In the general population, cyclothymic disorder appears to be equally common in both females and males, although in clinical settings female patients might be more likely to request treatment than their male counterparts (American Psychiatric Association, 2013). Lifetime prevalence of cyclothymia stands at around 0.4% to 1% while in mood disorder clinics, prevalence ranges between 3 and 5% (Perugi, Hantouche, Vannucchi, & Pinto, 2015). An epidemiological study by Regeer et al. (2004) in the Netherlands, found that cyclothymia may be experienced by up to 4.2% of people.

Merikangas et al. (2011) found that there is little information regarding the prevalence and correlates of the BD spectrum in global population-based studies. They, thus, set out to elucidate the prevalence, impact, patterns of comorbidity and service utilization for BD via the WHO Mental Health Survey Initiative. According to combined approximations of the prevalence of BD, around 1.0% of the general population meet lifetime criteria for BD I. Prevalence rates for BD II, only provided by one investigation, indicated a median lifetime prevalence of 1.2%. More recently, a review of BD I and II using the DSM-IV in population studies revealed an aggregate cross-study lifetime occurrence estimate of 1.2%, extending from 0.1% in Nigeria to 3.3% in the United States. The results of the study, focusing on a pooled sample of eleven countries, revealed lifetime prevalence rates of 0.6%, (BD I), 0.4% (BD II) and 1.4% (cyclothymia/subthreshold BD) (Merikangas et al., 2011). India has the lowest lifetime and 12-month prevalence of BD (both at 0.1%), while the United States has the highest (4.4% and 2.8% respectively). The results for Japan and Colombia were unexpected: Japan is a high-income country with notably low lifetime and 12-month prevalence rates of BD (0.7% and 0.2%) while Colombia, a low-income country revealed a high lifetime prevalence of BD of 2.6%. The study found higher rates of BD I and subthreshold BD in males than in females, whilst females showed higher rates of BD II. Family income, employment and marital status were not significantly linked to BD (Merikangas et al., 2011).

Determining prevalence rates for paediatric BD is more challenging. Although it is known that many individuals with BD experience their first episodes early in life, there are fewer studies that focus on prevalence in children and adolescents and less is known about the paediatric/adolescent experience of BD. Prevalence estimates of mood disorders in children and adolescents vary extensively although it is generally concluded that they occur less in children than in adults and increase markedly in adolescence (Garber & Carter, 2006; Barlow & Durand, 2009). As per the DSM-IV, bipolar I and II and BD-NOS generate a collective prevalence rate of 1.8% (in non-US communities) to 2.7% (in the US) in youths age 12 or older. Rates of diagnoses for children and adolescents have increased significantly and the growing number of young people needing intervention –pharmacological and psychotherapeutic, educational and other special services– has lead to increasing interest from researchers, clinicians, and the community into diagnosis, epidemiology and intervention for this population (Atladottir et al., 2014; Egan, 2008; Miller, Smith, Klein, & Germán, 2010; Olfson, Blanco, Wang, Laje & Correll, 2014; Polanczyk, Salum, Sugaya, Caye & Rohde, 2015; Sahakian & Morein-Zamir, 2007).

2.2.2. Functional impairment

Individuals diagnosed with BD experience significant impairment in their day-to-day lives. However, there has been limited literature focusing on the impact of functional impairment, although this has started to change. In the last decade research now focuses more on functional recovery in BD patients than clinical remission (Sanchez-Moreno, Martinez-Aran & Vieta, 2017). Functional impairment is an important criterion in terms of the DSM-5 (American Psychiatric Association, 2013) from which the diagnostic criteria for BD were introduced in this chapter and in Appendix A. This section focuses on ways in which BD affects the diagnosed individual, their family and society at large as an appreciation of the functional impairment of BD is important to understand the condition.

Functional impairment involves multiple domains such as independent living, occupational and educational achievement, ability to establish interpersonal relationships, engage in romantic life, and recreational activities (Rosa et al., 2012; Sanchez-Moreno et al., 2009; Zarate, Tohen, Land & Cavanagh, 2000). Both bipolar I and II disorders have an impact on individuals' functionality (American Psychiatric Association, 2013).

A substantial percentage of persons diagnosed with BD show severe impairment in work role function which often results in lower socioeconomic status regardless of equivalent education levels with the general population. Those with BD do not perform as well on cognitive tests as healthy individuals, and this may contribute to work-related and interpersonal difficulties that continue even when the individual is in recovery (American Psychiatric Association, 2013). In BD, cognitive deficits affect domains such as mental flexibility, verbal fluency, attention, decision-making and memory (Buoli, Caldiroli, Caletti, Zugno & Altamura, 2014). Sole et al. (2012) aimed to ascertain whether BD II patients in a (precisely defined) state of euthymia presented with neurocognitive disturbances. Participants showed cognitive impairment which in turn influenced psychosocial functioning. Sole et al. (2012) also reported that:

- Patients with bipolar II disorder in remission show cognitive dysfunction in attention, verbal memory, and executive functions.
- The presence of sub depressive symptomatology and executive dysfunction may influence these patients' psychosocial functioning.
- Neurocognitive rehabilitation should be considered in each subtype of BD to improve functional outcome (Sole et al., 2012).

Similarly, the results of a study by Rosa et al. (2010) indicate that a higher level of functional impairment can be observed in those in depressive states, followed by patients in a hypomanic episode. Clients with BD, despite being in clinical remission, showed poorer psychosocial functioning in comparison to those in the control group (Rosa et al., 2010). Buoli et al. (2014) found that even in euthymic states, individuals diagnosed with BD show cognitive impairment in various domains, and in particular in frontal cognitive abilities such as problem solving, memory and judgement.

Depressive or manic episodes may lead to emotional, family, social, occupational, academic and financial problems, and individuals experiencing a manic episode may cause damage to significant relationships, spend money recklessly, lose their jobs or engage in sexual transgressions (Sadock, Sadock & Ruiz, 2015). According to the DSM-5, anxiety disorder is present in nearly three quarters of those diagnosed with bipolar I disorder, and substance abuse often co-occurs with this disorder (American Psychiatric Association, 2013) which can add to the negative impact experienced in various spheres of life. Sullivan and Miklowitz (2010) note that "*families of adults with BD (and families containing children at risk for BD) are less organized, less cohesive, and experience more conflict than families of healthy individuals.*" (p.60).

For individuals with early onset BD the functional impact can be considerable. Miklowitz, Biuckians and Richards (2006, p.1248) describe the way in which BD can ‘derail’ a young person’s development, sometimes irrevocably, in their social, intellectual, and emotional development. Challenges faced may include “*frequent missed episodes, continuous cycling, impairment in academic and social functioning, suicidality, psychosis, and comorbidity with disruptive, anxiety, and substance misuse disorders*” (p.1247). Potter (2013) argues that having a BD diagnosis can make normal life decisions appear complex and significant life choices overwhelming. The associated effects of BD on the family with diagnosed children include distress, and notable economic, emotional and practical burdens. Parents with children with BD regularly develop depression and, often due to the stigma linked to mental illness in society, become contenders for psychiatric treatment themselves (Miklowitz et al., 2006; Perlick, Hohenstein, Clarkin, Kaczynski and Rosenheck, 2005).

Given the high prevalence rates of BD –it has been estimated that approximately 1 to 3% of the population are diagnosed with the condition (Johnson et al., 2013; see section 2.2.1)– the potential economic impact of the disorder is great. Das Gupta and Guest (2002) conducted a study which aimed to estimate the yearly socioeconomic cost exacted on the UK by BD. The study estimated:

a) the annual costs of managing BD from the perspective of the National Health Service (NHS);
b) the annual costs resulting from BD borne by other statutory agencies, such as local authorities and the criminal justice system; and
c) the indirect annual costs to society due to unemployment, absenteeism from work and premature mortality.

The annual cost attributable to BD diagnosed in 297 000 people was estimated to be 2 billion British pounds or around 6919 pound per person diagnosed. Four percent of this cost was estimated for use of non-healthcare resources, 10% for NHS resource use and 86% for indirect costs. Poor physical health is often linked to BD, as well as the possibility of limited access to appropriate screening and treatment for both cardiovascular and metabolic illnesses (Goodwin, 2012).

2.2.3. Comorbidity

Comorbidity can be defined as the co-occurrence or coterminous presence of two independent conditions at above chance levels (Parker, 2010). BD is known to be linked to a range of clinical comorbidities that affect the individual's family life, interpersonal functioning and work (Johnson et al., 2013). Goodwin and Jamison (2007) note that two-thirds of patients with BD have a comorbid psychiatric condition, with anxiety, behaviour and substance use disorders being the most common conditions identified in community-based and clinical studies. Merikangas et al. (2011) found that three-quarters of individuals diagnosed with BD met the criteria for another lifetime disorder as per the DSM-IV while more than half have three or more other disorders. At 62.9%, anxiety disorders and in particular, panic attacks are the most frequently found comorbid conditions, with behaviour disorders next (44.8%) followed by substance use disorders (36.6%). Persons diagnosed with BD I and BD II showed significantly higher rates of comorbid disorders: 88.2% and 83.1% respectively, in comparison to those with subthreshold BD[2] which had a rate of 69.1%. Kessler et al. (2005) found within a community epidemiological sample, hypomanic symptoms were more related to childhood externalizing disorders[3], anxiety disorders, and substance abuse than to depressive symptoms. Looking across the different countries that participated in their study, Merikangas et al. (2011) observed that patterns of comorbidity with anxiety and substance use disorders were similar across countries, although comorbid behaviour disorders were higher in the United States and New Zealand compared with the other participating countries. Comorbidity can negatively impact the outcome of BD as multiple disorders compound difficulties and compromise management, e.g. treating an associated anxiety disorder with a selective serotonin reuptake inhibitor antidepressant can trigger a manic episode.

Anxiety disorder is commonly associated with BP. Simon et al. (2004) suggest that over half of the individuals diagnosed with BD match the criteria for anxiety disorders and others authors estimate a higher figure of 62.9% (Merikangas et al., 2011).

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[2] Symptoms that fail to meet the criteria for the disorder (Merikangas et al., 2011).

[3] Externalising disorders refer to disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder and conduct disorder (Jenson, Harward & Bowen, 2012).

Simon (2009) referred to the National Comorbidity Survey which suggests that 17% of individuals diagnosed with Generalised Anxiety Disorder (GAD) also have BD. Fifty-one percent of individuals with BD had at least one type of lifetime anxiety disorder although rates were higher for BD I than for BD II. Simon (2009) notes that comorbid anxiety can negatively influence the course of BD and that anxiety disorders that coexist with BD are linked to earlier age of onset for BD, a reduced QoL, substandard role functioning, lower prospects for recovery, significantly less time spent in a euthymic state, a greater lifetime possibility of suicide attempts as well as greater risks of comorbid substance use disorder (SUD). Simon (2009) focused on patients who entered the Systematic Treatment Enhancement Program for bipolar disorder (STEP-BD), pointing out that individuals with BD and GAD experienced far shorter euthymic states than clients with BD only. Taking the longest time spent in a euthymic state into account, the average for the BP-GAD individuals was less than half than the clients with BD alone. Those with comorbid GAD lost approximately 29 more well days during the 12 months of follow-up in comparison with persons without an anxiety disorder.

Having comorbid GAD raises the risk of suicide: "*Around twice as many clients with BD and GAD have at least one suicide attempt in their past, compared to those without GAD (Simon, 2009). For patients with BD and current GAD, 62% reported having attempted suicide. For those with BD and lifetime GAD, the rate was about 53% compared to 22% of those without a lifetime anxiety disorder*" (Simon, 2009). Impulsivity, one of the fundamental traits of BD, has previously been theorised to be tempered by the presence of a comorbid anxiety disorder. However Taylor et al., (2008), using the Barratt Impulsiveness Scale, have shown that BD patients who also have an existing anxiety disorder have a significantly higher level of impulsivity than those without an anxiety disorder. Higher levels of baseline panic attack frequency, anxiety sensitivity, worry, fear of negative evaluation and phobic avoidance led to the prediction of higher impulsivity at the 9-month follow-up. Despite statistical adjustments for gender, SUD comorbidity, current mood episode and age, the link between anxiety symptoms and increased impulsivity in BD patients was still present (Simon, 2009; Taylor et al., 2008).

Simon (2009) concludes by arguing that in spite of the multiple instances of comorbidity, GAD is typically underdiagnosed as well as undertreated in those with other psychiatric conditions, in particular, BD, MDD and SUD. Individuals with anxiety disorders comorbid with other disorders are at an increased risk for suicidality, disability, a reduced QoL and impairments in role functioning. Prudent selection of treatment is recommended which should take into consideration each disorder so as to ensure optimal treatment outcome (Simon, 2009).

Behaviour disorders include oppositional defiant disorder (ODD), conduct disorder (CD) and attention deficit hyperactivity disorder (ADHD). Childhood attention deficit disorder or ADD is regularly co-morbid with BD (Nierenberg et al., 2005), as are eating disorders (McElroy et al., 2011). George, Miklowitz, Richards, Simoneau and Taylor (2003) state that obsessive personality disorders and histrionic personality disorder are most often observed in BD out of all the personality disorders. However, Johnson et al. (2013) point out that studies tend to exaggerate the incidence of comorbid personality disorders in BD by considering personality symptoms during mood episodes.

Substance abuse is prevalent amongst those diagnosed with BD, and men in particular have an increased risk of abusing substances (Hunt, Malhi, Cleary, Lai & Thiagarajan, 2016). SUDs are reported to be up to ten times more common in individuals with depressive illness, schizophrenia and BD, compared to the general population (Nesvåg et al., 2015). Alcohol use disorder (AUD) is strongly associated with BD, with co-morbidity of AUD in BD reaching 45% (Cardoso et al., 2008; Kessler, Rubinow, Holmes, Abelson, & Zhao, 1997). Regier et al. (1990) report estimates from community studies showing rates as high as 61% of those diagnosed with BD meet the lifetime diagnostic criteria for substance and alcohol dependence or abuse. The odds ratio for AUD in bipolar I disorder is higher than for bipolar II disorder (3.5 and 2.6 respectively) (Farren, Hill & Weiss, 2012). Together BD and AUD result in a substantially increased risk of associated psychopathology including longer duration of alcohol withdrawal, increased severity of manic and depressive symptoms, increased suicide risk, poorer prognosis, higher cost, increased morbidity and overall decreased degree of function (Cardoso et al., 2008; Feinman & Dunner, 1996; Strakowski, Delbello & Adler, 2005; Van Zaane, van den Berg, Draisma, Nolen, & van den Brink, 2012).

BD is concomitant with numerous features and comorbid conditions including mixed features and rapid cycling (Lai, Cleary, Sitharthan & Hunt, 2015). Mixed features, commonly seen in both bipolar I and II disorder, involve presenting with three or more symptoms of either mania, hypomania or depression during an episode from the opposite pole (American Psychiatric Association, 2013). The likelihood of substance abuse or suicidal behaviours increases when manic/hypomanic symptoms occur with depressive symptoms and individuals who have this pattern regularly need more rigorous treatment (Valenti et al., 2011). Rapid cycling, most often seen in those who develop bipolar symptoms at an early age, is defined as a pattern where an individual experiences four or more mood episodes a year, and can be triggered by factors such as particular types of antidepressants and sleep deprivation (Carvalho, Dimellis, Gonda, McIntyre & Fountoulakis, 2014). According to Nierenberg et al. (2010) in cases of rapid cycling there is an increased possibility that the anxiety, depression and mania will be severe and that the disorder will be chronic.

Manic episodes and their symptoms have a high comorbidity with both medical and psychiatric issues which can have a significant influence on outcomes (Johnson et al., 2013). The association between BD and high risk of untimely death is well known, with the foremost cause of excess mortality being cited as comorbid cardio-vascular disease (Leboyer et al., 2012). Individuals with a diagnosis of BD have 40% higher general medical costs than the costs of those in the same age and gender groups (Simon & Unützer, 1999).

Comorbidity can be difficult to accurately estimate. Parker (2010) cautions that most population-based studies report lifetime or 12-month data as opposed to current status, so that a precise definition of comorbidity is seldom put into practice and the results typically increase comorbidity estimates. Current status is frequently conflated with longer-term status largely because of the way in which typical psychiatric surveys are approached in a community sample. Interviewees are given a set of base questions to answer in relation to each disorder which, if confirmed, produce secondary questions to determine if adequate criteria are met for that particular disorder. Here, the likelihood of false-positive diagnoses of ADHD and conduct disorder are high as individuals diagnosed with BD are likely to have mood states driving inner tension, behavioural disturbances, anger and poor concentration.

Estimates are also inflated by moving beyond the precise definition of comorbidity (i.e., two independent conditions at one time point) where any additional diagnosis across the lifespan is taken into account (Parker, 2010).

2.2.4. Developmental considerations

2.2.4.1. Mood disorders in childhood

The DSM-5 does not distinguish child/adolescent onset from adult onset of BD and there is no separate listing for this group. Clinicians are required to make the diagnosis of BD in children and adolescents using the given criteria (American Psychiatric Association, 2013). The general consensus with regard to mood disorders is that they are intrinsically similar in children and in adults (Barlow & Durand, 2009; Weiss & Garber, 2003), although, as will be discussed in this section there are some important differences in the nature of BD over the lifespan. Although there are case studies of children as young as four years old presenting with the symptoms of BD, it is relatively rare in childhood (Barlow & Durand, 2009). BD prevalence rates increase considerably in adolescence and many adults report experiencing their first onset in their teens (Barlow & Durand, 2009).

BD among children and pre-adolescents is known as paediatric bipolar disorder (PBD) and affects approximately 1–2% of the population (Goldstein & Birmaher, 2012; Van Meter, Moreira & Youngstrom, 2011; West et al., 2014). When DSM-5 criteria are strictly applied a higher prevalence for BP-spectrum conditions is reported than BP I alone. BP-NOS diagnosed in youth is often a ‘gateway’ to a later diagnosis of BP-I or BP-II (Goldstein & Birmaher, 2012).

PBD is characterized by extreme episodic mood dysregulation accompanied by symptoms that significantly impair multiple domains of functioning (West et al., 2014). Symptoms may include a decreased need for sleep, hypersexuality and impulsivity. PBD is distinguishable from adult-onset BD by features including mixed mood states, rapid cycling, developmentally-specific psychosocial impairment and psychiatric comorbidity (Geller et al., 1995; Pavuluri, Birmaher & Naylor, 2005; West et al., 2014). Children with PBD display academic underperformance, neurocognitive deficits and disruptive school behaviour in comparison with healthy peers (Geller et al., 2002; Henin et al., 2007; Pavuluri, O’Connor, Harral, Moss & Sweeney, 2006;

West et al., 2014). For those with PBD, peer relationships are characterised by inferior social skills, peer victimisation and inadequate peer networks (Geller et al., 2002; West et al., 2014).

Barlow and Durand (2009) note that the nature of depression changes with age. In children under the age of three years, depression appears to be manifested through facial expressions, sleeping and eating patterns, and play behaviour in ways quite different from those in the nine to twelve age group. Parry and Levin (2012) suggest that onset of BD in the preschool age cohort is characterised by irritability as the core feature, not elevated mood. Luby and Mrakotsky (2003) emphasise the importance of setting aside the strict two-week duration requirement for the diagnosis of a mood disorder in children six years and under (preschool age) as mood fluctuations are generally understood to be normal. In addition, if these children have patently manifested the symptoms of anhedonia[4], irritability and sadness, then four symptoms as opposed to five seem sufficient. Even these core symptoms of hopelessness, social withdrawal, excessive sleep and anhedonia appear to alter with age, usually becoming more severe over time (Barlow & Durand, 2009; Garber & Carter, 2006; Weiss & Garber, 2003). Evidence indicates that dysthymia –persistent mild depression– is more prevalent in young children than major depressive disorder (MDD) but this ratio reverses in adolescence. As with adults, adolescents experience MDD more often than dysthymia (Barlow & Durand, 2009). MDD is predominantly a female disorder, with puberty seemingly triggering this sex imbalance (Garber & Carter, 2006).

Children below nine years of age appear to present with emotional swings and more irritability as opposed to typical manic states, and they are regularly mistaken as being hyperactive (Barlow & Durand, 2009). Children –boys in particular– have a tendency to become aggressive and destructive during depressive episodes and because of this, both childhood depression and mania are at times misdiagnosed as ADHD or CD. Symptoms in children are more chronic (always present) as opposed to the episodic nature seen in adults, and this presentation seems to carry on through adolescence (Biederman et al., 2000). However, adolescents typically

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[4] Anhedonia refers to a decreased capacity to feel pleasure, most notably in similar experiences previously perceived as pleasurable (Ho & Sommers, 2013).

appear more manic (Barlow & Durand, 2009). CD and depression regularly co-occur (Barlow & Durand, 2009). Biederman and colleagues (2000) found that 37% of children diagnosed with ADHD also met the criteria for major depression and between 60% to 90% of children and adolescents with mania also have ADHD (Singh, DelBello, Kowatch & Strakowski, 2006).

Barlow and Durand (2009) caution that mood disorders in both children and adolescents, regardless of presentation, should be taken seriously because of their possible consequences. Aggression, impulsivity, sexually provocative behaviour and a tendency to be accident-prone may be observed in adolescents with BD (Barlow & Durand, 2009; Doerfler, Connor & Toscano, 2011).

There is a substantial body of research suggesting that adolescents identified with MDD are at increased risk for the occurrence of anxiety disorders, suicide attempts, nicotine dependence, drug and alcohol abuse, early parenting and educational underachievement when compared to those who are not depressed (Barlow & Durand, 2009; Fergusson & Woodward, 2002; Lewinsohn, Rhode, Seeley, Klein & Gotlib, 2000; Weissman et al., 1999). Risk factors for additional depressive episodes as adults including being female, a higher percentage of family members experiencing depressive episodes and conflicts with parental figures (Barlow & Durand, 2009). Even subthreshold symptoms[5] which develop in adolescence can pose a risk, as shown by Fergusson, Horwood, Ridder and Beautrais (2005) who found that severity and extent of depressive symptoms as an adolescent predicted suicidal behaviours and depression as an adult. It is clear that depression in children or adolescents is a dangerous event and should be taken seriously, treated immediately and prevented if at all possible (Barlow & Durand, 2009).

As with adults, pharmacotherapy is the first-line treatment for PBD. However, it is complicated by "*low response rates, poor tolerability, and inability to address the full range of impairments associated with PBD*" (West et al., 2014, p.1169). Due to this, adjunctive psychosocial intervention is of vital importance for treatment efficacy (McClellan, Kowatch & Findling, 2007). Family functioning in families with PBD, when compared to those unaffected, is typically characterised by low levels of

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[5] Subthreshold symptoms refer to those that are not severe or numerous enough to meet the criteria for the specific disorder (Barlow & Durand, 2009).

cohesion, strained relationships and increased conflict and family dysfunction and stress increases according to symptom levels (Geller et al., 2000; Goldstein, Miklowitz & Mullen, 2006; Keenan-Miller, Peris, Axelson, Kowatch & Miklowitz, 2012; Kim, Miklowitz, Biuckians & Mullen, 2007; Rucklidge, 2006; West et al., 2014; Wilens et al., 2003) meaning that psychosocial treatments that contextualize the individual in his/her broader family unit environment are important. However, few psychosocial treatments for younger individuals diagnosed with BD have been studied systematically. Adapted versions of Dialectical Behaviour Therapy (DBT) (Goldstein et al., 2015) and Interpersonal Social Rhythm Therapy (IPSRT) (Hlastala, Kotler, McClellan & McCauley, 2010) for teenagers with BD have been tested in pilot studies. However, Multi-family Psycho-education Group Psychotherapy (MF-PEP) for youth with BD or unipolar depression aged 8–12 (Fristad, Verducci, Walters & Young, 2009) and Family-Focused Treatment (FFT) for adolescents aged 13–18 years old (Miklowitz et al., 2008b) are the only two interventions to have shown efficacy in randomised controlled trials. Both MF-PEP and FFT demonstrated positive effects on mood severity in children and depression relapse in adolescents, respectively.

Disruptive mood dysregulation disorder (DMDD) has been added to DSM-5 to account for children with extreme emotional and behavioural issues with the prominent feature of non-episodic or chronic irritability (Copeland, Angold, Costello & Egger, 2013; Dougherty et al., 2014). According to some, this phenotype had been conceptualized as paediatric bipolar disorder (PBD) (Wills, 2014; Pogge et al., 2001), but evidence from community and clinical longitudinal studies suggests that such irritability is associated with later unipolar, but not bipolar, mood disorder (Brotman et al., 2006; Copeland et al., 2013; Leibenluft, Cohen, Gorrindo, Brook & Pine, 2009; Stringaris, 2011).

DMDD is defined by severe temper tantrums that are disproportionate to the situation, inconsistent with developmental level, and occur at least three times per week. Mood between outbursts is persistently angry or irritable, and symptoms must be present for at least 12 months in at least two contexts. DMDD cannot be diagnosed in children before the age of 6 years and must be observed by 10 years (Dougherty et al., 2014).

The inclusion of this disorder in the DSM-5 is not without debate. Concerns centre on the potential consequence of pathologising common childhood behaviour, the possibility of increased medication use in young children, and the lack of an empirical basis for the definition (Axelson et al., 2012; Copeland et al., 2013; Parens, Johnson & Carlson, 2010; Stringaris, 2011; Taylor, 2011). Dougherty et al. (2014) suggest that little is known about the disorder and most support for DMDD stems from research related to Severe Mood Dysregulation (SMD). SMD is characterised by severe and chronic irritability along with hyperarousal symptoms, sharing many of its symptoms with depression, oppositional defiant disorder (ODD), ADHD and mania (Dougherty et al., 2014; Leibenluft, Blair, Charney & Pine, 2003). SMD was originally conceptualised as a possible phenotype for BD but this was not supported as longitudinal studies indicate that both SMD and dimensional measures of chronic irritability predict unipolar depressive and anxiety disorders, rather than BD (Brotman et al., 2006; Dougherty et al., 2014; Leibenluft et al., 2011; Stringaris, 2011).

Childhood and adolescent mood disorders are important topics requiring further research. However for the purposes of this study and due to various ethical obstacles and the availability of participants, this study will focus on young adults diagnosed with BD in their childhood, their significant others involved in the therapeutic process, and parents of those with BD, rather than children and adolescents themselves.

2.2.4.2. Mood disorders in the elderly

Despite the fact that mood disorders are a substantial healthcare concern for the elderly (Charney et al., 2003; Sajatovic, Madhusoodanan & Coconcea, 2005) BD has not received much empirical attention and there is limited data for this population (Goldstein, Herrmann & Shulman, 2006). BD usually manifests before the age of 30 and it has been estimated that nearly 90% of patients will be affected by the age of 50 (Hirschfeld, Lewis & Vornik, 2003; Oostervink, Boomsma & Nolen, 2008). Thus, around 10% of the population may present with BD for the first time after 50 years of age. This validates the findings of two studies which found that approximately 8% and 9% of patients with BD were aged 65 years and 60 years or over, respectively, at the time of their first contact with mental health services (Almeida & Fenner, 2002; Oostervink et al., 2008).

The results of numerous studies point towards differences between elderly and younger BD patients (Oostervink et al., 2008). Mania appears to be less severe in the elderly; the onset and course of illness differs; more elderly patients had experienced three or more depressive episodes before their first manic episode, and elderly people are found to be more likely to relapse into depression after mania (Oostervink et al., 2008). Linked to mood disorders in the elderly are issues such as disability, a reduction in one's QoL, increased need for health services, functional decline and marked caregiver burden (Charney et al., 2003; Sajatovic et al., 2005).

2.2.5. Aetiological factors

In this section, the biological and environmental factors related to BD will be examined. It is generally believed that these factors are integrative, working together to result in the occurrence of BD. However, to facilitate ease of reading and understanding, the researcher has chosen to present the aetiological factors underneath separate headings.

2.2.5.1. Biological factors

A metareview of the literature on the neuropsychology and neuroanatomy of bipolar disorder (Bearden, Hoffman & Cannon, 2001) showed that significant cognitive impairment may be present in bipolar illness, suggesting a possible toxic disease process. They suggested that the functional correlate of these cognitive deficits may be white matter lesions in the frontal lobes and basal ganglia. The etiology of these brain abnormalities, and their corresponding functional deficits, remains unknown (Bearden, Hoffman & Cannon 2001).

Evidence for the heritability of BD is compelling and prolific with scientific advances now able to indicate which genes are involved in the causes of mood disorders and that more than one gene plays a part (Baron, 1997; Edvardsen et al., 2008; Goodwin 2012; McInnis et al, 1998; Johnson et al., 2013). These authors describe studies involving families, twins and adoption which indicate that genetics play a significant part in the development of mood disorders. One twin study suggested estimates of up to 85% heritability for BD (McGuffin et al., 2003) and Goodwin (2012) described an 80% concordance rate in identical twins. It has been suggested that heritability appears to be distinct for manic and depressive symptoms within BD (Johnson et al., 2013). McGuffin et al. (2003) revealed that 71% of genes involved in causing mania are separate to those responsible for depression.

Neurochemicals such as serotonin, dopamine, noradrenalin/norepinephrine and gamma amino butyric acid (GABA) have long been thought to either directly or indirectly lead to the occurrence of mood disorders (Ashok et al., 2017). They can cause either mania or depression, depending on the interaction between the neurotransmitters and the levels in the brain (Austin et al., 2009). Norepinephrine was initially believed to be the primary neurotransmitter linked to BD, and the so-called dopamine hypothesis has dominated discussions of BD pathophysiology for several decades. Current research however, has shown that although the most widely used pharmacological treatments of BD provides relief from symptoms, it has no effect on noradrenergic pathways and thus the norepinephrine hypothesis has been abandoned. Similarly there are aspects of the neurobiological mechanisms of dopamine that are poorly understood (Ashok et al., 2017).

2.2.5.2. Environmental factors

Conceptions of BD as a genetically based biological disorder have been the most influential for the past century. However, the role of psychosocial processes in the onset, course, expression, and treatment of BD spectrum disorders has become increasingly emphasised (Alloy et al., 2005). This is mainly due to recognition that genetic and biological processes are unable to fully account for differences in the expression, timing and nature of symptoms observed, and that drugs' prophylactic effects are limited. Understanding the role of psychosocial factors in all aspects of BD is critically important. Austin et al. (2009) explain that stress is implicated in the development of mood disorders due to its emotional, cognitive, physical and physiological effects or changes on the body.

Stress-inducing life events and experiences, family history, severe childhood abuse, and substance abuse comorbidity are known risk factors influencing the prognosis of BD (Sigitova, Fisar, Hroudova, Cikankova & Raboch, 2017). Goodwin (2012) notes, in particular, that stress in adolescence is likely to influence the onset and course of BD, while Ellicott, Hammen, Gitlin, Brown and Jamison (1990) emphasise negative life events, and Miklowitz, Goldstein, Nuechterlein, Snyder and Mintz (1988) consider the importance of expressed emotion. Expressed emotion is a measure of the emotional attitudes of key relatives (Koenig, Sachs-Ericsson & Miklowitz, 1997) and can be understood as hostility, overinvolvement or family criticism directed at the person diagnosed with BD (Johnson et al., 2013). Other psychological and social variables have been noted as influencing factors in terms of being able to predict the course of disorder (see Johnson et al. 2013) essentially underscoring the importance of environmental factors and the wide-ranging factors that this may encompass.

In terms of neurobiology and symptomatology, there are many similarities between bipolar and unipolar depression (Cuellar, Johnson & Winters, 2005). This means that variables such as neuroticism which consistently predict unipolar depression also predict bipolar depression (Johnson et al., 2013; Lozano & Johnson, 2001). Negative life events and low perceived social support predict higher rates of bipolar depression over time according to prospective studies (Johnson et al., 2013). Yan, Hammen, Cohen, Daley and Henry (2004) emphasise the importance of expressed emotion which is highly predictive of depressive symptoms within BD and understood to be damaging for the course of symptoms in this disorder. Numerous studies provide evidence of the presence of overly negative cognitive styles in individuals with BD linked to the severity of prior and present depressive symptoms. Negative cognitive styles and low self-esteem predict an increase in depression over time (Cuellar et al., 2005; Johnson & Fingerhut, 2004).

Unlike with depression, psychosocial variables are not strong predictors of manic symptoms (Johnson et al., 2013). Two forms of predictors of mania: goal dysregulation and sleep deprivation/schedule disruption, are explained by available models. The goal dysregulation model suggests that extreme goal engagement may culminate in mania (Johnson et al., 2013). Individuals who have experienced mania in the past described themselves as having an increased sensitivity towards rewards in that they feel stimulated by the chance to chase goals and extremely happy when their goals were accomplished (Meyer, Johnson & Winters, 2001). Individuals with BD show high levels of frustration when goals are not achieved which helps connect reward sensitivity theoretically to symptoms of irritability in a manic episode (Wright, Lam & Brown, 2008). An intense focus on goals as well as a high degree of sensitivity to rewards may amplify reactivity to success leading to it being more likely that the symptoms of mania will appear after a goal-attaining life event. Johnson et al. (2013) explain that for those diagnosed with BD, reward responsiveness levels are higher, and this sensitivity can predict the course of the disorder.

Even when in remission, individuals with BD often place great value on goals and subscribe to more extreme life ambitions than those without the disorder (Johnson, Eisner & Carver, 2009; Lam, Wright & Smith, 2004). There is also evidence that individuals who are inclined towards manic symptoms may respond with elevated changes in cognition when faced with positive mood states; confidence specifically seems to be elevated after a period of positive mood (Mansell & Lam, 2006). Persons with BD who had an overly positive view of themselves were more likely to relapse over a period of six months; high confidence levels then inspire participation in even more challenging goals further increasing chances of manic symptoms within the subsequent two months (Lam, Wright & Sham, 2005; Lozano & Johnson, 2001). Johnson et al. (2013 p.326) explain that individuals with BD "*appear to overinterpret the meaning of hypomanic symptoms, taking them as signs to move forward and conquer goals*".

Sleep deprivation and schedule disruption are emphasised as triggers for manic episodes. Disruption of sleep caused by life events such as having a child or going on a long-haul flight often result in manic episodes in those with BD (Johnson et al., 2013). Experimental studies found that as little as one night of sleep deprivation can cause manic symptoms for over 10% of BD patients (Barbini et al., 1998). Ehlers, Frank and Kupfer (1988) argue that various social timekeepers or "*social zeitgebers,*" including jobs that have changing work hours, may interfere with daily rhythms. The Social Rhythm Metric (SRM) is used to measure the constancy of daily schedules (Monk, Frank, Potts & Capfer, 1990 in Johnson et al., 2013). Ashman et al. (1999) noted that SRM scores were lower amongst BD individuals, and Jones, Tai, Evershed, Knowles and Bentall (2006) reported fewer habitual activities in those with BD although their SRM scores were not lower in comparison to healthy controls. Children of parents with BD also appeared to have disrupted patterns of habitual activities. Together these studies indicate that disruption of social rhythm is impaired in BD, although the precise nature of the disruption requires elucidation.

Some studies indicate that children and adolescents diagnosed with BD have experienced more negative life events and fewer positive events than controls (Watson et al., 2014). Whilst childhood trauma is a well-documented indicator for poor prognosis in MDD, the influence of negative early childhood experiences has been the focus of less research for BD. Studies using the Childhood Trauma Questionnaire (CTQ) regarding the effects of childhood trauma on the development and course of BD indicate a higher rate of childhood trauma and emotional abuse (Aas et al, 2016; Fowke, Ross & Ashcroft, 2012; Spinhoven et al., 2014; Watson et al., 2014). Watson et al. (2014) found significant associations between BD and early childhood trauma and higher CTQ scores in both bipolar I and II clients in contrast with healthy controls.

The causal basis of BD, and other mood disorders remains unclear as there is clearly not only one particular cause for any of the mood disorders, and the dynamics of the interaction between the causal variables have yet to be fully identified. In African countries in particular, there is a need to elucidate the factors that result in BD (Segal & Douki, 2005), and the paucity of information specific to our context creates difficulties with regards to treatment because intervention strategies are typically based on etiological aspects of the disorder (Austin et al., 2009). Environmental and psychological factors play a key role in treatment with regards to handling the consequences of the disorder.

Individuals diagnosed with BD regularly question whether or not their children will develop BD. Literature suggests that children of parents with BD "*have a fourfold increase in risk for developing a mood disorder compared to children of parents without a psychiatric diagnosis*" (Johnson et al., 2013, p. 233). However, it should also be noted that most children do not develop BD and that there are many early intervention programs aimed at prevention of BD. Genetic factors interact with environmental factors in complex ways and there is a need for more work into understanding the interplay between genes and environment, and protective environmental factors that may lead to resilience.

2.3. Treatment of bipolar disorder

This section provides a review of treatment approaches to BD. Many of the approaches are beyond the scope of this research and therefore this review is selective in its focus on the most commonly used approaches and those most pertinent to the study.

Conventionally, the elimination of symptoms is the main objective of therapy for BD Intervention efforts focus on present symptoms and the prevention of future depressive, manic or hypomanic symptoms as persisting symptoms increase the chance of relapse (Geddes & Miklowitz, 2013). Berk et al. (2013) suggest that there are three main, coexisting goals for the optimal management of bipolar depression: 1) effectively treating the acute episode; 2) integrating the gains of acute treatment and stopping a depressive relapse from occurring (or a switch to hypomania/mania, and, 3) managing risk factors. Psychotherapy for clients with bipolar depression sets out to address problems such as anhedonia, depressed mood, decreased motivation, suicidal behaviours, interpersonal challenges, maladaptive thoughts, inconsistent routines and difficulties managing emotions (McMahon, Herr, Zerubavel, Hoertel & Neacsiu, 2016).

Sanchez-Moreno et al. (2017) consider that functional impairment in BD is a neglected research area, despite the fact that many patients experience substantial impairments in their everyday lives. Functional impairment refers to difficulties in domains including occupational and educational achievement, independent living, recreational ability and the ability to establish interpersonal relationships and engage in a romantic life (Sanchez-Moreno et al., 2017). Intervention should not only consider euthymia as the ultimate goal but also the cognitive and functional improvement of patients. Minimising the impact BD has on an individual’s functioning is essential for improving the person’s well-being and will ultimately assist in lowering the cost and burden to society. There is a great need for interventions that prevent cognitive and functional impairment in the early stages of the disorder.

2.3.1. Pharmacological interventions

Pharmacology is the most typically used treatment for all three phases of BD (Harrison et al., 2016). Antipsychotics are the first-line treatment (Harrison et al.,

2016) and mood stabilisers such as lithium and valproate are often given to adults with BD (Popovic et al., 2011). Mood stabilisers are used to combat relapse to the poles of the disorder, prevent recurrence and treat acute episodes (Goodwin, 2012; Johnson et al., 2013). Antidepressants can be used to treat depressive symptoms (British Psychological Society, 2006a,b) however, there is limited evidence that using anxiolytic agents or benzodiazepine medications, in addition to mood stabilizers, is effective for bipolar episodes (Johnson et al., 2013; Nemeroff et al., 2001; Simon et al., 2004). Berk et al. (2013, p.33) note:

> Despite the absence of clear evidence for their effectiveness, antidepressants are widely prescribed for BD and are the most widely used medication class for the depressive phase of the illness… A meta-analysis (Sidor & MacQueen, 2011) of the most recent, large-scale and rigorous trials found that they were discouragingly negative.

As a class, atypical antipsychotic agents are not effective in treating bipolar depression and those such as olanzapine and quetiapine which show some efficacy have clinically relevant limitations and side-effects for some patients, e.g. weight gain metabolic syndrome (Berk et al., 2013).

Pharmacological treatment for BD can be complicated and it is not uncommon for multiple medications to be used, or for many medication changes to occur before the optimal combination and dosage are found (Gitlin & Frye, 2012). The decision regarding which treatment to use varies according to the individual’s past and current symptoms including severe depression or mania as well as severity of symptoms, mixed or psychotic features and rapid cycling, comorbidities, history of response/tolerability of treatments and individual preference (Berk et al., 2013; Malhi, 2012; Nivoli et al., 2011). Repeated instances of chronic subsyndromal symptoms and mood episodes, especially depressive episodes, seem to be typical features of BD regardless of the use of medication even though many improvements have been made in the development and use of pharmacology. With this in mind, researchers have paid attention to psychological interventions as an accompaniment to medication.

2.3.2. Therapeutic interventions

Despite a smaller body of research, clients who take part in intensive psychosocial treatment have better functional outcomes in comparison to those who receive routine pharmacological care over a period of 1–2 years (Miklowitz, 2008). Adjunctive psychotherapy enhances the symptomatic and functional outcomes of BD over a 2-year period, supporting the view that drug treatments cannot support clients with BD in isolation (Malhi, 2012). Regardless of the differences in theoretical frameworks and how the therapy is administered, when it comes to the prevention of relapses in BD, most of the methods draw on similar aspects. These include the encouragement of medication adherence, maintenance of a daily routine and regular sleeping pattern, psychoeducation about the disorder, development of problem-solving and coping skills, monitoring of one's mood, detection and interpretation of early warning signs as well as implementation of strategies to prevent the development of full-scale episodes (British Psychological Society, 2006a,b).

2.3.2.1. Family-focused therapy

Family interventions for BD are often psychoeducational. This means family members, significant others and clients themselves are given information about BD and its treatment, training for phase-specific management strategies, lifestyle regulation and problem solving. Each of these aspects should be tailored to the specific needs of the patient and his/her family (Berk et al., 2013). Therapy that takes into consideration the family of the individual with BD, or group psychoeducation for caregivers, may aid these significant others to adjust to the illness, provide support to the person with BD and improve communication (Berk et al., 2013; Miklowitz, Goodwin, Bauer & Geddes, 2008). Improved social support and relationships between family members is likely to have a positive impact on depressive symptoms (Lauder et al., 2010).

Family environment is central for understanding the development and maintenance of severe psychopathology such as BD, and thus the family is an important component of therapeutic interventions. Researchers have linked the course of BD with expressed emotion and deliberated over whether the use of marital or family approaches to therapy may aid in the reduction of BD symptoms (Johnson et al., 2013; Koenig et al., 1997; Yan et al., 2004). Family-focused therapy (FFT) "*provides psychoeducation for patients and their family members, and draws on family interventions that have effectively improved family communication and delayed response in schizophrenia*" (Johnson et al., 2013, p. 330). Families receive coaching with regards to problem-solving and communication. They are encouraged to articulate both positive and negative feelings, listen to each other and ask for changes in the behaviour of others in appropriate ways.

In a study by Miklowitz, George, Richards, Simoneau and Suddath (2003), 101 individuals with BD were randomly assigned to either clinical management that is, a less intensive therapy, or to FFT while continuing to take the standard, prescribed medication. After 21 sessions, patients and their family members were assessed for two years, every 3–6 months. The results indicated that FFT was linked to a longer period before relapse and lower levels of symptoms, in comparison to clinical management. Significant interactions between time and treatment were observed for depression but not mania scores, suggesting that FFT may be more effective for managing depression symptoms of BD.

Miklowitz (2008) investigated efficacy of psychotherapy as an adjunct to pharmacotherapy for the treatment of BD in adolescents. Those who were assigned to family therapy had quicker recovery rates from depressive states, spent less time experiencing acute depressive episodes and overall had a more promising trajectory of depressive symptoms over two years than adolescents who only received short-term psychoeducation and pharmacotherapy. Family therapy, together with interpersonal, social rhythm therapy and systematic care interventions, resulted in benefits for clients who began participating in the study when in moderately or acutely ill states (Miklowitz, 2008). Clients with BD from families with a high measure of impairment or conflict show a greater stabilisation of depressive symptoms when taking part in family therapy than the clients from families with low degrees of disturbance.

A variety of psychosocial therapies including interpersonal therapy, cognitive-behavioural therapy, family-focused therapy, a focus on circadian rhythm and sleep-wake routines can play a major part in assisting clients with BD to tackle the social and psychological elements that influence mood instability, ultimately assisting them in managing the disorder (Geddes & Miklowitz, 2013; Soares-Weiser et al., 2007; Stein et al., 2015). These types of interventions allow for symptom severity reduction, relapse prevention and improved psychosocial functioning typically working together with medication maintenance treatments.

Progress in both pharmacological and psychosocial treatment in early-onset BD shows that early intervention may result in more positive outcomes. FFT slows down the occurrence of relapses and decreases the severity of symptoms among adult clients with BD (Miklowitz et al., 2006). FFT is also known to boost medication adherence and the emotional tone of family relations. In a comparative two year study of FFT (with standard medication) vs. a short-term psychoeducational treatment known as Crisis Management (CM) (and medication), participants in FFT were shown to have greater survival rates without relapse (52%) than participants in the CM group (17%). FFT proved more effective than CM in decreasing depressive symptoms, and to a smaller degree, manic symptoms. Those engaged in FFT also experienced lower levels of psychotic symptoms during the follow-up stages of the research and were more consistent in taking medication (Miklowitz et al., 2006). A second trial by these authors contrasted individually-focused psychoeducational treatment (IFPT) vs. FFT, again both treatments also included medication. During the first year of treatment, survival analyses showed no dissimilarities in rehospitalisation or relapse rates, but clients taking part in FFT had fewer relapses during a 1- to 2-year post-treatment period and were less likely to need hospitalisation when relapse did occur, in contrast to those participating in IFPT. Adjunctive FFT appears effective in delaying relapses and averting the need for rehospitalisations by training family members to identify relapses timeously and to seek emergency treatment. FFT is also likely to augment medication adherence and enable positive family interchanges which bring about improvements in mania and depressive symptoms (Miklowitz et al., 2006).

The apparent efficacy of FFT strengthens the researcher’s belief in the need for collaborative therapeutic practices. Yet, the use of the word ‘family’ could be viewed as exclusionary. Collaborative therapy, on the other hand, makes provision for all those the individual with BD views as significant and is not limited to family members alone. The word ‘collaboration’ implies choice; the significant other chooses to be involved in the therapeutic process and truly engage, while FFT may seem mandatory and family members, in some cases, may feel obliged to take part rather than having an authentic willingness to learn about BD and assist in bringing about changing dynamics.

2.3.2.2. Cognitive behavioural therapy

CBT involves psychoeducation about BD and includes interventions geared towards better treatment engagement (Johnson et al., 2013). It also places emphasis on recognising maladaptive negative thoughts about the self and aims to provide the skills needed to restructure these negative patterns of thinking (Berk et al., 2013). The British Psychological Society (2006a) defines CBT as "*discrete, time limited, structured psychological interventions derived from the cognitive behavioural model of affective disorders*" (p. 3) where the client works *collaboratively* with the therapist to recognise feelings as well as the types of thoughts, beliefs and interpretations of present symptoms and their effects. Lam, Jones, Haywood and Bright (1999) developed a CBT manual which contains strategies to support self-calming during the initial stages of a manic episode and to lessen excessive goal engagement. The manual created by Otto et al. (2009) provides anger and anxiety management and assertiveness skills training components which can be used in addition to the central treatment features of the approach.

Lam et al. (2003) conducted a trial to test the efficacy of CBT comparative to standard medicinal treatment as an intervention for BD. The intervention comprised 12–18 sessions within 6 months and two 'booster' sessions in the second 6 months of therapy. A marked reduction in bipolar episodes was noted, together with less depression and higher social functioning during the first year of follow-up, in contrast to the control group. The outcome in the two year follow-up study indicated substantial benefits in terms of CBT's efficacy in lessening depressive symptoms, although this was not the case in terms of manic symptoms. Similarly, to test a comprehensive CBT intervention that augmented regular cognitive interventions with tactics to aid in sleep and activities regulation, Scott, Garland and Moorhead (2001) randomly allocated individuals with BD to a waiting-list condition or to CBT. At 6- and 18-month follow-ups, there were pronounced improvements in depressive symptoms and global functioning reported by those assigned to CBT, however changes in manic symptoms were insignificant.

Zaretsky, Lancee, Miller, Harris and Parikh (2008) found that positive improvements in depressive symptoms could not be explained by the psychoeducation component of CBT alone. They randomly assigned clients with BD to six sessions of psychoeducation exclusively, or to the same, followed by 14 CBT sessions. Those who were allocated to the CBT group exhibited a considerable decline in depressive symptoms in comparison to those who did not take part in CBT interventions. The study was a relatively small pilot project with only 46 participants completing the intervention. Despite these favourable results, a large-scale study conducted by Scott et al. (2006) which aimed at exploring the benefit of CBT in a community setting, elicited disappointing results. The researchers examined the effect of 22 CBT sessions versus ‘treatment as normal’ for 253 patients. At the 18-month follow-up, the groups showed no changes in symptom intensity or reduction in time to episode recurrence.

It is clear that CBT is a useful intervention for BD, especially when it comes to controlling depressive symptoms (Johnson et al., 2013). Yet, questions persist about whether this type of therapy is useful in community settings and to date there is limited evidence as to whether all types of CBT are effective for the treatment of manic symptoms. For this reason, it is important to continue developing and researching interventions that may have the potential to effectively treat both the manic and depressive symptoms of BD and be used in both community and individual settings.

2.3.2.3. The early warning approach

The early warning approach is based on the premise that when clients are able to detect the initial signs of an episode, steps can then be taken to deter a full-blown episode from occurring (British Psychological Society, 2006a,b). Individuals diagnosed with BD can reliably report early signals of relapse although it appears easier to note the early signs of mania rather than early warnings of a depressive episode (British Psychological Society 2006b; Lam, Wong & Sham, 2001). Patterns of early warnings however, as well as the length of early warning periods, are not the same for all individuals (Jackson, Cavanagh & Scott, 2003; Lam & Wong, 2005; British Psychological Society, 2006a,b). A cross-sectional study found that the level of functioning of individuals with BD was highly related to how well they coped with the early warning signs and that adaptive cognitive and behavioural coping strategies for early warnings resulted in fewer manic symptoms, better functional outcomes and reduced relapses (Lam & Wong, 2005). Early warnings signs of a depressive episode include interrupted sleep, an inability to put one's worries aside and a loss of interest. Signals of a manic episode may include racing thoughts, increased activity, a decreased need for sleep and being more social (British Psychological Society, 2006a,b).

Although this intervention may be useful in predicting the onset of either a depressive or manic episode and thus coping with it, it would seem as though not much attention is given to helping the significant others of those with BD. A missing element of this intervention strategy is collaboration between all those affected by the disorder; educating significant others about BD in general as well as early warning signs would be highly beneficial and may lead to long term improvements in terms of QoL for all involved.

2.3.3. Traditional interventions

The belief that mental health issues are caused by "*demonic possession by witches and ancestors*" (Madzhie et al., 2014, p. 320) is common amongst indigenous people of South Africa. In a study conducted in the Thulamela Municipality of South Africa, researchers found that traditional healing is positively viewed as an alternative form of healthcare provision (Madzhie et al., 2014). Forty-five percent of patients attending a community mental health clinic had initially consulted a traditional healer for their problem and 26% were making use of both psychiatric and traditional healing services (Madzhie et al., 2014).

The consequence of mental illness is behaviour not viewed as culturally appropriate, and many of these individuals fear rejection from others and will avoid seeking medical assistance (Burns & Tomita, 2015).

There is certainly a collaborative element to the work done by traditional healers – in order to be healed the person seeking help needs to have faith in the traditional healers assessment of the situation, as well as in the power of one's ancestors and witchcraft. They need to endure treatment that is often painful or unpleasant. However, there appears to be a lack of collaboration between the traditional healer, patient and their significant others, as well as other medical professionals who can provide other types of medication if necessary. In addition, there appears to be limited focus on psychoeducation and provision of coping mechanisms for mental illness or the physical components involved in mental disorders such as BD.

2.3.4. Conclusions

There are many therapeutic interventions which have been shown to have some effectiveness in treating BD. However, it remains unclear whether the approaches have been maximised for effectiveness. Are they the *most* effective they can be? There is a need to develop a therapeutic intervention that involves treating individuals diagnosed with BD, as well as their families (significant others), has a positive impact on both depressive and manic episodes and can be successfully implemented in different settings. The apparent effectiveness of existing psychosocial interventions together with a need for a collaborative relationship between therapist and client motivated the present study on collaboration in a therapeutic setting.

2.4. Towards a collaborative approach to the treatment of bipolar disorder

2.4.1. Introduction

The following section presents a definition of collaboration as well as a rationale for its use. It provides a detailed explanation of what it means to put collaboration into practice. Following this, the narrative perspective will be examined.

2.4.2. Rationale for the use of collaborative therapy

The researcher has chosen to focus on a postmodern approach to therapy. A postmodern approach strongly encourages the need for collaborative forms of therapeutic intervention. Anderson (1997) understands collaboration as being linked to postmodernism in that a postmodern approach allows the therapist to assume a

> philosophical stance that invites a collaborative relationship and process… and moves the therapist from the position of a knower who discovers and collects information and data to that of a not knower who is in a being informed position within the therapeutic setting (p. 4).

The modern era or industrial age, according to Grenz (1996) can be described as a period concerned with the production of goods and represented by the factory while postmodernity centres on the production of information typified by the computer. The twentieth century saw the invention of cars, airplanes, spaceships, television, telephones, radios and cars. Advances in medicine improved life expectancy and enhanced the QoL for people in developed nations. Science and technology were viewed as a source of hope for the future, and the 'grand narrative' of modernism was the promise of nonstop progress and the belief that humanity was on an expedition of improvement and achievement (Tarragona, 2008). The social sciences were developed in the twentieth century and aimed to locate rules to explain and predict human behaviour. Psychology grew to be understood as a science that could be approached using similar methodology and metatheories as practiced by those in the natural sciences (Tarragona, 2008). At the heart of modernism lies the belief in a "*knowable world*" (Gergen, 1990, p. 25). The modern way of thinking believed that truth can be established using scientific methods. "*Knowledge is seen as a reflection or mirror of reality, and language is thought of as representational – its function is to give us a correct representation of the world*" (Tarragona, 2008, p. 4).

Postmodernism can be used as term for a cultural epoch or historical period (Tarragona, 2008). The postmodern movement began in academe in the 1970's and was most noticeably taken up by the social sciences where it called into question the possibility of being objective observers of reality, predominantly the reality of human experience. According to Anderson (2001,) postmodernism is an "*ideological critique of universal or metanarratives, including self-critique*" (p. 344) and refers to a philosophical movement that includes the opinions of thinkers such as Jacques Derrida, Jean-Francois Lyotard and Ludwig Wittgenstein. In his book *The Postmodern Condition*, Lyotard (2000) considered that postmodernism could be simply stated as a disbelief in meta-narratives, that is, incredulity towards 'grand stories' or world views that explain everything. A meta-narrative is the predominant assumption individuals make which typically goes unquestioned as we look for neat solutions rather than seeking out contradictions or partial solutions. Grenz (1996) argues that postmodernism

> marks the end of a single, universal worldview. The postmodern ethos resists unified, all-encompassing and universally valid explanations. It replaces these

> with a respect for difference and a celebration of the local and particular at the expense of the universal (in Tarragona, 2008, p. 4).

From a postmodernist point of view there are multiple realities; that which is constructed in and through language is "*multi-authored among a community of persons and relationships*" (Anderson, 2001, p.355). Postmodernism encourages a sceptical attitude towards knowledge, its meaning, nature, power and certainty. One of postmodernism's most significant features is its view of knowledge and language as relational and generative (Anderson, 2001). Knowledge is created linguistically by people in conversational exchanges and its evolution is a cooperative process that occurs through social construction (Tarragona, 2008). Knowledge created through and in language is fluid rather than static (Anderson, 2001). As that which is created in and through language by relationships and communities is merely one of several perspectives, there is no single or more accurate reality or truth. It follows that the reality or meaning we give to experiences, people or events in our lives is not the thing itself but socially constructed in our language and social practices. Rogers (cited in Anderson, 2001, p. 345) argued that:

> The only reality that I can possibly know is the world as I perceive and experience it at this moment. The only reality you can possibly know is the world as you perceive and experience it at this moment.

Language is one of the main concepts in the postmodern critique (Tarragona, 2008). It is fluid and obtains its meaning through its use (Anderson, 2001). "*Language, as the medium of knowledge, is any mode or mean we used to communicate, articulate or express with others and with ourselves, using words, gestures, eyes, hands*" (Anderson, 2012, p. 10). Language is the main way through which one creates and makes sense of their world. Words do not necessarily tell us what something is, but rather, take on their meaning through social intercourse (Anderson, 2001). Tarragona (2008) reiterates this point by stating that *"[t]he words we use do not simply reflect or express what we think or feel, but rather language configures our ideas and the meaning of our experiences*" (p. 4).

In terms of therapy from a postmodern standpoint, the therapist should not make a decision regarding the therapeutic intervention in isolation. The intervention and course of therapy should represent the views of all involved. Thorngren and Kleist

(2002) explain that this approach serves to highlight the social nature or co-construction of reality as opposed to devaluing the skill of the therapist. Postmodernism does not promote a particular school of therapy, instead it offers a different language or set of assumptions that help position the clinician in a therapeutic relationship (Anderson, 2007).

2.4.3. Defining collaboration in therapy

The word collaboration, which has its roots in Latin, is defined as *"the action of working with someone to produce something"* (Oxford Living Dictionaries, 2016). It can also be defined as *"to work with another person or group in order to achieve or do something"* (Merriam-Webster, 2016). Developed by Harlene Anderson and Harold Goolishian, collaborative therapy or collaborative language systems (CLS) is a postmodern, social constructionist means of therapy in which language and collaboration are used to conceptualise and do therapy (Gehart, Tarragona & Bava, 2007). Collaboration refers to a standpoint, a manner of relating to clients while language is understood as the medium through which individuals create and convey meaning and lived reality. Collaboration therapy suggests that human systems are linguistic systems (Gehart et al., 2007) constructed in and through language. People are entwined in relational networks and are continuously involved in numerous conversations. These conversations may be both external and internal and it is through these conversations that individuals make sense of their experiences. Thus, language systems are also meaning-generating systems. This approach views language as something that creates or represents lived reality.

Anderson (2007) refers to the way in which she prefers to relate to others as 'collaborative relationships'. A collaborative relationship is informed by the way in which one orients the self to be, act and respond with/to another individual that encourages the other into an engagement that is shared, inquiry that is mutual and action that is communal in nature. This is a relationship where the parties involved connect and create with each other, and the responses to and in the conversation create the context for the relationship. A collaborative relationship can be understood as a social activity, a partnership or process wherein all members have a sense of ownership, belonging and participation. Anderson (2012) quotes Saint George and Wulff (2011) who propose that "*The beauty of collaborating is that there are no set* *roles; there is a flexibility and fluidity that allows for leading and following to be in motion*" (p. 14).

Collaboration or collaborative therapy is a philosophical stance that reflects a way of being *with* people (Anderson, 2007). Here 'with' is the key word as a "*withness*" process is one that is intrinsically mutual and co-operative rather than hierarchical and dyadic. This way of being communicates to the other/s involved that they are unique and worthy of being heard. This belief enables connecting, constructing and collaborating with others to become a therapeutic action that is genuine and organic and does not necessitate the use of techniques or methods (Anderson, 2007). Collaboration does however "*require room for each person to be unconditionally present, and for their contribution to be equally appreciated and valued*" (Anderson, 2012, p.14). Feeling valued and appreciated brings about a sense of belonging which produces a feeling of participation which then prompts a sense of co-owning and sharing responsibility. Together, therapy and other types of practice become *withness-insider* practices. The content, process, and outcome of therapy are mutually determined by the participants and unfold as they interact with each other; they are not determined by a linear progression prestructure. Such practice is naturally collaborative and generative and promotes customised and sustainable outcomes (Anderson, 2012).

Madsen (2007) defines the collaborative approach as "*a combination of theoretical ideas and practices from narrative, solution focused, and collaborative language systems therapies*" (p. 13). He explains that a collaborative approach reflects a focus on the attitude or stance we take in relation to clients. It is this relational stance or way in which one approaches clients, that, according to Madsen (2007) is the basis for all clinical work and which he refers to as 'an appreciative ally'. Madsen argues that clinicians can purposefully choose the way in which they position themselves in relation to others; ways that either strengthen connection, hope, respect and curiosity in therapeutic settings or that draw the clinician toward disconnection, judgement and disapproval. Madsen's (2007) 'appreciative ally' phrase refers to a stance that allows clients to experience therapists as being on their side.

Collaborative approaches have gained popularity in recent years. Madsen (2007) notes:

> "*Families have responded well to the development of more respectful and responsive ways of interacting with them, and many agencies have found that services based on a collaborative stance are both effective and cost-efficient*" (p.12).

Focusing specifically on BD, there is a sufficient amount of evidence supporting the idea that social support from significant others leads to more positive outcomes (Alloy et al., 2005). Chatterton et al. (2017) contend, as per their network meta-analysis of psychosocial therapies as adjunctive treatment of BD in adults, that psychosocial interventions are important for families as they significantly reduce risk of relapse in people with BD. By expanding the conceptualisation of the family to include those who might function as a resource or community of support –immediate and extended family members, family of choice, neighbours and friends– clinicians and client alike can then tap into what is potentially the client's most powerful resource. Madsen (2007) assumes that the important people in a client's life would wish to form a resourceful community. From this perspective, significant others as well as relevant medical professionals can collaborate in client care.

2.4.4. Collaboration in practice

To understand the concept of collaboration, it is helpful to look at how it would take place in a therapeutic setting. Putting this philosophical stance into therapeutic practice involves inviting the client into a partnership (Anderson, 2007). This is achieved by taking a learning position and providing the client with a space in which it is their choice to discuss their narrative in their own way and at a pace set by the individual/s. The practitioner should engage authentically with, and be curious about, the client's story, listening and responding in a manner that is focused and mindful. The therapist operating from a philosophical stance of collaboration observes what the client says –and does not say– and keeps in mind that doing so involves constantly interpreting or translating another's words or non-words which opens one up to misinterpretation. Thus, it is useful for the therapist to confirm with the client that s/he has heard and understood the point the client is attempting to make. Pausing or allowing silences allows both or all parties involved in the collaborative therapeutic process to listen and reflect on what is taking place in the session. This collaborative way of being provides each client the opportunity to choose and discuss issues that peak their interest and invites them into both inner and outer conversation, as opposed to constantly following a topic or train of thought the therapist thinks the client should focus on (Anderson, 2007). The following examples elucidate successful collaboration in the treatment and alleviation of symptoms in those diagnosed with BD.

In a study on collaborative care for clients with BD conducted by van der Voort et al. (2015) in the Netherlands, collaborative care was shown to significantly reduce the time participants experienced depressive symptoms. The severity of depressive symptoms also decreased notably in comparison with treatment as normal. The researchers concluded that collaborative care is an important form of treatment for individuals with BD (van der Voort et al., 2015). The collaborative approach used in that study involved contracting, the point of which is to strive to reach an agreement within the team regarding the most important difficulties and treatment activities, develop a corresponding treatment plan and draw it up as a contract. Problem-solving, monitoring of outcomes, psychoeducation and systematic relapse prevention was also addressed by specifically trained collaborative care teams of nurses and psychiatrists (van der Voort et al., 2015).

Bauer et al. (2006) also designed a collaborative care intervention to study whether a collaborative model improves outcomes for BD. The clinic-based intervention made use of a speciality team: a nurse care coordinator and a psychiatrist based in the outpatient clinic that provided care via appointment accompanied by phone and clinic contact if necessary (Bauer et al., 2006). Those respondents randomly assigned to usual care continued with their previous psychiatrist or were assigned a psychiatrist if new to the clinic where the study was conducted. The researchers found that their intervention improved long-term clinical and functional outcomes for a sample of patients who were severely ill and had a range of comorbid challenges (Bauer et al., 2006). Positive changes in QoL were also noted, and the intervention cut down the weeks spent in both affective and manic episodes. Bauer et al. (2006) concluded that those with BD can successfully take part in and experience great rewards from highly collaborative and chronic care interventions.

In his article regarding the diagnosis of BD in children, Bradfield, (2010) suggests an integrative, collaborative approach to psychotherapeutic interventions, which involves engaging the system from which the child with BD comes in a therapeutic way. This approach is aimed at the parents and siblings of the individual diagnosed with BD, as well as the client with BD. The approach can be adapted into a school-based technique which enables the child's difficulties in that environment to be tackled (Bradfield, 2010).

Stringer, van Meijel, Koekkoek, Kerkhof and Beekman (2011) describe Collaborative Care Programs (CCPs) which have their origins in somatic health care and set out to increase shared decision making and enhance patients' self-management skills. The collaborative relationship begins when patients, informal carers, and care providers have shared goals and mutual understanding of roles, expectations and responsibilities. CCPs would usually involve the patient, his/her informal carer, a nurse, a psychiatrist and/or psychologist and can be extended to include others who have the potential to play a part in treatment and care. Patients describe an improvement in QoL as a result of improved self-management (Lorig & Holman, 2003; Stringer et al., 2001). CCPs have been shown to be effective for depressive and bipolar disorders in a range of studies (Gilbody, Bower, Fletcher, Richards & Sutton, 2006; Stringer et al., 2011; Van Orden, Hoffman, Haffmans, Spinhoven & Hoencamp, 2009).

2.4.5. The value of a narrative approach

Collaboration and a narrative approach to therapy are 'natural teammates,' both with strong ties to postmodernism. Postmodernism maintains a questioning stance with regards to universal truths or meta-narratives and also acknowledges that knowledge creation is an interactive process between the individual and the community to which they belong (Anderson, 2007). This manifests in narrative therapy (NT) through the questioning of one's meta-narrative; the story the individual as well as society has written about the individual in question (Swart, 2013). When operating from a narrative perspective, the therapist and client work together to develop alternative stories to the problem-saturated narratives that thus far may have defined the individual (Swart, 2013). Once a rapport has been established between the counsellor and client, both players "*enter the relationship in a collaborative stance*" (Ngazimbi et al., 2008, p. 163).

According to clinicians who approach therapy through a narrative lens, how and what we speak and the stories we tell ultimately become how we define ourselves and who we are (Swart, 2013). The aim of narrative work is to create distance from dominant problem-saturated narratives and to give these problem narratives a name. The problem narrative's history is examined, as well as the way in which the story has shaped, and has been shaped by, the client. Taken-for granted ideas and beliefs of the society to which the client belongs are studied to ascertain how these are informing and sustaining the problem narrative (Swart, 2013). Working collaboratively, the therapist and client search for relationships and moments in the client's history where the problem narrative was not present or was untrue or was not the truth in its entirety. These moments are then used to ignite the beginning of alternative narratives. The alternative narrative is given a name, and ideas, skills, gifts and beliefs that support this narrative are investigated. The narrative approach enables the re-writing of once held *"truths"* about one's life which in turn brings about change in the future of the client as well as in the society to which they belong (Swart, 2013).

Carrey (2006), a psychiatrist who operates from an NT orientation, explains that those using a narrative orientation aim at working collaboratively with people to co-construct empowering stories about healing and coping with physical and mental illness. This work involves acknowledging that truth and knowledge are not absolute, but biographical and interpretive, rather than prescriptive and paradigmatic. Carrey (2006) argues that narrative concepts can enhance collaborative work with clients and that the collaborative approach appreciates the knowledge that therapists, parents, youth and children possess. Carrey (2006) describes placing emphasis on "*the meaning behind symptoms, on strengths, and on generating hopefulness"* (p. 97). Similarly, Swart (2013) states that narrative practices stem from the necessity of interacting with clients in a collaborative and respectful manner which enables the clients to describe their everyday experiences. NT, with its emphasis on strengths rather than pathology, is an effective way to help older adults with BD reach a greater sense of personal power and importance, regain an attraction to past pursuits and come to accept past negative feelings. NT also assists those diagnosed with BD to change ingrained stories that individuals have been telling themselves for a long time, enabling them to create their own language for their particular situations (Burgin & Gibbons, 2016).

NT incorporates particular objectives, concepts, assumptions and techniques which differ from traditional approaches to therapy. However, there are common elements which might serve as entry points for those starting to use NT in their practice. For example, both NT and Person-Centred Therapy *"aim to encourage knowledge, skills and capacities for living to become consciously recognized, and transformative"* (Payne, 2006, p. 5). Likewise, cognitive therapies and NT share a mutual desire to re-structure illogical thinking, believed to be a key factor restricting individuals from overcoming their practical or emotional challenges (Payne, 2006).

2.5. Summary and conclusions

BD has far-reaching and potentially devastating consequences for those affected and their significant others. The ability to function successfully at work is affected and this often has a negative impact on the individual's socioeconomic status. Those diagnosed with BD also experience disruptions in their relationships, academic life and social circles. Family members often experience mental health issues of their own brought about by the burden of caring for their loved one.

There are numerous treatment options for BD and medication is typically the first line of defence (Harrison et al., 2016). Clients will often undergo multiple medication alterations before the correct combination and dosage is found. Although pharmacology is effective, the use of therapeutic interventions as an adjunct is increasing in popularity. There is now a substantial evidence base indicating that functional outcomes are improved for those who receive psychosocial therapies and support in comparison to individuals treated with medication alone (Miklowitz, 2008). Psychotherapy is effectively used in conjunction with pharmacology to alleviate symptoms of BD. Current therapeutic treatments for BD have varying levels of effectiveness with interventions such as CBT and family-orientated therapies showing significant success rates. Adding CBT to typical pharmacology treatment resulted in a significant reduction in episodes of BD as well as depressive symptoms and improvements to global functioning (Johnson et al., 2013). Miklowitz et al. (2003)

indicated that FFT (along with standard medication regimes) is associated with lower levels of symptoms and longer times between relapses.

Psychosocial interventions are not without problems. Their weaknesses include questionable success in treating manic symptoms as well as uncertainty with regards to utility in community settings (Johnson et al., 2013). The use of therapeutic methods involving traditional healers is highly sought after by many South Africans due to underlying beliefs that mental health issues are linked to demonic possession or ancestral interference. For these reasons alternative ways of approaching BD treatment are still sought. The type of intervention proposed in this study can also be used with clients who do not meet the diagnostic criteria for BD but have other diagnoses or difficulties requiring support.

Studies of collaborative interventions, i.e. interventions involving a range of medical professionals, carers and significant others, have yielded positive outcomes in terms of reduced time spent experiencing depressive symptoms, time spent in manic episodes, a decrease in severity of depressive symptoms and improved long-term clinical and functional outcomes (Bauer et al., 2006; van der Voort et al., 2015). NT, in particular, has been shown to be effective for individual clients, couples and families and holds potential as an effective therapeutic support for clients diagnosed with BD. Furthermore, NT can be used to help clients rewrite their personal narratives resulting in the ability to live more fulfilling lives (Arad, 2004; Ngazimbi et al., 2008).

There is a great need for further research on therapeutic interventions that work as effective adjuncts to pharmacology treatments. In particular there remains a need for therapeutic approaches that positively impact on manic symptoms, can be applied in a range of settings, reduce depressive symptoms and result in overall functional gains. Therapy that is collaborative in nature holds potential to fulfil this brief and requires further study to confirm this assertion.

3. CHAPTER 3 – METHODOLOGY

3.1. Introduction

This chapter focuses on the methodology used for the study, describing the research design and how data were collected and analysed. QoL is introduced and defined, along with the study participants and ethical considerations. QoL was chosen by the researcher to frame this study as it is a method for measuring ways in which an intervention impacts participants' lives. With this in mind, a therapeutic intervention that takes into account the subjective QoL of those with BD is assumed by the researcher to be the most likely method to bring about positive change and to alleviate suffering.

QoL is a fitting framework because it focuses on functional aspects of an individual's life. The measurement of QoL can play a vital clinical role in psychosocial treatment supporting the selection of treatment targets that are inspiring for the client, and boost adherence to treatment (Murray et al., 2017). Murray and Michalak (2012) note that there is significant consumer interest in QoL as a treatment goal and that this focus has been matched by meticulous methodological work on the measurement of QoL in BD.

In the following section, the distinction between QoL and well-being, terms often used interchangeably, will be discussed. Thereafter, various definitions of QoL will be given.

3.1.1. Quality of life or well-being?

In recent years, researchers have focused on the influence of mental and physical illness on one's overall QoL (Theofilou, 2013). Subjective QoL is an outcome variable receiving a great deal of attention (British Psychological Society, 2006b; Jones et al., 2013). People with BD also frequently report that improved QoL is a primary treatment goal (Murray et al., 2017). Including the measurement of psychosocial and biomedical issues is an important part of bringing about positive patient outcomes, from both a clinician and client perspective. QoL is an important outcome measure when evaluating treatment (Theofilou, 2013, p.150). It has however, been argued that the subjective nature of QoL makes it hard to measure and define.

QoL is a multifaceted concept that places value on the self-perceptions of an individual's state of mind (Bonomi, Patrick, Bushnell & Martin, 2000). In general, it refers to how the individual evaluates the 'goodness' of various aspects of their life, including satisfaction with relationships and work, disposition, emotional reactions to life events and sense of satisfaction and fulfilment regarding life (Theofilou, 2013). QoL is sometimes used interchangeably with 'well-being' but this has created some difficulty in terms of creating a valid and purposeful understanding of well-being and/or QoL literature. Almost 30 years ago, early proponents of the QoL concept suggested that QoL should refer only to a person's subjective assessment of their life, while well-being should speak about objective life conditions that apply to a population in general (Theofilou, 2013). This distinction is not always upheld due to the fact that it is generally acknowledged that QoL/well-being have both subjective elements such as personal assessments of one's own life and objective elements including components external to an individual and measurable by others (Theofilou, 2013).

Costanza et al. (2007) found that QoL centres on two methodologies of measurement: one method makes use of quantifiable economic or social pointers to reveal the level to which human needs are met while the other utilises self-reported levels of pleasure, happiness and fulfilment and is called 'subjective well-being'. 'Objective' measures of QoL typically pay attention to economic, social and health indicators and make use of tools which include the UN's Human Development Index (HDI) and GDP/capita (Costanza et al., 2007). In the medical realm, health related quality of life (HRQoL) research has given rise to the creation of individual tools which focus on measuring HRQoL for particular subdivisions of the population based on status of disease, age, condition and other variables. Costanza et al. (2007) argue that while these measurements may obtain some insight into how well one's social and physical needs are fulfilled, *"they are narrow, opportunity-biased, and cannot incorporate many issues that contribute to QoL such as identity and psychological security"* (p. 268). These supposedly 'objective' measures are really stand-ins for experience identified through subjective connections made by the decision-makers, resulting in a flimsy distinction between objective and subjective indicators.

In contrast, subjective measurement tools generally pay attention to personal accounts of experiences in the individual's life that complement health, social and economic indicators, for example, the level to which perceived needs are met and the significance placed on that perceived need to one's overall QoL (Costanza et al., 2007). QOL is primarily a subjective sense of well-being, and Easterlin (2003) proposes that the term 'subjective well-being' be used as a substitute for QoL in literature. Subjective tools for assessing well-being often have methodological flaws and fail to define preference adaptation, the fact that people tend to form an opinion regarding their well-being in comparison to their peers as opposed to in absolute terms (Costanza et al., 2007).

Using QoL and well-being separately can be limiting. Further, there is no single QoL measurement tool that is usable in all disciplines, at all times and in all cultures. With this in mind, Costanza et al. (2007) recommend an integration of both approaches and propose that *"overall human QOL is a function of both the level of human needs met and the extent to which individuals or groups are satisfied with this level"* (p. 268). For the purposes of this particular study, the terms QoL and well-being will be used interchangeably.

3.1.2. Definitions of quality of life

In disciplines such as psychology, economics, sociology, environmental science and medicine, QoL refers to the complete evaluation of human experience. It represents how well or poorly human needs are met and the satisfaction or dissatisfaction of individuals or groups in various life domains (Costanza et al., 2007). Martin-Subero et al. (2014) used the WHO definition of QoL in their study pertaining to quality of life and BD and schizoaffective disorder: *"Individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations, standards and concerns"* (p.1540). This is a wide ranging concept that will be affected in intricate ways by the individual's physical and psychological health, relationships, level of independence, personal belief systems as well as their relationship to the principal features of their environment. Martin-

Subero et al. (2014) also speak of HRQoL, a concept that specifically refers to factors in people's lives that have a direct influence on their health.

An integrated definition of QoL follows:

> QoL is the extent to which objective human needs are fulfilled in relation to personal or group perceptions of subjective well-being. Human needs are basic needs – subsistence, reproduction, security, affection, etc. Subjective well-being is assessed by individuals' or groups' responses to questions about happiness, life satisfaction, utility, or welfare. The relation between specific human needs and perceived satisfaction with each of them can be affected by mental capacity, cultural context, information, education, temperament, and the like, often in complex ways. (p.269).

3.1.3. Quality of life and the individual with BD

Based largely on Kraepelin's work[6], previously held conceptions about BD were influenced by the premise that compared to those with schizophrenia, BD individuals did not experience cognitive impairment and the resultant effects on psychosocial circumstances and QoL (Sierra, Livianos & Rojo, 2005). However, research has confirmed that up to a third of people with BD display both intellectual and social impairment that persists even during asymptomatic periods. This impacts on their functioning and lowers their level of wellbeing (Sierra et al., 2005).

The cyclical nature of BD, with its many remissions and symptom-rich periods of exacerbation, can affect an individual's physical, emotional, social and functional well-being and significantly impact their overall QoL. However, the conceptual model based on studies about subclinical symptoms suggests that the majority of bipolar patients suffer from symptoms most of the time, which would considerably affect their QoL. Impairments in the QoL of patients with BD persist, even in remission (Brissos, Dias & Kapczinski, 2008; Michalak, Yatham & Lam, 2005).

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[6] Emil Kraepelin was a German psychiatrist whose work had a significant influence on modern psychiatry and the understanding of mental illnesses based on natural scientific concepts (Ebert & Bar, 2010).

In general, QoL is noticeably impaired in people with BD (Gazalle et al., 2006; Leidy et al., 1998; Vojta et al., 2001). Depressive symptoms are linked to greater impairment in family, work and social life than manic episodes (Calabrese, Vieta & Shelton, 2003) and seem to be the chief determining factor for reduced QoL in those with BD (Bauer, 2001; Brissos et al., 2008; Vojta et al., 2001).

3.1.4. Researcher definition of quality of life

For this study, QoL will refer to the individual's subjective perception of life satisfaction with regards to domains of general functioning in terms of relationships, mental and physical health and social and professional capacities.

3.1.5. Summary

QoL has been chosen by the researcher to frame this study as it is an approach to measuring the ways in which an intervention impacts the lives of participants. With this in mind, a therapeutic intervention that takes into account the subjective QoL of those with BD is assumed by the researcher to be the most likely method to bring about positive change.

3.2. Nature of research and design

A qualitative research design was deemed appropriate for gathering the necessary data relevant to the aims of the study. Qualitative research is the systematic inquiry of social phenomena in natural settings. The phenomena may include how people experience aspects of their lives, how individuals or groups behave, and how interactions shape relationships (Teherani, Martimianakis, Stenfors-Hayes, Wadhwa & Varpio, 2015). As the researcher aimed to explore the participants' subjective experience of a postmodern therapeutic intervention, a qualitative research design was deemed most suitable as it *"provides the researcher with an opportunity to study meanings"* and it also *"allows the researcher to tap into the perspectives and interpretations of participants"* (Willig, 2001, p.150). Qualitative methods of data collection and analysis are almost like listening and their strengths lie in sensitivity to multiple manifestations of expression. Qualitative methods are able to withstand and even theorise frictions and contradictions found within the data and focus on atypical cases to obtain a more comprehensive view of the studied phenomena. This is in contrast to quantitative analysis which often discards unusual cases. According to Denzin and Lincoln (2000), qualitative research is holistic and calls for the researcher to attain an understanding of the research process in its entirety.

Use of a qualitative research design to conduct this study aided in maintaining ethical standards; researchers have the responsibility to prevent any harm coming to participants (Strydom, 2011). Participants were free to call a halt to proceedings at any stage without fear of retribution. The researcher was willing to stop the interview should he have noticed strong emotional reactions to the questions and then offer the services of the clinical psychologist overseeing the research. The clinical psychologist involved in this study and with whom the clients already had a (collaborative) relationship, was present during the interviews should any of the participants have needed immediate support and/or debriefing.

This study is also an observational one. Observational studies, sometimes known as a natural experiment, are an alternative to experimental studies (Hoffman & Lim, 2007) and are regularly used in medical research (Glasziou, Vandenbroucke & Chalmers, 2004) which relies heavily on cross-sectional, case-control or cohort studies (Von Elm et al., 2014). Participants are classified into groups by the presence of an exposure, known as a cohort study, or by the presence or absence of a disease, called a case-controlled study. This is in contrast to being randomised into one group or another to ensure statistical balance (Hoffman & Lim, 2007). Observational studies can be used when experiments are neither feasible in a practical sense nor ethical in terms of using treatments in a study that are unwanted or harmful (Rosenbaum, 2005). Observational studies elucidate cause-and-effect relationships where it is not feasible to use controlled experimentation. Different types of groupings are used in observational studies. Examples include:

- Cohort studies (retrospective): Having been exposed to asbestos in the workplace or not (or at different levels of asbestos exposure) with lung cancer as the outcome.
- Cohort studies (prospective): Choosing to smoke or not to smoke with the outcome being the development of lung cancer, emphysema, or heart disease.
- Case-control studies: Being part of a group that develops disease such as lung cancer compared with members of the group that do not develop the disease.

- Case-control (genetic association) studies: Comparing children with severe chronic asthma to typical children of the same age, gender, and ethnicity to identify genes (or markers) that are associated with the disease (Hoffman & Lim, 2007, p.19).

3.3. Study sample

Participants for this study were selected using purposive sampling from clients currently seeking therapeutic treatment from a practising clinical psychologist. Purposive sampling enables researchers to select participants who are willing and available to participate and who are believed to be typical of the population under study (Terre Blanche, Durrheim & Painter, 2006).

The participants were from the Western Cape and at the time of the study were either involved in counselling with a psychologist or had officially completed therapy but continued to seek support as needed from the psychologist. The treatment centre associated with this study provides a range of psychological services from both clinical and counselling psychologists, counsellors as well as physio- and occupational therapists.

The inclusion criteria for participants for this study included

- Individuals diagnosed with BD
- Individuals aged between 16 and 30 years old
- Individuals and families who have received postmodern, collaborative therapeutic interventions from the clinical psychologist involved in this study.

3.4. Data collection strategies

The ethos of grounded theory methods was used to collect data. Grounded theory was chosen as it is *"designed to facilitate the process of 'discovery', or theory generation"* (Willig, 2001, p.32) and thus allowed the researcher to assess the usefulness of this therapeutic intervention as the study proceeded. It also permitted the opinions of the participants to be heard and incorporated into the theory as it emerged.

During the 1960's, sociologists Glaser and Strauss worked together and it was through their collaboration that grounded theory methods emerged (Charmaz, 2003). Grounded theory is now a widely used qualitative research approach. Using systematic inductive procedures for collecting, synthesising, analysing and conceptualising qualitative data, researchers create theory (Charmaz, 2003). Grounded theory procedures are aimed at creating a set of concepts that provide an in depth account of particular social phenomena. Beginning with a research topic of interest, the researcher obtains data from relevant individual cases or experiences pertaining to the topic. Following this, the researcher increasingly creates more abstract conceptual categories that clarify what these data point toward; the categories synthesise and interpret data and identify patterned relationships contained by them (Charmaz, 2003). With its emphasis on process, grounded theory allows researchers to study how individual and interpersonal processes develop, are sustained or transform. Grounded theory is particularly useful for this study as it is suitable for discovery-orientated research in areas that are under-theorised and may be utilised by researchers working from a social constructionist paradigm (Burck, 2005).

Charmaz (2000) took a constructivist approach to grounded theory, saying *"[d]ata do not provide a window on reality. Rather, the 'discovered' reality arises from the interactive process and its temporal, cultural and structural contexts"* (p.524). "*It is assumed that the interaction between researcher and participants produces the data, and ultimately the meanings that the researcher observes and defines*" (Charmaz, 1995b, p. 35). The researcher is thus a co-producer of the data.

To observe language and behaviour and obtain the necessary data within a particular context, the researcher conducted face to face, semi-structured recorded interviews with participants. Semi-structured interviews are focused and facilitated by the use of open-ended questions (Alpaslan, 2010) and involve the interviewer using a series of prompts. The questions are general in nature and the interviewer may ask further questions in response to the participants' stories (Bryman, 2012). According to Willig (2001), semi-structured interviews allow the researcher to hear the participant talk about an experience or aspect of their lives relevant to the research topic. Although this particular style of interviewing can be viewed as non-directive, the research question gives the interview direction and the questions asked by those conducting the study serve as triggers which encourage the participant to share their information. Having an interview agenda can assist the researcher to keep the research question in mind while also allowing the participants room to re-define the topic and yield new insights for the researcher (Willig, 2001). Building a good rapport between interviewer and interviewee is an important part of semi-structured interviews. This can be complicated by ambiguity inherent in semi-structured interviews in that, on the one hand, the interview has formal elements such as the fixed roles of an interviewee and interviewer, a time limit and the existence of an interview agenda while on the other, it has a conversational feel due to the open-endedness of the questions and focus on experience and narrative. Rapport can be interrupted when it becomes overtly obvious that an interview, not merely an informal conversation, is indeed in progress, such as when the interviewer needs to adjust a recording device. Researchers need to be aware that semi-structured interviews require careful negotiation of rapport so that the participant is not coaxed into divulging more than they may be comfortable with once the interview is complete.

When conducting semi-structured interviews, it is important for the interviewer to be aware of how their own social identities, that is their age, ethnicity, gender, social class and nationality, may influence the interview process and the manner in which the participant(s) contribute (Willig, 2001). Willig (2001) also suggests familiarising oneself with the participant’s day to day context to gain insight into how the interviewee understands the interview process which will allow the researcher to fully understand his/her contribution. Linguistic variability is another important aspect to consider. Certain terms and phrases may not mean the same to all interviewees. Emphasis is on meaning in semi-structured interviews as opposed to lexical comparability which means that the researcher needs to comprehend what the participant *meant* by what was said rather than *how* it was said (Willig, 2001).

Three family interviews were carried out at the practice of the psychologist involved in the study, and under her supervision, as it was necessary for the researcher to be sensitive to the emotional needs of the clients. The number of interviews depended on when the researcher felt that the data were saturated. The clients were personally contacted by the psychologist as she was aware of which clients might be interested in participating in this study. For a list of the questions used as a guide during the semi-structured interviews, please see Appendix B.

3.5. Procedures

The researcher approached the psychologist[7] involved in the study with regards to participants; she suggested participants who she thought would be suitable. The participants were invited to participate in the study via a letter (Appendix C). The interviews were conducted at the treatment centre where the psychologist works, or at a quiet, private alternative location if necessary, at a time that was convenient. Consent from the head of the treatment centre was also obtained to carry out the study (attached in Appendix D).

Two out of the three interviews took place during office hours on weekdays in the office of the psychologist at the treatment centre. The third happened on a Saturday, as this was most convenient for the participants. Each dyad (participant with BD and their personally chosen significant other) took part in private interviews; no other participants were present. Each interview was conducted on separate days and thus exposure to other participant dyads was avoided. The researcher, assistant and psychologist each had their own chair and faced the participants and their significant others who shared a double-seated couch. The researcher, assistant and psychologist were separated from the participants by a low coffee table. The researcher audio-recorded the sessions, as stated in the letters requesting participation in the study, using an iPad which was placed on the coffee table. The participants were made aware of the location of the recording device and were asked to speak loudly and clearly for ease of listening and transcribing later.

The researcher introduced himself and his assistant and outlined the nature of the research, how the interviews were to be conducted and reiterated the voluntary nature of the study as well as the participant's right to terminate the interview at any stage and to request a debrief with the psychologist present if needed. The participants were then given an opportunity to ask any questions for clarity. Thereafter the participants were asked to sign the consent forms (attached in Appendix E) if they agreed to participate.

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[7] In order to qualify as a psychologist in South Africa, an approved master's degree in psychology is needed as well as the passing of the Health Professions Council of South Africa's board exam and resulting statutory registration as a psychologist.

Using the pre-planned questions as prompts, the researcher invited the participants to tell their stories. The researcher, assistant and psychologist each had copies of the prompts. The researcher led the interviews whilst the assistant and psychologist were permitted to ask clarifying questions and where appropriate, the psychologist provided clarity for either the researcher or the participants. The assistant ensured that the interviews did not stray over the allotted time of 90 minutes.

3.6. Data reduction techniques

The Gilligan *Listening Guide* (LG) was used to analyse data. Focusing on voice, resonance, and relationships, this qualitative method aims to gain access to the inner world of the participating individual (Gilligan, Spencer, Weinberg & Bertsch, 2006). The approach is most typically used in qualitative research to analyse interview transcripts (Woodcock, 2010). The LG involves listening to the interview transcripts sequentially to bring the researcher into a relationship with a person's distinct and multi-layered voice. The researcher is helped to tune in or listen to distinct aspects of a person's expression of her or his experience within a particular relational context (Gilligan et al., 2006). At each step, one "listens" rather than "reads" as this allows for active participation by both the speaker and those listening (Gilligan et al., 2006). The assumption is that the psyche, similar to the voice, is contrapuntal as opposed to monotonic, and this is why numerous listenings are necessary. Once the interviews have been recorded and transcribed, multiple listenings also reveal to the researcher the subtle nuances of the interviewee's narrative which enables the researcher to identify and explore significant plots or themes and relationships that surface from the text (Woodcock, 2010). The LG method involves audio- or visual recordings of the participants, and therefore gaining permission from the participants to take these recordings is essential.

The first step, known as *Listening for the Plot,* consists of two parts, firstly, listening for the plot by paying attention to the stories being told, being aware of the contexts surrounding the story and identifying what is taking place, where, when, why and to or with whom (Gilligan et al., 2006). The researcher pays attention to contradictions and what is *not* said, as well as any central themes or metaphors that may occur and also identifies the cultural and social contexts within which the stories take place. According to Woodcock (2010) listening out for "*the client's stories or 'plot',* *emotional resonance, repeated words, phrases, and images, information and comments*" (p.146) is an important part of this first step. It is recommended that the researcher makes use of colour-coding to organise themes as well as using some sort of marker to highlight what may need further attention in the subsequent listenings as this allows for the creation of an evidence trail to supporting the research claims (Raider-Roth, 2005; Woodcock, 2010).

The second part of the first step in the LG method includes actively addressing one's own responses to the story (Gilligan et al., 2006). The researcher is encouraged to monitor where and when a connection is felt with the speaker, where the story moves us and where strong connections or emotions are not experienced. This helps the researcher to separate his/her experiences from those of the participant. Woodcock (2010) argues that the researcher needs to pay attention to his/her own responses during this first reading, and be aware of personal feelings, questions or misunderstandings that may arise during this stage of the research. The researcher's responses can, and should be, used as a tool to guide the research process. Focusing on one's reactions to the participants' narrative also helps to strengthen validity by paying attention to personal reflexivity (Woodcock, 2010).

Gilligan's Listening Guide involves numerous readings or listenings of interviews to gain an understanding of the interior world of the participants (Gilligan et al., 2006). The aim of the second reading is to take note of the voice of the "I" who is talking and to do so the researcher needs to follow the use of this first-person pronoun in creating what are termed *I Poem*s. The researcher follows the use of "I" by the speaker to pay attention to the individual's first-person voice and to listen to how the person speaks about themselves, and in relationship to others (Woodcock, 2010). Concentrating on the first-person voice enables the researcher "*to closely attend to the thoughts, wishes, desires, needs, conflicts, and silences spoken by the client, by tracing them in a purposeful way*" (Woodcock, 2010, p.147). Elizabeth Debold (1990) termed this *I Poems* (in Gilligan et al., 2006, p. 162). To create an *I Poem*, the researcher highlights or underlines every first-person "I", the accompanying verb as well as any words that appear to be important which are contained within the chosen passage. This must be done while preserving the order in which the phrases occur in the text (Gilligan et al., 2006). Following this, the highlighted "I" phrases are extracted and kept in the order in which they materialise and placed on a separate line, similar to lines in a poem.

The *I Poem* frequently falls naturally into stanzas, revealing a change in meaning or voice and may capture something not explicitly said but which is fundamental to the meaning of what is being stated. Although this is not always the case,

> "*the I Poem will typically pick up on an associative stream of consciousness carried by a first-person voice, cutting across or running through a narrative rather than being contained by the structure of full sentences*" (Gilligan et al., 2006, p.163).

By slicing the text in this manner, subjectivity is pulled to the foreground which gives the researcher/listener the chance to focus on the interviewee's use of "I" in their narratives (Gilligan et al., 2006).

Listening for contrapuntal voices is the third step in this form of data analysis, and brings the analysis back to the research question (Gilligan et al., 2003) whilst enabling an insight into the multiple layers of the individual's communicated experience as it pertains to the question raised. At this stage of the research, two themes are mined from the narrative that are either in tension with one another or working harmoniously with each other (Raider-Roth, 2005; Woodcock, 2010). Gilligan et al. (2006) refer to the tension or interweaving of the two themes as 'contrapuntal,' that is acting as counterpoints to each other.

The researcher starts by specifying the voices to which they would like to listen and makes a decision with regard to what the markers of this specific contrapuntal voice are. This is followed by reading the text and paying attention to one voice at a time, which is subsequently underlined. By reading the text and listening for one contrapuntal voice per reading, the researcher allows for one statement to have multiple meanings and it may thus be underlined several times. This also enables the researcher to see and hear the relationship between the first-person voice and the contrapuntal voices (Gilligan et al., 2006). Contrapuntal voices are not always in opposition to one another. They may be complementary, opposing or contradictory. The researcher can then begin to question whether one particular contrapuntal voice moves with a specific *I Poem* more than with others, if they seem opposing to each other or whether certain voices move in an entirely distinct way from the I's.

This step helps create an understanding of the "*several different layers of a person's expressed experience as it bears on the question posed*" (Gilligan et al., 2006, p.164). It is at this stage in the analysis that the researcher must single out, catalogue and sort the various strands in the interview that may relate to the research question.

Pulling together what has been learned about the participant in relation to the research question, and putting this knowledge into an essay or analysis is the final step of this method (Gilligan et al., 2006). Now, the researcher interprets the interview in a way that pulls together what has been learned. After returning to the research question and enquiring about what has been learned about it through this process, and by looking at the evidence on which one's interpretations have been based, it may become apparent that the research question needs some amending or even a full transformation, in answer to the multiple listenings. Woodcock (2010) points out that although the third and fourth listenings are mostly done in two distinct steps, they are analysed at the same time. The researcher focuses on the relationship they have to each other, how they talk to each other and what is being communicated to the researcher about the client that is significant to the research by this relational conversation.

3.7. Participants

The following biographical data were gathered from the participants with the assistance of the psychologist involved in the study in order to compile a demographic profile:

- How old are you?
- What is your preferred language?
- Where do you live?
- Describe the make-up of your family
- Are you currently at school/university or working?
- Are you involved in an intimate relationship?

Table 3-1: Participant Particulars

	Participant 1	**Participant 2**	**Participant 3**
Age	18	18	23
Preferred Language	English	English	English
Region	Western Cape	Western Cape	Western Cape
Make-up of family	Mother, Father [married], older brother	Mother, Father[married], younger sister	Mother, Father [divorced and both remarried], two younger brothers
Education / Employment Status	Recently matriculated	High School	Working
Involved in intimate relationship	Yes	Yes	Yes

3.7.1. Ethical considerations

Due to the sensitive nature of the research, the following ethical issues were considered and addressed by the researcher as recommended by Alpaslan (2010): informed consent, confidentiality, and management of information, autonomy, nonmaleficence, beneficence and cultural context. Principles such as social value, fair selection of participants, scientific validity, ongoing respect for participants and study communities and favourable risk/benefit ratio were also adhered to during the course of this study (Emanuel et al., 2008; Wassenaar & Mamotte, 2012).

3.7.2. Informed consent

Informed consent is an important determining factor for ethical research (Wassenaar & Mamotte, 2012). Informed consent involves fully informing the participants of the potential risks of being a part of the study. Potential participants must be advised about the voluntary nature of participation in the study and will be thoroughly briefed regarding anonymity and confidentiality. Wassenaar and Mamotte (2012) state that the components of consent are (a) provision of appropriate information, (b) ensuring that participants are competent and understand, (c) voluntariness in participating and freedom to withdraw at any time, and (d) formalization of the consent, usually in writing (p.18). For the present study, participants were informed of the aims and purposes of the study and of their right to withdraw from the study at any stage of the process without facing any consequences or fear of being penalised or punished in any manner.

3.7.3. Confidentiality

The researcher guaranteed confidentiality to all participants. To protect their identity, the researcher made use of pseudonyms. Follow up interviews, aimed at validating the accuracy and trustworthiness of the data provided by the participants and the researcher's interpretations thereof, were conducted. The researcher aimed to be culturally sensitive and mindful of his own subjectivity as a researcher when conducting all interviews.

3.7.4. Management of information

According to Esterberg (2002) it is of vital importance that the researcher protects participant confidentially while collecting, analysing and publishing data. Names, contact details, addresses and data were protected by means of password protected files on a laptop to which only the researcher and his assistant had access. The participants' names were not stored with the data; instead the pseudonyms were used.

3.7.5. Autonomy, nonmaleficence and beneficence

Participation in this study was voluntary and participants were free to leave at any stage. In the case of any participants withdrawing from the study, their data would have been destroyed. Participants were treated with respect, and adverse reactions brought on by the interview process were not anticipated. Nonmaleficence pertains to the requirement that the researcher ensures no harm befalls the participants as either a direct or indirect result of the research (Babbie, 2005; Wassenaar, 2006).

3.7.6. Cultural context

The researcher took care to consider the multicultural context of the research and ensure that people of all cultures were approached with due care, consideration, sensitivity and respect.

3.7.7. Social value

Emanuel et al. (2008) suggest conducting research that is of value to society or specific communities in society. Specifying those who would benefit from the research and the manner in which they may either directly or indirectly benefit from it, aids in adding social value to one’s work. The participants of this study may have benefitted both directly and indirectly from being interviewed as they were provided with a safe space within which to discuss and make sense of their experiences with BD and collaborative therapy. The findings from this study could lead to improved or even novel treatment methods in the future that may impact positively on other individuals and their families experiencing mental health challenges.

3.7.8. Fair selection of participants

Participants should be individuals best suited to address the research question (Wassenaar & Mamotte, 2012). Where applicable, excessive incentives should be avoided as they might alter participant awareness of the possible risks associated with the research. The researcher confirmed that participants had all been independently diagnosed with BD or were significant others of an individual diagnosed with BD and had received or were receiving collaborative therapy from the clinical psychologist associated with the research. To ensure the information obtained from participants would answer the research question, particular selection criteria were put into place (see Section 3.3).

3.7.9. Scientific rigour

Wassenaar and Mamotte (2012) argue that invalid and/or unreliable methods waste valuable resources, subject participants to various risks and inconvenience and generate results that are effectively worthless and unusable. Wassenaar and Mamotte (2012) view poor science as unethical. Therefore, *“[t]he design, sample,* *method, and analysis of the study should be rigorous, justifiable, feasible, and lead to valid answers to the research question"* (Wassenaar & Mamotte, 2012, p.14). To safeguard against unethical science and to ensure the generation of valid and reliable knowledge, the researcher adhered to strict ethical and methodological research guidelines, met the requirements of the University of Kwa-Zulu Natal Ethics Committee and liaised with his supervisor throughout the research process with regards to the correct implementation of the study methodology. Wassenaar and Mamotte (2012) stress the importance of competence of the researcher and his or her research colleagues to embark on the study. The researcher holds an Honours degree in Psychology as well as a Master's degree in Research Psychology. The study supervisor is a clinical psychologist with many years of research experience who has been working at the University of Kwazulu Natal for over 30 years.

3.7.10. Ongoing respect for participants and study communities

The principle of ongoing respect for participants and study communities compels the researcher to treat participants with respect both during the study and after its completion (Emanuel et al., 2008; Wassenaar & Mamotte, 2012). To do so, the researcher needs to allow the participants to withdraw at any stage and to monitor their wellbeing throughout the study. Participants must be given any new information acquired during the research and their privacy must be preserved (Easter, Davis & Henderson, 2004). In this study, participants were informed about their right to withdraw from the research at any stage and while the interviews were conducted, the clinical psychologist overseeing the research was present to provide any support and to debrief if necessary. Participants were assigned pseudonyms to protect their anonymity and data were stored in a password operated laptop to which only the researcher and his assistant had access.

3.7.11. Favourable risk/benefit ratio

A favourable risk/benefit ratio requires a reasonable balance between research burdens and benefits. The researcher must identify all possible risks to participants that may arise during the course of the study and detail ways in which to minimise these (Emanuel et al., 2008; Wassenaar & Mamotte, 2012). With regards to this study, the researcher considered the potential risk to participants was low as the practising clinical psychologist overseeing the study was present during the interviews and could intervene or debrief participants as necessary. Possible benefits were an opportunity to better the current therapeutic process and relationship with their clinician. The study also provided a forum for the participants to be heard, and a chance to verbalise their experiences with BD.

3.8. Summary

A qualitative research design using semi-structured interviews with the assistance of grounded constructionist theory was used to conduct the study. This allowed the researcher to gain an understanding of the participants' subjective perspectives of collaboration as a therapeutic intervention with regards to the alleviation of the symptoms of BD and communication between the members of the dyad and other involved health professionals.

The participants were chosen from the practice of a clinical psychologist with offices in Cape Town where they had undergone collaborative therapy and/or were still receiving support from the psychologist. Each dyad comprised two people: Young adults who had been diagnosed with BD together with their choice of significant other. Participants were recruited using purposive sampling to allow the researcher access to those willing and mentally able to take part. The psychologist was able to identify and recommend clients that were well-suited to the study.

In terms of grounded theory, the researcher started to analyse the data as it was collected from the semi-structured interviews and began to categorise the data by making notes throughout the interview process. This method allowed the researcher to ask questions as new information emerged whilst the interviews were taking place. It also allowed for awareness of themes reaching saturation. Grounded theory facilitates the generation of new theories whilst conducting the research. Using semi-structured interviews and grounded theory, the researcher was able to collect relevant data and gain insight into the personal narratives of the participants. Prompts were used to guide the interviews as well as any additional questions that were necessary to obtain rich data and a deeper understanding of the participants' experiences with the intervention. The use of Carol Gilligan's Listening Guide (Gilligan et al., 2006) enabled the researcher to analyse the data in terms of identifying dominant themes/plots, *I Poems* and contrapuntal voices. Identifying themes or ‘listening for the plot’ involves focusing on the stories being told and ascertaining what is taking place, where, when, why and to or with whom. The researcher pays attention to contradictions, what is not said as well as any central themes or metaphors that may occur. The highest ethical standards were applied throughout the research process and were viewed as intrinsic to participants’ wellbeing as well as for producing high quality research. The findings of this study will be presented in Chapter four, followed by the interpretations and implications in Chapter five.

4. CHAPTER 4 – DATA FINDINGS

4.1. Introduction

The aim of this chapter is to describe the findings of the research. The study sought to gain an understanding of the effectiveness of collaboration in the treatment of BD and its impact on the QoL of clients and their significant others. First to be presented is an introduction to each participant and their significant others. The narrative themes or plots which emerged from participants' responses within the interviews are then presented . Following this, *I Poems* extracted from the interviews will be presented. Finally, participants' contrapuntal voices –contradictions or confirmations found within the narrative– will be put forward. Additionally, focus will be directed towards other important factors that emerged during the interviews through the participants' use of repeated words or phrases and metaphors, as recommended by the Gilligan Listening Guide (Gilligan, Spencer, Weinberg & Bertsch 2006) (see Appendix F).

4.2. Participants[8]

To place the research in context and to present the participants on a more personal level, the participants are briefly introduced below. For ease of reading, participants diagnosed with BD are referred to by interview number and 'a' (e.g. Jackson is 1a); while their significant others are referred to by interview number and 'b'.

Further biographical information can be found in Chapter 3 (section 3.7).

Interview 1: Jackson (1a) and Elsa (1b) [Significant other: Mother]

'I've never had this perception of depression/ADHD is a terrible thing…'

Interview 2: Elizabeth (2a) and Monica (2b) [Significant other: Mother]

'I am so much closer to my family, I can communicate with my family'

Interview 3: Maggie (3a) and David (3b) [Significant other: Boyfriend]

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[8] Pseudonyms have been used to protect the identity of the participants as per the ethical guidelines discussed in Chapter 3

‘So I’m not some kind of psycho moron?’

4.2.1. Interview 1: Jackson and his mother Elsa

> I’ve never had this perception of depression/ADHD is a terrible thing because I’ve always seen it as a way that, the way I have it, and the fact that I have it, I can help all my friends…I’m more than happy to have it. I have no issues with it now. I just want to use it to help people.

Jackson was 18 years old at the time of the interview and had recently finished high school. He was unmarried and resided in the family home. His diagnoses included BD as well as ADHD; he was medicated for the BD but stopped taking medication for the ADHD in high school due to its side effects. Jackson was receiving treatment from the psychologist involved in this study as well as a paediatric psychiatrist. As Jackson had recently turned 18 years of age, he needed to start seeing an adult psychiatrist and had recently met with him for the first time.

4.2.2. Interview 2: Elizabeth and her mother, Monica

> If I have the option because the benefits of doing it this way far outweigh anything else like I am so much closer to my family, I am so much closer to my family. I can communicate with my family… it’s a way healthier relationship

Elizabeth was 18 years of age and attending high school at the time of the interview. She had been diagnosed with BD and ADHD. She was receiving treatment from the psychologist involved in the study as well as a psychiatrist. She began seeing an adult psychiatrist the year before the interview took place. Elizabeth’s father was also diagnosed with BD at the age of 33, around the same time that a very young Elizabeth began showing the symptoms of BD. The family suspects that Elizabeth’s fraternal grandmother may have BD too.

4.2.3. Interview 3: Maggie and her boyfriend, David

“So I’m not some kind of psycho moron?”

Maggie was 22 years of age at the time of the interview and involved in a long-term, live-in relationship with her boyfriend, who also took part in the interview. She was employed full-time and was no longer having treatment with the psychologist involved in the study. She was looking for a new psychiatrist at the time the interview was conducted. Her diagnoses included both BD and ADHD.

4.3. Narrative themes

Gilligan's Listening Guide was used to uncover the participants' stories/plot. Emotional resonance, repeated words and phrases were used to extract dominant themes (refer to Appendix F for repeated words and phrases).

Each of the themes identified by the researcher are listed in tables for each of the interviews (Tables 4-1 to 4-3). The themes that are dominant and similar to each other, across all the interviews, are listed in the final table (Table 4-4). The dominant themes and contrapuntal voices are presented in the section following the tables.

Two of the participants had their mothers present as an involved significant other; the third invited her romantic partner/boyfriend to take part in the interview. Participants diagnosed with BD are referred to by interview number and 'a'; while their significant others are referred to by interview number and 'b'. The researcher conducting the study is referred to as the *Interviewer*, his research assistant shall be known as the *Assistant* and the psychologist associated with the study, the *Psychologist*. The psychologist involved in this study works closely with a particular psychiatrist, referred to as the *Psychiatrist* in this research.

Table 4-1: Interview 1 with Jackson and his mother

DOMINANT THEMES	SUBTHEMES
Early onset BD	
Comorbidity	
Helping others	Attention seeking; Form of Authority; Meaning making
Relevance of diagnosis	Feeling of relief; Stigma
Illness management	Psychoeducation; Strict with others regarding medicine but not with himself; Importance of medication; Importance of therapy
Relationships	Mother-Child; Family; Friends
Collaboration	Reliance on professional support system; Shared responsibility; Not alone – parent; Not alone – BD individual; Openness/Sharing/Communication; Openness /Sharing leading to trust; Coping mechanisms; Involvement of significant others; Reluctance to accept someone new in collaborative relationship
Silver-lining	Finding reasons to be happy about having BD
Acceptance	Accepting the BD diagnosis
Prevalence	Many fellow students appear to experience mental health issues
Difficulty of being the significant other/Parent of an individual with BD	Fear, confusion, loneliness, guilt associated with being the significant other – especially mother – of an individual diagnosed with BD

Table 4-2: Interview 2 with Elizabeth and her mother

DOMINANT THEMES	SUBTHEMES
Early onset BD	
Comorbidity	
Helping others	Meaning making
Relevance of diagnosis	Feeling of relief; Stigma
Illness management	Psychoeducation; Importance of medication; Importance of therapy
Relationships	Mother-Child; Family; Friends
Collaboration	Reliance on professional support system; Shared responsibility; Not alone – parent; Not alone – BD individual; Openness / Sharing / Communication; Openness/Sharing leading to trust; Coping mechanisms; Involvement of significant others.
Hereditary	Father and paternal grandmother have BD
Lack of diagnosis	Consequences of paternal grandmother and father not being diagnosed with BD earlier
Overshare	Sharing diagnosis when not necessary or relevant to the situation
Difficulty of being the significant other/Parent of an individual with BD	Fear, confusion, loneliness, guilt associated with being the significant other – especially mother – of an individual diagnosed with BD

Table 4-3: Interview 3 with Maggie and her boyfriend

DOMINANT THEMES	SUBTHEMES
Early onset BD	
Comorbidity	
Helping others	Meaning making
Relevance of diagnosis	Feeling of relief; Stigma
Illness management	Psychoeducation; Importance of medication; Importance of therapy
Relationships	Mother-Child; Family; Friends
Collaboration	Reliance on professional support system; Shared responsibility; Not alone – parent; Not alone – BD individual; Openness/ Sharing/ Communication; Openness/Sharing leading to trust; Coping mechanisms; Involvement of significant others
Overshare	Sharing diagnosis when not necessary or relevant to the situation

Table 4-4: Shared dominant themes across the interviews

SHARED DOMINANT THEMES
Early-Onset BD – I was still very young
Comorbidity – Is diagnosed with both
Helping Others – I have it, I can help all my friends
Relevance of Diagnosis – I just welcomed it, I can actually label this; a relief
Illness Management – She gave us ways to cope; my toolbox
Relationships – I'm able to connect with people
Collaboration – I wouldn't do it any other way
Stigmatisation - People don't talk about it
Overshare – I was very open about my bipolar, I would tell someone probably when I shouldn't have, "Listen, I have bipolar."
Difficulty of being the significant other/mother of an individual with BD – What did I do to deserve this?

4.3.1. Dominant themes

4.3.1.1. Early-onset bipolar disorder

All participants interviewed for this study indicated an early-onset of BD with symptoms becoming evident to family members from as early as three years of age. Although the participants themselves have little or no memory of incidents that had occurred, the significant others who were parents were able to discuss what they had observed at the time symptoms first became apparent. This is illustrated in the selected excerpts from the interviews below.

Interview 1:

Interviewer: '[Client's name] you came to see [psychologist's name] for therapy. Why [psychologist's name] ?'

Participant 1B: 'He was about three [years of age] or so and then I was with her [referring to first psychologist seen by client] for about three years and then she noticed there was some sort of a pattern in the behaviours so she sent us to [psychiatrist's name]. So we were with [psychiatrist's name] for, from about the age of 7 or 8, I think, and then [psychiatrist's name] sent us to [psychologist's name].'

Interviewer: '…at that time you didn't know that you um had bipolar. You were…'

Participant 1A: 'No, I was just 3 [years of age], running around, playing.'

Participant 1B: 'We didn't know, no. I just noticed certain behaviours in him which were problematic and I brought him to the, to [first psychologist's name] and she did all sorts of play therapies and things but then she already, she noticed that [client's name] wasn't the same all the time. There were patterns where he was worse, certain times of the year and so she started thinking maybe this is not just a behavioural thing, it's something else…'

Interview 2:

Interviewer: 'Well, let me start you off. What brought you to [psychologist's name]?'

Participant 2A: '…I know that my parents always tell me my Dad is also bipolar so he saw some of the traits that he had um when he was younger he saw in me when I was still very young…'

Participant 2B: 'Look, when [client's name] was quite small she started, she was always drawing. She had paper on a blackboard outside and she'd paint and draw her pictures, even in pre-primary. As soon as it was a sun, it started becoming a little house, probably age 5, around about from crèche and up and I would go *that's beautiful* and she'd call Daddy *come and see* and Daddy would look and come back. If I leave and come back she's drawn black paint. Why would she do that and you know what, so it went from a happy to a sad emotion. You know, if I think about it now, behaviour was just out of character, not normal for me and then she started building little puzzles and she could never finish a puzzle. I couldn't understand why she couldn't finish a puzzle. She'd do four or five and she'd never finish and eventually it was an issue. And then in Grade 1 she got annoyed with a little boy that pushed her when they were standing in a queue and she turned around and she look at the teacher, well, they reprimanded her and put her in a corner and she thought I don't need to take this crap and she left the school grounds and she walked out so it was quite a shock. And the school phoned me and they said: "Your daughter's left and we don't know where she's gone" so I was like cool. Anyway, we went to a psychologist [Psychologist's name] and then they sent us to [name of paediatrician with a special interest in neurology].'

Interview 3:

Interviewer: 'Can we go back to when your parents were concerned about your behaviour, what age was that?'

Participant 3A: 'Grade 5 or Grade 6…so that was about 11 or 12 I think…that's when the real signs started showing um I was very aggressive, I took it out on other people. I was confused, I was, I didn't know what was happening to me…Ok, I'll give you an example…I used to take it out on my brother a lot, my eldest younger brother…all my aggression and my bipolar, it just, I attacked him, basically, physically. I would get aggressive…so it was like those bursts of anger, it was depression, there was anxiety…'

4.3.1.2. Comorbidity

All three participants interviewed for this research have been diagnosed with BD as well as ADHD.

Interview 1:

Psychologist: I'm thinking about the time when you wanted to go off your ADHD meds…You wanted to stop your Ritalin.'

Participant 1A: 'Yeah, yeah that was when I was in school.'

Psychologist: '…because you felt it made you less sociable.'

Participant 1B: 'That's right, it made him feel like a zombie. That's right, I remember.'

Interview 2:

Participant 2B: '…where they medicated [client's name] a little bit…more for ADHD'

Psychologist: [referring to educational psychologist the client had seen prior] '…so seeing him with ADHD and some behavioural stuff would be appropriate but when the bipolar stuff started coming, that's when he made the referral and said this is out of my scope of practice.'

Interview 3:

Psychologist: '…[Client's name] was presenting, I think, with quite difficult behaviour initially, that her parents were struggling to manage and they took her to a psychologist and then she referred her to a psychiatrist and they made a diagnosis, I think a bit later on, of ADHD…'

Psychologist: 'Which can be a symptom of ADHD…that difficulty of organising yourself and focusing…it's not specifically got anything to do with bipolar…because [client's name] is diagnosed with both.'

4.3.1.3. Helping others

Two out of the three individuals diagnosed with BD interviewed for this study expressed an interest in helping others. The types of 'being of service' ranged from doing kindly acts in general to counselling other high school children with mental health difficulties, or advising peers about the importance of medication adherence. This manner of thinking about their illness as a way to assist others was viewed as adding a 'silver-lining' (something positive) to a very serious disorder; it serves as a way to find meaning in their difficulties and in addition, may shift focus from their own problems to that of others.

Interview 1:

Participant 1A: '…I've never had this perception of depression/ADHD is a terrible thing because I've always have seen it as a way that, the way I have it and the fact that I have it, I can help all my friends… who have it, so ja, I'm more than happy to have it. I have no issues with it now. I just want to use it to help people.'

Participant 1A: '…my biggest message to my friends who have bipolar and ADHD, I'm very strict on them and say to them, look make sure you have your medication. Take your medication because I don't want to see you guys end up where you don't want to be…'

Participant 1A: 'Ja, with my friends, I won't hesitate to tell them like are you guys on your medicine, can I maybe help you?'

Psychologist: '…I think that one of the things that was really striking for me was that [client's name] really, you really look out for a lot of your friends at school...and [client's name] really, kind of, really reached out to a lot of people because of the things he knew and had learnt about himself.'

Interview 3:

Participant 3A: '…I was joined in a peer counselling group where I would counsel other people…'

Participant 3B: '…[Client's name] basically having a positive impact on those around her, she really loves helping people…'

Participant 3A: '…that the bipolar isn't me, I just have it as a challenge or sometimes even, it can help people…'

Participant 3A: '…I get that secret satisfaction every time I see someone smile or they're happy about so they come back and say *this really helped* and it's almost like yes, I'm happy it helped but also I've improved someone's life'

*Participant 3A: '…*my purpose is to help people, in my opinion…'

4.3.1.3.1. Conclusion

All three of the participants expressed a clear desire to help others and often used their disorder as a catalyst, or reason, for this compulsion. The focus on helping others may be linked to their age: one could argue that their desire to be of service to others is naive. Conversely, many of the clients experienced times of helplessness, confusion, anger, frustration and fear prior to entering therapy and since benefitting from it, now have a need to assist others in altering their lives. This study sample is small and thus it is difficult to generalise this need to help others to all diagnosed with BD.

4.3.1.4. Relevance of diagnosis

The participants in this study all expressed multiple positive emotions relating to obtaining an official diagnosis. Having a diagnosis provided clarity about behaviours, feelings, relationships and various other domains of life that had been affected by BD and prior to a diagnosis, caused much concern, anxiety, fear and confusion for themselves, and their significant others.

Interview 1:

Interviewer: ‘So diagnosing was helpful for you?’

Participant 1A: ‘Yeah, I think it would be helpful, it was helpful otherwise then I don’t know where I would be without having it diagnosed or medicated or anything.’

Interview 2:

Participant 2A: ‘…so we picked up my condition really, really early um something I’m very grateful [for]…’

Participant 2B: ‘…for me it was like “Oh my gosh, there’s light at the end of the tunnel…” and you know, I just welcomed it because it was like, gosh, I can actually label this, if you want to call it like that. It’s not I just need to discipline her and she doesn’t listen, there’s actually a condition…’

Participant 2B: ‘It became, for me, it became real because we could actually, we hit the nail on the head, everything that they said was like, ah it’s so much clearer, gosh, there’s a way ahead and there’s light at the end of the tunnel…’

Interview 3:

Participant 3A: ‘…so it was important for me to have a name for it…if I have a name, I have a way of later on recognising, listen, this thing is bipolar, it’s not [me]…’

4.3.1.4.1. Conclusion

It is clear that for the participants and their significant others, finally having a reason for the extreme behaviour –a diagnosis– came as a relief. Life prior to an official diagnosis was often chaotic and emotionally painful but the diagnosis brought understanding of the illness, and most importantly, skills needed to better manage the disorder.

4.3.1.5. Illness management

Having the knowledge and skills needed to manage their BD is a theme that evidently assisted the participants greatly. Subthemes of 'Illness management' include going to therapy, taking medication, and the importance of being able to communicate effectively. Psychoeducation with regards to BD clearly has a significant impact on how the clients cope with their mental health difficulties, as evidenced in these excerpts.

Interview 1:

Participant 1B: '[Psychologist's name] uh um taught [client's name] a lot about how to manage his illness, like as far as medication goes, and, and how to cope with [his disorder].'

Participant 1B: '…and of course, [psychologist's name] taught, tried to teach us, you know, that if we are in a problematic situation to move away from it, not to aggravate the situation.'

Psychologist: So I just wanna say that a lot of the, a lot of the work has been around, there was around, helping [client's name] understand about his condition, and managing it and making sure that it doesn't get in the way of his day-to-day functioning. Helping the family understand the condition, not let it interfere…'

Participant 1A: '…I was able to identify look here, I need to apply this thing that I've learnt from [psychologist's name] to this sort of person…but with my therapy, I knew the best way to handle it was take a step back, go and get personal, private time…'

Interview 2:

Participant 2B: '…she didn't bite me anymore from a young age, when we started talking to [psychologist's name] and then we would understand that it's ok for her to be like, we labelled the emotion – [daughter's name] are you angry, are you sad?

Participant 2B: 'I think that's important because you can't, you cannot control, manage this, these conditions, this condition, with only therapy or only medication, there is no way…'

Participant 2A: 'I'm able to move through a situation from a completely different angle, [there's] so much more clarity in what's happening… a lot of thanks to [psychologist's name]…and I'll actually see that wasn't the best way to go about it and maybe do that a different way um some other time…'

Interview 3:

Participant 3A: '…we went basically to [psychologist's name] and she found, gave us ways to cope with it, an example would be my toolbox… my toolbox in my brain. I had a toolbox with each, it's basically like a bandage for healing wounds, everything like that, so that was my coping mechanism… When we went through therapy with my family… they would talk to [psychologist's name] about my behaviour and how we would cope with it and how would I almost be disciplined without having negative effects from it…'

Participant 3A: 'Um, life skills in general I developed from, through, here um, you know, communication…that went throughout my life, I've learned to communicate a certain way in the workplace, in a social situation…'

Participant 3A: '…[psychologist's name] has been the door to this way of communication. It's happening with my parents as well. I follow that procedure every time, you know, to make sure everyone understands what happened and this is how you go forward so it's a life skill I've picked up.'

4.3.1.5.1. Conclusion

According to the participants' accounts, having the skills needed to manage their condition led to an improvement in overall functioning for both the individual diagnosed with BD and their significant others. It also appears that having these tools resulted in the participants feeling empowered and more confident; that they are able to use this knowledge in various areas of their lives.

4.3.1.6. Relationships

The participants all made mention of having difficulty maintaining healthy relationships prior to engaging in collaborative therapy. Relationships in this context pertain to romantic, familial, friendship and work relationships. The relationship between mothers and their child with BD appears to be particularly fraught and beset with difficulties. The following excerpts are examples of how relationships were conducted before, and post, therapeutic intervention.

Interview 1:

Participant 1A: '…you [referring to mother] and I did not get along.'

Participant 1B: 'Well, we have our different relationship…'

Participant 1A: 'We've always got on well; it's just that we can be a bit grumpy.'

Participant 1B: 'Well, we love each other but it's difficult for us.'

Participant 1B: '…so if anything happens, if he's not well, if he's not in a good place, I'm the one who takes it.'

Interviewer: 'Do you think your relationships have changed in any manner [since taking part in collaborative therapy]?'

Participant 1A: 'Yeah, we are much more chilled now. We can at least understand where we both stand and all that, we are much more educated on the [subject of BD].'

Participant 1B: 'We have our difficult days.'

Participant 1A: 'Ja.'

Participant 1B: 'But I think that's normal with all children.'

Participant 1A: 'We are more, our difficult days are much less than they were, like as in, they happen on the odd occasion. Hey Ma, would you say?'

Participant 1B: ‘Maybe I’m learning to shut up a bit…’

Participant 1B: ‘…if [client’s name] is not in a good place then everybody is stressed and up in arms, everybody gets affected. Me, my husband, my, my other son, the granny, everyone.’

Participant 1B: ‘…a father can’t handle a son swearing and carrying on at him…’

Interview 2:

Participant 2B: ‘…she was manipulative, she would tell me what I wanted to hear so she was very sneaky in that kind of way…’

Participant 2A: ‘…my boyfriend came one time…so he came because it was a really difficult time, could see the signs – the downhill was coming – and being able to feel I don’t want to jeopardise an important relationship right now…’

Participant 2A: ‘It [referring to collaborative therapy] actually like brings me a lot closer to people as well like um I’m really close to my Dad because I’m able to speak to him about it. I can connect with people.’

Participant 2A: ‘…I’m so much closer to my family, I can communicate with my family… it’s a way healthier relationship…and I feel like if you have a healthy relationship with your family that generally impacts all your other relationships. You’re able to have a better relationship with all the other people around you…’

Participant 2B: ‘[referring to client]…she’s got friendships, they’ve been a bit more difficult, you know, they might be a bit more challenging…’

Participant 2A: ‘…like when my friends come over… the way my mom and I joke or have a conversation… they’ll say to me afterwards: “wow, you’re so close to your mom, like I want that…” and being able to have that gift from something like this because if my mom wasn’t able to understand my behaviour, we would never have that relationship.’

Interview 3:

Participant 3A: ‘I used to take a lot out on my brother, my eldest younger brother… all my aggression and my bipolar, it just, I attacked him, basically, physically. I would get so aggressive…’

Participant 3A: ‘…I’ll give you an example. Recently, at work, where something regarding my bipolar happened. I would sit down because my boss knows I’m, I have bipolar so she’s very open to it, she understands everything…’

Participant 3A: ‘Okay, he’s [referring to her romantic partner] a big one because I live with him now and he’s been through a lot of things with me um since we’ve been living together… there would be my parents um and then to some extent my siblings… my boss as well as my friends… they’re all learning how to interact with it [referring to her BD].’

Participant 3A: ‘…a lot of my friends did not understand how to handle it… if there was a situation where I would get out of hand, my friends wouldn’t understand… so it got very frustrating…’

Participant 3A: ‘Me and my brother are so close now…before it was such a different relationship… so our relationship is completely changed… especially since I’ve moved out my relationship with Dad has improved immensely but even since we started therapy with my family, you know, everything has changed…’

Participant 3A: ‘…we would have more constructive discussions… another thing which really changed is their patience, they were more patient with certain things… when I started [psychologist’s name], started seeing [psychologist’s name] things started changing…’

4.3.1.6.1. Conclusion

It is evident from the data above that repairing relationships amongst those with BD and their family members/significant others improved QoL for those affected. The ability to maintain healthy relationships ‘closer to home’ inevitably leads to better relations with those in the outer reaches of the BD individuals’ social milieu.

4.3.1.7. Collaboration

Under this heading, the participants discuss their ideas around the definition of collaboration, who to involve in the collaborative process and the effects collaboration has had on their lives.

Interview 1:

Participant 1B: '…if we had some sort of issue or problem then we would speak to [psychologist's name], [psychologist's name] would then speak to [psychiatrist's name] and we would all be copied in on the emails so we all knew what was going on all the time.'

Participant 1B: '…as a mother who is having problems with her child, you need someone to know what's going on, and so it was a help for me to be able to email [psychologist's name] and say the wheels are falling off here, there or wherever. Then you don't feel so alone.'

Participant 1B: '…I would let him [referring to client] know I'm speaking to [psychologist's name], not because I'm going to tell tales but because I feel she needs to know because we are trying to help you [referring to client] get better here. You see, so that's the way we would approach it.'

Participant 1A: '…I think it's just the safety of knowing that there is no one that's blacked out on the situation… so there's a lot of open dialogue, so it's pretty cool.'

Participant 1B: '…every decision we make, [psychologist's name] is in on it, the doctor's in on it, everybody's in on it. You know what I mean? It's not just us making a decision.'

Participant 1B: '…you've got someone to help you, that comfort of having the doctors talking to each other…'

Participant 1A: '…we want multiple people involved…'

Interview 2:

Psychologist: '…they're [referring to the school which the client attends – teachers, principal and school counsellor] not physically coming here [to therapy sessions] but they're very much part of the support team… So in that way, so ja, that, if it's necessary and [client's name] brings something to me that is specifically in the school context, that's not, just, you need to think about, it's actually a practical thing, then we have involved the school.'

Participant 2B: 'When she was at camp… I would always have the teacher's mobile number and they all have mine and they would ensure that she takes her medication on time and that kind of stuff…'

Participant 2B: '…[psychologist's name] and [psychiatrist's name] both made us feel welcome and it was never an issue, it was "Don't worry, we're going to work with this together, you're not on your own, we're a team…"

Participant 2B: 'Because I've been part of the therapy… I've become so knowledgeable with the help of [psychiatrist's name] and [psychologist's name]… then we can all collaborate and actually see the pattern that has formed because we've been together for so long…'

Participant 2B: '…knowing that they are there… I'm not alone…when the chips are down, you need to know those people are there for you.'

Interview 3:

Participant 3A: '…we were all very confused, we didn't know what to do and that's why we needed someone [referring to psychologist] to guide all of us. I don't know if you've been made aware but my parents also had sessions with [psychologist's name] and separately from me and the, I think we met a few times all together and that was, for me, very important…'

Participant 3A: 'Okay, so after a session with you [referring to psychologist], my parents would sit me down if they felt something was necessary to share and they'd say*, spoke to [psychologist's name] today* or they'd say okay, there's something we need to discuss with you, especially my mom. By the way, my mom would sit me down and say we were speaking to [psychologist's name] and we heard…that you feel this way… and we'd have a calm discussion. So [psychologist's name] was almost like a door… that helped open communication channels. We'd communicate through her and she would communicate back and we'd all communicate together.'

Psychologist: 'From time to time, when necessary [Referring to involving the school or keeping them informed with regards to the mental state of the client]. So in other words, for instance, when she [referring to client] was going through a really difficult time and she shouldn't really be doing extra assessments or she needs extra time… so it was very much on an ad hoc basis, so they were involved and they were aware but only when necessary.'

Psychologist: 'You [talking to the client] went back to see [previous psychologist's name] but the work that we did here, we communicated with [previous psychologist's name] and [previous psychologist's name] communicated with us. So [previous psychologist's name] would give feedback to me that I would pass on to the parents about work with [client's name] and I would give [previous psychologist's name] feedback about the work that I was doing with the parents for [client's name].'

4.3.1.7.1. Conclusion

Collaboration can be extended to involve those who are not necessarily viewed by the client as significant others, for example, teachers at school or work colleagues. The excerpts also clearly reveal the appreciation the clients have for this type of therapy and the difference it has made in numerous domains of their lives.

4.3.1.8. Stigmatisation

The participants were affected by stigmatisation to varying degrees. The excerpts below indicate how the participants feel about the possibility of being stigmatised due to their BD diagnosis and how this influences who they tell about it.

Interview 1:

Interviewer: '…how did you feel about the diagnosis of bipolar?'

Participant 1A: '…I've never had this perception of depression/ADHD is a terrible thing…'

Psychologist: '…we had discussions about whether we were going to discuss your diagnosis at school… we spoke about it. Who are we going to tell what…'

Participant 1B: 'He's quite open about it.'

Participant 1A: '…nowadays the people are very much, oh mental illness, brush it aside…'

Participant 1B: 'People don't talk about it.'

Participant 1A: '[referring to his time spent on a boat in Mexico]… I would keep my medication in the mess so that I can just grab it, take my food…'

Participant 1B: 'So you had to be open about it because he had this like bag of medicine.'

Participant 1A: '…the one night I was on a watch and I came down and they were looking at my medication and I sat down, explained to them. These are people from around the world who might not have come across these medications but I was able to take the medication with them seeing like, kids have to, or people of all ages have to take it and then I can use that to just explain this is what I have been taking.'

Participant 1B: 'And then you found out how many other people have problems when you started talking about it because people normally keep quiet.'

Interview 2:

Participant 2A: 'That's another thing that I wanted to say when you dealing with bipolar, especially, it's like a very um taboo, is that the right word to use, um and people are very scared um of the word um and the condition itself… [collaboration] allows for more people to have a greater understanding of the condition and I feel like if you allow for that, cannot take that understanding away from anyone and the more people you allow the ability to understand, the better you can make it and the easier you can make it for those who do have the condition and they're not going to fight themselves as much because they're not going to feel as embarrassed or scared about their condition.'

Participant 2B: '…often if I would say my daughter's got bipolar people would go, huh?, and I'm going no, it's maintained, it's controlled, she's got a totally normal life.'

Psychologist: '…it's like that destigmatising that takes away that kind of shock factor and that this is an awful thing [way of seeing BD].'

Participant 2A: ‘I think another girl um in my school, recently, um and like, she just came back now and everyone was like really happy to see her and everything and when I came back, people were still kind of like sceptical about what’s happening so I feel like it’s like then they saw that I was normal, I was okay, like I was fine so now it’s like oh, she’s ok, she’s back, she’s fine, like it’s like it’s okay.’

Participant 2A: ‘They’re scared that like she’s going to break loose or something, you know: let’s just not crack her up again, you know.’

Interview 3:

Psychologist: ‘…I can’t remember your exact response. For whatever reason, this sticks in my head from when we discussed your diagnosis and I remember you [directed at client] saying: “Oh my word so I’m not some kind of psycho moron?”

Participant 3B: ‘Um and then my mom is someone who is um kind of like one of these people who is not completely convinced about mental illnesses, she’s kind of like, “Why don’t you just stop taking medication?”

4.3.1.8.1. Conclusion

Stigma around mental health issues is not a new topic and many people with mental health disorders suffer because of discrimination and prejudice. Here, the participants were all relatively unconcerned about stigmatisation, and appear to be willing to share with others their experiences in the hopes of dispelling fear-inducing beliefs and general ignorance on the topic.

4.3.1.9. Overshare

One of the participants indicated a propensity for revealing her BD diagnosis at inappropriate times or ‘too soon’, as per her own reckoning, while another admitted to leaving his medication in the full view of others, inviting questions and conversation regarding it.

Interview 1:

Participant 1B: ‘He’s quite open about it.’

Participant 1A: ‘Ja, I basically say anything I want on my mind, so that’s why I share it.’

Interviewer: ‘You were able to, to share your experience with other people as well?’

Participant 1A: ‘…the one night I was on a watch and I came down and they were looking at my medication and I sat down, explained to them. These are people from around the world who might not have come across these medications but I was able to take the medication with them seeing like, kids have to, or people of all ages have to take it and then I can use that to just explain this is what I have been taking.’

Interview 2:

Interviewer: ‘…who knows about your condition?’

Participant 2A: ‘Pretty much everyone. I’ve never been one to hide it. I’m pretty open about it, if it comes up in a conversation. It’s never been something I’m secretive about, if it comes up, it comes up. I feel like if you are secretive about it and you want to make a game out of it then that’s when you don’t talk about it.’

Interview 3:

Participant 3A: ‘…I was very open about my bipolar. I would tell someone probably when I shouldn’t have: “Listen, I’m bipolar…”

4.3.1.9.1. Conclusion

The participants reported being open about their mental health issues and, at times, inviting others to ask questions about it. This may be due to their desire to educate others about mental health disorders in general and to decrease stigma by talking about it openly.

4.3.1.10. Difficulty of being the significant other/Mother of an individual with BD

One of the main reasons people choose to enter into collaborative therapy is due to the difficulty experienced by the individual diagnosed with a mental disorder as well as their significant others. What came through strongly in the interviews is the fact that significant others, and mothers in particular, suffer greatly from being close to an individual with BD.

Interview 1:

Participant 1B: ‘Can I just mention one thing about this with all the interaction? I think it was important for me as a mother because [client’s name] is a very um, sweet pleasant child, ummm out there. Ok, and sometimes it’s different at home. Like all children it’s different at home so I think for, as a mother, I’m the only one seeing the different behaviour at home, nobody else is seeing it. So where [client’s name] comes to [psychologist’s name] is always seeing the nice side of [client’s name]. She doesn’t see the other side and it’s import– as a mother, it’s important for me to be able to tell other people about the other side because otherwise you [directed at client] can’t be treated correctly… Otherwise everyone will think everything is always hunky-dory. [Client’s name] always shows everybody the nice side, I’m not running you [directed at client] down now, I’m just, this is now, how it is.’

Participant 1B: ‘He’s quite volatile… Um, if he gets stressed then he um ah has a problem keeping it together so he’ll get like shouty, hey? And rude, sometimes break things.’

Participant 1B: ‘Well, as a baby, for the first year, he was, he just slept. He was the most calm, he slept, he slept all day and then when he turned one, he never slept again and he became very lively. He didn’t sleep during the day, very hard to get him to sleep at night um uh, very lively. He would pull the door of the washing machine and throw it across the floor and he was like extremely destructive as a little thing and um he went to playschool from about the age of two and from about three, I noticed like every single time I went to the shop, I had a tantrum out of him. And I had already had one child and that child never had a tantrum. Every day I went to the shop, I had to stop taking him to the shop because he screamed all the time, screamed about everything, performed about everything. Screamed to go in the bath, screamed to get out the bath.’

Interview 2:

Interviewer: ‘…there was a build up for you to go to [psychiatrist’s name], so how were things?

Participant 2B: ‘In shambles… What have I done with this child? What have I done to get this child?’

Interviewer: ‘So from the chaos to a different lifestyle it sounds?’

Participant 2B: ‘Absolutely. It was calmer. It was from chaos to, to understanding, let’s not say calmer. From chaos to understanding and still it’s a learning curve, it’s not clear-cut. I’d love to tell you it’s clear-cut, it’s not. I mean, sometimes I want to cry because I wish I could help and carry what they [husband and daughter/client who both have BD], what they have.’

Participant 2B: ‘…what did I do to deserve this?’

Interview 3:

Participant 3A: ‘…everyone [referring to her family] was scared, we didn’t know what to do…’

Participant 3A: ‘…he’s [referring to boyfriend] been through with a lot of things with me um, since we’ve been living together and since before really…’

Participant 3A: ‘My parents were very scared, I think they kind of didn’t know what to do… they would hide my brother away from me… my mom later brought up that um she would get depressed… she would get really depressed you know, this is her child, this is her mistake… she would feel it was her fault, she didn’t know what was going on, she thought it was maybe the way she brought me up, you know?’

4.3.1.10.1. Conclusion

Having a child with BD often gave rise to feelings such as uselessness, powerlessness, self-doubt, depression and harsh questioning of their own parental methods and choices for those involved in this study. Mothers appear to bear the brunt of mood swings, violent/physical outbursts and other difficult behaviours and often do so with little to no support from their spouses.

4.4. I Poems

Interview 1:

In the following *I Poem*, the participant speaks in a rather forceful manner. His description of the interaction with his peers who also have mental disorder diagnoses and who have been prescribed medication is full of his attitude of taking control, giving instruction and persuading others to stick to their medical regimens.

Participant 1A:

I just observed

I realise

I don’t wanna

I can

I’m very strict

I say

I don’t want

In the following *I Poem*, when discussing his own adherence to taking medication, the participant’s language is less powerful, hesitant, almost feeble and hints at a loss of control. Whereas before, he seemingly had authority over his peers, his own medicine taking now appears to be out of his hands: he relies on his mother to make sure he takes his medication.

I mean

I always had a strict routine with my mom

I mean

I would be

I would be

I would

I was asleep

From the *I Poem*s, the researcher surmises that the participant is aware of how important it is to take medication for his mental health issue and although he is supportive, or to use his own words “very strict” with his friends, when it comes to his own compliance, he is less rigorous about it.

Interview 2:

In the following *I Poem* the speaker appears to be somewhat confused, uncertain and hesitant. This is appropriate for the situation she is describing; a period of time during which she had to reside in a mental health facility due to a bad reaction [involuntary muscle spasms] to her medication.

Participant 2A:

I’d never seen

I’d never done

I hadn’t

I saw it

I’m like

I got

I was like

I don’t want

I want to

I can’t say

The next *I Poem* highlights an alteration in attitude for the participant as she discusses how entering into collaborative therapy provided a great many benefits and allowed for positive change in her way of being, doing and understanding herself.

I still think

I’m able to

I’ve like experienced

I can

I come

I’ll see

I often

I come

I’ll be

I’ll have

I’ll have

I’m also

I shouldn’t

The language used here is self-assured, positive in nature and seemingly proactive. The participant’s way of expressing herself and discussing her frame of mind is a great deal more confident than in the previous *I Poem*.

These two *I Poems* allow the researcher to hear, in the participant’s own voice, how the extremely different sets of circumstances impact on her sense of self. During her hospital stay, the participant was scared, isolated and withdrawn; collaborative therapy has given her mental and emotional strength.

In this *I Poem*, the participant’s awareness of her abilities shines through.

I’m really close

I’m able to

I can connect

I’ve also learned

I don’t always

I can

I need

I now look

I’m

I need

I just be

I had

I was

Interview 3:

The next two *I Poems* were created from the same piece of text to highlight the participant’s change in mindset. The first *I Poem* covers a period in her life prior to collaborative therapy and indicates how she seemingly experienced events as happening *to* her, events over which she felt powerless and left her feeling scared, lost and confused.

Participant 3A:

I was punished

I did

I had time out

I’m feeling this

I was

I was scared

I’m scared

I am feeling

I feel like

I was taken aback

I was

The *I Poem* below, created from the latter end of the same text shows a turning point within the participant. It is at this time that she began to feel a sense of control and could take a more active role in her own life where she could exert influence over what was around her, not merely the other way round.

I said

I started

I started picking up on

I'm in a certain situation

I feel a certain way

I've felt

I deal

I kind of take it

I'm

I know what to say

The change in the participant's voice reveals a new sense of self as well as new ways of viewing and understanding the world around her. The participant moves from repeated use of the words "I feel" –signifying isolation and a non-revealing of her inner world– to "I said" and "I know what to say", indicating an openness and a wider range of action or willingness to speak her mind.

The next *I Poem*, like the one above, reiterates the recently discovered sense of self-awareness as well as the participant's newfound ability to speak her mind.

I

I found out

I was

I have a name

I have a way

I'm saying

I have a name for it

I can say

Once again, we hear the participant express a 'take-charge' attitude that is at odds with her previous voice which was stifled and impotent.

For the following *I Poems*, the researcher focused on the voices of the significant others involved in the process of therapy.

Interview 1:

The researcher made the decision to adhere to LG guidelines fairly closely to gain insight into the way in which participants speak of themselves. However, for this part of the analysis the first person plural pronoun "we" was also included. The researcher observed the use of "we" by the mother of the individual diagnosed with BD when questioned about her beliefs regarding the concept of QoL.

Participant 1B:

I think

We more or less

We would say

We haven't

I think

In the above *I Poem*, the mother's use of "I think" indicates a sense of isolation and a time characterised by her own innermost thoughts. Yet, the use of "I" at this juncture, the beginning and end of the text, can be understood as existing almost in parenthesis, an afterthought or something kept hidden. The use of "we" dominates the text under study and may represent the mother's desire to not be alone in dealing with the difficulties that accompany being the parent of a child with BD. Her use of "we" refers to the speaker and her husband and one could argue that she wears the "we" as a protective coat to shield from having to cope with the circumstances on her own. In contrast to the repeated use of "we", the mother admits later on in the interview that "[her] husband has switched off… years ago".

Interview 2:

This *I Poem* is taken from a passage in the interview where the mother discusses the relief associated with finally getting a diagnosis for her daughter and entering into collaborative therapy.

Participant 2B:

I

I

I thought

I just welcomed it

I can actually label this

I just need

I just think

I can understand

The act of thought is mentioned twice which illustrates that the mother is still relatively consumed by what is going on in her mind. In contrast, the following *I Poem* indicates far more outward-directed activity. The most notable voice here is one that points towards obtaining clarity and knowledge.

Participant 2B:

I've been part of the therapy

I have

I don’t think

I’m crazy

I want to know

I will

I’ve become so knowledgeable

I’d

I’m able to say

I can see

I can see

The mother’s voice is a positive one; it indicates participation (“I’ve been part of the therapy”), willingness (“I want to know”) and most importantly, understanding, knowledge and clarity (“I’ve become so knowledgeable” and “I can see”, a phrase she repeats) with regards to her daughter and BD. There is an undercurrent of pride to her words as evidenced by the phrases “I’m able…” as well as “I can…”

Interview 3:

The client’s significant other in this interview is her boyfriend. The passage from which this *I Poem* was extracted involved the client’s boyfriend discussing his finding out about the client’s diagnosis.

Participant 3B:

I don’t know

I’ve never

I never even knew what bipolar was

I also

I also

I

I didn’t realise how big of a thing this was

I had to

I didn’t see it

I haven’t

I’ve had no experience

Participant 3B:

I think

(if) I was in her position

I think

Upon reading the full text from which this *I Poem* has been extracted, one gets the feeling David is making excuses for his girlfriend for not having reached certain milestones in life, such as taking her learner’s and driver’s license tests. However, from the short *I Poem*, the researcher senses that the boyfriend thinks frequently and deeply about what his girlfriend goes through as someone with BD and places himself in her shoes to understand what she experiences on a daily basis. It is clear that he did not have much experience with mental disorders, and BD in particular, prior to meeting his girlfriend.

4.4.1. Conclusion

The *I Poems* permitted the researcher to get to know the participants on a deeper level and to understand how they view themselves in relation to the world. This insight allowed the researcher to delve into his own biases towards those with mental disorders and to empathise in a way not possible prior to the start of the study. It became clear that through the therapeutic process of collaboration, the participants with BD and their significant others gained a better understanding of the disorder and how to manage it.

4.5. Contrapuntal voices

Table 4-5 presents a summary of the contrapuntal voices emerging from the data. There were six contrasting voices which are described further in the following section.

Table 4-5: Contrapuntal voices emerging from the dataset

Contrapuntal voices
Voices of relevance *versus* Voices of irrelevance
Voices of relief *versus* Voices of confusion
Voices of reliance *versus* Voices of dependence
Voices of disclosure *versus* Voices of silence
Voices of burden *versus* Voices of care
Bad child *versus* Mentally ill child

The researcher noted when analysing the data and constructing the *I Poem*s that the participants felt relevant when being of service to others. This allowed them to be someone other than merely ‘the person with BD’ or someone who is deemed irrelevant due to their mental disorder. It is this voice of relevance that silences the voice that hints at a lack of purpose or a lack of usefulness in society.

Interview 1:

Voices of relevance versus Voices of irrelevance

To locate the voice of relevance, the researcher decided on certain markers which would allow him to know when this voice was coming through. In the case of the first interview, it became clear that when *Participant 1A* used the words ‘I have’ and spoke in the imperative, he was attempting to prove his significance in and to the world. Imperative clauses are used when we want to tell someone to do or not do something, and are most typically used for orders, commands or instructions (Merriam-Webster dictionary, 2017).

Participant 1A: Voice of relevance

‘I have it, I can help my friends… I have no issues with it now. I just want to use it to help my friends’.

‘I’m very strict on them and I say to look, look, make sure you have your medication. Take your medication because I don’t want to see you guys end up where you don’t want to be’.

‘Ja, with my friends I won’t hesitate to tell them like “Are you guys on your medicine? Can I maybe help you?” and all that. It’s great to know I am taking my medicine but seeing a lot of friends that are suffering from it to a really bad extent then I can at least use my example, here as an example, for them…’

Interview 2:

Similarly, Elizabeth, the individual with BD in the second interview also spoke in the imperative, especially in relation to her friends and how she can help them. The researcher used this as a marker for when her voice of relevance was coming through as well as descriptions of her BD as being useful or helpful, if not superior, in some way. The researcher believes that Elizabeth uses her BD as a way of showing others how ‘able’ or ‘capable’, indeed, *relevant* she is; it has given her abilities others just do not have, in her opinion.

Participant 2A: Voices of relevance

‘…when my friends say stuff, I’m able to move through a situation from a completely different angle… I can be like “don’t do that…” [I’m] able to identify other people’s reactions… I’ll be like: “Mom, this person is so irritating, look at what they’re doing, they’re so silly…”

‘It actually like brings me a lot closer to people as well… I can connect with people, like random people, on a really emotional level um without even having to know them for very long periods of time…’

Interview 3:

The word ‘help’ on its own, and when coupled with the theme of being of service to others, was identified by the researcher as a marker for the voice of relevance. The researcher deduces that this voice is used in an attempt to silence the voice of irrelevance; the voice which causes the participant to constantly apologise to others, as if her mere existence is offensive and worthy only of an apology.

Participant 3A: Voices of relevance

‘…I was joined in peer counselling group where I would counsel other people…’

‘…that bipolar isn’t me, I just have it as a challenge or sometimes even, it can help people…’

Participant 3B: Voices of relevance

‘Can I just butt in here? Ja, so basically, this sort of comes down to um another thing. [Client’s name] basically having a positive impact on those around her. She really loves helping people even if it’s someone who’s a complete stranger. I think she gets a lot of satisfaction and happiness [from helping others]’.

Participant 3A: Voices of relevance

‘Which is what I enjoy as well. I get that secret satisfaction every time I see someone smile or they’re happy about, so they come back and say *this really helped* and it’s almost like, yes, I’m happy it helped but I’ve also improved someone’s life’.

Participant 3B: Voices of irrelevance

‘He’s [referring to his own father’s response to the client/the speaker’s girlfriend having BD] very cool but like one of the things is that he’s always trying to train [client’s name] to stop saying sorry about everything’.

Participant 3A:

‘It’s a bad habit I have, I always say I’m sorry, even if it’s not needed’

Voices of relief versus Voices of confusion

In the course of the study, it was observed that the mothers of the individuals with BD felt great relief once a diagnosis was made as it provided an end to their confusion with regards to their child’s behaviour. This contrapuntal voice relates to the relief brought about by obtaining a diagnosis for the person with BD, as well from knowing that they [the mothers] are not alone, that the psychologist is there to provide guidance, support and to assist with any decision-making processes.

Interview 1:

To recognise the voice of relief, the researcher decided on the words ‘help’ or ‘helpful’ when the significant other/mother discussed her child’s BD in general and when mentioning the role the psychologist has played in their lives.

Participant 1B: Voices of relief

‘…as a mother who is having problems with her child, you need someone to know what’s going on and so it was a help for me to be able to email [psychologist’s name] …then you don’t feel so alone’.

‘[psychologist’s name] gonna help us with that’.

‘But that is, that feeling of, you’ve got someone to help you, that comfort of having the doctors talking to each other – “I’ve got your back”.’

‘Ja, because you know what I find very helpful? I might notice certain things happening with [child with BD] and then I will communicate that to [psychologist’s name] then she will have her session with him… and that is very helpful’.

‘You see, that’s a big help for me to have [psychologist’s name] to help me, I’m not gonna lie. That’s a big thing for me, I’m not alone’.

Interview 2:

As in the first interview, Monica, the mother was the most vocal in terms of the relief brought about by the diagnosis. The researcher used metaphor and speaking about BD in a positive manner as a marker of the voice of relief in this interview. Likewise, the marker chosen to highlight the voice confusion is also a metaphor and speaking of the time prior to diagnosis in a negative way.

Participant 2B: Voices of relief

‘I just, you know what, for me, it was just like oh my gosh, there’s a light at the end of the tunnel… I just welcomed it because it was like gosh, I can actually label this… it’s not just I just need to discipline her and she doesn’t listen, there’s actually a condition… you know, [psychologist’s name] would just guide us all the time, you know, this is behaviour at this age and this is the condition so how do you deal with the condition side, you know…then we’ve obviously got the medicine, it would just be like a great relief’.

‘It’s very exhausting you know so [psychologist’s name] has her place and we all have our little spot in the sun but together, we just make this, you know…’

‘For sure, most definitely, it’s exactly that. We each one has their little role to play, it is that spot in the sun and really, when it comes together it’s like an eruption, it’s amazing. It’s like, you know [sound of an eruption] and that explosion, it’s just awesome for us’.

‘A Godsend’.

Participant 2B: Voices of confusion

‘In shambles’ [in response to question from interviewer about life prior to diagnosis and collaborative therapy].

‘…it was calmer, it was from chaos to, to understanding…’

Interview 3:

In this interview, one hears about confusion turning to relief from the point of view of the client with BD as opposed to a significant other/mother’s emotional shift. This interview allows for first-hand experiences to be shared by the speaker and heard and understood by the listener. The researcher decided that the markers for voices of relief would involve the participant speaking about the skills she has developed through collaborative therapy as well as when she talks in a confident manner. Words such as ‘confused’ and ‘confusion’, ‘angry’ and ‘aggressive’ will serve as markers for voices of confusion.

Participant 3A: Voices of relief

‘…basically [psychologist’s name] …gave us ways to cope… an example would be my toolbox… my toolbox in my brain. I had a toolbox with each, it’s basically like a bandage for healing wounds, everything like that so that was my coping mechanism…’

‘Even um life skills in general, I developed from, through, here. Um you know, communication… so my family would have to sit down with me and talk a certain way… I’ve learned to communicate a certain way in the workplace, in a social situation…’

Participant 3A: Voices of confusion

‘…I was very aggressive. I took it out on other people. I was confused. I was, I didn’t know what was happening to me…’

‘I used to take it out on my brother a lot, my eldest younger brother. Um, he was, he was the only person who could really get to me so quickly. So all my aggression, all my bipolar, it just, I attacked him, basically, physically. I would get aggressive… I would come back and be like what just happened to me? So it was like those burst of anger, it was depression, there was anxiety, a whole bunch of things that just muddled up into me and I didn’t know how to deal with it…’

Voices of reliance versus Voices of dependence

The participants appeared to walk a fine line between drawing strength from the psychologist and the collaboration process, and depending on it. The researcher identified some potentially worrisome comments made by the interviewees in terms of their relationship with the psychologist.

Interview 1:

In this interview, it became apparent that the person diagnosed with BD has a healthy reliance on the psychologist while the mother appears to be explicitly dependent. This may be due to the phase of life that Participant 1A is in; he is on the verge of adulthood and is keen to test his independence while his mother mostly experiences great relief having the psychologist as a source of support. As markers, the words ‘always’, ‘every’ and ‘help’ have been chosen to identify the voices of dependence. When listening for voices of reliance, the researcher decided on the words ‘learn’ and ‘taught’, indicating a new skill that has been acquired.

Participant 1B: Voices of reliance

‘[Psychologist’s name] uh um taught [client’s name] a lot about how to manage his illness’.

Participant 1A:

‘…that educates each other… we all learn about it…’

Participant 1A:

‘…I’ve learnt so much…’

Participant 1B:

‘[Psychologist’s name] taught, tried to teach us, you know, that if we are in a problematic situation, to move away from it. Not to aggravate the situation’.

Participant 1A:

‘…so I had to learn how to deal with different genders, age barriers, all of this and through therapy I was like able to identify… I need to apply this thing and I’ve learnt through [psychologist’s name]… with my therapy I knew the best way to handle it was to take a step back…’

Participant 1B: Voices of dependence

‘Well it, for me, um I always know that uh there’s someone I can go to should we have a big problem. That is very important for me. And I know I can always contact [psychologist’s name] if something happens…’

Participant 1B:

‘Because we are living, it’s like we are living daily with it all the time. In other words, every decision we make, [psychologist’s name] is in on it, the doctor is in on it. Everybody’s in on it. You know what I mean? It’s not just us making a decision’.

Participant 1B:

‘You see, that’s a big help for me, to have [psychologist’s name] to help me. I’m not gonna lie, that’s a big thing for me; I’m not alone’.

Interview 2:

The researcher identified the words ‘guidance’ and ‘support’ as a markers for dependence in this interview as he believes the clients run the risk of imaging they are being ‘guided’ and ‘supported’ by the psychologist as opposed to admitting that they are almost entirely dependent on her in difficult times and when tough decisions are required. Another marker for the voice of dependence was when parents of the BD child were expected to make decisions but instead relied on the psychologist. As a voice of reliance, the researcher listened for the use of the pronoun ‘we’ and when the participants spoke in terms of a ‘united front’. This was used to signal a collaborative way of being in contrast to the psychologist as head and one who takes the lead in the decision-making process.

Participant 2B: Voices of reliance

‘It became, for me, it became real because we could actually, we hit the nail on the head, everything that they said was like ah, it’s so much clearer, gosh, actually there’s a way ahead and there’s a light at the end of the tunnel… [psychologist’s name] and [psychiatrist’s name] both made us feel welcome and it was never an issue, it was: “Don’t worry, we’re going to work through this together, you’re not on your own, we’re a team…’

‘Because I’ve been part of the therapy… my girls can tell me everything I want to know… I’ve become so knowledgeable with the help of [psychiatrist’s name] and [psychologist’s name] …then we can all collaborate… because we’ve been together for so long…’

‘But I think that the whole process with all this has made us as a family very open. We can talk about emotions, all four of us… and it’s just because we’ve, you know, we’ve been able to talk’.

Participant 2B: Voices of dependence

‘When [client’s name] had issues with her friends and she was going through a tough time last or… the counsellor actually called them in, called her friends in and said um and obviously with [psychologist’s name]’s guidance, [psychologist’s name] sent an email to the school and said this is where [client’s name] is at this stage, she’s fragile…’

‘…had a very bad reaction to one of her medications where she had involuntary muscle spasms, it was absolutely horrible to see but when as parents, we were going: “Oh my word, what are we going to do, how are we going to go about this? …then having to book her into a clinic, if it wasn’t for [psychiatrist’s name] and [psychologist’s name]… it’s definitely the support through [psychologist’s name] and [psychiatrist’s name] at that stage again, and continuous, you know…’

‘…she [referring to the client] was able to at least see [psychologist’s name] on a daily basis or even phone…’

‘…it’s okay, I know that I can just sit back and listen and then I know when I get home [psychologist’s name] [has] dealt with it, I don’t need to go back there’.

Interview 3:

In this interview, the researcher found that the client appeared to have a healthy relationship with the psychologist and that she relies on her to the degree one would expect in a therapeutic setting. With this in mind, the markers for the voices of reliance in this interview include the use of the word ‘help’ and the use of simile and/or metaphor when describing the psychologist and the knowledge she has imparted. However, it was noted that Maggie is heavily dependent on her live-in boyfriend, David as evidenced by his account of their everyday lives. The marker for the voices of dependence is thus the use of the word ‘we’ when discussing the ways in which they have had to adjust their lives due to Maggie’s BD.

Participant 3A: Voices of reliance

‘Okay, so after a session… my parents would sit me down if they felt something was necessary to share and they’d say: “Okay, spoke to [psychologist’s name] today… and we heard… that you feel this way” … and we’d have a calm discussion. So [psychologist’s name] was almost like a door, if that makes sense, that helped open communication channels. We’d communicate through her and she would communicate back and we’d all communicate together’.

‘[Psychologist’s name] has been the door to this way of communication…’

Participant 3B: Voices of dependence

‘Um, I wouldn’t say it [BD] disrupts it, it’s more like um… for example we would be… we now need to find a new psychiatrist and it would mean coming through to CT so um something like that… I would then take a day off from work in the week and then work it back on like the weekend…’

‘Ja, another thing is like, it’s silly but just like getting the meds, they’re like, you know, now that we’re completely independent, it’s like, you know, it’s a bit of a financial hit but it’s important so one makes arrangements, makes plans around it’.

Participant 3A: Voices of dependence

‘I can’t drive. I think that’s what we need to put in there’.

Voices of disclosure versus Voices of silence

Voices of disclosure and voices of silence refer to how the participants feel about telling others about the BD diagnosis. Disclosing one’s mental health issues can have several negative consequences and thus, many are hesitant to do so. For the most part, the participants with BD indicated strong tendencies to talk about their diagnosis as opposed to keeping it a secret.

Interview 1:

The participants of this interview seemingly lean more towards disclosing the BD as opposed to seeing it as something that should be hushed up. To listen for voices of disclosure, the researcher searched for instances where the participants spoke about BD in a positive manner and how they can use it to learn life skills in general and to help others. At various stages of this interview, the voices of disclosure and silence complimented each other: the one allowed for learning from the other. The interviewees were able to understand the [voices of] silence around mental illness from others but were able to use their voices of disclosure to normalise it and create a safe space for others to learn about BD.

Participant 1A: Voices of disclosure

‘…I’ve never had this perception that depression/ADHD is a terrible thing… I’m more than happy to have it, I have no issues with it, I just want to use it to help people’.

Participant 1B:

‘We’ve always spoken about his illness a lot…’

Participant 1A:

‘…I think just the safety of knowing that there is no one blacked out on the situation… um so there’s a lot of open dialogue, so it’s pretty cool’.

Participant 1B: Voices of silence

‘So you [directed at client] had to be open about it because he had this like bag of medicine’.

Participant 1A:

‘…and they were looking at my medication and… I explained to them. These are people from around the world who might not have come across these medications but I was able to take the medication with them seeing like, kids have to, or people of all ages have to take it and then I can use that to just explain this is what I have been taking’.

Participant 1B:

‘And you found out how many other people have problems when you started talking about it because people normally keep quiet’.

Participant 1A:

‘Like I’ve seen with all my friends who have bipolar and that their parents saw it at say a teenage age whereas it could easily just be: “Oh, he’s being a teenager” .

Participant 1B:

‘People are scared to, to recognise it’.

Interview 2:

To listen out for the voices of disclosure, the researcher chose any occasion where the participants speak about communication with others about having BD. This could involve revealing the diagnosis to extended family members, school friends, the teachers and principal at school, and includes verbal, written or electronic types of communication. Voices of silence pertain to when the participants have been open about BD and made note of people's reactions to it.

Participant 2A: Voices of disclosure

'High school, so I go to [school's name] and there's a counsellor there, [counsellor's name] and she's been a great help… if I have a tough day and I'm not coping in certain aspects I can go to her and say: "Look I'm really struggling right now, this isn't just like my school, my condition is playing a role in this um can you please look at like if I can get some extra time on this or I need an extension, can you please speak to the teachers…?" I wasn't able to go to school the last term of Grade 11… and the whole school was like generally supportive… but our school is like very understanding…'

Interviewer:

'...who knows about your condition?'

Participant 2A:

'Pretty much everyone. I've never been one to hide it. I'm pretty open about it if it comes up in conversation. It's never been something I'm secretive about, if it comes up it comes up. I feel like if you are secretive about it and you want to make a game out of it then that's when you don't talk about it'.

'My boyfriend came the one time… so he came because it was a really difficult time, could see the signs, the downhill was coming and being able to feel I don't want to jeopardise an important relationship right now and I feel like I can't explain it as well as I'd like to so I'd like to bring him to [psychologist's name] and see if she can explain what's happening… just to explain my condition to him a bit better… now he'll say, if I'm going to therapy he'll say, "*Say hi*" or whatever…'

Participant 2A: Voices of silence

‘That’s another thing that I wanted to say, when you’re dealing with bipolar especially, it’s like a very um taboo, is that the right word to use um and people are very scared um of the word um and the condition itself …It allows for more people to have a greater understanding of the condition and I feel like if you allow for that, cannot take that understanding away from anyone and the more people you allow the ability to understand, the better you can make it and easier you can make it for those who do have the condition and they’re not going to fight themselves as much because they’re not going to feel as embarrassed or scared about their condition.’

Participant 2B:

‘…often if I would say my daughter’s got bipolar, people would go huh? and I’m going no, it’s maintained, it’s controlled, she’s got a totally normal life’.

Participant 2A:

‘…when I came back people were still kind of like sceptical about what’s happening so I feel like it’s like then they saw that I was normal, I was okay, like I was fine so now it’s like: “Oh she’s okay, she’s back, she’s fine, like it’s, like it’s okay”.

Participant 2B:

‘They’re scared that like, she’s going to break loose or something, you know, let’s just not crack her up again, you know?’

Interview 3:

The marker for the voices of disclosure is the word ‘open’. By her own admission, the participant often reveals her BD diagnosis too soon or at inappropriate times, an act which raises questions about the fine line between sharing and ‘over-sharing’ personal information. Voices of silence are identified by negative self-speak pertaining to BD and how the client herself, as well as how others, may perceive mental disorders. In this instance, it was the psychologist who recalled a time that the client referred to her mental difficulties in a negative light which hints at how she may have perceived it at the time, or how she believes others may perceive mental health issues.

Participant 3A: Voices of disclosure

'…I was very open about my bipolar. I would tell someone probably when I shouldn't have: "Listen, I have bipolar…"

Psychologist: Voices of silence

'Can I just add something because I can't remember your exact response [but] for whatever reason, this sticks in my head from when we discussed your diagnosis and I remember you saying: "Oh my word, so I'm not some kind of psycho-moron?'" So she was like, there is actually something going on here or like otherwise, like before, it was like, what is wrong with me?'

Her response presents what may be an interesting paradox: prior to diagnosis she felt like a 'psycho-moron' and yet receiving a diagnosis – what some might argue is confirmation of 'craziness' – actually caused her to feel less 'psycho' and provided her with some comfort.

Voices of burden versus Voices of care

It became clear during the course of the interviews and analysis that the significant others, mainly the mothers, experience a great burden as a result of parenting a child with BD. There is seemingly an inner conflict between caring for their child, as loving mothers do, and feeling burdened by the responsibility of a child with mental illness.

Interview 1:

To identify when the mother in this interview was using the voice of burden, the researcher decided on the phrase 'as a mother' as a marker.

Participant 1B: Voices of burden

'As a mother who is having problems with her child, you need someone to know what's going on…'

'Can I just mention one thing about this with all the interaction? I think it was important for me as a mother because [client's name] is a very um, sweet, pleasant child umm, out there, ok. And sometimes it's different at home. Like all children it's different at home so I think for, as a mother, I'm the only one seeing the different behaviour at home, nobody else is seeing it… and it's impor– as a mother – it's important for me to be able to tell other people about the other side…'

Interview 2:

To identify the voices of burden, the researcher listened for when the mother questioned her role as a parent and how to correctly handle and/or discipline her child. Discussing how well she knows and understands her daughter, now that she has been correctly diagnosed and is involved in collaborative therapy, allowed the researcher to pinpoint voices of care.

Participant 2B: Voices of burden

'…there's light at the end of the tunnel because I could only reprimand [daughter's name] so much… it's not just I need to discipline her and she doesn't listen, there's actually a condition… [psychologist's name] would guide us all the time, you know, this is behaviour at this age and this is the condition, so how do you deal with the condition side?'

'What have I done with this child? Why did I get this child?'

'…and still it's a learning curve, it's not clear-cut. I'd love to tell you it's clear-cut, it's not, I mean, sometimes I want to cry because I wish I could help and carry what they [referring to child and husband who both have BD], what they have'.

Participant 2B: Voices of care

'When she was at camp, she doesn't like being away, she hates, she can't sleep. She hates sleeping out. I would always have the teacher's mobile number and they all have mine …'

'I could send an email [to the school] which is great, they do communicate via tech. I would say [client's name] is struggling bit, that's the time of year cycle and she can be down…'

'It made me understand, it made me not frustrated. It made me treat [client's name] differently…'

Interview 3:

The boyfriend in this interview clearly has had to adapt his life to cater for his partner with BD. Although he downplays the burden he bears, it is quite clear that her needs impact on him quite significantly in terms of his professional and financial life. The marker the researcher noted when listening for the voices of burden is denial of said burden. For voices of care, the researcher identified moments when the significant other put himself in the BD individual's shoes, or displays of empathy.

Through Participant 3A, the researcher was able to get a glimpse into the BD individual's mother's world, and the burden she experiences. This too is captured below.

Participant 3B: Voices of burden

'Um, I wouldn't say it disrupts, it's more like um, like for example, would be we now need to find a new psychiatrist and it would mean coming through to CT so um something like that would possibly, work – I would then take a day off from work in the week and then work it back like on the weekend um, ja. So either, we have like flexible work hours, so my boss would be very understanding. It wouldn't have a negative impact at all but it's something that we've, we didn't immediately jump to doing but like I feel it's necessary um and ja, another thing is like, it's silly but just like getting the meds. They're like you know, now that we're completely independent, it's like you know, it's a bit of a financial hit but it's important so one makes arrangements, makes plans around it'.

'Um, and then, ja, then basically, some mornings that I just go to work a bit later so that we can go get her meds first. So it's not anything that's majorly negative and it does help that I'm not working at a place that's super strict about when you have to be there and stuff, so ja'.

Participant 3A: Voices of burden

'…another thing is that my mom later brought up that um she would get depressed, almost, like this was a recent thing she told me. She would get really depressed you know, this is her child, this is her mistake… but she would quite um she would feel it was her fault, she didn't know what was going on, she thought it was maybe the way she brought me up, you know?'

Participant 3B: Voices of care

‘I think it’s also just important to mention er regarding doing her learner’s and her driver’s, it’s just er aside from bipolar and ADHD and all that, um it’s even just for, if I were in her position, it would be a difficult thing to arrange around because [partner’s name] works um basically six days a week. She gets an off day in the middle of the week which changes from week to week and then once a month she gets a weekend off. So it’s like really quite a slog, ja, from week to week, you know?’

Voices of bad child versus Voices of mentally ill child

Prior to obtaining a diagnosis, the mothers mentioned not knowing whether or not they have a ‘bad’ child or have engaged in unsuitable parenting practices. Once they found out that mental illness was involved, there was a noticeable sense of relief, an absolving of a possible ‘crime’.

Interview 1:

The researcher noted that when the mother spoke of the time and her experiences prior to her son’s BD diagnosis, she used the first-person pronoun ‘I’. This indicates that she felt very alone during this period of her life and inward focused as she tried to understand her child’s behaviour and her role in it. On the other hand, the voice post diagnosis, the voice that is now aware of the fact that her child is mentally ill and not just an unruly child in need of firmer discipline, was identified by the use of the ‘we’ pronoun.

Participant 1B: Voices of bad child

‘…and from about three [years of age] I noticed like every single time I went to the shop, I had a tantrum out of him and I had already had one child and that child never had a tantrum. Every day I went to the shop, I had to stop taking him to the shop because he screamed all the time, screamed about everything, performed about everything…’

Participant 1B: Voices of mentally ill child

‘…the way he is now, medicated, um, we more or less, every day, is more or less what we would say ‘normal’ in other words. We haven’t got performances all the time, screaming matches, uh, traumatic episodes…’

Interview 2:

To distinguish between the voices of ‘bad child’ and ‘mentally ill child’, the researcher listened for instances where Monica, the mother spoke about Elizabeth’s behaviour and how to raise and discipline her. When listening for the voice pertaining to a child that is mentally ill, the researcher sought out words that implied knowledge and information; psychoeducation regarding BD, such as ‘understanding’ and ‘condition’.

Participant 2B: Voices of bad child

‘…she [client/daughter] was manipulative; she would tell me what I wanted to hear so she was very sneaky…’

‘…why did I get this child?’

‘I’d go: “Why is she screaming into a pillow and tearing up telephone directories into little pieces?” And I’d go: “Luckily those are not my books!” There’s a hell of a lot of frustration here, you know, why would that be? Is that in all child behaviour?’

Participant 2B: Voices of mentally ill child

‘…gosh, I can actually label this, if you want to call it that. It’s not just I need to discipline her and she doesn’t listen, there is actually a condition… I just think I can understand… this is behaviour at this age and this is the condition, so how do you deal with the condition side, you know?’

‘…but then I would actually understand it, I’d say: “Go for it, work with it, don’t smack me, go for the books, it’s okay…” When we started talking to [psychologist’s name] and then we would understand that it’s okay for her to be like, we labelled that emotion: “[client’s name] are you angry? are you sad?”

Interview 3:

The client in this interview spoke a great deal about being disciplined by her parents and it is this that the researcher used as a marker for voices of bad child as well as the words ‘didn’t know what to do’ and ‘scared’ in reference to her parents’ feelings about her behaviour. To listen for the voices of a child with mental illness, the researcher identified times when the participant discussed having a ‘name’ or ‘label’ for her behaviour.

Participant 3A: Voices of bad child

‘My parents were very scared. I think they kind of didn’t know what to do like I didn’t know what to do but at the same time, they were extra harsh because they didn’t know what to do. My dad especially, he would get really harsh. I would obviously lash back and there would be this whole thing going on and eventually they got scared… they didn’t know what to do with it and they would hide my brother away from me because they didn’t know how to react…’

Participant 3A: Voices of mentally ill child

‘Yes, I originally no one told me [that she had been diagnosed with BD] when they found out. I found out a little while later and I was like: “Oh, that makes sense!” so it was important for me to have a name for it and for me to have an um ability, if I have a name, I have a way of later on recognising: “Listen, this thing, this bipolar, it is not [me].” So giving it two separate names… my mom for example or my dad, they’d say, “This is the bipolar.” And they would say: “This is [client’s name]”. It’s almost like a way of saying, you know, if I have a name for it then I can say: “This is not [me],” kind of pushing it there…’

4.6. Conclusion

The ultimate aim of this study was to determine whether a postmodern, collaborative approach within narrative therapy would assist in improving the QoL of patients presenting with BD, as well as the lives of their significant others. The objectives of this study include exploring whether or not this type of therapy has an effect on communication between the individual with BD and their SO’s and also to examine how involving various medical professionals in the therapeutic process may facilitate change in the lives of the individual with BD and their significant others. The themes that naturally arose during the course of the data collection and analysis assisted the researcher to make certain, relevant determinations.

Through the use of Gilligan’s Listening Guide, the researcher was able to extract important themes/plots from the participants’ narratives. These dominant themes will be further discussed in the following chapter.

5. CHAPTER 5 – DISCUSSION AND IMPLICATIONS OF FINDINGS

5.1. Introduction

In this chapter, an in-depth interpretation of the findings from Chapter 4 will be presented. Ten dominant themes emerged from the data, viz. Early-onset BD, comorbidity, helping others, relevance of diagnosis, illness management, relationships, collaboration, stigmatisation, overshare and difficulty of being the significant other/mother of an individual with BD. These themes are discussed in terms of the study's conceptual framework and research implications are considered.

5.2. Research implications

5.2.1. Early onset bipolar disorder (EOBD) / Paediatric BD (PBD)

- I was still very young -

All three of the participants diagnosed with BD were reportedly already showing symptoms of BD at a very young age. Bipolar spectrum disorders were originally believed to be the exclusive domain of adults. However, the general consensus from recent literature is that BD can have a childhood or adolescent onset and cases of this nature are frequently recorded (Schudlich et al., 2015). The last twenty years have seen much research focused on BD in children and adolescents (Goldstein et al., 2017). PBD, occurring before the age of 18 years old, is a developmental disorder considered one of the most debilitating and profound psychiatric conditions that can affect youth (Lopez-Larson et al., 2016). Merikangas et al. (2011) and Van Meter et al. (2011) suggest that PBD affects approximately 2% of individuals under the age of 18. Likewise, for 55–60% of adults with BD, the pathology begins in childhood and adolescence with subthreshold forms or prodromal signs of the disorder (Frias, Palma & Farriols, 2015). South African estimates of prevalence are similar (Kleintjes et al., 2006; Republic of South Africa, National Department of Health, *National Mental Health Policy Framework (NMHPF) and Strategic Plan 2013 – 2020*, 2013).

According to the diagnostic criteria of DSM-5, the mean age at onset of the first depressive, manic or hypomanic episode is 18 years of age for bipolar I while the average age for onset of bipolar II is in the mid-20's although it can begin in the later stages of adolescence and during the course of adulthood (American Psychiatric Association, 2013). Bradfield (2010) suggests that the DSM IV-TR diagnostic outline is a deficient account of its manifestation in children.

> "*With the DSM describing BD as defined by distinct episodes of mania or depression with inter-episode return to health functioning, paediatric BD, which manifests as a rapid cycle of fluctuating moods, falls into a nosological gap*" (Bradfield, 2010, p.242).

What this means in terms of diagnosis, treatment and the course of the disorder is that those with EOBD may be undiagnosed or misdiagnosed, and as a result, go untreated, mistreated and have no means of buffering the course of the illness, resulting in reduced QoL. Due to the frequency of mood fluctuations, children with incorrectly managed BD are frequently disabled by the disorder.

Bradfield (2010) points to two further consequences as a result of a lack of clarity in terms of diagnosis. The first involves evidence of a typically long period of time between onset and diagnosis, which can have particularly negative impacts on the disorder. Delayed recognition of BD leads to complex difficulties as far as the stabilisation of mood is concerned (Faedda, Baldessarini, Glovinsky & Austin., 2004). Delayed recognition and intervention is also correlated with disruptions in personality development, which may manifest in disordered personality traits. The second consequence of the lack of diagnostic clarity for paediatric BD relates to the mismanagement of the illness. The frequency with which ADHD (instead of paediatric BD) is diagnosed may reflect clinicians' tendencies to emphasise attentional processes during the assessment. Children with BD are frequently given the incorrect diagnosis of AD/HD, and consequent psychopharmacological treatment with a stimulant such as Ritalin. Ritalin can have a destabilising effect on the child's mood, with consequent debilitation in functioning at school and home (Faedda et al., 2004).

PBD is characterised by chronic, non-episodic, ultra-rapid cycling (Bradfield, 2010; Faedda, Baldessarini, Glovinsky & Austin, 2004; Vogel, 2000). In children with BD, impairments in peer and family relationships and school functioning have been observed (Bradfield, 2010). Symptoms common to depressive episodes include feelings of guilt or worthlessness, suicidal ideation, a sustained sad or irritable mood, changes in appetite, loss of interest in activities previously regarded as pleasurable and psychomotor retardation or agitation. Oscillations in mood ranging from great irritability, elation and fatuousness, increased rate, volume and quantity of speech, an indifference towards the dangers associated with high-risk activities and a heightened energy with a decreased need for sleep are some of the symptoms associated with manic episodes. A fundamental characteristic of PBD is irritable mood which "*manifests in aggressive, hostile behaviours with intense, inconsolable responses to stressors*" (Bradfield, 2010, p. 242).

The first interview revealed that Jackson demonstrated a cyclic nature or pattern in his behaviour that was discerned by his initial psychologist from around three to six years of age. In Interview two, Monica described observing rapid changes in her daughter's mood, especially noted when Elizabeth engaged in typical childhood activities such as painting, from around the time she was in pre-primary school. Impulsive and risky behaviour such as leaving the school grounds in Grade 1 was also described. In the third interview, Maggie recalled physically aggressive behaviour towards her brother in particular, from the age of 11.

5.2.2. Comorbidity

- … Is diagnosed with both -

All three of the participants in this study who had been diagnosed with BD, were also diagnosed with ADHD. Childhood ADD/ADHD is commonly comorbid with BD, and ADHD regularly precedes the diagnosis of early-onset BD in children (Jerrell, McIntyre & Tripathi, 2010). Distinguishing between paediatric BD and ADHD is a challenge since hyperactivity is at the heart of both disorders (Faedda et al., 2016). DSM-5 lists ADHD as a differential diagnosis and states that it may be misdiagnosed as BD, especially in children and adolescents (American Psychiatric Association, 2013, p.131). ADHD shares many symptoms with a manic episode including racing thoughts, distractibility, decreased need for sleep and rapid speech. DSM-5 suggests that "double counting" of symptoms toward BD and ADHD can be circumvented if the medical professional clarifies whether the symptom(s) represents a distinct episode.

According to Bradfield (2010) a significant element of prescriptive hygiene includes working with misdiagnosed PBD as AD/HD, or a bipolar-AD/HD comorbidity. Ritalin, a stimulant used in the treatment of ADHD has a well-documented potential to aggravate mood presentation of children diagnosed with BD and thus it is frequently necessary to fix diagnostic errors and redesign the treatment plan by concentrating on mood stabilisation, the chief concern in the treatment of BD. Mood stabilisation should be addressed as a matter of urgency, prior to attending to attentional symptoms, even in cases where ADHD presents as a genuine comorbidity (Bradfield, 2010). Testing whether objective measures of sleep, circadian rhythms and activity would assist in distinguishing paediatric patients with BD from ADHD and typically developing controls, Faedda et al. (2016) found that these were indeed atypical in individuals with BD. These researchers assert that the use of wearable sensor technology may provide bio-behavioural indicators that could aid in distinguishing between children with BD from those with ADHD and typically developing children.

Similarly, Faedda et al. (2004) note that children with BD regularly have histories which reflect a range of diagnoses including (in order of frequency): ADHD (60%), anxiety disorders including obsessive compulsive disorder (OCD) (39%), MDD (37%) and oppositional defiant disorder (ODD) and CD (21%) (Bradfield, 2010, p. 243). More recently, Yen et al. (2016) mention the ‘Course and Outcome of Bipolar Youth’ (COBY) project which aimed to examine the influence of comorbid disorders on the likelihood of recovery and recurrence of mania and depression in youth with BD. In this COBY sample at intake, 59.8% of the youth were diagnosed with ADHD, 39.5% with ODD, 39% with one or more anxiety disorders, 12.8% with CD and 9.1% with one or more substance use disorders. Singh, DelBello, Kowatch and Strakowsky (2006) suggest ADHD as a prodromal[9] condition preceding the emergence of PBD. Due to the strong correlation between BD and ADHD, some researchers hypothesise ADHD as a developmental forerunner of PBD, however minimal evidence has been found to support this postulation (Bradfield, 2010). There are three possible reasons for the link between BD and ADHD which include ADHD as a true comorbidity, a phenotypic variant of BD or ADHD as displaying symptoms within the BD spectrum.

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[9] Prodrome has its origins in the Greek word prodromos which means the forerunner of an event (Fava & Kellner, 1991 as cited in Yung & McGorry, 1996, p. 353). “*In clinical medicine, a Prodrome refers to the early symptoms and signs of an illness that precede the characteristic manifestations of the acute, fully developed illness*” (Yung & McGorry, 1996, p. 353).

The researcher has focused here on comorbidity with ADHD as this is what emerged from this particular study, making use of a bottom-up approach. However, it should be noted that studies have found BD to co-occur with various other psychiatric conditions such as panic disorder, eating disorders and obsessive compulsive disorder (Freeman, Freeman & McElroy, 2002; Krishnan, 2005; McElroy et al., 2001; McElroy, 2004; Singh & Rajput, 2006) which also need to be identified and treated appropriately to maximise outcomes. Asherson et al. (2012) note that:

> ADHD in adults can resemble, and often co-occurs with BD and borderline personality disorder (BPD). This can lead to mistaken diagnoses and ineffective treatment, resulting in potentially serious adverse consequences. All three conditions can substantially impair well-being and functioning, while BD and BPD are associated with suicidality (p.1657).

McElroy et al. (2011) point out that while much data suggests a co-occurrence with regards to BD and anxiety, substance use and impulse control disorders, the link with BD and eating disorders has received less attention. Comorbidity is linked to negative effects on the course, outcome as well as the treatment response of BD (McElroy et al., 2001; Merikangas et al., 2008; Nierenberg et al., 2005; Simon et al., 2004) and must be taken into consideration when the clinician is diagnosing and treating the patient.

5.2.3. Helping others

- I have it; I can help all my friends -

What came through strongly during the course of the interviews is a desire of those with BD to help others cope with their own experiences of mental ill-health as well as general ‘helpfulness’ in their daily lives. This can reasonably be argued and understood as a defence mechanism which helps the person handle anxiety. In the case of the participants wanting to help others, the defence mechanism of compensation (Corey, 2009) seems fitting. Compensation is the act of obscuring perceived weaknesses or creating positive traits to offset any limitations. Corey (2009) argues that this is not necessarily a negative way to behave as compensation “*can have direct adjustive value*” (p. 65) and it can also be the person’s way of getting others to shift focus from the ways in which they perceive themselves to be inferior. One could also argue that the participants in this study are using the defence mechanism or type of behaviour known as reaction formation. Some individuals perceive their own feelings and experiences as socially undesirable or they believe others feel this way about their traits and thus engage in attempts to convince others or themselves that the opposite is true; the anxiety inducing feeling, impulse or thought is repressed and its opposite is displayed by the individual (Eremie & Ubolum, 2016).

There is a need for humans to have purpose; a reason for having BD and a purpose in life in general. The researcher asserts that if the individual with BD focuses solely on the negative aspects of having a mental disorder, they can easily become disheartened and caught up in suffering. On the other hand, attention to the positive aspects such as being able to assist others with their mental disorders, allows the individual to feel as if their difficulties mean something and have a purpose. Renowned existential psychologist Viktor Frankl refers to this as the ‘will to meaning’, an adaptive frame of mind involving one’s attitude towards a given set of circumstances (Corey, 2009). According to Frankl:

> the essence of being human lies in searching for meaning and purpose. We can discover this meaning through our actions and deeds, by experiencing a value (such as love or achievements through work), and by suffering (in Corey, 2009 p.132).

By no longer focusing on the downside of mental illness and instead using their experiences to assist others, the person with BD can be seen as contributing to society, being relevant and useful. This, in turn, increases self-esteem and contributes to an improved QoL. In Australia, New Zealand, the US and UK, there has been significant expansion in the employment of peer support workers (PSW’s). In the US services run for and by individuals and their family members with serious mental health problems are so prolific that they double in number compared to the more traditional mental health organisations run by professionals (Repper & Carter, 2011). Ochocka, Nelson, Janzen and Trainor (2006) conducted a qualitative study of consumer views and noted that:

> Participation in peer support as both a provider and recipient resulted in an increased sense of independence and empowerment. Specially, consistent

> engagement in peer support increased stability in work, education and training, which will allow for a sense of empowerment. Furthermore, participants reported gaining control of their symptoms/problems by researching their illness independently, and, consequently becoming more involved in their treatment, thereby moving away from the tradition role of 'mental patient' (in Repper & Carter, 2011, p. 396).

This too may account for the reason the participants expressed a strong desire to assist others: It provides them with a feeling of empowerment. Numerous studies indicate that peer support can better both confidence and self-esteem (Repper & Carter, 2011). "*This has been attributed to the mutual development of solutions, the shared exploration of 'big' feelings and the normalisation of emotional responses that are often discouraged and seen as crises in traditional health care*" (Repper & Carter, 2011, p. 396).

In South Africa too, the government published report that recognises that community-based support is an essential means of providing services in under-resourced areas (Republic of South Africa, National Department of Health, *National Mental Health Policy Framework (NMHPF) and Strategic Plan 2013 – 2020*, 2013)

5.2.4. Relevance of diagnosis

- I just welcomed it; I can actually label this; a relief -

Having a diagnosis appears to have provided the participants and their significant others with a deep and abiding sense of relief. With a diagnosis comes understanding of previously confusing behaviours, cognitions, emotions and emotional responses to situations, dysfunctional relationships and impaired functionality with regard to school or work. The individuals involved in this study used phrases such as 'light at the end of the tunnel' and 'it was helpful otherwise then I don't know where I would be without having it diagnosed or medicated' in response to questions about obtaining a diagnosis which clearly reveals the extent to which being diagnosed had a positive effect.

Proudfoot et al. (2009) conducted a qualitative study which set out to explore the difficulties and experiences of individuals newly diagnosed with BD. Participants received email support from ‘informed supporters,’ people who had effectively managed their condition for two years and who received training to provide support to those recently diagnosed. This study found that many participants revealed feeling shock, denial, disbelief and anger at their diagnosis. In contrast, similar to what the researcher found when conducting this study, some participants, especially those who had a long delay before receiving the right diagnosis, described feelings of relief. Clinical experience and research both suggest that obtaining “*a diagnosis legitimates a person’s illness, both to the ‘self and the wider social world, and it gives meaning to the illness experience, which is often uncertain and confusing*” (Proudfoot et al., 2009, p.127). The participants of the study conducted by Proudfoot et al. (2009) were conflicted as to whether they placed a negative meaning on their recent diagnosis as it implied that they were crazy, or a positive meaning as it allowed a change of emphasis from a ‘characterological defect’ to a ‘neurochemical imbalance’. In contrast to these findings, the researcher noted that for all three participants of this study, the overall attitude was one of relief and a positive meaning was attributed to their BD diagnoses.

Early identification may serve to ward off various long-term repercussions of BD and a considerable percentage of children may show a course towards illness resolution upon long-term follow-up. Post (2014) found that duration of the delay to first treatment for either mania or depression is a predictor of more time and severity of depression in adulthood, highlighting the importance of obtaining a diagnosis. Singh and Rajput (2006) suggest that the misdiagnosis of BD results in treatment that is futile and thus the outcome may be further worsened. A misdiagnosis can cause a heightened risk in terms of recurrence and chronicity of episodes due to a lack of appropriate treatment.

The most common misdiagnosis given for those with BD is unipolar depression (Hirschfeld & Vornik, 2004) often treated with antidepressants, the consequences of which include rapid cycling and episodes of mania (Ghaemi, Lenox & Baldessarini, 2001). Patel et al. (2015) also found a significant association between the use of antidepressant therapy and mania. Vohringer and Perlis (2016) state that medical treatments used for MDD might “*actually worsen the long-term course of illness in BP disorders, resulting in increasing risk for manic episodes or simply more frequent mood episodes, or cycle acceleration*” (p.3).

Linked to the delay in treatment use of mood stabilisers in patients with BD is an increase in healthcare costs which also include increased attempts of suicide and higher hospital use rates (Singh & Rajput, 2006). Misdiagnosis of BD also has an economic effect as it results in higher treatment costs and a loss of productivity and work days for these patients. Those who have been misdiagnosed lead disrupted lives and with the onset of BD frequently occurring in the time of adolescence, this has the potential to negatively impact on interpersonal skills development, education and earning prospects. Meyer and Meyer (2009) suggest that *"[m]isdiagnosis of bipolar disorder has been found to be associated with other consequences such as high risk of suicidal attempts, longer hospitalisations and major psychosocial, legal or financial problems*" (p.174).

Hirschfeld et al. (2003) state that chart records indicate schizophrenia as the second most common misdiagnosis for BD. The repercussions of misdiagnosing an individual actually suffering from BD with schizophrenia can be severe and may lead to ineffectual treatment or treatment that causes harm. The diagnosis of schizophrenia as opposed to BD may lead to treatment involving neuroleptics which has numerous side effects (Meyer & Meyer, 2009). The correct diagnosis not only provides the individual and their significant others with emotional relief and an understanding of the disorder, but also paves the way for effective treatment which in turn can lead to a better QoL for both the person with BD and their significant others.

5.2.5. Illness management

- She gave us ways to cope, my toolbox -

The participants of this study and their significant others acknowledged the usefulness of having the tools needed to manage their disorder. Illness management includes psychoeducation regarding BD. At its core, family psychoeducation aims to educate family members about mental health issues and provide them with the skills needed to cope with the disorder, medication adherence, effective communication or interpersonal skills development and attending therapy.

Murray et al. (2010) conducted a study which aimed to describe self-management strategies deemed effective by high functioning individuals diagnosed with BD, and to discuss the results from a clinical point of view. These researchers suggest that historically, the outcome in BD has been determined by the assessment of objectively measured clinical material according to clinician-rated assessment scales. Clinical information in this instance includes relapse rates or the degrees by which symptoms have been reduced. The focus has now changed towards more meaningful forms of assessment to evaluate therapeutic outcomes, for example, functional outcomes or psychosocial functioning. The participants in the study of Murray et al revealed six self-management strategies including: *"(1) sleep, rest, diet and exercise; (2) ongoing monitoring; (3) reflective and meditative practices; (4) understanding BD and educating others; (5) connecting with others and (6) enacting a plan*" (p.97). These strategies arose from the participants' own experiences and were viewed as effective by these high functioning individuals. Murray et al. (2010) concluded that the results validate the importance of healthy behaviours which can be used by clinicians to increase hopefulness in clients with BD and enhance participation in psychosocial interventions.

It is essential to promote awareness of stressors, sleep disturbance, early signs of relapse, and adherence to regular patterns of activity. Sleep disruption is often a trigger for manic episodes and also associated with depression. Adopting regular patterns of daily activity is helpful (Goodwin, 2012) and education regarding illness management may assist with issues such as nonadherence to treatment. According to Sajatovic, Davies and Hrouda (2004) *"[n]onadherence to treatment has been identified as a frequent cause of recurrence or relapse of bipolar disorder that is associated with such negative consequences as rehospitalisation and suicide*" (p.264). It is estimated that as many as one in three individuals with BD fail to take approximately 30% of their medication (Kolostoumpis et al. 2015; Sajatovic et al., 2004). The results of the study undertaken by Sajatovic et al. (2004) revealed that psychoeducational interventions that focus specifically on BD can improve outcomes and treatment adherence and the most effective therapies for maximizing adherence are patient-focused and include family members and/or significant others.

The present study with its small sample size, dealt mainly with adolescents who attribute their ability to manage their illness to their psychologist. These individuals also revealed a heavy reliance on their mothers/significant others in terms of medicine adherence; one participant often does not wake up in time to take his medicine and while sleeping, his mother feeds him the tablets. This leads one to question whether or not the person diagnosed with BD is able to manage their illness without professional guidance and assistance from significant others, especially in younger individuals. From the testimony of the participants of this study as well as the literature discussed, it is clear that having the skills to manage BD improves the individual’s ability to function and participate in life.

5.2.6. Relationships

- I’m able to connect with people -

Relationships are an important aspect of most people’s lives, and this holds true for those diagnosed with BD. Researchers suggest “*that positive and secure relationships are of fundamental importance for human functioning, since it reflects the ‘basic need to belong*” (Hagenauer, Hascher & Volet, 2015, p. 387). In terms of optimal wellbeing, theoretical models place emphasis on the significance of meaningful and close personal relationships and their role in human flourishing. Empirical research shows that “*people who are more socially integrated and who experience more supportive and rewarding relationships with others have better mental health, higher levels of subjective well-being, and lower rates of morbidity and mortality*” (Feeney & Collins, 2015, p.113).

There are numerous psychosocial stressors that influence the course of BD and instances of recurrence of the disorder, but aspects related to family have probably attracted the most attention (Kolostoumpis et al., 2015). Caregiver burden, a variable of the family milieu that has been shown to impact on the course of BD, has been the focus of much research due to its significant prevalence among relatives of people with BD. According to Kolostoumpis et al. (2015) having a family member with a diagnosis of BD can negatively affect leisure activities and social encounters of the patient’s family members and lead to financial strain. This can have a considerable consequence in terms of the relationships between family members. The family members may experience feelings of anger and resentment toward the individual with BD, as their mental illness impacts negatively on their lives. In turn, the person with BD may feel guilty for influencing their family, resulting in unhappy relationships within the family.

In the present study, the researcher found that prior to collaborative therapy, relationships between the individuals with BD and their significant others were typically tumultuous, and in extreme cases, violent. The three participants of this study as well as their significant others all disclosed instances of difficulties within their relationships. Maggie, revealed a particular difficulty in her relationship with one of her siblings whom she had physically attacked. A mother described her daughter, prior to therapy, as ‘manipulative’, ‘sneaky’ and physically violent as well [the individual would bite her mother]. Jackson and his mother admitted that prior to therapy, ‘it was difficult for us’, and that they ‘did not get along’. Two of those interviewed for this study admitted to feeling concerned about how their diagnosis might interfere with their romantic relationships, and due to this, involved their partners in the therapeutic process to varying degrees.

Through collaborative therapy, those involved are given tools to enhance their communication skills and interpersonal skills. Understanding BD provides a way to better relationships and enhance overall QoL. After entering therapy, the participants of this study described new or improved abilities to connect with others on a deeply emotional level which enhanced the quality of their relationships significantly.

5.2.7. Collaboration

- I wouldn’t do it any other way -

As discussed in Chapter 1, the researcher’s definition of collaboration refers to a therapeutic process that can take place between two individuals (the mental healthcare professional and the client), and may also include other professionals in the medical field as well as family members or close friends of the client seeking treatment for BD. It involves a mutually agreed upon goal for intervention outcomes. In the first interview, Jackson expressed his understanding of collaboration in a therapeutic setting as those involved all working towards a common or ‘ultimate’ goal. His mother viewed collaboration as a pooling of information and resources so as to treat the client ‘correctly’ and also expressed relief with regards to knowing that ‘there’s always someone I can go to’ and not having to make decisions on her own. In the second interview, Monica used the saying ‘no man is an island’ to describe why she finds collaboration useful; and also said it allowed her to just ‘be a mom’ without having to take on the role of therapist for her daughter: she has someone to carry that load for her. The participants unanimously advocated collaborative therapy over individual therapy.

Research on the effectiveness of collaboration points toward a method that is seemingly beneficial and worthy of further study. Berk, Berk & Castle (2004) describe the value of a collaborative approach to the treatment alliance. Despite the limited research on collaboration, particularly in BD, confirmation from other mental illnesses brings to the fore the potential impact of the treatment alliance for BD (Berk et al., 2004). A collaborative communication style may have a positive influence on some risk factors including beliefs about medication and attitudes toward treatment and adherence behaviours. This type of communication style involves a reciprocal exchange of information between doctor and patient, a sharing of and listening to one another's points of view, an emphasis on the client's active role in treatment and an equal partnership for conflict resolution and problem solving. A collaborative communication style has been shown to increase patient knowledge of the medication schedule and beliefs about medication. Consequently this has led them to be more likely to go to follow up appointments (Berk et al., 2004).

Interventions are effective when the patient and his/her significant others are regarded as active partners in ongoing management (Bauer & McBride, 2003; Berk et al., 2004). Such interventions help maximize adherence. Berk et al. (2004) also suggest that referrals to various interventions and collaboration with significant others and other service providers, optimise collaborative care. In terms of progress made towards medication adherence, the most promising evidence comes from specific psychosocial interventions used alongside pharmacological treatment. The collaborative approach in psychosocial interventions is often extended to significant others and the service provider team, providing a supportive collaborative care network (Bauer & McBride, 2003). The doctor-patient alliance may benefit from some of the strategies suggested in psychosocial interventions such as involving the patient and other stake holders as active partners in illness management or using psychoeducation to develop insight about the illness (Berk et al., 2004). Collaboration with significant others does not mean that the client's right to confidentiality is violated, as the therapeutic process between client and therapist remains confidential and the client is in control of what information they would like to share with significant others.

Kolostoumpis et al. (2015) refer to a new variation of this type of therapy that combines FFT with health-promotion intervention which aims to alleviate the symptoms of BD by working only with caregivers in an attempt to better their illness-management skills and self-care (Perlick et al., 2010). Initial findings have supported the efficacy of this type of treatment, "*finding it associated with reductions in caregivers' depressive symptoms and health risk behaviour as well as with reductions in patients' depressive symptoms*" (p. 292).

As per the outcomes of this study, collaboration as a therapeutic technique appears to be successful. The researcher is aware, however, that this study involved a small group of participants. Therefore more research will be needed to make these findings truly generalisable. Furthermore, the willingness of these particular clients to take part in the study suggests that as individuals, they are quite likely to enjoy and thus benefit from, a collaborative type of therapy and this may not be the same for all persons with BD.

5.2.8. Stigmatisation

Stigma refers to "*a mark of disgrace associated with a particular circumstance, quality, or person*" (Oxford Living Dictionaries, 2016). Research indicates that those with mental illness are stigmatised more extremely than others with health conditions (van der Sanden, Pryor, Stutterheim, Kok & Bos, 2016). Due to stigma, it is likely that many individuals are, as Elsa, the mother from the first interview stated 'scared to recognise it (mental illness)'. Corrigan and Watson (2002) support this assertion and state that stigma can result in label avoidance, when people are reluctant to be diagnosed with –or be seen as seeking treatment for– a mental illness and often delay seeking treatment.

The participants of the present study appeared to be relatively unconcerned by the stigma of having a mental disorder although all expressed an awareness of possible negative attitudes towards those who have been diagnosed. In the first interview conducted for this study, Jackson mentioned that people often "brush it [mental illness] aside" while his mother noted that "people don't talk about it" and "people normally keep quiet” about mental issues. In the second interview, Monica mentioned that “they’re [society at large, the school the participants attends in particular] scared that like she’s going to break loose or something” implying that she is aware of people’s negative attitudes towards those with a diagnosis of mental illness.

Stigma can be divided into two types, namely public stigma –the reaction that the general population has to people with mental illness– and self-stigma which refers to the prejudice which people with mental illness have against themselves (Corrigan & Watson, 2002). Internalised stigma, according to Oliveira, Esteves and Carvalho (2015) is a prevalent issue for some individuals with mood disorders such as BD. These two forms of stigma can be understood in terms of three elements: stereotypes, prejudice and discrimination. Stereotypes represent communally agreed upon ideas of groups of people, and are efficient, social knowledge structures that are assimilated by the majority of members of a particular social milieu (Corrigan & Watson, 2002). In philosophical and psychological literature, it has been argued that stereotypes should be defined as accurate or inaccurate associations between individuals and attributes, where the associations are made due to the perceived social group membership of the individuals (Puddifoot, 2017). People may be aware of stereotypes but not in agreement with them; on the other hand, individuals who are prejudiced support negative stereotypes. In contrast to stereotypes, which are beliefs, prejudices typically have a negative evaluative element and elicit an emotional response such as fear or anger to the stigmatised group.

Picco et al. (2016) assert that stigma in general is ubiquitous and can affect everyone for various reasons, and more specifically, stigma directed at individuals with mental illness is present across all cultures and societies. Misconceptions regarding mental health issues often results in prejudice and thus those affected can be “*robbed of opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people*” (Corrigan & Watson, 2002, p.16). Oliveira et al. (2015) claim that mental illnesses and some mental healthcare environments can be extremely stigmatising and are linked to a decline in the quality of social relationships for people with mental disorders as well as a decrease in self-esteem.

There is a possibility that the fathers of the participants feel embarrassed by their children with a mental illness diagnosis, and that this stops them from fully engaging in the collaborative therapeutic process. The absence of fathers in the therapeutic process is discussed in more detail under the theme 'Difficulty of being the significant other/Mother of individuals with BD' (section 5.2.10). Stigma does not only affect the person with a mental illness; family members are affected too. 'Courtesy stigma' or 'stigma by association' occurs when someone is believed to be linked to an individual with a stigmatised identity (Bos, Pryor, Reeder & Stutterheim, 2013; van der Sanden, Pryor, Stutterheim, Kok & Bos, 2016). Those related to someone with serious mental illness are frequently stigmatised through numerous stereotypes and prejudices such as the belief that family members are either crazy by association or to blame for their family member's mental disorder and/or mental illness is viewed as a consequence of bad parenting. For family members, the result of stigma can be experienced in emotional, behavioural and social spheres, including feelings of guilt and shame, concealment of the mental disorder from others and loss of support from both friends and family (Muralidharan, Lucksted, Medoff, Fang & Dixon 2016). Courtesy stigma or stigma by association can have an enduring effect on the QoL of significant others as well as on the well-being of the family member with mental illness (van der Sanden et al., 2016). Family members may adopt various coping strategies to deal with the stress of having a relative with mental illness and these can either be adaptive[10] such as acceptance, positive reframing and the use of emotional support or maladaptive like self-distraction, denial or avoidance. Worthy of further study is the possible employment of unhealthy coping mechanisms such as denial or avoidance in fathers of those with mental illness, resulting in non-participation in therapy.

The researcher believes that the lack of fear of being stigmatised may have occurred in this study for a number or reasons. One may be as a result of collaborative therapy. Collaborative therapy as practised by the psychologist affiliated with this study largely involves open and honest communication between those participating in the therapeutic process. It would appear that this has built the confidence of the

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[10] In this context, adaptation refers to the level to which the individual copes psychologically, physiologically and socially when faced with a stressor (van der Sanden et al., 2016).

individuals with BD so that they are open about their mental illness with others. Other possible factors that may impact the way in which the participants experience stigma are the presence of a reliable support base (their mothers, for example) and the fact that they are still quite young. There is a chance that the participants may only experience stigma later on in life when forging romantic relationships or when attempting to enter the job market.

5.2.9. Overshare

- I was very open about my bipolar, I would tell someone probably when I shouldn't have: “Listen, I have bipolar” -

In terms of stigma, one might assume that those with a diagnosed mental disorder would choose to not disclose their illness to strangers. However, the participants of this study admitted to revealing their diagnosis to others, often even when not particularly ‘necessary’. It is this propensity for [over]sharing that may have inspired the participants to agree to take part in the study. This tendency to overshare the BD diagnosis may be linked to a lack of experience with stigma. The age of the participants –most were in their teens– may also be a contributing factor regarding oversharing as they may still be learning about establishing and adhering to socially accepted boundaries. Baez et al. (2013) suggest that this can be referred to as social cognition, the processes underpinning behaviour which enable individuals to take advantage of being part of a social group. As a construct, social cognition involves domains such as empathy, knowledge of social norms, and emotional processing. Several studies suggest that individuals who experience neuropsychiatric conditions such as BD have deficits in this area (Cusi, Macqueen & McKinnon, 2010; Ibanez et al., 2012; Kohler, Hoffman, Eastman, Healey & Moberg, 2011; Schaefer, Baumann, Rich, Luckenbaugh & Zarate, 2010; Seidel et al., 2012). Many BD patients cannot judge social interactions with any true accuracy (Baez et al., 2013) and this may result in the tendency to overshare; the BD individual may not be aware that a disclosure of their diagnosis makes the person with whom they are conversing uncomfortable, for instance. Social cognition, at its centre, necessitates the assimilation of contextual information so that one may gain access to the social meaning (Baez et al., 2013) however, limited research has been conducted with regards to context processing in BD. Individuals with BD may show a context processing deficit of non-social information resulting in the inappropriate sharing of personal information.

The age of the participants may also have had a significant influence on the degree of personal information shared with others. Adolescents are prone to impulsivity, risk-taking, emotionality and engaging in spur of the moment actions despite consequences (Leshem, 2016). While development of the ability to control executive functions is still underway, adolescents are not as competent when it comes to the regulation and control of their behaviour, especially in social and emotional situations. This may account for the seemingly easy manner in which the adolescents involved in this study shared their BD diagnosis.

There are also deficits in interpersonal and social functioning, even in euthymic states, connected to BD (Hawken et al., 2016). Hawken and colleagues (2016) set out to compare Theory of Mind (ToM)[11] decoding abilities using the ‘Eyes’ task among patients in the euthymic, depressed and manic phases of both BD I and BD II. These researchers found that those in the manic phase were significantly less accurate at interpreting the subtle social features of eye expressions than those in either the depressed or euthymic phases, and this difference was driven by the disorganized speech and appearance, language/thought disorder, and delusional symptoms of mania (Hawken et al., 2016). The results of this study correspond with other studies of ToM reasoning, such as the work of Bora, Bartholomeusz & Pantelis (2016) which suggests that the phase most strongly correlated to deficits in social cognition is mania. Although these types of deficits occur most severely during a manic phase, the deficits also occur in depressive and euthymic states which may influence the extent to which individuals diagnosed with BD (over)share details of their disorder.

5.2.10. Difficulty of being the significant other/mother of individuals with BD

- What did I do to deserve this? -

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[11] “*Theory of mind (ToM) – the ability to decode and reason about others’ mental states, including beliefs, desires, emotions, and intentions – forms the foundation of social cognition and, thus, is critical to successful social and interpersonal functioning*” (Premack & Woodruff, 1978 cited in Hawken et al., 2016 p. 275).

It became evident during the course of this study that for the most part, the burden of care fell upon the mothers of the clients with BD. Mothers may perceive a higher caregiving burden than fathers because they are in closer contact with their child, feel more responsible for the disorder, or are more affected by their child’s relapses or crises. The knowledge that the burden of caring for a psychiatric patient in the home is significantly heavy is not new (Kolostoumpis et al., 2015).

The burden associated with a family member with BD may be high. An estimated 90% of relatives of people with BD report moderate to high levels of subjective burden (Kolostoumpis et al., 2015; Perlick et al., 2007). High levels of financial strain are associated with patients with BD, and impairments in social encounters and leisure activities are frequently noted. Furthermore, clinically significant depressive symptoms, using self-report screening tools, are observed in 24–38% of relatives of those with BD (Perlick et al., 2007). Suicidal behaviours and ideation exhibited by the patient are associated with higher symptoms of depression in family members (Chessick et al., 2007). Relatives who hold assumptions about BD and in particular, beliefs about the BD individual’s ability to control his/her symptoms are also likely to experience a significantly greater burden (Kolostoumpis et al., 2015).

A variable of the family milieu that has been shown to influence the course of BD is the caregiver burden. In particular, studies have suggested that high levels of caregiver burden are linked to emotion-focused coping and lower mastery among caregivers, as well as poorer medication adherence and less favourable clinical outcomes in patients (Perlick et al., 2008; Perlick, Rosenheck, Kaczynski & Kozma, 2004). It is noteworthy that the degree of burden reported by relatives may impinge on the patient’s recovery process during both the acute and stabilization stages of the illness (Perlick, Rosenheck, Clarkin, Raue & Sirey, 2001). Furthermore, highly burdened relatives have been found to be less likely to practice adequate self-care and to suffer from poor physical health due to caregiving, which in turn leads them to have poor resilience and readiness to handle acute or subacute problems of the patient with BD (Perlick et al., 2007).

The mothers of those diagnosed with BD in this study all expressed gratitude for collaborative therapy and the positive changes it has made in terms of carer burden and on their QoL overall. This is in line with a study conducted by Kolostoumpis et al.

(2015) which aimed to determine the effectiveness of relatives' psychoeducation on family outcomes in BD. According to the study, "*this had a beneficial influence on the relatives' outcomes, and in particular, intervention was found to advance family members' knowledge about the illness, reduce their burden, and distress*" (Kolostoumpis et al., 2015).

5.2.11. Summary and conclusion

EOBD or PBD appear to have a higher prevalence than first anticipated by the researcher. Misdiagnosis or non-diagnosis can have devastating effects on the individual as well as their significant others. On the other hand, early diagnosis can improve QoL of those diagnosed as well as their significant others, buffer the course of the disorder and lead to better treatment outcomes.

The participants of this study all have a comorbid diagnosis: BD and ADHD. Current literature regarding comorbidity appears to be conflicting. On the one hand, researchers argue that surveys have the potential to escalate comorbidity rates while on the other, studies suggest that BD is frequently comorbid with disorders like ADHD. This conflict has the potential to lead to significantly negative outcomes, e.g. incorrect treatment, such as the prescription of Ritalin which may result in the occurrence of manic episodes and can have major consequences for the individual.

Helping others is a theme featured quite heavily in this study and the researcher attributes this to the need of the individuals with BD to feel that their disorder has a purpose; it allows them to feel relevant and useful. Peer support, defined in this context as those with a mental disorder diagnosis helping others with their mental health difficulties, has numerous benefits to both the helpers and the helped, and has been shown to increase self-esteem and confidence as well as leading to the normalisation of emotional responses often discouraged and viewed as crises in more traditional mental health settings. The researcher views this need to help others as an adaptive coping mechanism as it helps draw attention to the more positive aspects of having mental illness. It is something the individual gains as opposed to loses due to the presence of a disorder.

The participants and their significant others in this small study emphasised the relevance of a diagnosis, both in terms of the relief it brings as well as how it lead on to effective treatment. An incorrect diagnosis can lead to treatment that can actually be harmful to the individual with BD and their significant others, proving again that a correct diagnosis is vital.

Illness management, which includes psychoeducation regarding medication adherence, interpersonal skills, maintaining a balanced and healthy lifestyle and adaptive coping mechanisms, was crucial to the participants of this study. One participant said that without the education he had had (psychoeducation regarding interpersonal skills and taking responsibility) he would not have performed well at his job and let his colleagues down. Another spoke of her newfound ability to relate to others and being able to 'do that (in) a different way', leading to healthier relationships with others. Illness management seemingly led to improved QoL overall for those who took part in this study.

The capacity to engage in healthy relationships can influence how one views their QoL in general. Relationships impact on various spheres of life, including social, occupational and mental and physical health domains. The participants of this study discussed the various ways in which having BD has impacted on their relationships and how collaborative therapy has allowed them to learn better ways to communicate, handle emotionally charged situations, be sensitive to the needs of others and maintain healthy relationships in general. One of the objectives of this study was exploring the ways in which collaboration impacts on communication between the individual with BD and their significant others. After meeting with the participants, listening to their narratives and analysing the data, it is clear that collaboration impacts positively on this vital component of healthy relationships. Collaboration appeared to aid the participants in learning new, more effective ways of communicating, resulting in better relations with others.

Before entering into a therapeutic relationship with the clinical psychologist involved in this study, all of the participants had been exposed to individual therapy rather than collaborative therapy. The participant from the first interview, Jackson, initially met with a child psychologist from around the age of three and was involved in play therapy. This psychologist noticed a pattern in the behaviours and referred him to the psychiatrist associated with this study. Likewise, Elizabeth from interview two, began therapy with a child psychologist from an early age and moved to the psychologist involved in the study when her symptoms of BD were recognised. Maggie attended therapy as a young child, but as she entered her adolescent years, she and her family decided that she needed a change and ‘a more adult setting’. Although the clients expressed having had some success with individual therapy, they all are now strong advocates for collaborative therapy with one mother going so far as to say that she would not ‘do it [therapy] any other way’. Participants and their significant others expressed relief and happiness about being part of a team, having ‘a very personal interactive communication and relationship’ and, noting that when the collaboration works ‘it’s like an eruption, it’s amazing’. Additionally, participants reported better communication and positive changes to interpersonal relationships, especially but not limited to, those directly involved in the therapeutic process. The researcher noted that collaboration also appears to have lessened instances of self-stigma amongst the participants of this study, as the confidence to be open and honest [about oneself in general and with regards to BD in particular] between those in the process seemingly generalises to other relationships and situations too. This type of therapy, according to Monica, the mother from the second interview, allowed her to ‘just be the mom’ as opposed to having to play the role of therapist as well.

Prior to the data collection stage of this study, the researcher had assumed stigmatisation would be something the participants would have to face on a regular basis. The expectation was that it would be a major theme and that the clients would have numerous stories relating to stigma that caused feelings of shame, anger and isolation. However, stigmatisation became a theme because it was *not* a significant problem for those involved in the study. The participants mentioned a few instances of hurtful attitudes towards those with mental illness. For example, Elizabeth had to take time off school and enter a treatment facility due to an extreme reaction to medication, and upon her return, encountered scepticism, feeling as though her peers were waiting to see that she was normal. However, for the most part, they seem if not untouched, at the very least unfazed, by attitudes towards their illness. One participant left his medication in full view of others in a shared public space while working on a boat, knowing full well that this could lead to speculation, discrimination and/or exclusion.

The researcher decided to include oversharing of the diagnosis as a theme in this study. An observation made in a personal capacity was that people with BD have a tendency to overshare. All three of the participants either mentioned it directly ['I would tell someone, probably when I shouldn't have: "Listen, I have bipolar."] or indirectly by engaging in behaviours that would make it public knowledge, such as leaving medication in clear view of others. This proclivity for oversharing personal information may have multiple explanations, including age, impulsivity, poor interpersonal skills, deficits in social cognition and/or a lack of experience in terms of stigma.

It became evident during the course of the data collection that there is significant difficulty with regards to being the significant other of individuals diagnosed with BD. The plight of mothers was especially highlighted as two out of the three participants brought their mothers to the interviews. It became apparent that mothers bear the brunt of the burden in the home in terms of illness management, behavioural and emotional difficulties of the individual with BD and general parenting/taking care of the person with BD. Mothers were also most involved in the therapeutic process. Fathers do not appear to take part as frequently or to the extent that mothers do. Mothers expressed feelings of fear, confusion, anxiety, shame [in terms of their parenting abilities], and isolation or being alone in the situation. Monica questioned: 'What have I done with this child? Why did I get this child?' Determining the effects of collaboration on the QoL for those who are significant others of a person with BD was an objective of this study. The researcher noted the heavy burden significant others –and in this case particularly mothers– carry and that this load is lifted with the help of medical professionals involved in the collaborative process. The mothers in this study reported feeling less alone and responsible once entering into a collaborative therapeutic process and that this improved their QoL in general.

The objectives of this study were to explore the effectiveness of collaborative therapy on the QoL of individuals with BD and their significant others, the effects on communication between significant others and those diagnosed with BD, and the effects of involving medical professionals in the therapeutic process, with the overall aim of determining whether a collaborative approach would be beneficial in improving the QoL of individuals with BD. It was clear from the study that collaboration did indeed positively impact the variables that contribute to improved QoL, such as understanding of the diagnosis, the ability to engage in healthy relationships, and better communication between everyone involved.

This study provides information about what individuals find important in terms of their QoL, and highlights the domains judged as crucial for improving QoL according to those who participated in the study. In the first interview, QoL for the mother involved wanting ‘her child to be relatively happy… to be able to cope with everyday life’ and to feel a sense of ‘peace’ as well as the ability to live ‘a normal life’; a life without ‘performances’, ‘screaming matches’ and ‘traumatic episodes’. Jackson, in the first interview, stated that QoL for him involves being able to ‘achieve what I want to achieve’ and to see that his ‘QoL is equal to other people’s lives, just chilled and laidback’ and ‘doing stuff that assists people’. For Monica, the mother in the second interview, QoL meant ‘being able to spend quality time with… my family where we actually understand each other’. For her, a vital domain in QoL has much to do with understanding each other in the family unit. Her daughter, Elizabeth, found emotional well-being a significant QoL domain and she emphasised ‘how big and how bright and how real [her] smile is and all those happy moments and how many of those [she] is able to get out of life’. Likewise, the participant in the third interview focused on happiness ‘being as happy as you can be’ as well as having ‘a happy social life’ as she likes ‘being surrounded by people who… are supportive’. She also mentioned ‘tak[ing] a lot of joy’ from her family life and improved relationships with her siblings and needing ‘financial security’. For her, social, financial and family life domains are of immense importance. This is one of the first, if not *the* first occasion, in which Gilligan’s Listening Guide has been used in conjunction with grounded constructive theory. From this study, other studies of this nature may take place leading to the generation of new information.

The following chapter is concerned with the potential shortfalls of collaboration in the therapeutic setting as well as the contribution, limitations and recommendations of this study.

6. CHAPTER 6 – SHORTFALLS OF COLLABORATIVE THERAPY, CONTRIBUTION, LIMITATIONS AND RECOMMENDATIONS OF STUDY

6.1. Introduction

This chapter concludes the thesis by offering a critique of the use of collaboration in therapy for people with BD and their families. Following this, the contribution of this study is examined, together with ways in which QoL can be improved for those with BD as well as their significant others. The chapter closes with consideration of the limitations of this research, the researcher’s recommendations for further studies and personal reflections from the researcher.

6.2. Shortfalls of collaboration

The researcher has identified three main shortfalls with regards to the use of collaboration in a therapeutic setting. The first is the tendency of the individual with BD and their significant others to become overly dependent on the therapist, especially in terms of decision-making processes. A vital aspect of therapy is for the client to develop skills and abilities which allow him or her to make healthy life choices. The participants and their SO’s in this study showed a heavy reliance on the therapist when it comes to making decisions rather than having learned the skills to do so on their own. This could lead to therapy continuing indefinitely as the clients may fear making their own life choices. This was especially noticeable amongst the significant others of the BD individuals. Elsa, the mother from the first interview, repeatedly mentioned that ‘it was a big help for me to be able to email [the therapist]… then you don’t feel so alone’ and that ‘I always know that uh there’s someone I can go to should we have a big problem… I know I can always contact [the therapist] if something happens’ and that ‘[psychologist’s name] would just guide us all the time’. The son with BD, Jackson, also maintained contact with his therapist via WhatsApp while working on a boat overseas.

The second criticism is the potential over-involvement of the therapist in the lives of the clients. Having a close collaborative relationship with a client over a number of years can cause the therapist to identify too closely with their client and to find it difficult to retain professional distance. Countertransference[12] or a therapist's emotional responses to a client constitute a pivotal element of the therapeutic relationship across the board in terms of theoretical approaches to treatment (Tanzilli, Colli, Del Corno & Lingiardi, 2016). Additionally, the researcher found that the clients involved in this study tended to find it difficult to make decisions on their own and would rely on the therapist for this. This was especially evident in the second interview conducted for this study. The individual with BD, Elizabeth, 'had a very bad reaction to one of her medications where she had involuntary muscle spasms'. After realising that normal day-hospitals would not provide adequate treatment, Elizabeth's parents did not know what to do, as indicated by the following statement: 'When we as parents were going oh my word what are we going to do, how are we going to go about this… if it wasn't for [the psychiatrist and the therapist]…' Furthermore, this mother mentioned knowing that she does not have to deal with certain things as '[the therapist] dealt with it, okay, I don't have to go back there'.

The third problem is that there are not always family members or significant others who are willing to engage in collaboration. For example, in this study, only the mothers were actively involved while the fathers tended to take a backseat in the therapeutic process. The clients themselves may not wish to collaborate with certain people, as evidenced by Jackson from the first interview who appeared to be resistant to the idea of working with the new psychiatrist. Collaboration can only take place if there are available and willing people with whom to collaborate.

Collaboration has other potential shortfalls including the fact that it is highly dependent on the individual seeking therapy as well as the therapist, neither of whom may be willing to collaborate with others. Additionally, clients may be uncooperative (therapy may have been court-ordered) or not at a level of mental health or competency that allows for collaboration with others.

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[12] Countertransference is a concept introduced by Freud (1910) and is defined as being the consequence of a client's impact on the analyst's unconscious feelings (Tnzilli et al., 2016).

6.3. The positive impact of collaboration

Collaboration appeared to have a positive impact on the QoL of people with BD as well as the lives of their significant others. Participants reported:

- Less conflict – both verbal and physical.

Maggie, the individual with BD from the third interview, admitted to being ‘very aggressive’ and described how she had attacked her younger brother. Once she entered into therapy that involved collaboration, she learned how to better communicate. She refers to that as a ‘life skill’ and because of this, she and her brother ‘are so close now…before [collaborative therapy] it was such a different relationship’.

- Family members understood each other better.

Jackson’s brother attended some therapy sessions so that he could ‘understand better’. Through collaboration, which in this instance involved emails and then a therapy session, Jackson and his father who were ‘really bumping heads quite a lot’ at the time, came to a place of better understanding which resulted in less friction between them. Prior to therapy, Monica, the mother from the second interview admitted ‘[she] couldn’t understand’ her daughter’s behaviour but since receiving a diagnosis and understanding of BD, this has changed for the better. Elizabeth mentioned: ‘If my mom wasn’t able to understand my behaviour, we would never have that relationship’. Understanding the condition and subsequent ways of being, allowed Monica and Elizabeth to form a healthy, happy relationship. Maggie, from the third interview, stated that ‘since we started therapy with my family, you know, everything has changed’.

- Improved communication.

Communication improved within the family of the person diagnosed with BD as well as in other situations, after being involved in therapy that made use of collaboration. Communication between Elizabeth and her friends also improved as ‘she [is] a bit more open to speak about what’s happened’. Maggie, from interview three, mentioned that she had ‘learned to communicate in a certain way in the workplace’ as well as ‘in a social situation’. She stated that ‘[the therapist] has been the door to this way of communication’ and now she ‘follow[s] that procedure every time’.

- Adopting effective coping mechanisms.

Elsa, the mother from Interview one, stated that ‘[the therapist] …taught Jackson a lot about how to manage his illness like as far as medication goes’ which was made evident when he spoke about his time overseas working on a boat. He would identify instances when he was not ‘getting enough sleep’ and speak with his boss/captain about it. He had learnt that ‘seeing all the symptoms is a way to prevent those symptoms’ and this allowed him to, as his mother stated, ‘adjust his behaviour, make sure he sleeps, make sure the meds are on time and so on’. Maggie stated that ‘[the therapist] gave us ways to cope… a toolbox in my brain’ and added ‘even um life skills in general I developed from, through, her’.

- Decreased negative reaction to stigma and little to no self-stigma.

Jackson seems to carry very little self-stigma with regards to his mental disorders stating ‘I have it, I can help all my friends’ and going so far as to say he is ‘more than happy to have it’. Although both he and his mother recognise that there is stigma attached to mental illness, Jackson noted ‘nowadays the people are very much oh mental illness, brush it to the side’ while his mother stated that ‘people don’t talk about it’ and ‘people normally keep quiet’. When asked who knows of her diagnosis, Elizabeth admitted that ‘pretty much everyone’ knows and that she’s pretty open about it if it comes up in a conversation’. Maggie did initially have issues with self-stigma prior to being diagnosed, asking the therapist ‘so I’m not some kind of psycho moron?’ after receiving a diagnosis. As discussed previously being given a diagnosis actually served to lessen the issue of self-stigma for this particular participant.

- More clarity with regards to BD and how to cope with it.

Both Jackson and his mother admitted to having a better understanding of BD and an improved relationship as a result of it. Jackson noted that ‘we are much more chilled now, we can at least understand where we both stand and all that; we are much more educated’. Elsa mentioned that the therapist taught her ‘that if we are in a problematic situation to move away from it, not to aggravate the situation’. Monica, the mother from the second interview expressed her relief at knowing ‘there’s actually a condition' and learning from the therapist to identify 'this is behaviour at this age and this is the condition so how do you deal with the condition side?' In addition, she mentioned that 'it's so much clearer now' after having entered therapy and that their home life went from a place of 'chaos to understanding'. She learnt 'not to be frustrated'. Prior to collaborative therapy, Maggie and her family 'were all very confused' and 'didn't know what to do' and that she in particular was 'this confused mess'. Since learning about BD she realises that 'the bipolar isn't me, I *have* bipolar but the bipolar isn't in control of me'.

6.4. Contribution to the field of study

Literature that focuses specifically on collaboration as a therapeutic tool and its effects on participants' QoL is limited, and there is particularly limited literature of this nature in the South African context. Emphasis is placed on family therapy or psychoeducation. While these do involve other people beyond the client and therapist, they appear to lack a true collaborative element. This small study contributes to existing literature on collaboration in a therapeutic setting and thus contributes to the limited evidence base for current treatment protocols.

6.5. Limitations of this study

6.5.1. Limitations of the literature review

There was a limited amount of literature on the use of collaboration in the therapeutic process, especially with patients who are mentally ill and postmodern therapists, which meant that literature older than ten years needed to be included in some cases.

6.5.2. Limitations of studying collaboration and the use of human participants

There are few therapists in South Africa using collaborative therapy so the researcher was limited to the clients that one specific therapist was able to access. This meant that the study size was small which has an impact on the generalisability of the study findings. More research needs to be conducted to support or refute its conclusions. However data analysis was detailed and grounded theory studies do not typically have large numbers of participants due to the level of rich detail that a few participants can yield.

Mental illness is deeply personal. The use of qualitative methods such as face-to-face interviews may therefore have been an inhibiting factor in data collection. Likewise, the therapeutic process itself is private and therapists and participants alike may find it difficult and/or intimidating expressing their views and experiences of it. Attempts were made to take these factors into account and the interviews yielded much rich data suggesting that participants were relatively unconstrained in what they said. Participants were interviewed in front of the psychologist from whom they sought or are seeking treatment. This may have led to their being unwilling to point out any negative aspects of the therapeutic process.

6.5.3. Limitation of the methodology

Grounded theory allows the participants to relate their story and experiences, which are by definition subjective and personal. This means it is difficult to generalise their experiences to what others might feel (transferability).

6.5.4. Limitations in data analysis

Grounded theory requires the researcher to suspend preconceived knowledge. This was difficult as the degree application required a literature review to be conducted as part of the application process. This is not an uncommon problem encountered by researchers when making use of grounded theory according to Ramalho, Adams, Huggard and Hoare (2015). The existing literature was used therefore as part of the analytic strategies of the research. In most research studies, a literature review precedes data collection and analysis as it helps the researcher to contextualize the research within existing knowledge (Creswell & Clark, 2017). However, in grounded theory research, conducting a literature review prior to data collection and analysis is commonly presented as a constraining exercise rather than as a guiding one. Funding bodies usually expect that applicants will demonstrate knowledge in the field of inquiry through a literature review, and ethics committees typically require a brief review of the topic of interest. This tension between expectations of a literature review and the grounded theory research methodology can be challenging for those engaging with this type of project.

6.5.5. Limitation of the theoretical framework

QoL is a subjective issue and thus not entirely easy to define or assess although measures of it number in the hundreds (Lam, 2010). A latent variable that cannot be measured directly, it needs to be changed into indicators of its constituent dimensions and domains to be assessed. The indicators must be valid, important, representative and adequate; the indicators are presented as items that can be rated on response scales and these are conferred as a profile domain score or a synthesized index of QoL (Lam, 2010).

6.6. Personal reflection

According to Miller and Brimicombe (2010), the PhD process can be viewed as a journey. They state that "*a journey is the act of moving from one place to another. The journey of life also includes both the passage of time and changes of phase in our being as we age, learn, and develop*" (p.408). My dissertation has indeed been a journey and I am not in the same emotional or intellectual place as I was when I started out.

I chose my topic because my Masters degree had been community-based, and I wanted to gain knowledge of how post-modern psychotherapy is applied in clinical pathology. Starting out, I had no first-hand experience with pathology such as BD and no understanding of how such pathology affects the lives of those diagnosed with this disorder nor the impact on the lives of their significant others.

Having immersed myself in post-modern therapy, particularly narrative therapy, through my counselling work and personal development activities, I was ideally placed to research the effects of collaboration using narrative therapy with patients diagnosed with BD. The data collection and analysis that I chose were meaningful to me as I had come into contact with these methods during my Honours project as well as my Masters dissertation.

6.6.1. Emotional journey

I have gained a better understanding of BD and it has helped me to be more empathetic and understanding, both personally and professionally, of people with mental illnesses. Society tends to be dismissive of people with serious mental health difficulties, and my research showed me how much they suffer. Their journey is not an easy one and we need to be more understanding and supportive. I also realised just how strong the genetic factor is in BD and sufferers cannot help the place that they find themselves.

I found conducting the interviews to be frustrating at times due to just how disordered the thinking of people with BD is, possibly compounded by elements of ADHD that they experience. I had to learn to deal with constant topic changes and interruptions which was not always easy for me as I can be impatient at times. In future I would structure my interviews more carefully to obtain the information needed more efficiently. Grounded theory looks good on paper but in practice, using it with people with pathology is very challenging.

Each of the participants elicited a different emotional response in me and I needed to be aware of this in order to maintain my neutrality.

Interview 1: The participant takes medication for his BD but has chosen not to be medicated for ADHD. He talked a great deal and interrupted frequently, so it was difficult to keep the interview on course. I had to be mindful of my feelings of frustration and irritation and not allow these feelings to spill over into the interview.

Interview 2: I found this to be an enjoyable interview. The participant's symptoms were well-controlled by both pharmacological and therapeutic interventions, highlighting the importance of both and providing evidence of the effectiveness when these interventions are used together.

Interview 3: This participant was easy to relate to due to her positive attitude. She had been through many difficulties which she fought hard to overcome and I was inspired by her optimistic outlook.

I found it very encouraging to discover that collaboration can indeed help people with PBD and their significant others to manage their illness and lessen its impact on their day-to-day lives.

I run my own business full-time, and I found it challenging to give both my work and my PhD the attention that they both needed. I learnt to delegate work tasks to others and to trust that they would make the right decisions, which was not easy for me as I like to be in control.

I saw parallels between my own life and those of the people I interviewed. I have my own learning challenges, and as a child suffered rejection and stigmatisation. It has been helpful for me, as it is to the participants in this study, to have the support and understanding of the people around me.

I initially felt concerned that I did not interact as often as I thought I would with my PhD supervisor and sometimes I questioned whether my supervisor should have been more involved with my thesis. However, with the passage of time, I have come to realise that at a PhD level, the journey is mine and I needed to navigate it myself. For example, I spent a lot of time on a theoretical framework that I eventually had to discard. As frustrating as this was, I learnt a lot more by going through this experience myself than I would have had my supervisor simply told me it would not work.

6.6.2. Intellectual/academic journey

I found it easier using Gilligan's guide again after using it for my Masters dissertation. I understood it much better this time around and was able to use it more effectively to uncover nuances of meaning that I might have previously missed. I have refined my skills in reading, summarising and referencing academic books and journals.

I delved deeper into the use of grounded theory and found myself moving away from the original methods of Strauss and Glaser and using Constructivist Grounded Theory (CGT), as developed by Charmaz (2000). CGT acknowledges "*the researcher as the author of a coconstructor of experience*" (Charmaz, 2000, as cited in Mills & Francis 2006, p.7). I found this to be true as I had to complete a considerable amount of reading on my topic before I commenced my research and brought my own experience to bear. Although I was not a completely 'blank slate', at the same time I had to listen to what the participants had to say without judgement. Gilligan's guide allowed me to draw out the voices of the participants, and I found this method to be particularly useful with this type of data collection.

6.7. Recommendations for future studies

The following are areas of interest for the researcher as a direct result of this study and could potentially be important lines of enquiry for future research.

- The researcher believes that adding a quantitative aspect to this research may yield more generalizable, reliable and valid results. Therefore a mixed method approach may be appropriate for future studies.
- The plight of mothers of children with BD and other mental health disorders requires further investigation. Having an understanding of the experience of being a mother to a mentally ill child may result in the devising of treatments aimed at mothers/primary caregivers in particular.
- There was an apparent reluctance of fathers to be involved in the therapeutic process; how and why does this occur?
- Future studies could explore early-onset and PBD to enhance treatment techniques and provide clarity in terms of diagnostic criteria.
- Future studies could evaluate the effectiveness of collaboration in community settings as there appears to be a dearth of literature pertaining to this. Having a therapeutic tool or method that is useful in a number of settings enhances the likelihood of it being used by mental health professionals and may result in better client compliance if it can be trusted to be effective in various domains.
- The use of collaboration in conjunction with therapeutic modalities that do not fall under the postmodernist banner, for example, psychodynamic therapy.
- Some participants of this particular study experienced anxiety, even hostility, towards new medical professionals entering the collaborative relationship. Future studies could focus on the individual’s experience of adding someone new, be it a professional or layperson, to the collaborative process.
- The addition of DMDD to the DSM-5 has opened up debate with regards to the existence of PBD in children, a disorder not yet added to or recognised by the DSM-5. This study found BD to be prevalent in children, certainly amongst the participants of this research and according to information gathered for the literature review. It may be worth examining the instances of PBD diagnoses and whether or not DMDD may have been more appropriate and if PBD should indeed be recognised by future editions of the DSM.

6.8. Conclusion

This study set out to determine whether a postmodern, collaborative approach to therapy would assist in improving the QoL of patients presenting with BD, as well as their significant others from a sample of clients who were currently seeking or who had sought therapeutic intervention from a narrative therapist. The following main conclusions were reached. Participants reported:

- Having gained a better understanding of their disorder;
- Experiencing improved relations with others;
- Gaining tools or life skills to function better in their social and work lives, and
- the ability to detect symptoms early on and make adaptive changes to lessen symptom severity.

The results of the study indicate that using collaboration in this unique manner within the therapeutic process is beneficial to both the individual with mental illness and their significant others and improved their QoL in various domains. The results suggest that collaboration in the therapeutic space has the ability to positively influence QoL for those involved. This initial study indicates potential value of a collaborative approach to intervention for young adults diagnosed with BD and their significant others and could be used as the basis for further research into collaboration as part of the postmodern therapeutic process. If these findings are replicated on a larger scale, the widespread use of collaboration may be able to improve the QoL of many individuals and families affected by mental illness.

7. REFERENCES

Aas, M., Henry, C., Andreassen, O. A., Bellivier, F., Melle, I., & Etain, B. (2016). The role of childhood trauma in bipolar disorders. *International Journal of Bipolar Disorders*, *4*(1), 2.

Aldinger, F., & Schulze, T. G. (2017). Environmental factors, life events, and trauma in the course of bipolar disorder. *Psychiatry and Clinical Neurosciences 71,* 6–17.

Alloy, L. B., Abramson, L. Y., Urosevic, S., Walshaw, P.D., Nusslock, R., & Neeren, A.M. (2005). The psychosocial context of bipolar disorder: Environmental, cognitive, and developmental risk factors. *Clinical Psychology Review, 25,* 1043–1075.

Almeida, O. P., & Fenner, S. (2002). Bipolar disorder: similarities and differences between patients with illness onset before and after 65 years of age. *International Psychogeriatrics*, *14*(3), 311–322.

Alonso, J., Petukhova, M., Vilagut, G., Chatterji, S., Heeringa, S., Üstün, T. B., ... & Bruffaerts, R. (2011). Days out of role due to common physical and mental conditions: results from the WHO World Mental Health surveys. *Molecular Psychiatry*, *16*(12), 1234.

Alpaslan, N. (2010). Social Work Research: A step-by-step guide on how to conduct a research project and write a research report – SCK4810. Pretoria: University of South Africa.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Pub.

Anderson, H. (1997). *Conversation, Language, and Possibilities: A Post Modern Approach to Therapy*. New York: Basic Books.

Anderson, H. (2001). Postmodern collaborative and person-centred therapies: what would Carl Rogers say? *Journal of Family Therapy, 23*, 339–360.

Anderson, H. (2007). *The therapist and the postmodern therapy system: A way of being with others.* Retrieved from http://www.europeanfamilytherapy.eu/wp-content/uploads/2012/10/anderson.pdf

Anderson, H. (2012). Collaborative relationships and dialogic conversations: Ideas for a relationally responsive practice. *Family Process, 51*(1), 8–24.

Arad, D. (2004). If Your Mother Were an Animal, What Animal Would She Be? Creating Play‐Stories in Family Therapy: The Animal Attribution Story‐Telling Technique (AASTT). *Family Process*, *43*(2), 249–263.

Asherson, P., Young, A.H., Eich-Hochli, D., Moran, P., Porsdal, V., & Deberdt, W. (2012). Differential diagnosis, comorbidity, and treatment of attention-deficit/hyperactivity disorder in relation to bipolar disorder or borderline personality disorder in adults. *Current Medical Research and Opinion, 30(8),*1657–1672.

Ashman, S. B., Monk, T. H., Kupfer, D. J., Clark, C. H., Myers, F. S., Frank, E., & Leibenluft, E. (1999). Relationship between social rhythms and mood in patients with rapid cycling bipolar disorder. *Psychiatry Research*, *86*(1), 1–8.

Ashok, A. H., Marques, T. R., Jauhar, S., Nour, M. M., Goodwin, G. M., Young, A. H., & Howes, O. D. (2017). The dopamine hypothesis of bipolar affective disorder: the state of the art and implications for treatment. *Molecular Psychiatry*, *22*(5), 666.

Atladottir, H. O., Gyllenberg, D., Langridge, A., Sandin, S., Hansen, S. N., & Leonard, H. & Parner, E.T. (2014). The increasing prevalence of reported diagnoses of childhood psychiatric disorders: A descriptive multinational comparison. *European Child & Adolescent Psychiatry*, 24(2), 173–183.

Axelson, D., Findling, R.L., Fristad, M.A., Kowatch, R.A., Youngstrom, E.A., Horwitz, S.M., … Gill, M.K. (2012). Examining the proposed disruptive mood dysregulation disorder diagnosis in children in the Longitudinal Assessment of Manic Symptoms study. *Journal of Clinical Psychiatry, 73(10),*1342.

Babbie, E. (2005). *The basics of social research* (4th ed.). Belmont, CA: Wadsworth.

Baez, S., Herrera, E.,Villarin, L., Theil, D., Gonzalez-Gadea, M. L., Gomez, P., Mosquera, M., Huepe, D., Strejilevich, S., Vigliecca, N.S., Matthaus, F., Decety J., Manes, F., & Ibanez, A.M. (2013). Contextual social cognition impairments in schizophrenia and bipolar disorder. *PLOS One, 8(3).* https://doi.org/10.1371/journal.pone.0057664

Bahrer-Kohler, S. (2016). Engagement for and investment in global mental health. *Mathews Journal of Psychiatry & Mental Health, 1(2),*007.

Balanza-Martinez, V., Crespo-Facorro, B., Gonzalez-Pinto, A., & Vieta, E. (2015). Bipolar disorder comorbid with alcohol use disorder: focus on neurocognitive correlates. *Frontiers in Physiology, 6,* 108.

Baldessarini, R.J., Tondo, L., & Vazquez, G.H. (2019). Pharmacological treatment of adult bipolar disorder. *Molecular Psychiatry 24,* 198-–217.

Barbini, B., Colombo, C., Benedetti, F., Campori, E., Bellodi, L., & Smeraldi, E. (1998). The unipolar–bipolar dichotomy and the response to sleep deprivation. *Psychiatry Research*, *79*(1), 43–50.

Barlow, D. H., & Durand, V. M. (2009). Mood disorders and suicide. *Abnormal psychology: An integrative approach*, *239*.

Baron, M. (1997). Genetic linkage and bipolar affective disorder: progress and pitfalls. *Molecular Psychiatry*, *2*(3), 200.

Bauer, M.S., McBride, L., Williford, W.O., Glick, H., Kinosian, B., Altshuler, L., Beresford, T., Kilbourne, A.M., & Sajatovic, M. (2006). Collaborative care for bipolar disorder: Part II. Impact on clinical outcome, function and costs. *Psychiatric Services, 57(7),* 937–945.

Bearden, C. E., Hoffman, K. M., & Cannon, T. D. (2001). The neuropsychology and neuroanatomy of bipolar affective disorder: a critical review. *Bipolar Disorders*, *3*(3), 106–150.

Berk, M., Berk, L., & Castle, D. (2004). A collaborative approach to the treatment alliance in bipolar disorder. *Bipolar Disorders: An International Journal of Psychiatry and Neurosciences, 6(6),* 504–518. https://doi.org/10.1111/j.1399-5618.2004.00154.x

Berk, M., Berk, L., Davey, C.G., Moylan, S., Giorlando, F., Singh, A.B., Kalra, H., Dodd, S., & Malhi, G.S. (2013). Treatment of bipolar depression. *Medical Journal of Australia, 199(6),* 32–35. doi: 10.5694/mja12.10611.

Biederman, J., Mick, E., Faraone, S. V., Spencer, T., Wilens, T. E., & Wozniak, J. (2000). Pediatric mania: a developmental subtype of bipolar disorder? *Biological Psychiatry*, *48*(6), 458–466.

Bonomi, A. E., Patrick, D. L., Bushnell, D. M., & Martin, M. (2000). Validation of the United States version of the world health organization quality of life (WHOQOL) instrument. *Journal of Clinical Epidemiology*, *53*(1), 1–12.

Bora, E., Bartholomeusz, C., & Pantelis, C. (2016). Meta-analysis of Theory of Mind (ToM) impairment in bipolar disorder. *Psychological Medicine*, *46*(2), 253–264.

Bos, A. E., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, *35*(1), 1–9.

Bradfield, B. C. (2010). Bipolar mood disorder in children and adolescents: in search of theoretic, therapeutic and diagnostic clarity. *South African Journal of Psychology, 40,* (3), 241–249.

Braun, V & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3 (2),* 77–101.

Brissos, S., Dias, V.V., & Kapczinski, F. (2008). Cognitive performance and quality of life in bipolar disorder. *The Canadian Journal of Psychiatry, 53 (8),* 517–524.

British Psychological Society (2006a) National Collaborating Centre for Mental Health UK. (2006). *Psychological therapies in the treatment of bipolar disorder.* British Psychological Society.

British Psychological Society (2006b). National Collaborating Centre for Mental Health (UK). *Bipolar disorder: The management of bipolar disorder in adults, children and adolescents, in primary and secondary care.* Leister (UK): NICE Clinical Guidelines, No. 38.1.

Brotman, M. A., Schmajuk, M., Rich, B. A., Dickstein, D. P., Guyer, A. E., Costello, E. J., ... & Leibenluft, E. (2006). Prevalence, clinical correlates, and longitudinal course of severe mood dysregulation in children. *Biological Psychiatry*, *60*(9), 991–997.

Bryman, A. (2012). *Social research methods* (4th ed). Oxford: Oxford Press.

Buoli, M., Caldiroli, A., Caletti, E., Zugno, E., & Altamura, A.C. (2014). The impact of mood episodes and duration of illness on cognition in bipolar disorder. *Comprehensive Psychiatry, 55,* 1561–1566.

Burck, C. (2005). Comparing qualitative methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy, 27,* 237–262.

Burgin, E. C., & Gibbons, M. M. (2016). “More life, not less”: Using narrative therapy with older adults with bipolar disorder. *Adultspan Journal 15(1)*, 49–61.

Burns, J. & Tomita, A. (2015). Traditional and religious healers in the pathway to care for people with mental disorders in Africa: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 50(6)*, 867-877.

Calabrese, J. R., Vieta, E., & Shelton, M. D. (2003). Latest maintenance data on lamotrigine in bipolar disorder. *European Neuropsychopharmacology*, *13*, 57–66.

Cardoso, B. M., Sant'Anna, M. K., Dias, V. V., Andreazza, A. C., Ceresér, K. M., & Kapczinski, F. (2008). The impact of co-morbid alcohol use disorder in bipolar patients. *Alcohol*, *42*(6), 451–457.

Carrey, N. (2006). Practicing psychiatry through a narrative lens: Working with children, youth, and families. In C. Brown & T. Augusta-Scott (Eds.), *Narrative therapy: making meaning, making lives* (pp.77–102). California: Sage Publications.

Carvalho, A.F., Dimellis, D., Gonda, X., McIntyre, R.S., & Fountoulakis, K.N. (2014). Rapid cycling in bipolar disorder: a systematic review. *The Journal of Clinical Psychiatry, 75*(6), 578–586.

Chang, C. K., Hayes, R. D., Perera, G., Broadbent, M. T., Fernandes, A. C., Lee, W. E., ... & Stewart, R. (2011). Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. *PloS one*, *6*(5), e19590.

Charmaz K. (2000). Grounded theory: Objectivist and constructivist methods. In Denzin N., Lincoln Y. (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509–535). Thousand Oaks, CA: Sage.

Charmaz, K. (2003). Grounded theory. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp.81–110). London: Sage Publications.

Charney, D. S., Reynolds, C. F., Lewis, L., Lebowitz, B. D., Sunderland, T., Alexopoulos, G. S., ... & Borson, S. (2003). Depression and Bipolar Support Alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. *Archives of General Psychiatry*, *60*(7), 664–672.

Chatterton, M. L., Stockings, E., Berk, M., Barendregt, J. J., Carter, R., & Mihalopoulos, C. (2017). Psychosocial therapies for the adjunctive treatment of bipolar disorder in adults: network meta-analysis. *British Journal of Psychiatry*, *210*(5), 333–341.

Chen, Y. W., & Dilsaver, S. C. (1996). Lifetime rates of suicide attempts among subjects with bipolar and unipolar disorders relative to subjects with other Axis I disorders. *Biological Psychiatry*, *39*(10), 896–899.

Chessick, C. A., Perlick, D. A., Miklowitz, D. J., Kaczynski, R., Allen, M. H., Morris, C. D., ... & STED-BD Family Experience Collaborative Study Group. (2007). Current suicide ideation and prior suicide attempts of bipolar patients as influences on caregiver burden. *Suicide and Life-Threatening Behavior*, *37*(4), 482–491.

Copeland, W.E., Angold, A., Costello, E.J., & Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *Journal of Psychiatry, 170(2),* 173–179.

Corey, C. (2009). *Theory and practice of counseling and psychotherapy* (8th ed.). California: Brooks/Cole, Cengage Learning.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1,*(1), 16–20.

Costanza, R., Fisher, B., Ali, S., Beer, C., Bond, L., Boumans, R., Danigelis, N. L., Dickinson, J., Elliott, C., Farley, J., Gayer, D. E., MacDonald Glenn, L., Hudspeth, T., Mahoney, D., McCahill, L., McIntosh, B., Reed, B., Abu Turab Rizvi, S., Rizzo, D. M., Simpatico, T., & Snapp, R. (2007). Quality of life: an approach integrating opportunities, human needs, and subjective well-being. *Ecological Economics, 61,* 267–276.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Cuellar, A. K., Johnson, S. L., & Winters, R. (2005). Distinctions between bipolar and unipolar depression. *Clinical Psychology Review*, *25*(3), 307–339.

Cusi, A., MacQueen, G. M., & McKinnon, M. C. (2010). Altered self-report of empathic responding in patients with bipolar disorder. *Psychiatry Research*, *178*(2), 354–358.

Dalton, E. J., Cate‐Carter, T. D., Mundo, E., Parikh, S. V., & Kennedy, J. L. (2003) Suicide risk in bipolar patients: the role of co‐morbid substance use disorders. *Bipolar Disorders*, *5*(1), 58–61.

Das Gupta, R & Guest, J.F. (2002). Annual cost of bipolar disorder to UK society. *British Journal of Psychiatry, 180,* 227–233.

Denzin, N.K., & Lincoln, Y.S. (Eds.). (2000). *Handbook of qualitative research* (2nd edition). London: Sage Publications.

Doerfler, L., Connor, D., & Toscano, P. (2011). Aggression, ADHD symptoms, and dysphoria in children and adolescents diagnosed with bipolar disorder and ADHD. *Journal of Affective Disorders, 131(1)*, 312-319.

Dougherty, L.R., Smith, V.C., Bufferd, S.J., Carlson, G.A., Stringaris, A., Leibenluft, E., & Klein, D.N. (2014). DSM-5 disruptive mood dysregulation disorder: correlates and predictors in young children. *Psychological Medicine, 44(11),* 2339–2350.

Easter, M. M., Davis, A. M., & Henderson, G. E. (2004). Confidentiality: More than a linkage file and a locked drawer. *IRB: Ethics & Human Research*, *26*(2), 13–17.

Easterlin, R. A. (2003). Explaining happiness. *Proceedings of the National Academy of Sciences*, *100*(19), 11176–11183.

Ebert, A., & Bar, K. (2010). Emil Kraepelin: A pioneer of scientific understanding of psychiatry and psychopharmacology. *Indian Journal of Psychiatry, 52(2),* 191–192.

Edvardsen, J., Torgersen, S., Roysamb, E., Lygren, S ., Skre, I., Onstad, S., Oien, P. A. (2008). Heritability of bipolar spectrum disorders. Unity of heterogeneity? *Journal of Affective Disorders, 106,* 229–240.

Egan, J. (2008). The bipolar puzzle. *New York Magazine*.

Egbe, C., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G. & Petersen, I. (2014). Psychiatric stigma and discrimination in South Africa: perspectives from key stakeholders. BMC Psychiatry*, 14*: 191.

Ehlers, C. L., Frank, E., & Kupfer, D. J. (1988). Social zeitgebers and biological rhythms: a unified approach to understanding the etiology of depression. *Archives of General Psychiatry*, *45*(10), 948–952.

Ellicott, A., Hammen, C., Gitlin, M., Brown, G., & Jamison, K. (1990). Life events and the course of bipolar disorder. *The American Journal of Psychiatry*, *147*(9), 1194–1198. http://dx.doi.org/10.1176/ajp.147.9.1194

Emanuel, E. J., Grady, C. C., Crouch, R. A., Lie, R. K., Miller, F. G., & Wendler, D. D. (Eds.). (2008). *The Oxford textbook of clinical research ethics*. Oxford University Press.

Eremie, M., & Ubolum, W. (2016). Review of psychoanalytic approach to counselling. *International Journal of Innovative Psychology and Social Development, 4(2), 22*–25.

Esan, O., & Esan, A. (2016). Epidemiology and burden of bipolar disorder in Africa: a systematic review of data from Africa. *Social Psychiatry and Psychiatric Epidemiology, 51(1),* 93–100.

Esterberg, G. (2002). *Qualitative methods in social research.* Boston: McGraw-Hill.

Evans-Lacko, S., Rose, D., Little, K., Flach, C., Rhydderch, D., Henderson, C., & Thornicroft, G. (2011). Development and psychometric properties of the reported and intended behaviour scale (RIBS): a stigma-related behaviour measure. *Epidemiology and Psychiatric Sciences*, *20*(3), 263–271.

Faedda, G. L., Baldessarini, R. J., Glovinsky, I. P., & Austin, N. B. (2004). Pediatric bipolar disorder: phenomenology and course of illness. *Bipolar Disorders*, *6*(4), 305-313.

Faedda, G.L. Ohashi, K., Hernandez, M., McGreenery, C.E., Grant, M.C. Baroni, A., … & Teicher, M.H. (2016). Actigraph measures discriminate paediatric bipolar disorder from attention deficit hyperactivity disorder and typically developing controls. *Journal of Child Psychology and Psychiatry, 5(6)*, 706–716. https://doi.org/10.1111/jcpp.12520

Farren, C. K., Hill, K.P., & Weiss, R.D. (2012). Bipolar disorder and alcohol use disorder: a review. *Current Psychiatry Reports, 14(6)*, 659–666.

Feeney, B.C. & Collins, N.L. (2015). A new look at social support: A theoretical perspective on thriving through relationships. *Personality and Social Psychology Review, 19(2)*, 113–147.

Feinman, J. A., & Dunner, D. L. (1996). The effect of alcohol and substance abuse on the course of bipolar affective disorder. *Journal of Affective Disorders*, *37*(1), 43–49.

Fergusson, D. M., Horwood, L. J., Ridder, E. M., & Beautrais, A. L. (2005). Subthreshold depression in adolescence and mental health outcomes in adulthood. *Archives of General Psychiatry*, *62*(1), 66–72.

Fergusson, D. M., & Woodward, L. J. (2002). Mental health, educational, and social role outcomes of adolescents with depression. *Archives of General Psychiatry*, *59*(3), 225–231.

Fowke, A., Ross, S., & Ashcroft, K. (2012). Childhood maltreatment and internalized shame in adults with a diagnosis of bipolar disorder. *Clinical Psychology & Psychotherapy*, *19*(5), 450–457.

Freeman, M. P., Freeman, S. A., & McElroy, S. L. (2002). The comorbidity of bipolar and anxiety disorders: prevalence, psychobiology, and treatment issues. *Journal of Affective Disorders*, *68*(1), 1–23.

Frias, A., Palma, C., & Farriols, N. (2015). Comorbidity in pediatric bipolar disorder: prevalence, clinical impact, etiology and treatment. *Journal of Affective Disorders, 174,* 378–389.

Fristad, M. A., Verducci, J. S., Walters, K., & Young, M. E. (2009). Impact of multifamily psychoeducational psychotherapy in treating children aged 8 to 12 years with mood disorders. *Archives of General Psychiatry*, *66*(9), 1013–1021.

Garber, J, & Carter, J. S. (2006). Major depression. *Comprehensive handbook of personality and psychopathology: Child psychopathology*, pp.165–216. Hoboken, NJ: Wiley.

Gardner, H. H., Kleinman, N. L., Brook, R. A., Rajagopalan, K., Brizee, T. J., & Smeeding, J. E. (2006). The economic impact of bipolar disorder in an employed population from an employer perspective. *Journal of Clinical Psychiatry*, *67*(8), 1209–1218.

Gazalle, F. K., Andreazza, A. C., Hallal, P. C., Kauer-Sant'Anna, M., Ceresér, K. M., Soares, J. C., ... & Kapczinski, F. (2006). Bipolar depression: the importance of being on remission. *Brazilian Journal of Psychiatry*, *28*(2), 93–96.

Geddes, J. R., & Miklowitz, D.J. (2013). Treatment of bipolar disorder. *The Lancet, 381*(9878), 1672–1682.

Gehart, D., Tarragona, M., & Bava, S. (2007). A collaborative approach to research and inquiry. In H. Anderson & D. Gehart (Eds.). *Collaborative therapy: Relationships and conversations that make a difference* (pp.367–387). New York: Routledge.

Geller, B., Bolhofner, K., Craney, J. L., Williams, M., DelBello, M. P., & Gundersen, K. (2000). Psychosocial functioning in a prepubertal and early adolescent bipolar disorder phenotype. *Journal of the American Academy of Child & Adolescent Psychiatry*, *39*(12), 1543–1548.

Geller, B., Sun, K., Zimerman, B., Luby, J., Frazier, J., & Williams, M. (1995). Complex and rapid-cycling in bipolar children and adolescents: a preliminary study. *Journal of Affective Disorders*, *34*(4), 259–268.

Geller, B., Zimerman, B., Williams, M., DelBello, M. P., Frazier, J., & Beringer, L. (2002). Phenomenology of prepubertal and early adolescent bipolar disorder: examples of elated mood, grandiose behaviors, decreased need for sleep, racing thoughts and hypersexuality. *Journal of Child and Adolescent Psychopharmacology*, *12*(1), 3–9.

George, E. L., Miklowitz, D. J., Richards, J. A., Simoneau, T. L., & Taylor, D. O. (2003). The comorbidity of bipolar disorder and axis II personality disorders: prevalence and clinical correlates. *Bipolar Disorders*, *5*(2), 115–122.

Gergen, K.J. (1990). Towards a postmodern psychology. *The Humanistic Psychologist, 18*(1), 23-24.

Ghaemi, S. N., Lenox, M. S., & Baldessarini, R. J. (2001). Effectiveness and safety of long-term antidepressant treatment in bipolar disorder. *The Journal of Clinical Psychiatry*, *62*(7), 656-569.

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine*, *166*(21), 2314–2321.

Gilligan, C., Spencer, R., Weinberg, M. K., & Bertsch, T. (2006). On the listening guide. *Emergent Methods in Social Research*, 253–272, https://dx.doi.org/10.4135/9781412984034.n12

Gitlin, M. (2006). Treatment-resistant bipolar disorder. *Molecular Psychiatry*, 11, 227–240.

Gitlin, M., & Frye, M.A. (2012). Maintenance therapies in bipolar disorders. *Bipolar Disorders 14*(2), 51–65.

Gitlin, M. J., Swendsen, J., Heller, T. L., & Hammen, C. (1995). Relapse and impairment in bipolar disorder. *The American Journal of Psychiatry*, *52*(11), 1635-1640.

Glasziou, P., Vandenbroucke, J., & Chalmers, I. (2004). Assessing the quality of research. *BMJ*, *328* (7430), 39–41.

Goldstein, B.I., & Birmaher, B. (2012). Prevalence, clinical presentation, and differential diagnosis of pediatric bipolar disorder. *The Israel Journal of Psychiatry and Related Sciences, 49(1)*, 3.

Goldstein, B.I., Birmaher, B., Carlson, G.A. DelBello, M.P. Findling, R.L., Fristad, M., … & Van Meter, A. (2017). The International Society for Bipolar Disorder task force report on pediatric bipolar disorder: knowledge to date and directions for future research. *Bipolar Disorders, 19(7)*, 524–543.

Goldstein, B. I., Herrmann, N., & Shulman, K. I. (2006). Comorbidity in bipolar disorder among the elderly: results from an epidemiological community sample. *American Journal of Psychiatry*, *163*(2), 319–321.

Goldstein, T. R., Fersch-Podrat, R. K., Rivera, M., Axelson, D. A., Merranko, J., Yu, H., ... & Birmaher, B. (2015). Dialectical behavior therapy for adolescents with bipolar disorder: results from a pilot randomized trial. *Journal of Child and Adolescent Psychopharmacology*, *25*(2), 140–149.

Goldstein, T. R., Miklowitz, D. J., & Mullen, K. L. (2006). Social skills knowledge and performance among adolescents with bipolar disorder. *Bipolar disorders*, *8*(4), 350–361.

Goodwin, G. M. (2012). Bipolar disorder. https://doi.org/10.1016/j.mpmed.2012.08.011

Goodwin, F. K., & Jamison, K. R. (2007). *Manic-depressive illness: bipolar disorders and recurrent depression* (Vol. 1). Oxford University Press.

Grande, I., Berk, M., Birmaher, B., & Vieta, E. (2016). Bipolar disorder. *The Lancet, 387(10027)*, 1561–1572.

Grant, B. F., Stinson, F. S., Hasin, D. S., Dawson, D. A., Chou, S. P., Ruan, W., & Huang, B. (2005). Prevalence, correlates, and comorbidity of bipolar I disorder and axis I and II disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *The Journal of Clinical Psychiatry*, *66*(1), 1205-1215.

Grenz, S. J. (1996). *A primer on postmodernism*. Wm. B. Eerdmans Publishing.

Hagenauer, G., Hascher, T., & Volet, S.E. (2015). Teacher emotions in the classroom: associations with students' engagement, classroom discipline and the interpersonal teacher-student relationship. *European Journal of Psychology of Education, 30(4)*, 385–403.

Harrison, P. J., Cipriani, A., Harmer, C. J., Nobre, A. C., Saunders, K., Goodwin, G. M., & Geddes, J. R. (2016). Innovative approaches to bipolar disorder and its treatment. *Annals of the New York Academy of Sciences, 1366(1)*, 76–89.

Havens, L. L., & Ghaemi, S. N. (2005). Existential despair and bipolar disorder: The therapeutic alliance as a mood stabilizer. *American Journal of Psychotherapy*, *59*(2), 137–147.

Hawken, E.R., Harkness, K.L., Lazowski, L.L., Summers, D., Khoja, N., Gregory, J.G., & Milev, R. (2016). The manic phase of Bipolar disorder significantly impairs theory of mind decoding. *Psychiatry Research, 239,* 275–280.

Henin, A., Mick, E., Biederman, J., Fried, R., Wozniak, J., Faraone, S. V., ... & Doyle, A. E. (2007). Can bipolar disorder-specific neuropsychological impairments in children be identified? *Journal of Consulting and Clinical Psychology*, *75*(2), 210.

Herman, A. A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African stress and health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *SAMJ: South African Medical Journal, 99(5)*, 339–344.

Hirschfeld, R., Lewis, L., & Vornik, L. A. (2003). Perceptions and impact of bipolar disorder: how far have we really come? Results of the National Depressive and Manic-Depressive Association 2000 survey of individuals with bipolar disorder. *The Journal of Clinical Psychiatry*, *64*(2), 161-74.

Hlastala, S. A., Kotler, J. S., McClellan, J. M., & McCauley, E. A. (2010). Interpersonal and social rhythm therapy for adolescents with bipolar disorder: treatment development and results from an open trial. *Depression and anxiety*, *27*(5), 457–464.

Ho, N., & Sommers, M. (2013). Anhedonia: a concept analysis. *Archives of Psychiatric Nursing, 27*(3), 12–19.

Hoffman, R. G., & Lim, H. J. (2007). Observational study design. In W. T. Ambrosius (Ed.), *Topics in Biostatistics* (pp.19–31). Totowa, New Jersey: Humana Press Inc.

Hunt, G.E., Malhi, G.S. Cleary, M., Lai, H.M.X., & Thiagarajan, S., (2016). Prevalence of comorbid bipolar and substance use disorders in clinical settings, 1990–2015: Systematic review and meta-analysis. *Journal of Affective Disorders, 206*, 331–349.

Ibanez, A., Urquina, H., Petroni, A., Baez, S., Lopez, V., do Nascimento, M., ... & Beltrachini, L. (2012). Neural processing of emotional facial and semantic expressions in euthymic bipolar disorder (BD) and its association with theory of mind (ToM). *PLoS One*, *7*(10), e46877.

Jackson, A., Cavanagh, J., & Scott, J. (2003). A systematic review of manic and depressive prodromes. *Journal of Affective Disorders*, *74*(3), 209–217.

Jenson, W.R., Harward, S., & Bowen, J. M. (2012). Externalising disorders in children and adolescents: Behavioral excess and behavioral deficits. In M.A. Bray & T.J. Kehle (Eds.). *The Oxford handbook of school psychology* (pp.379–411). New York, NY: Oxford University Press, Inc.

Jerrell, J.M., McIntyre, R.S., & Tripathi, A. (2010). A cohort study of the prevalence and impact of comorbid medical conditions in pediatric bipolar disorder. *Journal of Clinical Psychiatry, 71(11)*, 1518–1525.

Johnson, S.L., Applebaum, A.J., & Otto, M.W. (2013). Bipolar disorder. In L. G. Castonguay & T. F. (Eds.), *Psychopathology: From science to clinical practice* (pp.319–344). The Guildford Press: New York City.

Johnson, S.L., Eisner, L.R., & Carver, C.S. (2009). Elevated expectancies among persons diagnosed with bipolar disorder. *British Journal of Clinical Psychology*, *48*(2), 217–222.

Johnson, S.L., & Fingerhut, R. (2004). Negative cognitions predict the course of bipolar depression, not mania. *Journal of Cognitive Psychotherapy*, *18*(2), 149.

Jones, S. (2004). Psychotherapy of bipolar disorder: a review. *Journal of Affective Disorders*, *80(2-3),* 101–114.

Jones, S. H., Tai, S., Evershed, K., Knowles, R., & Bentall, R. (2006). Early detection of bipolar disorder: a pilot familial high-risk study of parents with bipolar disorder and their adolescent children. *Bipolar Disorders*, *8*(4), 362–372.

Judd, L. L., & Akiskal, H. S. (2003). The prevalence and disability of bipolar spectrum disorders in the US population: re-analysis of the ECA database taking into account subthreshold cases. *Journal of Affective Disorders*, *73*(1–2), 123–131.

Keenan-Miller, D., Peris, T., Axelson, D., Kowatch, R. A., & Miklowitz, D. J. (2012). Family functioning, social impairment, and symptoms among adolescents with bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(10), 1085–1094.

Kessler, R. C., Rubinow, D. R., Holmes, C., Abelson, J. M., & Zhao, S. (1997). The epidemiology of DSM-III-R bipolar I disorder in a general population survey. *Psychological Medicine*, *27*(5), 1079–1089.

Kim, E. Y., Miklowitz, D. J., Biuckians, A., & Mullen, K. (2007). Life stress and the course of early-onset bipolar disorder. *Journal of Affective Disorders*, *99*(1–3), 37–44.

Kleintjes, S., Flisher, A. J., Fick, M., Railoun, A., Lund, C., Molteno, C., & Robertson, B. A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *African Journal of Psychiatry*, *9*(3), 157–160.

Koenig, J. E., Sachs-Ericsson, N., & Miklowitz, D. J. (1997). How do psychiatric patients experience interactions with their relatives? *Journal of Family Psychology*, *11*(2), 251.

Kohler, C. G., Hoffman, L. J., Eastman, L. B., Healey, K., & Moberg, P. J. (2011). Facial emotion perception in depression and bipolar disorder: a quantitative review. *Psychiatry Research*, *188*(3), 303–309.

Kolostoumpis, D., Bergiannaki, J. D., Peppou, L. E., Louki, E., Fousketaki, S., Patelakis, A., & Economou, M. P. (2015). Effectiveness of relatives' psychoeducation on family outcomes in Bipolar Disorder. *International Journal of Mental Health,* 44, 290–302.

Krishnan, K.R.R. (2005). Psychiatric and medical comorbidities of bipolar disorder. *Psychosomatic Medicine*, *67*(1), 1–8.

Lai, H.M.X., Cleary, M., Sitharthan, T., & Hunt, G.E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 154,* 1–3.

Lam, C.L.K. (2010). Subjective quality of life measures – *General principals and concepts*. In: Preedy V.R., Watson R.R. (Eds.). Handbook of Disease Burdens and Quality of Life Measures. Springer, New York, NY.

Lam, D. H., Jones, S. H., Haywood, P., & Bright, J. A. (1999). *Cognitive therapy for manic depression*. Chichester: Wiley.

Lam, D. H., Watkins, E. R., Hayward, P., Bright, J., Wright, K., Kerr, N., ... & Sham, P. (2003). A randomized controlled study of cognitive therapy for relapse prevention for bipolar affective disorder: outcome of the first year. *Archives of General Psychiatry*, *60*(2), 145–152.

Lam, D., & Wong, G. (2005). Prodromes, coping strategies and psychological interventions in bipolar disorders. *Clinical Psychology Review*, *25*(8), 1028–1042.

Lam, D., Wong, G., & Sham, P. (2001). Prodromes, coping strategies and course of illness in bipolar affective disorder–a naturalistic study. *Psychological Medicine*, *31*(8), 1397–1402.

Lam, D., Wright, K. I. M., & Sham, P. A. K. (2005). Sense of hyper-positive self and response to cognitive therapy in bipolar disorder. *Psychological Medicine*, *35*(1), 69–77.

Lam, D., Wright, K., & Smith, N. (2004). Dysfunctional assumptions in bipolar disorder. *Journal of Affective Disorders*, *79*(1–3), 193–199.

Larner, G. (2004). Family therapy and the politics of evidence. *Journal of Family Therapy, 26,* 17–39.

Lauder, S. D., Berk, M., Castle, D. J., Dodd, S., & Berk, L. (2010). The role of psychotherapy in bipolar disorder. *Medical Journal of Australia*, *193*, S31–S35.

Leboyer, M., Soreca, I., Scott, J., Frye, M., Henry, C., Tamouza, R., & Kupfer, D. J. (2012). Can bipolar disorder be viewed as a multi-system inflammatory disease? *Journal of Affective Disorders, 14(1),* 1–10.

Leibenluft, E., Blair, R. J. R., Charney, D. S., & Pine, D. S. (2003). Irritability in pediatric mania and other childhood psychopathology. *Annals of the New York Academy of Sciences*, *1008*(1), 201–218.

Leibenluft, E., Cohen, P., Gorrindo, T., Brook, J.S., & Pine, D.S. (2009). Chronic Versus Episodic Irritability in Youth: A Community-Based, Longitudinal Study of Clinical and Diagnostic Associations. *Journal of Child and Adolescent Psychopharmacology, 16*(4), 456-466.

Leidy, N. K., Palmer, C., Murray, M., Robb, J., & Revicki, D. A. (1998). Health-related quality of life assessment in euthymic and depressed patients with bipolar disorder: psychometric performance of four self-report measures. *Journal of Affective Disorders*, *48*(2–3), 207–214.

Leonenko, G., Di Florio, A., Allardyce, J., Forty, L., Knott, S., Jones, L., Gordon-Smith., K., Owen, M.J., Jones, I., Walters, J., Craddock, N., O'Donovan, M.C., & Escott-Price, V. (2018). A data-driven investigation of relationships between bipolar psychotic symptoms and schizophrenia genome-wide significant genetic loci. *American Journal of Medical Genetics, 177(4),* 468–475.

Leshem, R. (2016). Brain development, impulsivity, risky decision making, and cognitive control: Integrating cognitive and socioemotional processes during adolescence – An introduction to the special Issue. *Developmental Neuropsychology, 41(1–2),* 1–5. https://doi.org/10.1080/87565641.2016.1187033

Lewinsohn, P. M., Rohde, P., Seeley, J. R., Klein, D. N., & Gotlib, I. H. (2000). Natural course of adolescent major depressive disorder in a community sample: predictors of recurrence in young adults. *American Journal of Psychiatry*, *157*(10), 1584–1591.

Lopez-Larson, M.P., Shah, L.M., Weeks, H.R., King, J.B., Mallik, A.K., Yurgelun-Todd, D.A., & Anderson, J.S. (2016). Abnormal functional connectivity between default and salience networks in pediatric bipolar disorder. *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging 2(1),* 85–93.

Lozano, B. E., & Johnson, S. L. (2001). Can personality traits predict increases in manic and depressive symptoms? *Journal of Affective Disorders*, *63*(1–3), 103–111.

Luby, J. L., & Mrakotsky, C. (2003). Depressed preschoolers with bipolar family history: a group at high risk for later switching to mania? *Journal of Child and Adolescent Psychopharmacology*, *13*(2), 187–197.

Lyotard, J. F. (2000). The postmodern condition. *Sociology of Education: Theories and methods*, *1*, pp.362.

Mansell, W., & Lam, D. (2006). "I Won't Do What You Tell Me!": Elevated mood and the assessment of advice-taking in euthymic bipolar I disorder. *Behaviour Research and Therapy*, *44*(12), 1787–1801.

Madsen, W. C. (2007). *Collaborative therapy with multi-stressed families* (2nd ed.). New York: The Guildford Press.

Madzhie, M., Mashamba, T.M., & Takalani, F.J. (2014). African traditional healers' perception and diagnosis of mental illness. *African Journal for Physical, Health Education, Recreation and Dance, 1(2),* 319–328.

Malhi, G. S. (2012). Bipolar Antidepressant Agents: Shaken not stirred. Australian & New Zealand Journal of Psychiatry, 46(4), 289–292. https://doi.org/10.1177/0004867412445131

Martin-Subero, M., Berk, L., Dodd, S., Kamalesh, V., Maes, M., Kulkarni, J., De Castella, A., Fitzgerald, P.B., & Berk, M. (2014). Quality of life in bipolar and schizoaffective disorder – a naturalistic approach. *Comprehensive Psychiatry 55,* 1540–1545.

Martinez-Aran, A., Vieta, E., Reinares, M., Colom, F., Torrent, C., Sanchez-Moreno, J., Benabarre, A., Goikolea, J. M., Comes, M., & Salamero, M. (2004). Cognitive function across manic or hypomanic, depressed, and euthymic states in bipolar disorder. *American Journal of Psychiatry, 161(*2), 262–270.

McClellan, J., Kowatch, R., & Findling, R. L. (2007). Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(1), 107–125.

McElroy, S. L. (2004). Diagnosing and treating comorbid (complicated) bipolar disorder. *Journal of Clinical Psychiatry*, *65*, 35–44.

McElroy, S. L., Altshuler, L. L., Suppes, T., Keck Jr, P. E., Frye, M. A., Denicoff, K. D., ... & Rush, A. J. (2001). Axis I psychiatric comorbidity and its relationship to historical illness variables in 288 patients with bipolar disorder. *American Journal of Psychiatry*, *158*(3), 420–426.

McElroy, S.L., Frye, M.A., Hellemann, G., Altshule, L., Leverich, G.S., Suppes, T., … & Post, R.M. (2011). Prevalence and correlates of eating disorders in 875 patients with bipolar disorder. *Journal of Affective Disorders, 128(3)*, 191–198.

McGuffin, P., Rijsdijk, F., Andrew, M., Sham, P., Katz, R., & Cardno, A. (2003). The heritability of bipolar affective disorder and the genetic relationship to unipolar depression. *Archives of General Psychiatry*, *60*(5), 497–502.

McInnis, M. G., Mackinnon, D. F., McMahon, F. J., Foroud, T., Edenberg, H. J., Goate, A., ... & Reich, T. (1998). Evidence for a susceptibility locus for bipolar disorder on chromosome 11p11.5. *American Journal of Medical Genetics-Neuropsychiatric Genetics*, *81*(6), 463.

McMahon, K., Herr, N.R., Zerubavel, N., Hoertel, N., & Neacsiu, A.D. (2016). Psychotherapeutic treatment of bipolar depression. *Psychiatric Clinics 39(1),* 35–56.

Merikangas, K. R., Herrell, R., Swendsen, J., Rossler, W., Ajdacic-Gross, V., & Angst, J. (2008). Specificity of Bipolar Spectrum Conditions in the Comorbidity of Mood and Substance Use Disorders. *Archives of General Psychiatry 65(1)*, 47–52.

Merikangas, K. R., Jin, R., He, J-P., Kessler, R. C., Lee, S., Sampson, N. A…& Zarkov, Z. (2011). Prevalence and correlates of bipolar spectrum disorder in the world mental health survey initiative. *Archives of General Psychiatry 68(1)*, 241–251.

Merriam-Webster Dictionary online. Collaboration. (n.d.). Retrieved from https://merriam-webster.com/dictionary/collaborate

Merriam-Webster Dictionary online. Family. (n.d.). Retrieved November 16, 2017, https://www.merriam-webster.com/dictionary/family

Merriam-Webster Dictionary online. Imperative. (n.d.). Retrieved from https://www.merriam-webster.com/dictionary/imperative

Meyer, B., Johnson, S. L., & Winters, R. (2001). Responsiveness to threat and incentive in bipolar disorder: Relations of the BIS/BAS scales with symptoms. *Journal of Psychopathology and Behavioral Assessment*, *23*(3), 133–143.

Meyer, F., & Meyer, T.D. (2009). The misdiagnosis of bipolar disorder as a psychotic disorder: Some of its causes and their influence on therapy. *Journal of Affective Disorders 112(1–3)*, 174–183.

Michalak, E. E., Torres, I. J., Bond, D. J., Lam, R. W., & Yatham, L. N. (2013). The relationship between clinical outcomes and quality of life in first‐episode mania: a longitudinal analysis. *Bipolar Disorders*, *15*(2), 188–198.

Michalak, E. E., Yatham, L. N., & Lam, R. W. (2005). Quality of life in bipolar disorder: a review of the literature. *Health and quality of life outcomes*, *3*(1), 72.

Miklowitz, D. J. (2007). The role of the family in the course and treatment of bipolar disorder. *Current Directions in Psychological Science, 16(4)*, 192–196.

Miklowitz, D. J. (2008). Adjunctive psychotherapy for bipolar disorder: State of the evidence. *The American Journal of Psychiatry 165(11)*, 1408–1419.

Miklowitz, D. J., Axelson, D. A., Birmaher, B., George, E. L., Taylor, D. O., Schneck, C. D., ... & Brent, D. A. (2008). Family-focused treatment for adolescents with bipolar disorder: results of a 2-year randomized trial. *Archives of General Psychiatry*, *65*(9), 1053–1061.

Miklowitz, D.J., Biuckians, A., & Richards, J.A. (2006). Early-onset bipolar disorder: A family treatment perspective. *Development and Psychopathology, 1,* 1247–1265.

Miklowitz, D. J., George, E. L., Richards, J. A., Simoneau, T. L., & Suddath, R. L. (2003). A randomized study of family-focused psychoeducation and pharmacotherapy in the outpatient management of bipolar disorder. *Archives of General Psychiatry*, *60*(9), 904–912.

Miklowitz, D. J., Goldstein, M. J., Nuechterlein, K. H., Snyder, K. S., & Mintz, J. (1988). Family factors and the course of bipolar affective disorder. *Archives of General Psychiatry*, *45*(3), 225–231.

Miklowitz, D. J., Goodwin, G. M., Bauer, M. S., & Geddes, J. R. (2008). Common and specific elements of psychosocial treatments for bipolar disorder: a survey of clinicians participating in randomized trials. *Journal of Psychiatric Practice*, *14*(2), 77.

Miller, A. L., Smith, H. L., Klein, D. A., & Germán, M. (2010). Engaging suicidal youth in outpatient treatment: Theoretical and empirical underpinnings. *Archives of Suicide Research*, *14*(2), 111–119.

Miller, N., & Brimicombe, A. (2010). Mapping research journeys across complex terrain with heavy baggage. *Studies in Continuing Education, 26(3),* 405–417.

Mills, J., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods, 5(1),* 1–10.

Moller, H. J., & Nasrallah, H.A. (2003). Treatment of bipolar disorder. *The Journal of Clinical Psychiatry*, 64, 9–17.

Muralidharan, A., Lucksted, A., Medoff, D., Fang, L.J. & Dixon, L. (2016). Stigma: a unique source of distress for family members of individuals with mental illness. *The Journal of Behavioral Health Services & Research, 43*(3), 484–493.

Murray, G., Leitan, N. D., Thomas, N., Michalak, E.E., Johnson, S. L., Jones, S., Perich, T., Berk, L., & Berk, M. (2017). Towards recovery-oriented psychosocial interventions for bipolar disorder: Quality of life outcomes, stage-sensitive treatments, and mindfulness mechanisms. *Clinical Psychology Review,* 52, 148–163. http://dx.doi.org/10.1016/j.cpr.2017.01.002.

Murray, G., Suto, M., Hole, R., Hale, S., Amari, E., & Michalak, E.E. (2010). Self-management strategies used by 'high functioning' individuals with bipolar disorder: From research to clinical practice. *Clinical Psychology and Psychotherapy 18(2),* 95–109. DOI: 10.1002/cpp.710

Nemeroff, C. B., Evans, D. L., Gyulai, L., Sachs, G. S., Bowden, C. L., Gergel, I. P., ... & Pitts, C. D. (2001). Double-blind, placebo-controlled comparison of imipramine and paroxetine in the treatment of bipolar depression. *American Journal of Psychiatry*, *158*(6), 906–912.

Nesvåg, R., Knudsen, G. P., Bakken, I. J., Høye, A., Ystrom, E., Surén, P., ... & Reichborn-Kjennerud, T. (2015). Substance use disorders in schizophrenia, bipolar disorder, and depressive illness: a registry-based study. *Social Psychiatry and Psychiatric Epidemiology*, *50*(8), 1267–1276.

Ngazimbi, E.E., Lambie, G.W., & Shillingford, M.A. (2008). The use of narrative therapy with clients diagnosed with bipolar disorder. *Journey of Creativity in Mental Health, 3(2),* 157–174.

Nierenberg, A.A., Akiskal, H.S., Angst, J., Merikangas, K.R., Petukhova, M., & Kessler, R.C. (2010). Bipolar disorder with frequent mood episodes in the national comorbidity survey replication (NCS-R). *Molecular Psychiatry, 15,* 1075–1087.

Nierenberg, A., Henin, A., Mick, E., Ostacher, M., Borrelli, D. J., Gironde, S. V. M., ... & Biederman, J. (2005). Relationship between comorbid psychopathology among adults with bipolar disorder and their offspring: phenotypic implications for genetic studies. In *Bipolar Disorders* (Vol. 7, pp. 82-82). Oxford, UK: Blackwell.

Nivoli, A. M., Colom, F., Murru, A., Pacchiarotti, I., Castro-Loli, P., González-Pinto, A., ... & Vieta, E. (2011). New treatment guidelines for acute bipolar depression: a systematic review. *Journal of Affective Disorders*, *129*(1–3), 14–26.

Novick, D., Swartz, H. & Frank, E. (2010). Suicide attempts in bipolar I and bipolar II disorder: a review and meta-analysis of the evidence. *Bipolar Disorders, 12*(1), 1-9.

Ochocka, J., Nelson, G., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3 - A qualitative study of impacts of participation on new members. *Journal of Community Psychology*, *34*(3), 273–283.

Olfson, M., Blanco, C., Wang, S., Laje, G., & Correll, C. U. (2014). National trends in the mental health care of children, adolescents, and adults by office-based physicians. *JAMA Psychiatry*, *71*(1), 81–90.

Oliveira, S.E.H., Esteves, F., & Carvalho, H. (2015). Clinical profiles of stigma experiences, self-esteem and social relationships among people with schizophrenia, depressive, and bipolar disorders. *Psychiatry Research, 229(1–2),* 167–173.

Oostervink, F., Boomsma, M.M., & Nolen, W.A. (2008). Bipolar disorder in the elderly; different effects of age and of age of onset. *Journal of Affective Disorders, 116,* 176–183.

Otto, M. W., Reilly-Harrington, N. A., Kogan, J. N., Henin, A., Knauz, R. O., & Sachs, G. S. (2009). *Managing bipolar disorder: A cognitive-behavioral approach workbook*. NY: Oxford University Press.

Oud, M., Mayo-Wilson, E., Braidwood, R., Schulte, P., Jones, S., Morriss, R., Kupka, R., Cuijpers, P. & Kendall, T. (2016). Psychological interventions for adults with bipolar disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 208*(3), 213–222. doi:10.1192/bjp.bp.114.157123

Oxford Living Dictionaries online. Collaboration. (n.d.). Retrieved from https://en.osforddictionaries.com/definition/collaboration

Oxford Living Dictionaries online. Stigma (n.d.). Retrieved from https://en.osforddictionaries.com/definition/collaboration

Parens, E., Johnston, J., & Carlson, G. A. (2010). Pediatric mental health care dysfunction disorder? *New England Journal of Medicine*, *362* (20), 1853–1855.

Parikh, S. V., Zaretsky, A., Beaulieu, S., Yatham, L. N., Young, L. T., Patelis-Siotis, I., ... & Velyvis, V. (2012). A randomized controlled trial of psychoeducation or cognitive-behavioral therapy in bipolar disorder: a Canadian Network for Mood and Anxiety treatments (CANMAT) study. *J Clin Psychiatry*, *73*(6), 803–810.

Park, J.W. & Park, K.H. (2014). Validation of the bipolar disorder etiology scale based on psychological behaviorism theory and factors related to the onset of bipolar disorder. *PLoS ONE, 9(12)*: e116265. https://doi.org/10.137/journal.pone.0116265

Parker, G.B. (2010). Comorbidities of bipolar disorder: models and management. *The Medical Journal of Australia 19(4),* 18–20.

Parry, P.I., & Levin, E.C. (2012). Pediatric bipolar disorder in an era of “mindless psychiatry”. *Journal of Trauma & Dissociation 13(1),* 51–68.

Patel, R., Reiss, P., Shetty, H., Broadbent, M., Stewart, R., McGuire, P., & Taylor, M. (2015). Do antidepressants increase the risk of mania and bipolar disorder in people with depression? A retrospective electronic case register cohort study. *BMJ Open, 5*(12), e008341.

Pavuluri, M. N., Birmaher, B., & Naylor, M. W. (2005). Pediatric bipolar disorder: a review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, *44*(9), 846–871.

Pavuluri, M. N., O’Connor, M. M., Harral, E. M., Moss, M., & Sweeney, J. A. (2006). Impact of neurocognitive function on academic difficulties in pediatric bipolar disorder: A clinical translation. *Biological Psychiatry*, *60*(9), 951–956.

Payne, M. (2006). *Narrative Therapy: An Introduction for Counsellors* (2nd ed). London: Sage Publications.

Perlick, D. A., Hohenstein, J. M., Clarkin, J. F., Kaczynski, R., & Rosenheck, R. A. (2005). Use of mental health and primary care services by caregivers of patients with bipolar disorder: a preliminary study. *Bipolar Disorders*, *7*(2), 126–135.

Perlick, D. A., Miklowitz, D. J., Link, B. G., Struening, E., Kaczynski, R., Gonzalez, J., ... & Rosenheck, R. A. (2007). Perceived stigma and depression among caregivers of patients with bipolar disorder. *British Journal of Psychiatry*, *190*(6), 535–536.

Perlick, D. A., Miklowitz, D. J., Lopez, N., Chou, J., Kalvin, C., Adzhiashvili, V., & Aronson, A. (2010). Family‐focused treatment for caregivers of patients with bipolar disorder. *Bipolar Disorders*, *12*(6), 627–637.

Perlick, D. A., Rosenheck, R. R., Clarkin, J. F., Raue, P., & Sirey, J. (2001). Impact of family burden and patient symptom status on clinical outcome in bipolar affective disorder. *Journal of Nervous and Mental Disease*, *189*(1), 31–37.

Perlick, D. A., Rosenheck, R. A., Kaczynski, R., & Kozma, L. (2004). Medication non-adherence in bipolar disorder: a patient-centered review of research findings. *Clinical Approaches in Bipolar Disorders*, *3*(2), 56–64.

Perlick, D. A., Rosenheck, R. A., Miklowitz, D. J., Kaczynski, R., Link, B., Ketter, T., ... & STEP-BD Family Experience Collaborative Study Group. (2008). Caregiver burden and health in bipolar disorder: a cluster analytic approach. *Journal of Nervous and Mental disease*, *196*(6), 484.

Perlis, R. H., Miyahara, S., Marangell, L. B., Wisniewski, S. R., Ostacher, M., DelBello, M. P., ... & STEP-BD Investigators. (2004). Long-term implications of early onset in bipolar disorder: data from the first 1000 participants in the systematic treatment enhancement program for bipolar disorder (STEP-BD). *Biological psychiatry*, *55*(9), 875–881.

Perugi, G., Hantouche, E., Vannucchi, G., & Pinto, O. (2015). Cyclothymia reloaded: A reappraisal of the most misconceived affective disorder. *Journal of Affective Disorders*, 183: 119–33. doi:10.1016/j.jad.2015.05.004

Picco, L., Pang, S., Lau, Y.W., Jeyagurunathan, A., Satghare, P., Abdin, E., … & Subramaniam, M. (2016). Internalised stigma among psychiatric outpatients: Associations with quality of life, functioning, hope and self-esteem. *Psychiatry Research, 246,* 500–506.

Pogge, D. L., Wayland-Smith, D., Zaccario, M., Borgaro, S., Stokes, J., & Harvey, P. D. (2001). Diagnosis of manic episodes in adolescent inpatients: structured diagnostic procedures compared to clinical chart diagnoses. *Psychiatry Research*, *101*(1), 47–54.

Polanczyk, G.V., Salum, G.A., Sugaya, L.S., Caye, A., & Rohde, L.A. (2015). Annual Research Review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents. *Journal of Child Psychology and Psychiatry, 56(3),* 345–365.

Pompili, M., Gonda, X., Serafini, G., Innamorati, M., Sher, L., Amore, M., ... & Girardi, P. (2013). Epidemiology of suicide in bipolar disorders: a systematic review of the literature. *Bipolar Disorders*, *15*(5), 457–490.

Popovic, D., Reinares, M., Goikolea, J. M., Bonnin, C.M., Gonzalez-Pinto, A., & Vieta, E. (2011). Polarity index of pharmacological agents used for maintenance treatment of bipolar. *European Neuropsychopharmacology 22,* 339–346.

Post, R. M. (2014). Differentiating pediatric bipolar disorder from attention-deficit/hyperactivity disorder. *Psychiatric Annals 44(9),* 406–408. Doi.org/10.3928/00485713-2014090803

Potter, N. (2013). Narrative selves, relations of trust, and bipolar disorder. *Philosophy, Psychiatry & Psychology 20(1),* 57–65.

Proudfoot, J.G., Parker, G.B., Benoit, M., Manicavasagar, V., Smith, M., & Gayed, A. (2009). What happens after diagnosis? Understanding the experiences of patients with newly-diagnosed bipolar disorder. *Health Expectations 12(2),*120–129. DOI: 10.1111/j.1369-7625.2009.00541.x

Puddifoot, K. (2017). Stereotyping: the multifactorial view. *Philosophical Topics, 45*(1), 137–156.

Raider-Roth, M. B. (2005). *Trusting what you know: The high stakes of classroom relationships*. Jossey-Bass.

Ramalho, R., Adams, P., Huggard, P., & Hoare, K. (2015). Literature review and constructivist grounded theory methodology. *Forum Qualitative Sozilforschung/Forum: Qualitative Social Research, 16(3).*

Regeer, E. J., Ten Have, M., Rosso, M. L., Hakkaart‐van Roijen, L., Vollebergh, W., & Nolen, W. A. (2004). Prevalence of bipolar disorder in the general population: a Reappraisal Study of the Netherlands Mental Health Survey and Incidence Study. *Acta Psychiatrica Scandinavica*, *110*(5), 374–382.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) study. *Jama*, *264*(19), 2511–2518.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health 20(4)*, 392–411.

Republic of South Africa, National Department of Health (2013). National Mental Health Policy Framework (NMHPF) and Strategic Plan 2013 – 2020.

Robertson, E., Jones, I., Haque, S., Holder, R., & Craddock, N. (2005). Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal (post-partum) psychosis. *The British Journal of Psychiatry*, *186*(3), 258–259.

Rosa, A. R., González‑Ortega, I., González‑Pinto, A., Echeburúa, E., Comes, M., Martínez‑Àran, A., Ugarte, A. Fernández, M. & Vieta, E. (2012). One‑year psychosocial functioning in patients in the early vs. late stage of bipolar disorder. *Acta Psychiatrica Scandinavica*, *125*(4), 335–341.

Rosa, A. R., Reinares, M., Michalak, E. E., & Bonnin, C, M., Sole, B., Franco, C., Comes, M., Torrent, C., Kapczinski, F., & Vieta, E. (2010). Functional impairment and disability across mood states in bipolar disorder. *Value in Health, 13(8)*, 984–988.

Rosenbaum, P. R. (2005). Observational study. In B. S. Everitt & D. C. Howell (Eds.), *Encyclopedia of Statistics in Behavioral Science* (pp.1451–1462). Chichester: John Wiley & Sons, Ltd.

Roshanaei-Moghaddam, B., Katon, W. J., & Russo, J. (2009). The longitudinal effects of depression on physical activity. *General Hospital Psychiatry*, *31*(4), 306–315.

Rucklidge, J. J. (2006). Impact of ADHD on the neurocognitive functioning of adolescents with bipolar disorder. *Biological Psychiatry*, *60*(9), 921–928.

Sadock, B.J., Sadock, V.A., & Ruiz, P. (2015). *Kaplan & Sadock’s synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (Eleventh edition). Philadelphia: Wolters Kluwer.

Sahakian, B., & Morein-Zamir, S. (2007). Professor’s little helper. *Nature*, *450* (7173), 1157.

Sajatovic, M., Davies, M., & Hrouda, D.R. (2004). Enhancement of treatment adherence among patients with bipolar disorder. *Psychiatry Services, 55*(3), 264–269. DOI:10.1176/appi.ps.55.3.264

Sajatovic, M., Madhusoodanan, S., & Coconcea, N. (2005). Managing bipolar disorder in the elderly. *Drugs & Aging*, *22*(1), 39–54.

Sanchez-Moreno, J., Martinez-Aran, A., Tabarés-Seisdedos, R., Torrent, C., Vieta, E., & Ayuso-Mateos, J. L. (2009). Functioning and disability in bipolar disorder: an extensive review. *Psychotherapy and Psychosomatics*, *78*(5), 285–297.

Sanchez-Moreno, J., Martinez-Aran, A., & Vieta, E. (2017). Treatment of functional impairment in patients with bipolar disorder. *Current Psychiatry Reports,19*(1), 3. https://doi.org/10.1007/s11920-017-0752-3

Schaefer, K. L., Baumann, J., Rich, B. A., Luckenbaugh, D. A., & Zarate Jr, C. A. (2010). Perception of facial emotion in adults with bipolar or unipolar depression and controls. *Journal of Psychiatric Research*, *44*(16), 1229–1235.

Schudlich, T.D.R., Youngstrom, E.A., Martinez, M., KogosYoungstrom, J., Scovil, K., Ross, J., … & Findling, R.L. (2015). Physical and sexual abuse and early-onset bipolar disorder in youths receiving outpatient services: frequent, but not specific. *Journal of Abnormal Child Psychology, 43*(3), 453–463.

Scott, J., Garland, A., & Moorhead, S. (2001). A pilot study of cognitive therapy in bipolar disorders. *Psychological medicine*, *31*(3), 459–467.

Scott, J. A. N., Paykel, E., Morriss, R., Bentall, R., Kinderman, P., Johnson, T., ... & Hayhurst, H. (2006). Cognitive–behavioural therapy for severe and recurrent bipolar disorders: randomised controlled trial. *British Journal of Psychiatry*, *188*(4), 313–320.

Segal, J., & Douki, S. (2005). CANMAT guidelines for bipolar disorder: commentary from the African perspective. *Bipolar Disorders*, *7*, 77–82.

Seidel, E. M., Habel, U., Finkelmeyer, A., Hasmann, A., Dobmeier, M., & Derntl, B. (2012). Risk or resilience? Empathic abilities in patients with bipolar disorders and their first-degree relatives. *Journal of Psychiatric Research*, *46*(3), 382–388.

Sidor, M. M., & MacQueen, G. M. (2011). Antidepressants for the acute treatment of bipolar depression: a systematic review and meta-analysis. In *Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews [Internet]*. Centre for Reviews and Dissemination (UK).

Sierra, P., Livianos, L., & Rojo, L. (2005). Quality of life for patients with bipolar disorder: relationship with clinical and demographic variables. *Bipolar Disorders*, *7*(2), 159–165.

Sigitova, E., Fisar, Z., Hroudova, J., Cikankova, T., & Raboch, J. (2017). Biological hypotheses and biomarkers of bipolar disorder. *Psychiatry and Clinical Neurosciences 71,* 77–103.

Simon, G. E. (2003). Social and economic burden of mood disorders. *Biological Psychiatry, 54 (3),* 208–215.

Simon, G. E., & Unützer, J. (1999). Health care utilization and costs among patients treated for bipolar disorder in an insured population. *Psychiatric Services*, *50*(10), 1303–1308.

Simon, N. M. (2009). Generalized anxiety disorder and psychiatric comorbidities such as depression, bipolar disorder, and substance abuse. *The Journal of Clinical Psychiatry*, *70*(suppl 2), 10–14.

Simon, N. M., Otto, M. W., Wisniewski, S. R., Fossey, M., Sagduyu, K., Frank, E., ... & STEP-BD Investigators (2004). Anxiety disorder comorbidity in bipolar disorder patients: data from the first 500 participants in the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *American Journal of Psychiatry*, *161*(12), 2222–2229.

Singh, M. K., DelBello, M. P., Kowatch, R. A., & Strakowski, S. M. (2006). Co-occurrence of bipolar and attention-deficit hyperactivity disorders in children. *Bipolar Disorders*, *8*(6), 710–720.

Singh, T., & Rajput, M. (2006). Misdiagnosis of bipolar disorder. *Psychiatry 3 (10),* 57–63.

Soares-Weiser, K., Bravo Vergal, Y., Beynon, S., Dunn, G., Barbieri, M., Duffy, S., Geddes, J., Gilbody, S., Palmer, S., & Woolacott, N. (2007). A systematic review and economic model of the clinical effectiveness and cost-effectiveness of interventions for preventing relapse in people with bipolar disorder. *Health Technology Assessment, 11 (39).*

Sole, B., Bonnin, C.M., Torrent, C., Balanza-Martinez, V., Tabares-Seisdedos, R., Popovic, D., … & Vieta, E. (2012). Neurocognitive impairment and psychosocial functioning in bipolar II disorder. *Acta Psychiatrica Scandinavica, 125 (4),* 309–317.

Sorsdahl, K. R., Flisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry, 13(4),* 284–290.

Spinhoven, P., Penninx, B. W., Hickendorff, M., van Hemert, A. M., Bernstein, D. P., & Elzinga, B. M. (2014). Childhood Trauma Questionnaire: Factor structure, measurement invariance, and validity across emotional disorders. *Psychological Assessment*, *26*(3), 717.

Stein, B. D., Celedonia, K. L., Swartz, H. A., Burns, R. M., Sobero, M. J., Brindley, R. A., & Frank, E. (2015). Psychosocial treatment of bipolar disorder: Clinician knowledge, common approaches and barriers to effective treatment. *Psychiatric Services (Washington, D.C.), 66*(12), 1361–1364.

Strakowski, S. M., Delbello, M. P., & Adler, C. M. (2005). The functional neuroanatomy of bipolar disorder: a review of neuroimaging findings. *Molecular Psychiatry*, *10*(1), 105.

Stringaris, A. (2011). Irritability in children and adolescents: a challenge for DSM-5. *European Child & Adolescent Psychiatry*, *20*(2), 61–66.

Stringer, B., van Meijel, B., Koekkoek, B., Kerkhof, A & Beekman, A. (2011). Collaborative care for patients with severe borderline and NOS personality disorders: A comparative multiple case study on processes and outcomes. *BMC Psychiatry, 11*(1), 102.

Strydom, H. (2011). Ethical aspects of research in the social sciences and human service professions. In A.S. de Vos, H. Strydom, C.B.Fouche & C.S.L.Delport (Eds.), *Research at grass roots: For the social sciences and human service professions* (pp.113–129). Pretoria: Van Schaik Publishers.

Sue, D., Sue, D. W., Sue, D., & Sue, S. (2014). *Understanding abnormal behaviour* 11th ed). USA: Cengage Learning.

Sullivan, A. E., & Miklowitz, D. J. (2010). Family functioning among adolescents with Bipolar Disorder. *Journal of Family Psychology, 24(1),*60–67.

Swart, C. (2013). Re-authoring the world: The narrative lens and practices for organisations, communities and individuals. Johannesburg: Knowledge Resources Publishing.

Sylvia, L.G., Shelton, R.C., Kemp, D.E., Bernstein, E.E., Friedman, E.S., Brody, B.D…& Calabrese, J.R. (2015). Medical burden in bipolar disorder: findings from the Clinical and Health Outcomes Initiative in comparative effectiveness for bipolar disorder study (Bipolar CHOICE). *Bipolar Disorders 17*(2), 212–223.

Tanzilli, A., Colli, A., Del Corno, F., & Lingiardi, V. (2016). Factor structure, reliability, and validity of the Therapist Response Questionnaire. *Personality Disorders: Theory, Research, and Treatment, 7*(2), 147.

Tarragona, M. (2008). Postmodern/poststructuralist therapies. In J.L. Lebow (Ed). *Twenty-First Century Psychotherapies: Contemporary Approaches to Theory and Practice* (pp.167–205). Hoboken, New Jersey: John Wiley & Sons.

Taylor, C. T., Hirshfeld-Becker, D. R., Ostacher, M. J., Chow, C. W., LeBeau, R. T., Pollack, M. H., ... & Simon, N. M. (2008). Anxiety is associated with impulsivity in bipolar disorder. *Journal of Anxiety Disorders*, *22*(5), 868–876.

Taylor, E. (2011). Diagnostic Classification: current dilemmas and possible solutions. *Child Psychology and Psychiatry*, 224.

Teherani, A. Martimianakis, T., Stenfors-Hayes, T., Wadhwa, A., & Varpio, L. (2015). Choosing a qualitative research approach. *Journal of Graduate Medical Education, 7*(4), 669–670.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for social science* (2nd ed.). Cape Town: University of Cape Town Press.

Theofilou, P. (2013). Quality of life: definition and measurement. *Europe's Journal of Psychology, 9*(1), 150–162.

Thorngren, J. M., & Kleist, D. M. (2002). Multiple family group therapy: An interpersonal/postmodern approach. *The Family Journal, 10*(2), 167–176.

Valenti, M., Pacchiarotti, I., Rosa, A.R., Bonnin, C.M., Popovic, D., Nivoli, A.M.A., Murru, A., Grande, I., Colom, F., & Vieta, E., (2011). *Bipolar Disorders, 13,* 145–154.

Vancampfort, D., Vansteelandt, K., Correll, C. U., Mitchell, A. J., De Herdt, A., Sienaert, P., ... & De Hert, M. (2013). Metabolic syndrome and metabolic abnormalities in bipolar disorder: a meta-analysis of prevalence rates and moderators. *American Journal of Psychiatry*, *170*(3), 265–274.

Van der Sanden, R.L., Pryor, J.B., Stutterheim, S.E., Kok, G., & Bos, A.E. (2016). Stigma by association and family burden among family members of people with mental illness: the mediating role of coping. *Social Psychiatry and Psychiatric Epidemiology, 51*(9), 1233–1245.

Van der Voort, T. Y. G., van Meijel, B., Goossens, P. J.J., Hoogendoorn, A. W., Draisma, S., Beekman, A., & Kupka, R. W. (2015). Collaborative care for patients with bipolar disorder: randomised controlled trial. *The British Journal of Psychiatry, 206,* 393–400.

Van Orden, M., Hoffman, T., Haffmans, J., Spinhoven, P., & Hoencamp, E. (2009). Collaborative mental health care versus care as usual in a primary care setting: a randomized controlled trial. *Psychiatric Services*, *60*(1), 74–79.

Van Meter, A. R., Moreira, A. L. R., & Youngstrom, E. A. (2011). Meta-analysis of epidemiologic studies of pediatric bipolar disorder. *The Journal of Clinical Psychiatry, 72*(9), *1250-1256*

Van Meter, A. R., Youngstrom, E. A., Birmaher, B., Fristad, M. A., Horwitz, S. M., Frazier, T. W., ... & Findling, R. L. (2017). Longitudinal course and characteristics of cyclothymic disorder in youth. *Journal of Affective Disorders*, *215*, 314–322.

van Zaane, J., van den Berg, B., Draisma, S., Nolen, W. A., & van den Brink, W. (2012). Screening for bipolar disorders in patients with alcohol or substance use disorders: performance of the mood disorder questionnaire. *Drug and alcohol dependence*, *124*(3), 235–241.

Vogel, W. (2000). Early onset bipolar disorder: Review article. Journal of Depression and Anxiety, 3, 19–20.

Vöhringer, P. A., & Perlis, R. H. (2016). Discriminating between bipolar disorder and major depressive disorder. *Psychiatric Clinics*, *39*(1), 1–10.

Vojta, C., Kinosian, B., Glick, H., Altshuler, L., & Bauer, M. S. (2001). Self-reported quality of life across mood states in bipolar disorder. *Comprehensive psychiatry*, *42*(3), 190–195.

Von Elm, E., Altman, D.G., Egger, M., Pocock, S.J., Gotzsche, P.C., Vandenbroucke, J.P., & Strobe Initiative. (2014).The strengthening the reporting of observational studies in epidemiology (STROBE) statement guidelines for reporting observational studies. *International Journal of Surgery, 12*(12), 1495–1499.

Wassenaar, D. (2006). Ethical issues in social science research. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.). *Research in practice* (pp.60–79). Cape Town: University of Cape Town Press.

Wassenaar, D. R., & Mamotte, N. (2012). Ethical issues and ethics reviews in social science research. *The Oxford handbook of international psychological ethics.* London: Oxford University Press. pp. 268-282.

Watson, S., Gallagher, P., Dougall, D., Porter, R., Moncrieff, J., Ferrier, I. N., & Young, A. H. (2014). Childhood trauma in bipolar disorder. *Australian and New Zealand Journal of Psychiatry 48(6),* 564–570.

Weber, H., Kittel-Schneider, S., Gessner, A., Domschke, K., Neuner, M., Jacob, C. P., ... & Baune, B. T. (2011). Cross-disorder analysis of bipolar risk genes: further evidence of DGKH as a risk gene for bipolar disorder, but also unipolar depression and adult ADHD. *Neuropsychopharmacology*, *36*(10), 2076.

Weiss, B., & Garber, J. (2003). Developmental differences in the phenomenology of depression. *Development and Psychopathology*, *15*(2), 403–430.

Weiss, R. D., Griffin, M. L., Greenfield, S. F., Najavits, L. M., Wyner, D., Soto, J. A., & Hennen, J. A. (2000). Group therapy for patients with bipolar disorder and substance dependence: results of a pilot study. *The Journal of Clinical Psychiatry, 61*(5), 361-367*.*

Weissman, M. M., Wolk, S., Wickramaratne, P., Goldstein, R. B., Adams, P., Greenwald, S., ... & Steinberg, D. (1999). Children with prepubertal-onset major depressive disorder and anxiety grown up. *Archives of General Psychiatry*, *56*(9), 794–801.

West, A. E., Weinstein, S. M., Peters, A. T., Katz, A., Henry, D., Cruz, R., & Pavuluri, M. (2014). Child- and family-focused cognitive-behavioral therapy for pediatric bipolar disorder: A randomized clinical trial. *American Academy of Child and Adolescent Psychiatry 53(11),* 1168–1178.

WHO. (2013). Comprehensive mental health action plan. 2013-2020.

Wilens, T. E., Biederman, J., Forkner, P., Ditterline, J., Morris, M., Moore, H., ... & Wozniak, J. (2003). Patterns of comorbidity and dysfunction in clinically referred preschool and school-age children with bipolar disorder. *Journal of Child and Adolescent Psychopharmacology, 13*(4), 495–505.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* United Kingdom: Open University Press.

Wills, C. (2014). DSM-5 and Neurodevelopmental and Other Disorders of Childhood and Adolescence. *Journal of the American Academy of Psychiatry and the Law, 42(2),*165-172.

Winslade, J., Crocket, K., & Monk, G. (1997). The therapeutic relationship (Abstract). psycnet.apa.org

Woodcock, C. (2010). The listening guide for coaching: Exploring qualitative, relational, voice-centered, evidence based methodology for coaches. *Coaching: An International Journal of Theory, Research and Practice*, *3*(2), 144–154.

Wright, K. A., Lam, D., & Brown, R. G. (2008). Dysregulation of the behavioral activation system in remitted bipolar I disorder. *Journal of Abnormal Psychology*, *117*(4), 838.

Yan, L. J., Hammen, C., Cohen, A. N., Daley, S. E., & Henry, R. M. (2004). Expressed emotion versus relationship quality variables in the prediction of recurrence in bipolar patients. *Journal of Affective Disorders*, *83*(2–3), 199–206.

Yen. S., Stout, R., Hower, H., Killam, M.A., Weinstock, L.M., Topor, D.R., … & Keller, M.B. (2016). The influence of comorbid disorders on the episodicity of bipolar disorder in youth. *Acta Psychiatrica Scandinavica, 133*(4), 324–334.

Yung, A. R., & McGorry, P. D. (1996). The prodromal phase of first-episode psychosis: Past and current conceptualizations. *Schizophrenia Bulletin 22*(2), 353–370.

Zarate, C. A., Tohen, M., Land, M., & Cavanagh, S. (2000). Functional impairment and cognition in bipolar disorder. *Psychiatric Quarterly*, *71*(4), 309–329.

Zaretsky, A., Lancee, W., Miller, C., Harris, A., & Parikh, S. V. (2008). Is cognitive-behavioural therapy more effective than psychoeducation in bipolar disorder?. *The Canadian Journal of Psychiatry*, *53*(7), 441–448.

Zhang, L., Norena, M., Gadermann, A., Hubley, A., Russell, L., Aubry, T., ... & Palepu, A. (2018). Concurrent disorders and health care utilization among homeless and vulnerably housed persons in canada. *Journal of Dual Diagnosis*, *14*(1), 21–31.

Zimmerman, M., Galione, J. N., Ruggero, C. J., Chelminski, I., Young, D., Dalrymple, K., & McGlinchey, J. B. (2010). Screening for bipolar disorder and finding borderline personality disorder. *Journal of Clinical Psychiatry*, *71*(9), 1212.

APPENDICES

Appendix A: DSM-5 Diagnostic Criteria for Bipolar I and II and Cyclothymic Disorder

(Source: American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing, Inc).

Bipolar Disorder I

Diagnostic Criteria

For a diagnosis of BD, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode

A. 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 1 week and present most of the day, nearly every day (or any duration if hospitalisation is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behaviour:

   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal directed activity).

7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to physiological effects of a substance (e.g. a drug or abuse, a medication, or other treatment) or to another medical condition.

NOTE: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

NOTE: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Bipolar II Disorder

Diagnostic Criteria

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

Hypomanic Episode

A. A distinct period of abnormally or persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behaviour, and have been present to a significant degree:

   1. Inflated self-esteem or grandiosity.

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalisation. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physical effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, not necessarily indicative of a bipolar diathesis.

NOTE: Criteria A-F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of Bipolar II disorder.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from the previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feels sad, empty, or hopeless) or observation made by others (e.g. appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or a decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain).
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilty about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar II disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive in addition to normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgement based on the individual's history and cultural norms for the expression of distress in the context of loss.

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A-D under "Manic Episode" above).

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A-F under "Hypomanic Episode" above) and at least one major depressive episode (Criteria A-C under "Major Depressive Episode" above).

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorders.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Cyclothymic Disorder

Diagnostic Criteria

A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.

B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.

C. Criteria for a major depressive, manic, or hypomanic episode have never been met.

D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Appendix B: List of questions used to guide semi-structured interview

The following questions were used to guide the semi-structured interview:

- What brought you to therapy with the psychologist?
- Have you had help for this issue/problem before?
- Who do you consider important in your life?
- Do you feel your condition affects those close to you and if so, how?
- How did you experience having those close to you being involved in this process?
- Have your relationships with those close to you changed since you started working with the psychologist?
- How did the help you received before differ to what you have done/are doing with the psychologist?
- What did you find helpful about the way you worked together with the psychologist and psychiatrist?
- What did you like most about the way you worked together?
- Have you noticed through this process that you have gained any coping strategies or skills and if so, would you like to tell me about them?
- Were there things about the way you worked together that you would have done differently?
- What was it like being included in the correspondence with other medical professionals and your parents/child/significant other?
- Do you think about yourself and your life differently since starting this work? If so, how?
- If you had to tell someone else about your work together, what would you say?
- Would you recommend this kind of work to others, if so, why?
- If I were to use the phrase ‘quality of life’, how would you understand it?
- Do you feel that the quality of your life has changed in any way since working with the psychologist and psychiatrist?

Appendix C: Letters to participants

Insert applicable letters, e.g. Invitation letter

Appendix D: Consent from the Treatment Centre

Insert applicable forms

Appendix E: Participants’ consent forms

Insert applicable forms

Appendix F: Repeated Phrases/Words in interviews

Interview	**Repeated Phrases/Words**
Interview 1	Problematic
Interview 1	Perfection/Perfect/Perfectly
Interview 2	The condition/My condition/A condition
Interview 2	Understanding/Understand
Interview 2	Clear/Clarity
Interview 2	Safe/Safe space
Interview 3	Communicate/Communication
Interview 3	Understand/Understanding/Understood